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

**February 24, 2021**

**Cristi Moore:** Welcome to DHEC’s February 24th media briefing on Covid-19, 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’s senior deputy for public health. Nick Davidson will provide a brief update, followed by a segment of questions. Before we begin, I'd like to ask for everyone to please remain muted. Nick I’ll turn it over to you now for today's update.

**Nick Davidson:** Great, thanks so much Cristi, I appreciate it and hello everyone.

Good afternoon, there are two topics I'd like to mention briefly up front, and then we'll get to answer as many of your questions as is possible.

The first topic is one that we've been receiving several questions about, and that's vaccine waste. All providers are expected to document instances of vaccine waste into VAMS, there are a few examples or categories that we can list. Those are unusable doses, and so these are considered broken vials or syringes lost or unaccounted for, vaccine open vials but the vial is not administered, and then vaccine that is drawn into the syringe but not administered.

The wasted doses reported by providers into VAMS is really quite minimal for our state, compared to the roughly 800,000 doses that have been administered for Pfizer and Modena combined. Providers have indicated the largest contributor to an unusable dose is a broken vial or syringe, so these could be vials or syringes that were damaged during shipping or transfer to storage freezers, or they could be dropped while being handled or probably a variety of other reasons. Frankly, the doses reported as wasted because of broke of a broken vial or a syringe is 2,619 doses of Pfizer and Moderna combined, and of course remember that when a vial is broken that would be five or in the case of Modena and now six for Pfizer. Or in the case of Moderna, ten, so even one broken vial or certainly can add up pretty quickly. That's a pretty minimal amount when you consider that in particular.

The next highest reported reason for waste is an open vial, but not all doses are administered, and that's 815 doses combined. I think if I’m running a clinic, that's the one that is probably the one that I’m most concerned about, because particularly as I get toward the end of that clinic, I might have doses left over. So to get to a number that low across the state, over almost frankly almost a million doses, is really impressive of the work that our providers are doing.

Vaccine drawn into the syringe but not administered is reported as 177 doses, and then lost or unaccounted for vaccine doses total just 19. So we're really proud of all the efforts that our providers are taking to keep vaccine wastage to a minimum. When you look at them, they're really tiny vials, and you know you're wearing gloves, and so manipulating all that can be really challenging too. So clearly the providers that are doing it are doing so with great training and with great finesse, and so they're really working to handle them. Storing them appropriately, certainly taking every bit of last effort that we can make to ensure that every dose that we have available to us gets used. We have provided guidance to providers on safe handling and storage, and we're really appreciative of how much our providers are following that guidance. And that’s each vaccine manufactures guidance, because that's a little bit different between Pfizer and Modena, and again making sure that every last drop feasible gets into arms as quickly and safely as possible.

Second topic I'd like to briefly touch on is a recent discussion related to Horry County Fire and Rescue. We're continuing, we continue really, to value the relationship we have with Horry County Fire and Rescue. They're providing absolutely necessary services under some really challenging conditions across their community, and the same goes really for all of our providers, essential services that they're providing to both protect everybody day-to-day but also protect them through our state vaccination efforts. We want to get vaccine into the arms as quickly as possible. We certainly have to do this carefully, it has to be in a phased approach, because our doses are so limited right now it's critical for all providers to vaccinate within the state's guidelines and recommendations. The agency, you know we're going to continue to reserve the right to limit vaccine allocations if we determine providers are knowingly choosing to not follow state guidelines, but we're going to continue to work with Horry County officials just as we have been to move forward in our ongoing mission to save lives across the state. With that Cristi I’ll stop and hand it back to you.

**Cristi Moore: Thank you Nick, and at this time our public health experts Dr. Linda Bell and Nick Davidson will answer questions that we've received. The first several questions are going to be for you Nick. So first question- is there a time frame for when the agency will decide to go with VAMS or the developed appointment scheduler?**

**Nick Davidson:** We've had an awful lot of meetings about that recently. I'd love to be able to share an exact date, I just don't have it yet. We are, as I've said previously on these types of calls, we want to make sure we do it and we do it well, and that it doesn't interrupt or put a burden or difficulties in the way of providers. So, no date yet but we're actively discussing that, I promise you that.

**Cristi Moore: Did the anticipated upgrades take place over the weekend as expected, and are there any VAMS upgrades expected in the future?**

**Nick Davidson:** Those upgrades did take place in VAMS, they haven't heard about any problems with them and no I actually am not aware of future upgrades that are planned for the system at this time. I’m not saying that certainly there aren't some in the works potentially but I’m not aware of any that are pending.

**Cristi Moore: Have providers been informed of the VAMS upgrades, and secondly what were hospitals’ reactions?**

**Nick Davidson:** Providers and facilities that use VAMS got email notifications to indicate that the system essentially is taken down for a very short period of time, kind of the middle of the night on a Saturday type of a thing, and those notices came very early on. They're all additions that should do nothing but make it easier for clients and providers to use the system. For instance, you know, not requiring emails, so if you're calling to make an appointment and you're using VAMS to schedule that that appointment taker can make the appointment for you regardless of whether you have email or not. So we certainly haven't heard any negative feedback, and everything we've heard has been along the lines of it being helpful as far as the upgrades go.

**Cristi Moore: Has DHEC given any guidance to providers about how they should go about scheduling second doses, and then are providers encouraged to schedule those second doses once they get their first?**

**Nick Davidson:** Absolutely they are. We couldn't emphasize that too much I don't think. As soon as you have some, as a provider has a client with them in that first clinic, whatever scheduling system that they are using because I think many or probably even most at this point in time are using scheduling systems that are simple. And for them simple means it links to their electronic medical record, for providers who use an electronic medical record, because it's a pointing system that they're used to using. So I clearly, I definitely want to make sure that I don't insinuate that VAMS is the standard that everybody is using, but for those that are using VAMS, yes it does allow providers who are using the system to schedule second dose appointments before they leave their first, and very clearly we would ask that regardless of what scheduling system providers are using that they do indeed do that. It's easiest for the patient, and that ultimately is the goal that we all have.

**Cristi Moore: Additionally, is DHEC aware of people crossing from provider to provider to get their second dose after getting their first?**

**Nick Davidson:** And I want to make sure I interpret the question correctly, but how I’m interpreting what you just said is crossing from provider to provider. I think that alludes to sort of vaccine hunting, in other words this relates to second vaccines, so if they have had their first, looking for where and how quickly they can get their second vaccinations scheduled. Vaccine hunting clearly does occur, I mean whenever there is not enough of something, people are going to look for where they can get it as soon as they can get it. Of course, you still have to adhere to the minimum spacing requirements between the vaccines, either approximately three weeks, approximately four weeks depending on which vaccine they got. But there seems to be a tendency for people to hunt if they don't have a second appointment when they leave their first, so it almost goes back to the last question and us urging, and I know providers are doing this, but continuing to remind folks that the vaccine allocations will also be much more predictable if we can ensure that people are coming back to the place where they got their first dose. And that can most easily be done if they get an appointment before leaving their first appointment.

**Cristi Moore: Okay, since the second dose allocations are equal to the first dose allocations, do you have any concerns about clinics squeezing too many doses out of the first and then not being able to get as many out of the second dose, leading to a shortage of second doses?**

**Nick Davidson:** Right, no, I really don't. Frankly there are times when somebody may get, let's just take Modena, somebody may get an 11th dose out of a Modena vial, there may be times when they will and times when they won't. I think that is probably about the same for any given vial, so the chances of that happening is probably somewhat random. And based on, of course, the ability and the supplies that they have, I’m much less concerned about it now. Because for the Pfizers here, which are now officially labeled as six doses per vial starting this past week, the supplies being shipped with those vials do ensure that providers can get, if you will, every last drop of all six doses out of that vial. I think it's even less concerning now.

**Cristi Moore: Thank you Nick. The next few set of questions are for Dr. Bell. Yesterday Dr. Simmer told the ways and means subcommittee that Phase 1B is projected to formally begin in two or three weeks. In terms of a percentage how much of Phase 1A is expected to be vaccinated by the end of the phase?**

**Dr. Bell:** Thank you Cristi. We actually are looking at the demand for vaccine instead of the percentage of people covered who are estimated in Phase 1A, so for example we want to make sure that we have vaccinated the majority of people who are seeking vaccination and the way that we'll monitor that is by looking at appointments that are being requested. And so once we see that appointments are beginning to drop off, meaning that the demand is better matching the supply, then we will give additional consideration to transitioning from Phase 1A to Phase 1B.

**Cristi Moore: And does DHEC expect to add any groups into Phase 1B after that phase begins, as the agency did with Phase 1A?**

**Dr. Bell:** We're continually monitoring how efficiently and how effectively we are meeting the demand and the expectations, and we are continually adjusting our plans to take into consideration everything from those expectations, how well we're covering the at-risk population and the vaccine supply, so as we're learning more about anticipated increases in vaccine supply and monitoring how well we're meeting the demand, we are giving consideration to that transition time frame and this is continually under discussion and we may actually be providing an update about any anticipated changes in the near future.

**Cristi Moore: And Dr. Bell, who will be finalizing Phase 1B guidance for South Carolina since it appears that the responsibilities of the Vaccine Advisory Committee have shifted, and when can we expect Phase 1B to be finalized?**

**Dr. Bell:** Well the Vaccine Advisory Committee never had responsibility for those decisions, the Vaccine Advisory Committee always served as an advisory body to DHEC, so those decisions rest with DHEC leadership and decisions about who is included in the various phases are made by the DHEC leadership, in consultation with the governor's office, in consultation with our partners. For the feasibility of including additional groups, and taking into consideration all the logistical concerns of the vaccine supply, and all that must be taken into consideration but those decisions are made by the DHEC leadership.

**Cristi Moore: Thank you Dr. Bell. Nick the next set of questions is for you- we are currently seeing lengthy wait lists for vaccinations in urban areas while providers are struggling to fill slots in rural areas. Does DHEC plan to send additional doses to urban areas to help finish Phase 1A in a timely fashion?**

**Nick Davidson:** I think the most important thing that I want to emphasize here is that we want to make sure we're exhausting all possibilities. We want to make sure that the vaccine is getting out to every place that needs it. So I know our first attempt in areas maybe potentially more rural where we're hearing that occasionally they may not be able to fully fill those clinics, we want to make sure that we're doing everything possible to do as much outreach in those areas as we can.

I think we realize that in in you know more rural communities, it can be more difficult for messages to spread. Technology might not be as abundant, transportation might be more challenging, and so we need to frankly make sure that we're doing everything possible. And at least from DHEC’s perspective, we're going to first try harder to make sure that we are reaching everybody who needs to be reached. Now it is a balancing act so I’m not saying that we won't be providing more to areas where the demand is high, we very likely may do that, but we need to make sure that we are equitably providing vaccine across the state, and that means sometimes having to try harder in those areas where we need to. But we're going to be hearing about more vaccine coming our way next week, additional doses of vaccine, and so we will probably, if there are areas where we're not filling, we'll simultaneously work on getting more outreach there while at the very same time pushing more vaccine to areas that we know can and do need and will use it. So a combination of efforts really.

**Cristi Moore: With the Johnson & Johnson likely to be the next vaccine on the market, how does the state envision using it based on its storage requirements. And single dose administration- is it better suited for certain scenarios than the other vaccines?**

**Nick Davidson:** Right, it could be, and we're talking about that right now because certainly Johnson & Johnson and the Janssen vaccine coming as well are both single dose. Certainly more flexible with the vaccine storage and handling requirements than something like Pfizer, and so we will probably spread it pretty widely. I doubt that we're going to focus on any one particular situation, because there's probably a lot of different entities who could use it. Hospitals probably can use it for some of their patients who might be there for an unexpected reason, and it's an inpatient event and they'll be gone and so they want to take the opportunity to get them the vaccine if they qualify.

Then there could also be some communities that are more difficult to reach, where transportation could be limited, and we might be able to use it in some of those communities. So it really is probably not going to be that we target any one vaccine to any one particular area or provider, we'll probably do a fair amount of spread with it.

According to federal data, this week's allocation is supposed to be the largest of the year so far, with Pfizer and Modena first and second doses combined, but according to CDC and DHEC data we don't seem to be receiving our full allocation on a weekly basis.

**Cristi Moore: And Nick I've got a couple questions for you. The first one is why is that?**

**Nick Davidson:** We are receiving our full allocation of the full amount that we are able to. We draw down every single week, there is a system into which we see our virtual allocation provided to us midweek, and so the hospitals are ordering against that and we are pulling that down. We're pulling down 100 percent of that each week. There were a few weeks right at the beginning when the number of second doses being ordered were not quite as high as what we could theoretically be allocated. We have long since exhausted any excess that was out there in second doses, and so we pull down the full amount we're receiving each week.

**Cristi Moore: Nick can you speak to what accounts for that discrepancy between the federal data and DHEC data?**

**Nick Davidson:** Sure, there are, I think we've talked about this a fair amount, there's a small amount of long-term care facility doses that we set aside right at the beginning. I’ll remind you all, and it doesn't take a reminder I realize, but I’ll just bring to the conversation the fact that for the last two weeks with all the winter weather we've seen significant delays. We were concerned about supply problems from the very beginning and the potential for future supply problems still exists. We've seen that before in previous flu vaccine seasons for instance, and so some of the most vulnerable are in nursing homes and assisted living facilities. So right from the beginning, we wanted to make sure there was never going to be a problem with vaccine. I have a grandmother who's in one of those and so I can understand the need to make sure we protect those individuals. So we set that aside right from the beginning in a virtual allocation such that when Walgreens and CVS needs it, they pull it down. We've since seen that they have not needed all of that, because rightly so not every single resident and every single facility gets vaccinated.

We have transferred out of that allocation, that virtual allocation, and brought back into our real allocation and just combined it with the rest of it, and sent it out to our providers. We'll continue to do that, but there is a still a small amount that's that is sitting over in the long-term care facilities, and you know you can look at our website and see how much that we have received and how much we have used. That received amount has actually been decreasing, and that may seem odd but that's only because we're transferring doses out of that that are not needed. That's really the only discrepancy to be had out there, and it's not even a discrepancy, it's just an understanding of where the doses are and for what purpose they're intended. We are we expecting to receive our largest allocation yet this week, and I say we should be careful when we say this week we this week, it is slightly larger than it was last week and we've been notified that next week will be slightly larger as well. Right now we are just below 100,000 first doses when you combine Moderna and Pfizer for this week, and next week will be just above 100,000 doses combined for Pfizer and Modena both. About an 8,000 dose increase that we'll be expecting next week.

**Cristi Moore: Okay Nick, and this is the last one I have for you for a little bit, how are you all going about getting vaccines to rural area pharmacies? Some are saying that they have applied or filled out paperwork and still don't have any- is there anything else as rural area pharmacies can do to receive vaccines?**

**Nick Davidson:** Sure, and again I think I used the word balancing act previously. We currently have, I think, 217 pharmacies, and that's off of memory so be careful there, but 217 pharmacy locations that are activated providers. Activated means receiving vaccine. Sorry let me take that back- we have a little over 140 activated receiving pharmacies around the state, and there are others that want to come on, and those are everybody from Walmart to Walgreens to independent pharmacies, not even chains, as independent pharmacy stores. We have activated many around the state, but it really becomes a supply problem. You know it doesn't do us good to spread too thinly, so to get three vaccines out, and I’m exaggerating of course, but to one facility gets people's attention like oh this facility has it and now all of a sudden they don't, and we just sort of create a run on that facility and create false hope.

We're trying to get it out where we can get it out through enough entities with enough quantity, and that's part of that balancing act right now. So there are definitely more providers of all types who are ready, who say they can take vaccine, and as the vaccine doses climb so will we give more to many providers. We have given more to pharmacies over the last several weeks, particularly the big chain pharmacies, because they are coming on board and really have their mechanisms in place and they can help us do it consistently and safely and in large numbers. And then we also have probably a dozen or so independent pharmacies around the state. We'll continue to look for gaps in our coverage

**Cristi Moore: Thanks Nick. Dr. Bell what has driven the recent significant decline in the new daily Covid-19 cases in South Carolina?**

**Dr. Bell:** Well there are, there are probably several contributing factors. The first being that when you have such a significant surge as we've seen here in South Carolina nationwide, we know that once people are infected, they have a presumed period of immunity from natural infection following that infection. So for a period of about 90 days it's very unlikely to be reinfected, and when we have a virus circulating in the community the virus has a harder time finding susceptible people when you've recently had that many people who are infected.

The other factor is- I cannot overemphasize the fact that ongoing prevention measures still work. So it is my hope that people are still paying more and more attention to the use of masks and the physical distancing and the personal hygiene measures, and certainly when disease rates were really high I think that people were paying more attention to that. The other factor is probably the weather. We had a real bout here of just nasty weather and people were probably avoiding socializing in outdoor activities and group gatherings and things like that. And it's important to point out that when we limit those types of activities within a really short period of time, modifying those behaviors does drive cases down, and the fact that the weather was keeping a lot of people in could be a factor.

I think another consideration, but not yet a significant effect yet, is that once we begin to vaccinate more and more people then more and more people will have that that more long-lasting immunity. But a cautionary note is that when we look back at previous surges and then the following downward trends. Each of those surges following large holidays and whatnot. Remember we're coming off the Thanksgiving / Christmas / New Year's eve holidays that were largely driving that upward surge. When we see that downward surge people begin to relax those prevention measures, and we go right back up again.

This is really the time I want to emphasize that if we don't want to see another upward surge, we have to continue to practice all those things that have contributed to the decline in cases. Right now, when we have limited vaccine supply, that relies so heavily on people continuing to observe the use of masks, physical distancing, avoiding gatherings and whatnot. Those drive our cases down.

**Cristi Moore: Dr. Bell, on the contrary, we received a question from another outlet regarding a report that indicates cases in South Carolina remain high. The New York times is looking at the places where the outbreak is worse, according to average daily cases for the last two weeks, seven South Carolina cities have made it to the top 20. More were on the list earlier this week, and North Carolina and Georgia have several cities in the top 20 as well. How is South Carolina faring compared to the other states?**

**Dr. Bell:** I haven't actually taken an opportunity to compare our rates to other states, but I can say that within certain communities, we recognize that there is not equal distribution of cases and disease activities statewide, and within certain communities we do see higher rates

A couple of things to consider, if you look at communities with mask ordinances, in the past when we've evaluated that, we have seen that communities and county-wide mask ordinances are areas where cases fall. And when they don't exist, we have attributed, not only in our own DHEC studies but the CDC has published this data, that we see increases widespread within jurisdictions. This means at the city or county level, but other contributors. We actually monitor for disease outbreaks and we have not detected any widespread outbreaks. But it's important to note that even small gatherings, small family gatherings that may include groups of 10 or 20 people, we see transmission within those small gatherings. We see the greatest number of secondary cases within households, so those relatively small numbers in small groups within communities do drive circles of spread around those cases. And so those can be contributing factors to pockets of higher transmission within our state.

**Cristi Moore: Dr. Bell I think you spoke to this when you were answering the previous question, but is there anything else you want to add that that accounts for the elevated case numbers in the state and regionally compared to other parts of the nation?**

**Dr. Bell:** I can't say I have much to add to what I what I just said about factors that drive those increases, so I would just add that most importantly there's always a need to focus on what prevents those things that drive increases, so at the community level policies that can prevent exposure. When we look at community-wide mitigation measures, those are very effective in driving down case rates in a particular community. We look at the state as a whole, and that's how we report our numbers, and we also report them at the county level and we want people to be aware to look at their own county rates and ask themselves what more that they can be doing on a personal level and within their own jurisdictions to protect the communities that they're in.

**Cristi Moore: Dr. Bell, there are growing calls to vaccinate people with pre-existing conditions. Are they going to be considered in Phase 1B?**

**Dr. Bell:** We are continually aware of all populations who are at increased risk for exposure and who are at increased risk for complications, and those individuals who have underlying medical conditions, we know that they are at higher risk for more severe complications and hospitalizations. And as I mentioned earlier, we are looking at how to, as rapidly as possible, meet the demands of these communities at higher risk, with the ultimate goal of preventing disease morbidity, disease cases and deaths. For those individuals, and it's not just those with comorbid conditions, but we are also including individuals that we're hearing from who have underlying disabilities, individuals in certain work sectors who believe that they are at increased risk of exposure or complications. We have to take all of those groups into consideration holistically. We can't take any of those individual groups into consideration, because any decision made for one single group because vaccine supply is so limited has an impact on all those other groups who want to receive vaccine. So again, we are continually evaluating the availability of vaccine, the demands for those vaccines, and how we can most quickly open up at least vaccine appointments for those who are at highest risk. Any of those decisions will not increase the vaccine availability, but we can potentially increase the availability for at least people making appointments and that's a very important thing that we're now taking under consideration, as to how we can accomplish that sooner rather than later. But it will be several more weeks before we can make any new transitions I believe.

**Cristi Moore: Dr. Bell, the last question I have for you, how many with pre-existing conditions are dying from viruses in South Carolina, and then secondly why are they not being prioritized if they are at high risk?**

**Dr. Bell:** I don't have the data in front of me about the rates of deaths within each group of people who are at increased risk, so this would include people who have diabetes, high blood pressure, underlying heart disease, underlying lung disease. I don't have the data on the death rates within those groups. Another factor is that there are actually limitations on the availability of that information, because that comes from our case investigation interviews when we identify cases if they're interviewed, and we're not able to collect that information about those underlying conditions. Even what we have, there's a lot of missing information, and so we may actually be underestimating deaths and morbidity and mortality associated with those with underlying conditions.

The second factor, we are currently following the CDC guidance for those individuals who are in phase 1C for being between the ages of 16 and 64 and having comorbid conditions, and once again that's one of the one of the things that's under our consideration now for how we can best meet their needs more quickly.

**Cristi Moore: Okay thank you Dr. Bell. Nick I've got a question for you here: MUSC has said that they never know for sure how many doses they've gotten on shipment day until they open the box. Who is the last entity- is that DHEC, the federal government, a vaccine manufacturer, to know how many doses a provider will receive in a week before it arrives at the provider's doorstep?**

**Nick Davidson:** I’ll try to be brief because I know time for a few questions, but what I will say is that providers have to use a system called VAMS for ordering their vaccine. All providers do this each week by close of business on Tuesday. The providers enter their vaccine orders into VAMS for first doses and second doses, we find out mid-week what we're getting and then for first doses by Friday. On Friday we said we enter into VAMS what they will be receiving. Occasionally they'll get something on Friday but that's on that's not the norm. Usually they get those on Monday, and so on Friday all providers can go into VAMS and see what they will be getting.

I will say over the last couple weeks, the vaccine because of the weather has been all over the place as far as timing. So I certainly understand that this question could be somewhat rooted in that, but again on Friday for first doses all facilities can go into VAMS and see what they're going to be getting.

Additionally, VAMS has an allowance, I guess a functionality that enables providers to say that they will actually want to be notified to a particular email, so there are administrators in their system who get notifications from us through the VAMS system about vaccine delays and that kind of a thing. The system can notify them for instance on Friday when we put the information in VAMS, they can get an email. The same is true on Monday, typically, for second doses, because those ship a little bit later. So on Monday we put into VAMS what their amounts they'll be receiving, and then typically on Wednesday they receive those second dose allocations. So VAMS is clearly the way to do that. I would imagine that indeed sometimes the supplies come separate from the doses, so when they open a box, indeed they might be surprised because sometimes those are often not shipping together, they come from separate vendors. That might be a little bit of a surprise as well, but certainly we would expect that individuals if they're using VAMS, particularly if they're using the notification process that VAMS allows, that they wouldn't be surprised.

**Cristi Moore:** Okay thanks Nick, we're now going to open it up for live questions. I would ask members of the media to only ask one brief question by raising your hand and I’ll call on you by either name or phone number. Kailyn I believe you had your hand up first so please ask your question.

**Kailyn: Good afternoon everyone, so as you know earlier on there's been an ongoing concern of providers requesting doses and only receiving small portions of that due to supply and other reasons. I’m wondering with these new higher allocations that we're expecting not only this week but next week and possibly into the future, are we getting closer to that amount of what the product providers are requesting, and meeting that need- is that something that you project?**

**Nick Davidson:** We will be incrementally, frankly I think that most providers are asking for so much, and that's great they have the capacity to provide more vaccines, it's just a small portion of what they need and want. So we will, you're exactly right, begin to see more providers begin to see more. We're working to make it more predictable as far as how much they will receive each week, that predictability is, I think, probably the most important part of it. That understanding what that minimum amount that you can be essentially guaranteed. We're not doing that quite yet but we're getting close to that over the next couple weeks.

**Cristi Moore:** Morgan you've got a question?

**Morgan Newell: Yes thank you Cristi, I was just wondering how many doses CVS should be expecting from the state tomorrow.**

**Nick Davidson:** I don't have that number with me, but we can certainly get that for you. Tomorrow is a Thursday, so typically they would not be receiving doses from us on a Thursday, but we can tell you how many they have received this week already, and we probably couldn't yet tell you because we haven't finalized the allocations yet what they would be getting next weeks. But we could tell you what CVS got this week.

**Cristi Moore:** Mike you've got a question?

**Mike: Yeah thank you. When the weather delay doses arrived, it seems like with the regular doses and the weather delay we should have had a tremendous spike at some point, but I don't think we've seen that in some of our providers right? I watched the doses every day and really with the exception of this weekend, maybe saw a little bit of a drop.**

**Nick Davidson:** I was shocked last week that we didn't actually see a drop, which means that providers are doing their best to even out their clinics as the week goes along and trying to utilize their supply well. And so those vaccine deliveries- last week was the major week of delays- and actually all providers with the exception of two I think received it within one or two days of when they should have received it. There were two pharmacy chains, and for the life of me I couldn't even tell you which ones those were, that were delayed until this week. I believe they got it yesterday or the day before.

**Cristi Moore:** Judy Gatson you've got a question?

**Judy Gatson: I do, good afternoon thank you so much Dr. Bell. I was wondering about this issue of herd immunity and if I understood you earlier one of your questions you were saying obviously we are not there yet. We're seeing some conflicting information or opinions I guess from experts from Johns Hopkins and other places saying that 55 would be ideal, or maybe as low as 40 percent. Can you give us an idea about what the minimum level is that you would feel good about here in South Carolina and where we are right now in terms of reaching that number?**

**Dr. Bell:** The first thing about herd immunity- it's really not effective in terms of population-based protection, unless you get a pretty high coverage rate. At the rate of say 40 or 50 percent, the way herd immunity works is that when the virus is circulating and it has trouble finding susceptible people in a population, then disease rates will continue to decline. When you only have about half the people who are immune, then the virus has the opportunity to find about half the people who are susceptible. What we've been saying is really the goal to get up to about 70 or 80 percent is the level of herd immunity when enough people in the population would be protected that would allow us to consider relaxing these measures that we continue to reinforce.

It's not until we get to those levels when we can resume some normalcy, so until we reach that point people would need to continue to wear the mask, practice those prevention measures to prevent ongoing spread in the community, and so similarly in South Carolina that's what we would want to achieve. The projections of when we might get to those rates depend on all those factors that we have discussed- things like vaccine acceptance, vaccine availability to make sure that everybody has access, so that they can get enough people in the population to reach 70 to 80 percent who have been vaccinated to achieve that herd immunity. That would significantly diminish ongoing disease spread in our communities.

**Cristi Moore:** Madison you've got a question?

**Madison: Yeah thank you. Grand Strand Medical Center hasn't been booking their second dose appointments during their first dose appointments, and we've just been getting a lot of questions from people who are still not able to book their second dose appointments because Grand Strand says that they're not available. Does DHEC know why Grand Strand is doing this, and are there any actions that are being taken to alleviate that issue that has been going on for weeks for a lot of our viewers, since many are now seeking out their second dose from a different provider?**

**Nick Davidson:** I haven't spoken to Grand Strand directly, but I was engaged in an email, no I maybe it was a conversation about a week or so ago, that we heard that they weren't doing second dose appointments. We did reach out to them at that point in time and they confirmed that indeed they were. but they just like everybody don't have a lot of doses. Again, we have assurance that they are when they have vaccine available to them, but I know that vaccine is just awfully hard to come by. I believe providers in general, and we've heard this you know from others as well, they are really quite challenged to make sure that they have enough vaccine for the appointments that they have scheduled. Appointments are one method, but there are some facilities around the state that are also using more of what I would call a waiting list, and I always think and I’m sure you know I don't mean to tell providers how to do their job, but it is certainly something we would encourage providers to consider as to using the wait-less concept so you collect the person's desire, and when you have enough vaccine that week you then call and schedule those people into the appointments. It's a bit more labor intensive, but when we're that short of vaccine or when the demand is outpacing the supply as it is right now, that's another good way for providers to at least consider, if they haven't done so already.

**Cristi Moore:** Thank you Nick. For planning purposes, we plan to hold another 45-minute briefing this Friday and we'll send an advisory with details moving forward. We're making changes to improve our media briefings for everyone, so each week we'll hold two 45-minute briefings on Wednesday and Friday. This will allow more time for our experts to answer your questions. If you have follow-up questions, please send them to our Covid-19 joint information center and we'll work to get them answered for you. In conclusion I'd like to thank you all for your time and dedication to share the latest updates about Covid-19 and our state's vaccine rollout with South Carolinians. This concludes today's briefing, thank you.