**DHEC COVID-19 Vaccine Update and Q & A with Dr. Linda Bell**

**February 10, 2021**

**Cristi Moore:** Welcome to DHEC's February 10th media briefing on Covid-19 vaccine in South Carolina. I’m Cristi Moore, DHEC chief communications officer, and I’ll be facilitating today's briefing with Dr. Linda Bell, state epidemiologist, and Nick Davidson, DHEC senior deputy for public health.

Dr. Bell will provide today's update followed by as many previously submitted questions as we can get to, and if time allows, I’ll open it up for questions at the end. Before we begin, I’d like to ask you all to please remain on mute. Dr. Bell, I’ll turn it over to you to provide today's update.

**Dr. Bell:** Thank you Cristi, and good afternoon everyone. I will give a brief update on a few items, and then Nick Davidson and I will try to answer as many of the questions that have been submitted as we can in the time allowed.

We continue to receive a lot of questions from members of the public, from the media, from elected officials and others about when and how certain people will be included in certain phases of the state's vaccination plan. I know there's been national attention about the CDC considering smokers to be among those individuals with conditions that increase the risk for Covid-19 complications. We're also receiving requests about when people with certain medical conditions or certain disabilities will be included in our state's vaccine phases. As you know, South Carolina, like most states, has a vaccine advisory committee that helps make state-specific recommendations for the fair, equitable and ethical distribution of the Covid-19 vaccines. The vaccine advisory committee is that- it is an advisory board- it doesn't make our state's final phase decisions, but the vaccine advisory committee that I’ll refer to as the VAC is a key part of our state's vaccination planning. The VAC is composed of about 40 individuals who were selected to help represent the state's various communities and constituencies. We have representation from educators, from physicians, from various sub-specialties, the Office of Rural Health, PASOs, which is a Latino community partner, ABLE SC, which is an advocacy group for people with disabilities, the Office of Minority Affairs, Palmetto AgriBusiness, the faith community, the NAACP, and many others serve on the VAC.

We are currently meeting every other week to discuss how the limited doses of vaccine can best be distributed in a fair and ethical way to protect those at highest risk of exposure or complications. First, these are really difficult decisions that need to be made until more vaccine is available for everyone. The VAC receives questions and input from the public and others, and as a body we consider the input and make recommendations for those who should be included in which phase. And again, these are very difficult decisions, because there is simply not enough vaccine at the national or the state level at this time to meet the demand.

While the VAC has made its recommendations for phase 1B, which are available on the DHEC website, phase 1A is the only guidance that has been finalized and formally adopted in the state. DHEC is working to follow evidence-based guidance in making decisions about groups to include in each phase, while considering the logistics of how to meet those expectations. But our number one priority is to save lives, so we can't state with any certainty as to when people in very large and ill-defined groups like smokers will be eligible to receive vaccine. I know that's frustrating for people to hear, because everyone wants to know exactly when they or someone they love or someone who has a health condition or disability can receive their shots, and we really of course wish that there was enough vaccine to provide for everyone right now, but there just isn't.

There are also a lot of unknowns right now with regard to vaccine production and when the state's allotments will increase, and when new vaccines will receive their emergency use authorization and become available to the public

But DHEC also remains dedicated to ensuring that those individuals included in phase 1A in our rural and underserved communities are receiving their fair access to the vaccines.

I’d like to update that as of yesterday, DHEC has held 134 vaccine clinic events with 17,052 vaccinations given. Of those, 79 clinic events were in predominantly rural counties with a total of 9,982 vaccinations given. We also have 88 Federally Qualified Health Centers across the state that are accepting vaccine appointments. The Federally Qualified Health Centers, we refer to these as FQHCs, are community-based healthcare providers that receive federal funding to ensure primary care services are available in underserved areas.

We're also working with other rural health care providers, pharmacies and other partners who provide services for under-resourced populations. Additionally, DHEC has a public health department in every county of the state, and we're continuing to offer vaccination clinics at as many of our health department sites as often as we can with the vaccine allotments that we have, with many of these taking place in our rural counties like Barnwell, Bamberg and Edgefield counties. Our health departments also serve as regional hubs to help connect hospitals and providers at the local level to vaccine resources. And so with that update Cristi, I believe that we can take questions now and I thank everyone for their attention this afternoon.

**Cristi Moore: Thank you Dr. Bell. We're going to get to our previously submitted questions, so Nick this first one is actually for you. Does DHEC know why shipments were delayed in major hospitals this week, and secondly do we expect those delays to continue?**

**Nick Davidson:** We do want to be clear that any hospital who experiences shipping delays, the shipment delay is due to the ability of the manufacturer and the federal government to get that vaccine shipped to those facilities. The majority of the hospitals in our state receive their vaccine directly from the federal government and through those vendors each week. DHEC does not have a hand in that.

We're aware that there were issues with getting Pfizer shipments from the manufacturing location in Michigan, I believe, out on time this week, and we're still determining exactly the cause of that shipping delay. I do know you know you can visit our vaccine allocations web page and click on our “by facility” spreadsheet all see all the facilities that are listed as direct ship facilities, but I believe we we've learned that we had at least 14 facilities that were delayed that shipment, and we fared somewhat better than some of our neighboring states as I understand. I believe there are a total of 12 states that did not receive their shipments, or at least not their entire shipments yesterday.

It's important to realize the tempo for the shipments from the manufacturers via the federal government. The first doses must be ordered by the state by Thursday of each week, and those first doors doses arrive in the state on Monday. Those second dose deliveries must be ordered by the state on Sunday and those second doses arrive in the state on Wednesday, so I do want to take just a minute to mention that it's really important that all vaccine providers, hospitals, local clinics, everybody be administering shots as quickly as possible, to get it out to many as many people as possible. We want shots in arms, but it's also important to understand that we've urged that all providers do so in an appropriate way, and not doing walk-in clinics or large-scale events. We want to make sure that this is done on a scheduling basis, there is a very limited amount of vaccine in all states and we want to make sure that people aren't turned away, that there aren't people believing that there's something for them that there isn't, so those appointment-based clinics are absolutely the way to go until the vaccine supply exceeds demand. We have continued to advise against doing otherwise. We've sent several reminders to facilities and providers around the state that all vaccine administrations should be done on an appointment basis, so that so that they also can ensure that they have enough first and second doses for the clients that come to them.

**Cristi Moore: Thank you Nick. Dr. Bell we are hearing reports of people who aren't currently in phase 1A receiving their vaccines. We've heard of some teachers who have already been vaccinated and some viewers are upset about people skipping the line, what is DHEC’s response to this?**

**Dr. Bell:** DHEC has provided very clear guidance to all of those that we onboard to receive the vaccine that they follow the recommendations from DHEC for who to include in the current phase. And that's because those phases were designed to reach those first who are at highest risk.

We do recognize though that some people, perhaps by their occupation, may fit into another category and so they may be vaccinated under those criteria. We also recognize that with the very limited supply of vaccine that we don't want to waste any doses, so there may be an occasional individual who receives a dose of the vaccine that is not currently in the phase. But we continue to work with our providers and reinforce the importance of the fact that there should be no pattern of behavior where people are routinely administered the vaccine out of the phase, and that we ask providers to find ways to have advanced planning for doses that are left over, to have a call down list for people who are eligible to those doses. We strongly discourage others from attempting to skip the line because we are trying to reach those first who are at highest risk of exposure.

**Cristi Moore: Dr. Bell, based on CDC's statistics, coronavirus would be the third leading cause of death in the United States behind heart disease and cancer. Is it unusual for an infectious disease to be this high on the list, and what would you say to someone who hasn't taken the virus seriously?**

**Dr. Bell:** Well yes this is quite unusual, and this is what happens when novel viruses emerge. The way that pandemics occur is because a completely new virus emerges, and there is complete susceptibility in in a worldwide population, meaning that no one has been exposed to this virus before and no one has immunity. And so it's under those circumstances that we see very high rates of transmission and deaths. If the virus is particularly virulent, which we all know that the virus that causes Covid-19 is, what I would say to those who aren't taking it seriously is that we provide the statistics about the number of deaths and hospitalizations. Those are real and that's a real picture that many people can appreciate, but I think I would also add in asking people to take this seriously that there's a background picture that many people may not be aware of, and those are the potential long-term consequences of Covid-19 infection.

We recognize this virus is rather unique in being able to affect almost any organ system in the body, so a picture that people might not be seeing that they should take seriously is long-term consequences of the heart, the lungs, the kidneys, neurologic complications. There are reports of blindness due to clotting in the blood supply to the eyes, there are prolonged recoveries that many people experience, there's everything from hair loss, we're increasingly aware of multi system inflammatory syndrome in children, and I can go on and on with the list. I only mention these selectively to ask people to take this seriously. It is a leading cause of death now and we can prevent these complications deaths and hospitalizations by taking this seriously and practicing the prevention measures consistently and correctly.

**Cristi Moore: Dr. Bell, when will DHEC decide, I know you spoke to this a little bit in your update on whether smokers will in fact be in 1C with the underlying health conditions.**

**Dr. Bell:** This is an interesting consideration, because smoking is a behavior, it's not a diagnosis. It is a fact, however, that smoking has been shown to increase the risk of complications if someone is infected with Covid-19. However, the concern about smoking is the underlying conditions that it causes. We know that smoking causes heart disease, it can contribute to high blood pressure due to hardening of the arteries, and it results in other complications, so we have very strong data about these other underlying health problems that are associated with smoking that we will be able to address. We will have a diagnosis to be able to target individuals who have those underlying problems.

When we think about smokers, this is such an ill-defined category because the risk could be dependent on how much you smoke, how long you smoke, and there would be no easy way to verify that someone was a smoker to include them in a phase. At this time creating a phase, or putting people who smoke in a phase to be vaccinated, is not as logical as addressing the underlying health problems for which we have abundant data showing that there are also increased risk, so we continue to advise people that they should not smoke and as we roll out the phases we will give a consideration to those diagnoses that we can verify in terms of including people when they should be vaccinated.

**Cristi Moore: Nick, if South Carolina teachers are moved into phase 1A, when can they reasonably expect to be vaccinated, and how will those teacher doses be obtained? Will there be mass vaccination clinics for teachers?**

**Nick Davidson:** There have been a lot of changes to that bill if you've been watching it closely over the past week or so. As far as the logistics go, I think it's difficult to answer that part of the question, just because we have to see how that bill turns out. At the same time, my understanding is at this time that teachers and daycare workers would be added to phase, the way it's written right now, would be added to phase 1A. So if that were the case, all individuals in phase 1A would try to schedule their appointments just like anybody, just like any of the elderly folks, like any of the people who are at risk, like any of our medical responders. As far as how soon they could be vaccinated, frankly, it all depends on the amount of vaccine that we have available to administer. And so I think it's important for us to understand the numbers and the facts and the figures behind this.

Currently in 1A, not including teachers, the current 1A has approximately 1.3 million South Carolinians in it. If you look at the number of people that we have vaccinated based on the number of first doses that we have out there, it's about 470,000. So not even yet a half a million of 1.3 million people have been vaccinated. Now not everybody's going to want to take it, we understand, but if you do the math and you know assume even 70 or 80 percent take it, there are a lot of people left to go in 1A, so if we're to save lives, it's all about vaccinating those people. As Dr. Bell has said a number of times, it's all about vaccinating those people who are most at risk. Teachers are not currently in 1A because of their level of risk. We need to focus now on those that are most at risk.

**Cristi Moore: Thank you Nick. And what is the current status on the approximately 38,000 vaccine doses originally allocated to the long-term care program that the governor has deemed a surplus? When will those doses be accessible for other vaccine providers to use?**

**Nick Davidson:** Sure, good question. You're correct, just over 38,000 doses, and so the about half of those are, exactly half of the 37,800 doses is the exact number. Half of those the first doses of Moderna have been redirected to vaccine providers across the state, so we tried to spread it, we want to make sure that we're reaching our both rural our underserved, minority communities around the state. We tried to spread that across the state as far, as wide as we could.

A large part of that 18,900 first doses went to the large pharmacy chains- Kroger, Publix, Walgreens and Walmart, because of course they have a great reach and they're in so many of our communities and so many people visit them every day. We wanted to make sure that those were immediately available to people, and so like I say we've spread them far and wide across South Carolina.

The other half of those 37,800 doses, in other words the other 18,900 doses, haven't yet been transferred out of the program, as they are second doses. W they will, as soon as those second doses are ready to be utilized, they will also be transferred out of the program so all of them are set aside, ready to use across the state, because we've determined that we don't need them in that long-term care program. They weren't going to be used. So we want to put the shots in people's arms when they're going to be used, and like I say half of those are first doses and half of those will be second doses.

**Cristi Moore: Thank you Nick. Dr. Bell, where do people with disabilities currently stand in the state's vaccine plan, and secondly, was this population ever a category specifically named in any prior versions or drafts of the plan?**

**Dr. Bell:** Individuals with disabilities is a very broad category, and I guess similar to the question about the smoking, we understand that individuals with certain disabilities have been shown to have an increased risk of complications should they be infected with the virus that causes Covid-19. However, there are other individuals who can be categorized as disabled for whom there is no increased risk demonstrated from data that they are more likely to have complications. So when we think about those with disabilities, we've had numerous discussions about that potential risk but they have not ever been categorized by DHEC in any prior version of the drafts. We have had those discussions, but when we look at individual disabilities to include them as a whole, we are potentially putting those who could be categorized as disabled ahead of individuals who have underlying medical conditions like heart disease or diabetes or things like that. Individuals who are not disabled, but who have underlying condition, behind people who have disabilities, like things like hearing loss, there are just a number of conditions that can be considered as a disability but they're not an increased risk for Covid-19, and so in the rollout of the phases this is another significant challenge in making these difficult decisions. We will continue to focus on reaching those first including individuals within the disabled population for whom we do have strong data like down syndrome, like medically fragile children, and others where there's data to show that they're at increased risk. Their care providers have been prioritized and we'll continue to work to reach those for whom we have data showing they're at highest risk with vaccination as soon as the vaccine supply allows.

**Cristi Moore: Dr. Bell do you regret instituting the phase system in South Carolina, and secondly in hindsight would it have been easier to simply roll out vaccines by age bracket like the United Kingdom?**

**Dr. Bell:** No, I don't think we should have any regrets about following science-based recommendations from the advisory committee on immunization practices that make recommendations to the CDC about how the vaccine should be rolled out in phases. Following that guidance is what allowed us to target those first who are at highest risk of being exposed among our health care workers, our frontline emergency medical responders, and individuals in a long-term care setting. So if we had not had a phased roll out and we had just done it simply by age brackets, I think we could have had a situation where individuals who are the most mobile and have the most access to services could have received the vaccine ahead of others, including our health care workers, including those in long-term care facilities. So our deliberate plan to roll this out to reach those first and to provide access to those who have limitations, I think is actually a benefit to our population, to our health care system and assured that we didn't have a system where in metropolitan areas people had ready access and our rural areas would not have been well served, had we just opened it up to everyone on essentially a first come first serve basis based on age brackets. I think some of the activities that we've seen, that have been mentioned about jumping the line, speaks to the importance of having a deliberate plan to reach those who are at highest risk and to assure access to those who are disadvantaged.

**Cristi Moore: Dr. Bell, does DHEC plan to reshuffle the phases to make them more equal in size and not overwhelm the system when phase 1C launches?**

**Dr. Bell:** Nick has spoken to, we continue to re-evaluate this as we move along, and decisions have been made to include other groups as we move along. The question about reshuffling the phases to make them more equal, I would say that in our current plans we are doing a great deal to assure that equity geographically by risk group, and so in in our plans when the question is to make them more equal in size and not overwhelm the system, we are working with our health care providers so that they have as much advanced planning as possible to accommodate those expectations. In our decisions, in terms of reshuffling, we are giving careful consideration to the logistics of adding additional individuals based on the vaccine supply, the vaccine utilization and how well we're getting it out into those communities.

**Cristi Moore: Thank you Dr. Bell. Nick, when can we expect to see demographic data be made available for vaccine distribution in the state?**

**Nick Davidson:** Thanks Cristi, I appreciate that the vaccine demographics dashboard that we have is being finalized. I know we've had a lot of questions about, it's very interesting, it's a point that a lot of people are interested. I know we have the data clearly, that data is being captured and our web teams are using the raw data from the two systems that we have, both VAMS that I think most people on this call are probably familiar with, and SIMON, which is the electronic way that we use to keep track of immunizations across the state, and also the federal Tiberius system as well, because we want to provide information that's complete and also of course accurate. So we will, I believe that dashboard that we're working on is being demonstrated internally as we speak, and so we'll make sure it's in a user-friendly fashion and that it's displayed in a way that people can understand it. But it's in short order now.

**Cristi Moore: And Nick, also as the CDC continues to make upgrades to the VAMS system, any update on which scheduling tool DHEC thinks it will stick with?**

**Nick Davidson:** Yes, we're continuing to look at and evaluate the upgrades to VAMS. They have been pretty significant I have to say, because I do know that that federal system, VAMS, there have been a lot of concerns with it. There's challenges to the system, and so it, the new system of the new version of VAMS, appears to be making it quite a bit easier. So again we're still evaluating it, but for example, you won't need an email address to access an appointment in the system, and that was a major issue, still is a major issue around the state when VAMS was initially launched and people began making appointments. So we have VAMS points of contact that we're working with and we're trying to stay connected so that we fully understand the system, because we want to use that which is the easiest for people to use, because the easier the system is to use the faster people can get an appointment and the faster that we can get shots in arms. So like I say we're basically, right now, weighing the best options between the significantly improved VAMS and our new scheduling system that some of you may have seen. We've been piloting it in only in our DHEC sites, so we will see which one provides the best experience for people- easiest, fastest, and of course accurate data that we can get from it. And that's the system we'll be deploying, but certainly expect to announce that soon, we just want to make sure we do it right.

**Cristi Moore: Thank you Nick. Dr. Bell this will probably be the final question: can you give further clarification into the reasoning behind adding additional groups at this point to phase 1A when our weekly allocations have had minimal growth?**

**Dr. Bell:** Yes, well as more and more people are vaccinated, and in fact we're at more than half a million doses administered in the state now, that means that we can steadily open up vaccine appointments to more and more people. But we have to be careful and really calculated about this, because the vaccine doses are still very limited. But we know that those 65 and older are among those most at risk for dying or developing severe complications from Covid-19, and our number one priority is to prevent additional deaths. So as we add more groups, it does give more people at least an opportunity to make an appointment. But we understand that does not mean that the supply will increase, but it does give others for whom there was previously a barrier a chance to be vaccinated.

**Cristi Moore: Thank you Dr. Bell, and Nick I’m actually gonna toss one more back your way. What kind of strain would be placed on the state's distribution if educators and teachers were bumped into phase 1A?**

**Nick Davidson:** Okay, I believe the estimate for teachers and day care workers, and I know the numbers have varied, but for the perspective of this conversation around 150,000 individuals, teachers and daycare workers. So it's really important to understand that adding a large amount of people to an already large group that I talked about earlier, 1.3 million people, would mean that vaccine appointments would not be immediately available to everyone who is in phase 1A, because they would all be vying for a very limited amount of vaccine.

I certainly understand there's a desire to bring normal normalcy back to the classroom, but I also think that we need to understand that those that are currently in 1A are in there because of the level of significant risk for severe illness and death that they face. It is a fact that by having more people in that category, it will mean it will be harder and it will take longer for the most at risk to get their vaccine.

**Cristi Moore: Thanks Nick, and do you have a little bit more time we can answer a few more questions? Considering the actions taken in the legislature on how doses should be allocated statewide, does the administration still plan to present plans to the board tomorrow on the logistics of a strict per capita distribution?**

**Nick Davidson:** Yes we do understand, the board certainly asked us last time, they considered the various models of the two models that were presented, understanding that they were most interested in hearing us come back and discuss with them the logistics of doing the per capita model by county. So yes, we'll be doing that with them with them tomorrow Cristi. I know I do have a call with one of our federal DHHS partners, so I probably should break away so it's not to be more than a couple minutes late for that.

**Cristi Moore: Dr. Bell do you have time for just a few more questions? Let's see if we can get to two more questions and I appreciate the extra time for our media partners today. For people who are about to get their first dose of the vaccine, how is the vaccine's efficacy impacted if they have to wait months for their second dose, and secondly is this becoming a more widespread scenario now that vaccine appointments have opened to more populations?**

**Dr. Bell:** Well for the first question, if they're able to get their first dose and they can't get an appointment for the second dose within that really strict window of either 21 days or 28 days depending on which product they received, it's actually okay to receive the second dose a few days before or for as long as six weeks after the second dose. They would not have to start the series again if they are delayed in getting the second dose, and it should not significantly impact the body's immune response to the second dose. This is something that we actually frequently do with other vaccines that are administered as a series of more than one dose, that it's okay. You don't want to go too far inside of the minimum interval, but exceeding the maximum interval is not is not a significant worry with the efficacy of the vaccine.

As to whether or not this is becoming a more widespread scenario, we are asking providers when they schedule the first appointment to please make the second appointment at the time of the first, so that the individual can ideally return to the same setting to make sure that they get the second dose with the same product and that they simplify that appointment system. I really can't speak to whether or not this is becoming more of an issue more of a widespread scenario, because I do know that we are making improvements with our appointment system. It just depends on the planning of some of the providers, hoping that they will, as recommended, schedule that second appointment along with the first one.

**Cristi Moore:** Thank you Dr. Bell and I know you've got a call to get to, so that'll be the last question for today. I would like to thank you for joining us, for Nick who's already hopped off, and our media members for your time today and your dedication to share clear accurate and timely information with fellow South Carolinians. We will continue our Covid-19 vaccine discussion later this week. Thank you all for attending today's briefing.