Good afternoon. I'm Commander Ibad Khan, and I'm representing the Clinician Outreach and Communication Activity, COCA, with the Emergency Risk Communication Branch at the Centers for Disease Control and Prevention. I'd like to welcome you to today's COCA call, Updated Recommendations for COVID-19 Vaccine Use. All participants joining us today are in listen-only mode. Free continuing education is offered for this webinar, and instructions on how to earn continuing education will be provided at the end of the call.

In compliance with continuing education requirements, all planners and presenters must disclose all financial relationships in any amount with ineligible companies over the previous 24 months, as well as any use of unlabeled products or products under investigational use. CDC, our planners, and presenters wish to disclose they have no financial relationships with ineligible companies whose primary business is producing, marketing, selling, reselling, or distributing healthcare products used by or on patients. Content will not include any discussion of the unlabeled use of a product or a product under investigational use. CDC did not accept financial or in-kind support from ineligible companies for this continuing education activity.

At the conclusion of the session, participants will be able to accomplish the following: Describe current recommended vaccine doses for people ages 6 years and older; Cite where to find in-depth tables for COVID-19 vaccines indicated for children ages 6 months to 5 years; Discuss the difference in recommendations for use of COVID-19 vaccines between those with and without immunocompromise; And name two populations who can receive an optional additional dose of the updated COVID-19 vaccines.

After today's presentations, there will be a Q&A session. You may submit questions at any time during today's presentation. To ask a question using Zoom, click the Q&A button at the bottom of your screen. Then type your question in the Q&A box. Please note that we receive many more questions than we can answer during our webinars. If you're a patient, please refer your questions to your healthcare provider. If you're a member of the media, please contact CDC Media Relations at 404-639-3286 Or send an email to media@cdc.gov.

I would now like to welcome our presenters for today's COCA Call. We are pleased to have with us Commander Sarah Oliver, lead of the COVID-19 Coordinating Unit for CDC's COVID-19 Response and ACIP Workgroup Lead for COVID-19 Vaccines. Dr. Evelyn Twentyman, who's the lead of the COVID-19 Vaccine Policy Unit for CDC's COVID-19 Response and ACIP Workgroup Co-Lead for COVID-19 Vaccines. And Commander Brendan Jackson, the Incident Manager for CDC's COVID-19 Response, who will share a few updates about the end of the Federal COVID-19 Public Health Emergency Declaration. It is my pleasure now to turn it over to Commander Oliver. Commander Oliver, please proceed.

Thank you so much and happy to be here. I will note that many of these slides were discussed and topics were discussed at the ACIP meeting that was April 19th. Those slides are all publicly posted. We can't obviously go over everything on this call, but I'm happy to, in a little bit, put the links to the slides in the chat so people can have access to them. Next slide.

So this slide shows the COVID hospitalization rates by age group from our COVID-NET platform. You can see that throughout the pandemic, hospitalization rates have been the highest

among those who are ages 65 years and over. Although I do want to highlight in the most recent year that's on the far right of the graph, previously, you can see when there are surges, the hospitalization rates for all really increased and mirrored what was happening in the older adult population. But this last year, we've really seen a decoupling of hospitalization rates from the youngest to the oldest, where the younger groups remained relatively low. Next slide.

And again, this is a slide from the ACIP meeting. What I'm going to do is really go over kind of the framework and data for these updates to policy. And then Dr. Twentyman will go through in detail kind of the practical implications of these recommendations. But we continue to move towards a goal of simple recommendations.

It's not a single step that we'll be able to take. It will continue to be a process. But we've taken several important steps, and we'll walk through those today. First, the single formulation of mRNA COVID-19 vaccines, a single possibly annual dose for most individuals, and then flexibility for vulnerable populations. Next slide.

So first to discuss the single formulation for mRNA COVID-19 vaccines. Next slide. I won't go over this in detail, but again, this is a summary of data that's been previously presented at ACIP meetings, either from September of 2022 or both February or April of 2023. We know that bivalent vaccines are able to induce an immune response when given either as a primary series or as a boost for dose. Then while in the U.S. , we have limited data to compare monovalent and bivalent vaccines at the exact same time, we know from antibody studies that the bivalent vaccines show an improvement for Omicron variants and expanded diversity of the immune response. Next slide.

So updates from FDA, the authorizations for the monovalent mRNA products have been removed, and the bivalent mRNA vaccines are now authorized for all indications. I do want to note there have been no changes to the current language in the authorizations or recommendations for either the Novavax or the Janssen COVID-19 vaccines. Next slide.

So the implications for CDC recommendations. We know that a transition to bivalent vaccines could simplify the presentation, reduce administration errors, and allow continued access to vaccines with the expiration of many of the monovalent products. So bivalent mRNA COVID-19 vaccines are now recommended for all indications. Next slide.

So now to move to discussion of a single possibly annual dose for most individuals. Next slide. This slide looks at vaccine infection-induced or immunity from both in persons ages 16 years and over, over time. While there's a lot on this slide, I'll draw your attention to the green, which is those who have no prior exposure through either infection or vaccination. And you can really see that as time has progressed, that proportion has continued to decline over time and is now only a very small proportion of the population. Next slide.

This slide shows similar data, but focused on the pediatric age groups. It's not surprising that the youngest children have lower exposure to either prior infection or to vaccination. Next slide.

So as was discussed at previous ACIP meetings, for most older children, adolescents, and adults, future vaccine doses are going to be a boost after either prior infection, prior vaccination, or both. However, we acknowledge that a young pediatric population may still need multiple doses to achieve that prime then boost to the immune system. We know that plans for a fall booster dose could provide added protection at a time when many are around a year out from their last dose. And we also know that time since the last dose may both increase the benefits and decrease the risk of myocarditis. Next slide.

So updates from FDA. FDA authorized a single age-appropriate mRNA COVID-19 vaccine dose for most individuals, then authorized one, two, or three doses of a bivalent mRNA vaccine for young children. The number of doses depends on age, as well as the number and type of prior COVID-19 vaccine doses received. And never fear, we have much more information on this later in the talk today. Next slide.

So we know that a COVID-19 vaccine framework for a single dose could be easy for COVID-19 vaccine providers to implement and for the public to understand. The current recommendations for a single dose may evolve over time and could move to an annual recommendation. So a single bivalent dose is now recommended for everyone ages six years and over. Again, we'll hear more on this, but for most people, this isn't a change. If you've not received a bivalent vaccine dose, you're recommended to receive one. Now you're recommended regardless of your previous vaccine history. The children six months through five years will all receive at least two vaccine doses, including at least one of those as a bivalent vaccine. We've got tables and detailed guidance that are published in our interim clinical considerations, and again, we'll go over in a bit on this call. Next slide.

So finally, the flexibility for vulnerable populations. Next slide.

We know that older adults have higher rates of hospitalization than younger adults. And again, the population we're focusing on here is adults ages 65 and over. However, sadly, we know that among older adults, vaccination rates with even one bivalent vaccine dose remain low. It's important for older adults to be up to date on current recommendations, including receiving a bivalent booster. At previous ACIP meetings, ACIP had discussed that data were insufficient to support routine recommendations for older adults to get a vaccine dose every six months from now on but acknowledged that this population may continue to be more vulnerable to severe COVID and really needs flexibility with the vaccine recommendations. Next slide.

So that flexibility now exists in our recommendations. We know that the bivalent vaccine continues to provide protection against severe COVID, and rates of hospitalization or deaths among older adults who've received a bivalent booster continue to be low. However, some adults may benefit from an additional updated COVID-19 vaccine dose prior to possible future recommendations for updated vaccines this fall. So adults ages 65 years and over may now choose to receive another updated COVID-19 vaccine dose. Next slide.

Then there's another population that we know has been vulnerable throughout the pandemic and really has had recommendations that have differed slightly from the overall population throughout. For people who are immunocompromised, we've had additional doses

recommended, and the current updates allow for additional added protection to this vulnerable population. The updates also allow for flexibility now to adjust to an individual's specific circumstances, including timing of immunosuppression, as well as the need for possible revaccination after particular events that may have been immunoablative, such as a stem cell transplant or other things. So people who are immunocompromised may now choose to receive another updated vaccine dose, and again, have the flexibility to receive additional doses based on their clinical circumstances, and again, more details to follow. Next slide.

We also want to acknowledge that we're not done. We're not quite yet to the goal of simple recommendations. We've taken some steps. We hope to have additional steps available in the future. While these were focused on simplifications for mRNA vaccines, we look forward to simplifications for all COVID vaccines. We look forward to discussions around possible updated vaccines this fall. And we continue to evaluate data-driven ways to simplify the pediatric program. We acknowledge that across the board, that's the population that we really still have the most room to grow for the simple recommendations. However, the goal continues to be flexibility and simple guidance. Next slide.

On that, we will continue to review data and evaluate the COVID vaccine program in the context of evolving epidemiology. Our early COVID-19 vaccine recommendations were made in light of a highly susceptible immune-naive populations with limited treatment options. However, that's not where we are right now. We've had increases in population-level immunity through both vaccine and infection. The SARS-CoV-2 virus has continued to evolve. We now have availability of antiviral treatments. And we continue to review COVID-19 epidemiology and hospitalization rates. And the totality of that information can continue to lead to evidence-based updates in vaccine policy. The work is ongoing to review additional data and to continue efforts for simplification. Next slide.

So with this, I will turn it over to Dr. Twentyman, who can really walk through the clinical considerations with some incredibly practical updates for what these changes in policy mean for providers. Dr. Twentyman?

Thank you so much, Dr. Oliver, and thanks all for being here today. I am going to start talking through our updates to interim clinical considerations with an overview of implications of these changes, including implications for clinicians and vaccine providers. And then I'll walk through several resources that CDC is making available to assist those who offer COVID-19 vaccination. Next slide, please.

Let's start with the overview of implications. Next slide. These new recommendations are simple and singular for most people. They are flexible for those at higher risk, and they offer customized protection for young children. Next slide.

These new recommendations are simple and singular for most people. Next slide. Here's what we mean. Here are the previous recommendations for people aged six years and older without immunocompromised, including specific recommendations for both a primary series and booster with variation by age and product. Next slide, please.

Here is the new recommendation for people aged six years and older without immunocompromised who have not yet received a bivalent mRNA dose. Super simple. Just get your bivalent mRNA dose, and you're done. Next slide. This is the recommendation for people aged six years and older without immunocompromised, regardless of their COVID-19 vaccine history. Regardless of what number of monovalent doses you did or did not have, if you haven't yet received a bivalent mRNA dose, that's the recommendation for you. Next slide, please.

And here's the good news for people who've already received a bivalent mRNA dose. In other words, those who already received an updated COVID-19 booster, whether that was Pfizer or Moderna bivalent vaccine, your vaccination is complete. No doses are indicated at this time. Come back and see us this coming fall. Next slide, please.

I want to pause to underscore an important message here. Although our new recommendations are simplified, and although everyone ages six years and older will now be up to date following receipt of an updated vaccine, most people in the United States have not yet received an updated vaccine, specifically just 16. 8% of our entire population and just over 20% of adults. In other words, four out of five adults have not yet received a bivalent mRNA vaccine and are not up to date with COVID-19 vaccines at this time. If you are on this call, thank you for your help in getting Americans vaccinated against COVID-19. Next slide, please.

To return to our overview of implications, the new recommendations also offer flexibility for people at higher risk. Next slide.

One of the groups of people at higher risk of severe COVID-19 disease are those ages 65 years and older. For these folks who have not yet received a bivalent mRNA dose, they're recommended to get that dose. Additionally, they have the option of receiving an additional bivalent mRNA vaccine dose when it's been at least four months following that first bivalent mRNA dose. Next slide.

This means that those ages 65 years and older who've already received a bivalent dose, for example, who received their updated booster when they were first recommended in September 2022 or sometime thereafter, are already up to date. Vaccination is complete. With these new flexible recommendations, they have the option of receiving an additional bivalent mRNA dose when it's been at least four months following that first bivalent dose. Next slide, please.

People at higher risk of severe disease, for those people aged six years and older who've already received a bivalent mRNA dose, an optional additional bivalent dose may be administered at least two months after their first bivalent mRNA dose, and additional bivalent mRNA doses may be administered as needed. Next slide, please.

The changes we're discussing here today additionally offer customized recommendations for young children. We're going to dig into these customized recommendations in a few moments as we present the updated guidance materials that CDC is making available for those who offer COVID-19 vaccines. Before we dig into our many new guidance materials, though, I just want to offer some high-level reflections on implications of new guidance for vaccine providers. Next slide, please.

First, I want to point out that these new recommendations result in fewer total COVID-19 vaccine products in use, which might be a very helpful thing for providers. Here is a depiction of the 13 different COVID-19 vaccine products available prior to these new recommendations. Next slide, please. There will now be just five total bivalent products in use and one monovalent product in use. Next slide, please.

Here are the COVID-19 vaccine products now in use. If you're able to, please take a moment to look at this graphic depiction of these products. You will see these symbols of these vaccine vials, along with their milliliter volume to be drawn and microgram dosage accordingly, multiple times throughout the rest of this presentation as we offer an in-depth look at current recommendations for COVID-19 vaccines for children and recommendations for use in people with moderate or severe immunocompromised and show you some of the tools that we've created for providers of COVID-19 vaccines to people in these populations. Next slide, please.

We'll now be moving into our deep dive into recommendations for use of COVID-19 vaccines by age and immunocompromised status. Next slide, please.

Let's start with children ages six months through four years. In the era of monovalent mRNA COVID-19 vaccines, children were previously recommended to receive either two or three primary series doses and were later recommended to receive at least one bivalent mRNA dose. Next slide, please.

The new recommendations are customized by COVID-19 vaccination history, such that all children receive at least two vaccine doses in total, including at least one bivalent dose. We've developed a flowchart, which I'll show you on the next slide, to depict how to easily determine what customized recommendation is relevant to a child, given their personal COVID-19 vaccine history. For our interim clinical considerations on the CDC website, we've also developed complete tables of the recommendations for vaccine doses moving forward, given any particular history of COVID-19 vaccination by both age and immunocompromised status. Next slide, please.

Here's the first flowchart I want to show you. This is recommendations for COVID-19 vaccines for people without immunocompromised, aged six months through four years. And this pertains to the mRNA vaccines, and this is as of this month.

As you can see, there's a recommendation for each child, whether they're completely unvaccinated, like you'll see on the left, have started part of a primary series in the middle, or have completed both primary series and booster doses. As you can see here on the left side of the slide, unvaccinated children need either two doses of bivalent Moderna vaccine, shown here in green, or three doses of bivalent Pfizer vaccine, shown here in orange. On the other end of the vaccination completion spectrum are children in this age group who already received all previously recommended monovalent doses and at least one bivalent dose. Their vaccination is complete. And, as you see here, we have specific guidance for children in the middle of the spectrum as well, having received some, but not all, of previously recommended doses. Next slide, please.

Here you will see the exact same flowchart as on the previous slide, but now including product-specific vials and doses. If you're a provider, you can use this to see exactly what needs to be drawn up to vaccinate any given child in this age group by any given COVID-19 vaccine history. We're going to walk through this particular infographic in depth so you can see how these infographics work to assist your clinical practice. And then we'll move more quickly through subsequent infographics.

All of these infographics will also be made available on our interim clinical considerations website. So on this slide, let's start on the left again. Unvaccinated children need either two doses of bivalent Moderna vaccine drawn up as 0. 25 mL from the blue-capped, gray-labeled vial, or three doses of bivalent Pfizer vaccine drawn up as 0. 2 mL from the maroon-capped, maroon-labeled vial.

A child who has received one dose monovalent Moderna needs one dose bivalent Moderna drawn up as 0. 25 mL from the blue-capped, gray-labeled vial. A child who has received two doses monovalent Moderna needs one dose bivalent Moderna drawn up as 0. 2 mL from the pink-capped, yellow-labeled vial. A child who has already received two doses monovalent Moderna and one dose bivalent Moderna has no doses indicated at this time.

Their vaccination is complete. A child who has previously received one dose monovalent Pfizer needs two doses bivalent Pfizer drawn up as 0. 2 mL from the maroon-capped, maroon-labeled vial. A child who has received either two or three doses of monovalent Pfizer needs one dose bivalent Pfizer drawn up as 0. 2 mL from the maroon-capped, maroon-labeled vial.

And a child who has received two doses monovalent Pfizer and one dose bivalent Pfizer has no doses indicated at this time. Vaccination is complete. For the remainder of this presentation, you're going to see very similar tools as that which I've just walked through with you here. I will now more briefly summarize what we have created for vaccine providers for other age groups and possibilities for use in patients with moderate or severe immunocompromised who are not yet vaccinated or who require revaccination. Please know that complete tables of all recommended vaccine doses by age, immunocompromised status, and history of COVID-19 vaccination are already available for you on our interim clinical considerations website. And all of the infographics you see here will be available shortly. Next slide, please.

Updated recommendations for children aged five years are also customized by history of COVID-19 vaccine. Next slide, please.

The difference between those ages six months through four years and those aged five years is that five-year-olds seeking Pfizer vaccination are recommended to receive at least one bivalent dose. In other words, it's a very simple recommendation analogous to that for those ages six years and older. Next slide, please.

Here is your infographic for children aged five years. Next slide.

And here is your infographic complete with product vials and dosages. Next slide, please.

Here are the previously recommended doses for people aged six years and older without immunocompromised. Next slide, please.

And here are the simplified updated recommendations, including the optional additional bivalent mRNA vaccine dose that people aged 65 years and older may choose to receive. Next slide, please.

Here is your infographic for people without immunocompromised aged six years and older. Next slide, please.

Here is your infographic with vials and doses for people without immunocompromised aged six to 11 years. Next slide, please.

Here is your infographic with vials and doses for people without immunocompromised aged 12 years and older. Next slide, please.

We're now going to turn to recommendations for people with moderate or severe immunocompromised. Here is a summary of previous recommendations. Next slide, please.

And here are the new recommendations for people with immunocompromised, not yet vaccinated, including with at least one bivalent dose. Please note that providers have substantial flexibility when it comes to vaccination of those with immunocompromised. Analogous to the customized recommendations for children who have not yet received a bivalent vaccine dose, we are offering you a way to easily identify recommended doses by history of prior COVID-19 vaccination. Please note that you as a provider are covered by the PrEP Act in providing doses along the lines of these recommendations, and you have substantial additional flexibility in terms of additional doses and intervals between doses. Next slide, please.

Here is your infographic for vaccination of people aged six months through four years with moderate or severe immunocompromised. Next slide.

And here is your infographic for people aged six months through four years with immunocompromised, along with vials and doses indicated. Next slide, please.

Here is your infographic for vaccination of people with moderate to severe immunocompromised aged five years old. Next slide.

And now that same infographic with vials and doses. Next slide.

Here is your infographic for vaccination of people with moderate or severe immunocompromised aged six years and older. Next slide, please.

And that same infographic now with vials and doses for those ages six through 11 years. Next slide, please.

And for those aged 12 years and older, again, with immunocompromised. In addition to these infographics -- next slide, please -- in addition to these infographics, tables have already been posted on our interim clinical considerations website with complete recommendations, including number of bivalent doses indicated, doses, vaccine, vial, label, cap, and -- sorry, vial, color, label, color, cap, color, and intervals between doses. As these tables are all available online, I'm hoping, moderator, could you please proceed through to slide 71, please? And one more. Oh, actually, let's just keep going through the tables for people with immunocompromised. These are all available online. Next slide. Next slide. Great. Wonderful.

In conclusion, we know that COVID-19 vaccines continue to be the most effective tool we have to prevent serious illness, hospitalization, and death from COVID-19. Unfortunately, uptake of the updated, that is to say, bivalent COVID-19 vaccines is not yet equitable and remains generally low. Simpler recommendations are easier to communicate, which may improve vaccine uptake. And CDC materials for vaccine providers, clinicians, and the general public are available on the CDC website to make it easy for everyone to get up to date and stay up to date with COVID-19 vaccines. Next slide, please.

Before closing, I want to offer sincere thanks to the many individuals and teams who worked extremely hard to bring this guidance forward. Next slide, please. Next slide.

Let's go ahead to the knowledge check. Keep going. Next slide. Great. Let's stop here. Here's our self-knowledge check for the day. People who are not immunocompromised are able to get one additional updated bivalent COVID-19 vaccine dose if they are aged, is it A, 6 months through 4 years, B, 18 through 49 years, C, ages 50 plus, or D, 65 years or older? Who that is not immunocompromised is able to get one additional optional updated, that is to say, bivalent COVID-19 vaccine dose? And for the big reveal, next slide, please.

Correct answer is D. People aged 65 years and older are able to receive one additional updated bivalent COVID-19 vaccine dose if it's been at least 4 months since their first updated bivalent COVID-19 vaccine dose. And with that, I'm going to thank you for your attention, and I am going to turn the mic over to Dr. Brendan Jackson for an important update. Thank you.

Thanks so much, Evelyn and Sarah. That was an incredible amount of material that you conveyed there. And I know there's lots of questions about where people can access this, and people are addressing that in the chat. So I'm embarrassed to say I don't have slides given how many slides you presented there, but I think I'm going to be very quick and talk about the end of the public health emergency. I'm going to link to a number of resources, or actually my colleague is going to put them into the chat for people who want to know more.

Here's a couple bottom lines up front about what people might want to know about the public health emergency expiration. Again, one is it has minimal impacts for most clinicians. So again, I want to reiterate, minimal impacts. There are some that we'll get to in a second. While the public health emergency declaration is ending, COVID is not, I think as you all know, and CDC has established a new program that helps address COVID for the long term.

So we are absolutely still taking COVID seriously, even though the declaration is still not in place. I'll also mention that the World Health Organization issued the end of their public health emergency of international concern declaration at the end of last week. That is separate, and it does not really have any major impacts on the United States itself. So what are the impacts of the federal, the U. S. public health emergency expiration? There's no major impacts on vaccines or treatments. Both are still going to be provided free by the federal government, although there are a few nuances that I won't get into here, like pharmacy, dosing for children, et cetera. Insurance coverage for some at-home tests may end. However, there's going to be a range of other testing options still available. I know there's a lot of tests out there and in the stockpile and that are being delivered through a range of community sites. There's also pharmacy-based testing available for the uninsured.

So vaccines, testing, treatments will all still be available and for free of charge, at least for the next several months. Even once commercialization happens and we move to sort of a more private market for that, there still will be a program to provide these things to the uninsured after that time for a period of time. There's been a number of questions I'm already seeing about, questions about vaccine requirements for international travelers, federal employees, healthcare facilities, the administration has announced that those requirements will be ending at the end of today. It doesn't mean that vaccines are not important. They absolutely are still very important. We're just in a phase where the requirements to get vaccines are no longer necessary, and we'll drop a link to that in the chat here.

Now, those were sort of largely outside of CDC's purview. The stuff that's in CDC's purview is, in addition to all this vaccine information, is the sort of data sources that we're using to monitor COVID. So some of the data sources are changing, but what I want to reiterate here is that we still have the data needed to track it. So the key source of data we're going to use going forward is hospitalizations, and it's actually what we've been using for quite a while as well. Partly, it's very granular data. It's available for all hospitals, more or less, across the country. It's available down to the county level. It's not perfect, but it's a very solid indicator of spread as well as severity. This will be moving to a weekly cadence.

Now, there are a couple indicators that give a slightly more advanced look at how fast COVID might be spreading in a certain area. Basically, it leads hospitalization by a couple days. Those are emergency department visits, wastewater data, as well as test positivity, which we're going to have in a new sentinel voluntary format from a network of laboratories. And so, these are also going to be posted on our COVID data tracker this evening, and those are ways to track for people who really want to go that extra step and go beyond hospitalizations and track early indicators.

I'll mention for a second on the way we track death data. The way we at least display it is going to change a bit. We're going to be pivoting to focus more on death certificate-based data. This gives almost the same numbers, pretty much exactly the same numbers as what we've been getting from the aggregate data, basically what's been taken from jurisdiction websites or direct feeds from them, from the states. But what it does is it's more the gold standard, and it's much more timely than it's been earlier in the pandemic.

And so, what it does is it allows us to report based on the date of death. Previously, a lot of these reports were happening based on the date of report, and that's why you would tend to get sort of this lagging and sort of batched indicators where deaths would kind of go up and down pretty frequently, and this will be a more stable way to look at deaths. We still very much want to track them closely. There's been much made about the fact that we're not going to be tracking case data on our website after today, at least in the aggregate, like total numbers format.

There's a couple reasons for this. One is several states are not going to be collecting or have the authority to collect those data anymore after the public health emergency expires. And also the fact that it's been a long time coming where use of home testing and all the mild and asymptomatic infections that are out there, the cases that get reported are very much a biased subset of the true infections that are out there, and we have better ways of tracking where COVID is and where it's going. Another thing that's changing, and this is more directly tied to the expiration of the public health emergency, is that the federal government no longer has the authority to require laboratories to report negative tests, so we can't calculate test positivity anymore at a national and county level. Again, we're going to have this sort of sentinel network of labs, 450 labs plus, that have agreed to send data to CDC on a voluntary basis, and we'll be reporting on that. And we have a paper, an MMWR from last week, showing that it provides very similar results, just not as granular of a level.

Now, these changes mean there's a couple levels that we've been using to sort of track and inform about COVID. They can no longer be calculated. So one, the COVID community levels, which have been used to inform a lot of our community guidance and guidance to individuals. Because they use those case data, we're going to switch to focusing just on hospital admission levels. It turns out when you compare those two, over the past year, you get roughly 99% concordance between them, so it's pretty much a one-to-one switch there.

You know, people are saying, well, the community levels are going away. I mean, that's technically true. We're just switching to something that's nearly identical, which is the hospital admission levels. The second is the COVID transmission levels, which were based on case data and test positivity. Those are both not going to be available on a national level or at a county level, and so those are going to be coming off our website. They were used primarily to guide healthcare masking decisions. They're also used to inform in general, but again, we have other ways of informing people about early indicators of spread.

There was updated guidance for healthcare facilities about masking that was posted on the CDC website on Monday, and we can link to that in the chat later if that's helpful. Back to vaccines for a second, which was the main topic of this call, of course. Vaccine administration data, you know, the way it works, right, I think just have to reiterate even this point in the pandemic that CDC does not have direct authority to collect many types of data. Much of what we get comes through our state and other jurisdictional health departments. The requirement to send us those vaccine administration data goes away with the end of the public health emergency. However, we have signed individual data use agreements with over 60 of the 64 jurisdictions, which includes states and some of the other jurisdictions, to continue sending that data on a monthly basis, and so we'll continue to display what we get. Other people can speak to this better than I can, but there will be some degradation in quality over time because there may be some people

who provide vaccinations who do not necessarily report to the state systems, and then we can't get them from us.

I want to reiterate there's several things that are not going to be changing in terms of our surveillance. Genomic surveillance is going to continue. We're constantly tracking the latest variants. You know, there's always stuff that pops up in the news about it. What is this new one that's named XBB.1.16? I mean, these names are kind of terrible, right, and hard to follow. They call it Arcturus. This is not a game-changing variant. It's much like the same ones that we've been dealing with before, but we're still tracking these. We're sequencing thousands of specimens a week.

We're sequencing specimens from incoming travelers to the United States. We're sequencing specimens from wastewater to look at variants. We have our eye very much on the variant ball, and I will say when it comes to variants, none of them are changing any of our recommendations right now, including for vaccines, so all of what Sarah and Evelyn just presented remain in place when it comes to vaccines, despite what any of the variants that we're seeing right now. We're going to have sentinel surveillance that continues, like COVID-NET, which is our very intensive hospital-based surveillance, wastewater surveillance, studies for long COVID or post-COVID conditions, vaccine effectiveness studies. All those are continuing, and I'm going to say in terms of the data changes that I mentioned, they will go live on our website tonight on COVID Data Tracker.

We have a webpage and an MMWR article that explains the rationale and all the changes that we're making, both in plain language and in more technical detail, and we'll put those in the chat to help with any questions that you may have there. So I just want to end by saying I want to reemphasize that CDC is very much keeping its eye on the COVID ball. It still takes COVID very seriously. The end of the PHE does not mean the end of COVID. It is here to stay with us, and we are going to stay on top of it. Thank you.

Thank you very much. I think we need to go back to Dr. Twentyman for some frequently asked questions that she would like to share. In the meantime, while we are scrolling, I just want to reiterate for our audience that there are a lot of questions about some of these tables and charts and where you can find them. All of these slides are available on the COCA webpage. So if you direct your browser to emergency.cdc.gov/COCA, you'll be able to find all these slides under today's COCA calls webpage. With that, back to you, Dr. Twentyman.

I will say, this is Dr. Oliver. I'm going to take it. Dr. Twentyman's voice was giving out just a little bit, so it may be easier to hear. So yeah, we're happy to -- we anticipated that we may get a few questions. So happy to walk through these, and then we can open it up to questions that people have been putting in the chat. So has the vaccine changed? We've gotten questions for that. No. These spring updates are changes to the recommendations and the authorizations, but not actually of the vaccine.

The monovalent vaccines are no longer authorized, but these bivalent vaccines that we've been talking about are the same as what we've been using in fall of 2022. I will say, while we're talking about this, though, that FDA has announced on June 15th, they're actually going to have a

VRBPAC, which is their advisory committee, that's going to discuss the possibility of having an updated vaccine this fall. So I did see that question in the chat. I can go ahead and answer that one. Next slide.

So just want to acknowledge that the Moderna dosing for young children, the receipt of whether you get the blue cap or the pink cap, those are two different vials, and we just want to acknowledge that they are not interchangeable. So based on what you've received before, the authorizations are very specific for which dose and which vial you get, which is why we've tried to have the color-coded figures posted here and then soon to be posted on the clinical considerations. Next slide.

Then, how are vaccination errors reported? As always, this has not changed. Vaccine errors are reported to VAERS. The information is there. You can call. There's actually a website. There's a YouTube video if you want help and assistance for filing a VAERS report. So there's lots of information that's out there, but vaccine errors should be still reported to VAERS. Next slide.

Then, interchangeability. This is also something that I noticed come up quite a bit in the chat. So want to acknowledge that for everyone six and over, the mRNA products, you can get either mRNA vaccine based on what you've received before. However, the language in the EUA does not allow for quite as much mix and match in the youngest age group.

So if children or additional guidance is kind of there, you can see, but just wanted to highlight that the interchangeability, we hope we get there, but we're not quite there yet. Then, just wanting to highlight these, all this FAQ stuff will be posted, but we know that there's questions about when people transition from a younger to an older age group. In general, we recommend that people receive the age-appropriate product and dosage based on the age of the vaccination. So for the most part, they should receive the dose for that older age group, but there are a couple of exceptions. These are written into the EUAs.

So this is what we, you know, what we have to recommend. The children who received Pfizer and transitioned from four to five during the three-dose series are supposed to complete the series they start, three doses with the maroon cap, and if they transition from five to six during the Moderna transition, they receive both doses of that 25-microgram blue cap. Next slide.

And then, can they self-test to the immunocompromised status? The short answer to this is yes. We have a list, the list of conditions that would be considered for moderate to severe immunocompromised have not changed with these updates to the recommendation. So they're in the clinical considerations, but people can self-attest to their status. So they don't have to prove that they have any of these medical conditions to account for the additional doses. Next slide.

And then, I saw this, should they get a dose now or wait for the fall? If you're eligible for your vaccination, especially if you're in that older population or a population with chronic medical conditions, we still think that it's important to get it now. As always, there is typically some sort of minimum interval before the next dose is due, but we're probably not quite there yet.

So we anticipate that there may be additional recommendations this fall, but we fully anticipate that if people get their vaccine now, they should be able to get that vaccine this fall. And we'll continue to work with both CDC and FDA as we look towards fall recommendations. Next slide.

And then, vaccines. gov, we do get lots of questions about, well, how can I find it? Where do I need to go? And so, vaccines.gov still is the best place to find the vaccines that you're looking for. Next slide.

Okay. Now, we're back to the knowledge deck. So happy to turn it over to everyone for us to take additional questions.

Thank you, Commander Oliver. I want to thank all the presenters first for joining us during this Q&A. We also want to welcome CDC SMEs Mimi Eckert, who's a public health advisor in Immunization Services Division COVID Vaccine Unit Lead for the COVID-19 response, as well as Dr. Alexander Callan, Chief of the Prevention and Response Branch for CDC's Division of Healthcare Quality Promotion.

And for our audience, please remember to ask your question using Zoom. Please click the Q&A button at the bottom of your screen, then type your question. And please note that we receive many more questions than we can answer during our webinars.

So we have quite a lot of questions, both about the vaccines, as well as the PHE. So starting first with a vaccine question, for those eligible for the single bivalent mRNA updated boosters moving forward, does the agency consider the different mRNA vaccines interchangeable?

Yeah. So this is Dr. Oliver. If you are, you know, six and over and need to get that bivalent dose, you can get either Pfizer or Moderna. And we just say get the vaccine that's available to you. If you've not had any vaccine, there's not one in particular that we lean on, and then you can get either regardless of what you've had before. Again, the interchangeability is different in that young population. We primarily recommend that if you need more than one dose, you do stick -- the subsequent doses are what you got previously. Although there is some language for some exceptional circumstances where exceptions can be made to that. But overall, the products, the bivalent mRNA vaccines, you can get the one that's available to you.

Thank you, Commander Oliver. And again, for our audience, for the various infographics and charts that you saw, please direct your browser to emergency.cdc.gov/COCA. You can click on the webpage for today's COCA call where you'll find the slides posted. Okay. Our next question asks, can you explain a little bit about somebody without immunocompromised who's currently up to date on their vaccine status and want to be aligned with this new guidance? How long should they wait before getting that booster? And how is that different if, say, they were immunocompromised?

Yes. So let me make sure. So if they've already had a bivalent dose since this fall, then for the most part, they're good and can stay tuned. So if they're kind of six and over, then they can be good. If they're 65 and over, then there's the option for that second dose. The interval there is four months. If they're immunocompromised, they also have the option for an additional dose.

That interval is two months. And then if they're immunocompromised, there's also some additional flexibility, you know, kind of based on individual clinical circumstances. And for those, it may be best to talk to a medical provider and kind of figure out what timing may be best around, say, timing of immunosuppressive medications or something like that. But I hope that answered the question.

It did. Thank you. Our next question is regarding, are there any monovalent COVID-19 vaccines that remain recommended for use?

Are you going to take that one, Evelyn?

This is Dr. Twentyman in my failing voice. I did want to clarify, thank you for the opportunity. There is one COVID-19 vaccine that remains available for use that is monovalent, and that is the Novavax COVID-19 vaccine. It is a protein subunit vaccine. It is not an mRNA vaccine. So I believe we actually had a typo on a previous slide that accidentally read monovalent vaccines are no longer authorized for use. It should have said monovalent mRNA vaccines are no longer authorized for use because Novavax COVID-19 vaccine does remain an alternative for some patients. Thank you.

Thank you, Dr. Twentyman for that clarification. We'll also make sure that the slides reflect that. Our next question is regarding the PHE ending, and the question asks, how does the PHE ending affect infection prevention and control recommendations for healthcare providers both in and outpatient settings?

Hey, this is Alex Callan from DHQP. So the PHE only affects -- so as Brendan mentioned, the IPC guidance was updated earlier this week. The only changes address issues that were directly affected by the public health emergency, which as he mentioned were the fact that the community transmission metric, which has been used to guide just a couple of interventions in healthcare settings, including testing, admission testing in nursing homes, and also masking, are now having to change since we won't have access to that specific metric. So and Brendan, I think put the link to the guidance in the chat, but really the upshot of it now is that although most of the masking requirements have not changed, there is now some inserted flexibility and examples that could be used to help facilities decide how to address identifying increased transmission within their individual jurisdiction since we will not be able to rely on the community transmission metric any longer. So the key point, I think, is none of the infection control guidance is changing other than those very small things that I mentioned that, again, are related to the fact that that one particular metric, community transmission, is no longer going to be available. Thanks.

Thank you very much. Our next question asks, and I guess it goes along with vaccine reporting recommendations or guidance, you mentioned VAERS. Is V-safe still being used and available?

Please go ahead. I didn't know if we had anyone on, but that's great, you answered, Sarah.

Well, I was mostly going to say our vaccine safety colleagues are not on, but I will say there was a presentation at our last April 19th ACIP meeting that addressed that. So they are working to

kind of transition some of the V-safe work. There was an entire presentation that was based on that. I will put that in the chat so people can have access to it. Brendan, anything else?

Nope, that's it. Great, thanks.

Okay, perfect, thanks.

Thank you very much for sharing that. Our next question asks, with the way data is being collected changing, will the hospitalization data let folks in communities predict their regional transmission rates as well?

Can you repeat that question? I wasn't sure I quite followed.

Sure. Will the hospitalization data let folks predict their regional transmission rate? If I was to kind of read between the lines, I think they're trying to figure out if they can determine their community level of transmission from some of the data. I guess extrapolate that to see what the transmission rates might be in their community.

Got it. So we are going to be updating the COVID Data Tracker webpage with information on the hospital admission rates. And it'll have that same format that people are used to with, if they're ever looking at it, with the community levels, the sort of green, yellow, orange framework, you know, low, medium, high. That is going to have that same framework for the COVID hospital admission levels. And it'll also provide the exact numbers and granular data. I will say we also have the forecasts, the weekly forecasts for hospitalizations that are posted as well. So there'll be no shortage of hospitalization data to look at, at a county basis or at a state basis.

Great. That's very helpful. Thank you so much for sharing that. And we have time for one more question. So this question is back to the vaccination updates.

And the question asks, has the guidance changed on how long to wait after an active COVID infection when getting an updated booster?

This is Dr. Oliver. Thanks for asking that. I did see that a few times. So the answer is there is no absolute minimum interval that you have to wait, other than please don't go get a vaccine if you're kind of actively infectious. Follow kind of the recommendations. We don't want to put the people who are going to be providing the vaccines at risk. But once you pass that time, there is no minimum interval you have to wait. However, we do have guidance in the clinical considerations that says you can consider waiting about three months.

We know that for the vaccine to really have kind of the optimal boost in the immune response, waiting a little bit of time can give the time for your immune system to, you know, have recovered from that infection and be ready to boost with the vaccine. So we say you can consider waiting about three months. But you certainly do not have to get tested before you get a vaccine, nor is there like a mandatory minimum time that you have to wait.

Thank you very much. And I also want to draw attention to the link that Commander Oliver has just posted to the chat regarding the direct link to the V-safe presentation PDF that she had mentioned earlier. So I invite all the attendees to please take a look at that. That will have V-safe and other vaccine safety information.

Okay. So at this time, I want to thank everyone for answering these questions and for sharing your expertise with us today. Please note that all continuing education for COCA Calls is issued online through the CDC training and continuing education online system at tceols.cdc.gov. Those who participate in today's live COCA Call and wish to receive continuing education, please complete the online evaluation and post-test before June 12, 2023 with the course code WC4520-051123. The access code is COCA051123. Those who will participate in the on-demand activity and wish to receive continuing education should complete the online evaluation and post-test between June 13, 2023 and June 13, 2025 and use course code WD4520-051123. Again, that access code is COCA051123. Continuing education certificates can be printed immediately upon completing your online evaluation. A cumulative transcript of all CDC CEs obtained through the CDC training and continuing education online system are maintained for each user.

Today's COCA Call will be available to view on-demand a few hours after the live call at emergency.cdc.gov/COCA. A transcript and closed-captioned video will be available on-demand on the COCA Calls webpage next week. You can visit emergency.cdc.gov/COCA for more details about this COCA Call and other upcoming COCA Calls.

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Again, thank you for joining us for today's COCA Call and have a great day.