

**Task Force on Infectious Disease Preparedness and Response**  
**APPROVED Meeting Minutes**  
**Thursday, December 2, 2021**  
**1:00 p.m.**

**TEAMS Live Events Virtual Meeting**

**Agenda Item 1: Call to Order**

The Task Force on Infectious Disease Preparedness and Response (IDTF) meeting was called to order at 1:00 p.m. by Commissioner John Hellerstedt, M.D. Dr. Hellerstedt welcomed everyone to the fourteenth meeting of the Task Force on Infectious Disease Preparedness and Response. Dr. Hellerstedt announced that questions and comments on agenda items #3 through #7 will be taken at the end of the presentation on agenda item #7.

Ms. Kayla Cates-Brown, Advisory Committee Coordination, Health and Human Services Commission (HHSC), conducted roll call and asked each task force member to briefly introduce themselves after they confirm attendance. She announced that the meeting was being conducted in accordance with the Texas Open Meetings Act and noted that a quorum was present for the meeting.

Table 1 notes Task Force member attendance.

Table 1: IDTF member attendance at the Thursday, December 2, 2021 meeting.

<b>MEMBER NAME</b>	<b>YES</b>	<b>NO</b>	<b>MEMBER NAME</b>	<b>YES</b>	<b>NO</b>
Ogechika K. Alozie, M.D.	X		Kristy Murray, D.V.M., Ph.D.	X	
Toby Baker* - Michelle Havelka	X		Major General Tracy Norris *Colonel Peter Caldwell, PH.D.		X
Christopher R. Frei, Pharm.D.	X		Patrick O'Daniel	X	
Sheila Haley, Ph.D.		X	Dorothy Overman, M.D.		X
John Hellerstedt, M.D.	X		Daniel Owens	X	
Peter Hotez, M.D., Ph.D.	X		Gerald Parker, D.V.M., Ph.D.	X	
Deputy Secretary of State – Joe Esparza	X		Victoria Sutton, Ph.D.	X	
Harrison Keller		X	The Honorable Nancy Tanner		X
Nim Kidd		X	Surendra Kumar Varma, M.D.	X	
Thomas Ksiazek, D.V.M., Ph.D.	X		Marc Williams (rich McMongale – proxy)	X	
David Lakey, M.D.	X		Bobby Wilkinson	X	
James Le Duc, Ph.D.	X		Executive Commissioner Cecile Young	X	
Scott Lillibridge, M.D.	X		Edward E. Yosowitz, M.D.		X
Tony Marquardt	X		The Honorable Ben Zeller		X
Steve McCraw * Freeman Martin	X				
Michael Morath		X			

Yes: Indicates attended the meeting

P: Indicates phone conference call

No: Indicates did not attend the meeting

\* Designee in attendance on behalf of Task Force Member.

**Agenda Item 2: Approval of September 21, 2021 meeting minutes**

Dr. John Hellerstedt called for a motion to review and approve the minutes of the September 21, 2021 meeting.

## **Motion:**

Dr. Surendra Kumar Varma moved to approve the minutes from the September 21, 2021 meeting as presented. Dr. Christopher Frei seconded the motion. Ms. Kayla Cates-Brown conducted roll call vote and announced the Task Force members approved the minutes unanimously, with 19 approves, no disapproves, and no abstentions.

## **Agenda Item 3: COVID-19 Situation Update**

Commissioner John Hellerstedt, M.D., Chair, and Dr. Jennifer Shuford, Chief State Epidemiologist, provided a situational update on the COVID-19 pandemic and referenced a PowerPoint presentation entitled "COVID-19 Update". Highlights of the update and task force member discussion included:

### Dr. Hellerstedt:

- As of today, almost 3.6 million cases have been identified in Texas.
- Hospitalizations have been remained static over the last few weeks but has been slightly increasing. Hospitalizations are a good measure because it shows how many individuals have infection severe enough to be hospitalized and it is one of the only metrics (other than deaths, but those lag) where the denominator is the entire population.
- Testing is robust but we are not testing everyone all the time, but because testing is so good, testing positivity is a good leading indicator of transmission.
- Positivity rate is 8.75% right now and is increasing.
- Right now, the delta variant was responsible for the surge that started at the start of July and we are just at the tail end of that surge. Hospitalizations have not decreased to the levels prior to the delta variant so community spread is still high.
- On November 30, CDC classified omicron as a variant of concern. We now know of 2 cases in the U.S. and no cases in Texas.
- Prevention is key and prevention has been key all along. The thing we should have been doing all along is prevention, which comes in the forms of vaccination and non-pharmaceutical interventions that we all know about.
- It was quite easy for us to focus on things early on that were not of importance, such as the number of new cases in a county over the last week. But what is important is that the virus is in communities and we need to take action to prevent spread. We really need to remember the lessons learned and move forward with what we know works, prevention.
- We still do not know much about omicron, such as if it is more contagious or causes more severe disease, and only experience and time will be able to answer this. What we know is prevention is key, we have still not gotten over the delta surge cases, and hospitalizations have plateaued and if we want to mitigate the effects of omicron, we need to focus on what we know works.
- It took delta weeks to months to overtake and replace the other circulating variants and we are just now at the stage of identifying omicron. We should focus on reducing transmission before omicron becomes widely spreading.

Dr. Shuford:

- Talking about the epi that we are seeing in the U.S. and Texas now before moving to omicron. Looking at a week's worth of sequencing data: Every week CCDC lists the proportion of variants seen in testing.
- For months now, delta has predominated between 96-99% of sequences. Looking at Texas data, it looks similar to what we saw nationwide. This is sequencing data within Texas; delta predominates here and has for months.
- Texas new cases per day over the last year – there was a large peak of cases in January 2021 and a low point in June 2021 and another peak in August/September 2021.
- On June 20, delta became the predominate variant in Texas and then we saw a dramatic increase in cases following that date.
- There is a slight decrease of cases but mostly we have plateaued at a higher rate than the low in June.
- COVID activity in the U.S. over the most recent week – a lot of the U.S. is red, meaning that there is high community transmission, orange is substantial. In areas of high/substantial community transmission, the CDC recommended all individuals including vaccinated people wear masks.
- Texas hospitalizations over the last year – huge peak of hospitalizations in January 2021 and there was a decline that bottomed out in June, and then another peak in August/September, and the increase was very steep and reached the same peak as in January. We are currently increasing in hospitalizations again in recent weeks. ICU patients in any given TSA – TSA E Dallas, TSA O Austin, TSA Q Houston, TSA P San Antonio –
- 40-50% of ICU beds were being taken up by COVID-19 patients and that was impacting our ability to provide care and stressing the healthcare systems.
- Currently things have decreased, however, in TSA A Amarillo and TSA I El Paso, we have high rates of COVID ICU patients, but they have been able to move patients to other regions for care.
- Hospitalization rates stratified by age – the oldest ages still have the highest rates of hospitalization. The second peak that we had during the delta surge, the oldest age groups that have the highest rates of vaccinations did not see the same peak as in January. The younger ages exceeded the peak in January, showing that younger individuals were severely sick and required hospitalization.
- New Fatalities reported by day – 7-day rolling average smooths out the differences in reporting over the days of the week. We are seeing decreases now, but this is a lagging indicator and while it is currently decreasing, we may see a plateau like we saw with hospitalizations.
- Multisystem inflammatory syndrome – critical illness in children. Right now, there have been 300 cases reported to Texas DSHS throughout the entire pandemic. Male predominance and minority/ethnic group predominance, which matches the trends seen in the U.S. These children do become severely sick and require ICU hospitalization and there have been 3 deaths in Texas due to MIS-C.

- We expect to see a surge in MIS-C following a surge in positive cases. We have not seen the surge in MIS-C following the recent surge of delta, but we believe that this is a reporting lag since we know other states are seeing an increase in MIS-C now that reporting is rolling in.
- Omicron – first identified in Botswana, now identified in more than 20 counties. The concerning things about omicron are the mutations; there are many mutations in the spike protein. The spike protein is the protein that the virus uses to enter human cells and it is the protein targeted by our vaccines and treatments for COVID. This is the most divergent variant that has significant spread.
- Looking ahead with omicron – there are still many things that we do not know. But we know that testing should still be able to identify the variant. Not sure about the impact on vaccine effectiveness. Not sure about the impact on therapeutics. We need to continue testing to be able to answer these questions. We have a lot of sequence data, but we do not have a lot of grown virus of omicron right now to answer these questions.
- Looking at a slide shared by South Africa on the transmission of omicron. Variant beta was predominant in South Africa until delta was introduced, which then quickly replaced beta. There is now an increase in omicron. The sequencing they have done shows that omicron went from 5% of cases sequenced to over 50%, suggesting that omicron is outcompeting delta, which is concerning because delta was so transmissible.

Dr. Hellerstedt:

- Is the steep increase in omicron due to a decline in cases overall?

Dr. Shuford:

- There was a decline in cases, but it doesn't look like it was a single super spreader event that caused this increase. They are not seeing an increase in severity, but they are seeing an increase in infections in younger individuals.
- There have been a couple of presidential proclamations and travel restrictions for regions in South Africa.
- For DSHS, we are currently increasing compacity of testing and trying to increase the number of samples sent to the lab for sequencing. They have partnered with UT Public Health and private labs across the state to ensure that we are sampling a wide variety of samples across the state. With the partnership they can focus in on areas that need more sequencing if needed.
- There will be communications over the holidays and communication about omicron.
- It's important to understand that the predominant variant in the U.S. and Texas right now is delta. We know that masking, distancing works against other variants and we are hoping to see the same with omicron when it becomes more predominant in the U.S. and Texas. There are Texas COVID-19 data tools available.

**Agenda Item 4: COVID-19 Vaccine Recommendations Update**

Saroj Rai, Ph.D., Senior Scientific Advisor, DSHS, provided an update on the COVID-19 Vaccine Recommendations and referenced a PowerPoint presentation entitled "COVID-19 Vaccine Recommendations Update". Highlights of the update and task force member discussion included:

- We wanted to share some vaccine developments that have happened since the last time we met. The information that we are about to share is only current as of today.
- Excellent development is the vaccine for the pediatric population: Looking at ages 5-11 and the regulatory process – Pfizer vaccine; it has been over a month since FDA granted EUA for the Pfizer vaccine pediatric formulation. Beginning on Nov 3 we started vaccination children 5 and older.
- Pfizer COVID Vaccine Pediatrics – it is a different product. The product that the providers have been using since December 2020 is for the 12+ ages and is a different formulation than the vaccine for 5-11.
- The 5-11 vaccine comes in a vial with an orange cap; 12+ vaccine comes in a vial with a purple cap.
- The regimen is still a two-dose series. The 5-11 vaccine is 10 micrograms and is a third of the dose for those 12+. The vaccine for 12+ is a 30-microgram dose.
- The 5-11 vaccine formulation has a different buffer to help stability at normal storage temperatures
- Providers that serve pediatrics and adolescents will be carrying two separate products so there were multiple educational webinars to update these providers and educational materials for providers to be aware of the differences.
- Both formulations require dilution with diluent but with differing volumes needed.
- As we are speaking the purple cap will become a vial with a grey cap formulation, which is a change in the buffer system to match the buffer used in the pediatric formulations.
- What is happening with the other manufacturers and vaccines for the younger ages?
  - Pfizer is the most advanced as far as the number of age groups being tested. Pfizer is currently testing a formulation in ages 2-4 years; the dose is 3 microgram dose; they do not know if it will be a unique formulation yet as that is forthcoming. The manufacturer is doing ongoing trials in the 6 months to 2-year age groups and they are doing dose finding studies for this age group, but there is no definitive information to release about that at this time.
  - Moderna has submitted a request to expand down to age 12, but at the end of October, FDA told Moderna they would need additional data from the manufacturer before review and the evaluation date is anticipated for January 2022. They have completed the study for the 6-11 age group but have held off on submitting the request until the review for the 12-17 age group.
  - J&J has ongoing trials in 12-17 and no information to share right now.
- COVID-19 Vaccine Boosters – in light of the omicron variant we encourage all individuals to receive boosters.
- In late September, the FDA authorized, and CDC recommended the Pfizer COVID-19 vaccine for boosters for those 65 years and older.

- In October, there was further authorization for Moderna vaccine and J&J and four different age groups. Pfizer/Moderna booster was recommended for those 65+ 6 months post dose 2. J&J COVID-19 booster for all individuals 18+ 2 months post vaccination. Immunocompromised individuals should receive a booster 6 months following their 3 additional doses (which was approved in August). The Moderna booster dose was half of the primary series.
- In mid-November, the FDA met, and CDC authorized an expanded recommendation to those 50+; the recommendations for J&J stayed the same.
- As of Monday November 29, CDC made a strong recommendation for all individuals 18+ to receive a booster dose either 6 months following mRNA or 2 months following J&J.
- Mix and matching booster dose brands is allowed.
- We developed an infographic for providers and have held training webinars for providers on when and to whom boosters are recommended and how to administer them.
- As of November 29, in response to the omicron variant, the UK has made a recommendation for booster for those who have received a primary series to receive a booster 3 months following completion of the primary series.
- In the last week, Pfizer has requested to expand boosters to those 16-17.

#### **Agenda Item 5: Vaccine Update and COVID-19 Vaccine Distribution Plan**

Ms. Imelda Garcia, Associate Commissioner, Laboratory and Infectious Disease Services, provided an update on the COVID-19 Vaccination Plan and referenced PowerPoint entitled "COVID-19 Vaccination Distribution Plan Update". Highlights of the update and task force member discussion included:

- The first map we have here is a map of the population of kids 5-11 and where they are distributed across the state. We are starting with this group since they were the most recent group to be approved for the vaccine. There are about 2.9 million kids ages 5-11 in Texas.
- In about 2 weeks, we will have been distributing COVID vaccine for a full year.
- Pfizer COVID vaccine for pediatric – CDC had to allocate doses to the states for this age group.
- Texas received over 1 million doses at the time of allocation launch to further allocate to Texas providers.
- Pharmacies in the federal pharmacy program were able to order directly from the federal government and did not need allocations from Texas.
- The way the allocations were given to states was over waves, so Texas did not receive the 1 million doses at once but over the course of a few weeks.
- We have continued to ship a single vial to providers because many providers said the minimum order size is still too high for most providers to store in office. We have continued to do this with pediatric providers because parents have indicated they would prefer for their children to receive their vaccine in the pediatrician's office.

- We continue to enroll more practices and providers in the COVID-19 provider program in Texas and continue outreach to increase participation.
- Across the state we have had over 36 million doses administered by all of our providers:
  - 59% 5+ have been fully vaccinated
  - 66.1% 12+ have been fully vaccinated
  - 67.7 18+ have been fully vaccinated
  - 82.7 65+ have been fully vaccinated
- We focused on getting people to get their second dose in light of delta and now with boosters and omicron, we are encouraging individuals to get boosted.
- We see steep increases in the booster doses trend due to the expanded eligibility and a steep increase in the first doses due to the expanded eligibility to those 5-11.
- 5-11-year-olds are currently at less than 1% fully vaccinated but they were only recently made eligible.
- Latest data in regard to race and ethnicity; in the other race category, we have many individuals identifying as multiracial than the census estimates.
- Vaccine uptake for ages 5-11 for first doses only, the lighter the color the lower the vaccine uptake. The patterns that we see in this age group is following the same patterns that we have seen in all of the other age groups over the rollout of the vaccines.
- For ages 12-17, we continue to see numbers increasing in all age groups. TEA and TDEM have been a great partner to help get individuals vaccinated across the state. The TEA has helped to have schools hold vaccine clinics onsite for children and parents.
- COVID-19 boosters – the complicated guidance for boosters likely contributed to low booster uptake, but now that the recommendations have simplified, we hope to see an increase in uptake.
- The Expert Vaccine Allocation Panel (EVAP) rolled out to specific age groups at the beginning of the rollout and so over the next few months, more individuals will become eligible to receive a booster dose due to the timing of the rollout to all groups in Texas.
- As we move through the coming months, as we get to May 2022, we still have over 6 million Texans eligible for a booster dose.
- 18+ 21.6 million Texans in this age group – 8.9 million are eligible to receive a booster and only 2.9 million have actually received a booster dose.
- 65+ 3.7 million Texans in this age group – 1.4 million eligibility for booster, 1.3 million have received a booster.
- Looking at the largest counties for booster doses: Bexar, Collin, Dallas, Denton, El Paso, Harris, Tarrant, Travis, Williamson – about 50% of 65+ have received a booster dose. We want to continue to encourage booster doses. We are really focusing on the older age group, 65+, because we continue to see high hospitalizations in this age group.
- Looking at it geographically across the state – looking at those eligible and those who have received a booster. Dallas, Tarrant, Travis, and Bexar counties have some of the

highest rates of booster dose administration, and we will continue to encourage/push efforts throughout the winter months and into the next year.

- Now that the CDC allows everyone 18+ to be eligible for a booster dose, we will continue to message this to the public. This has been confusing until the simplification of the recommendations.
- In light of the omicron variant, we are continuing to encourage those who are unvaccinated to be vaccinated if eligible and those eligible for a booster to get boosted.
- Areas of focus- 9.66 million eligible Texans are completely unvaccinated – we know that some of these individuals will never get vaccinated, but we are partnering with organizations and faith entities to conduct outreach to their communities to encourage vaccination.
- Updates on other vaccines:
  - Data from the National Immunization Survey – this is something that CDC does at the national level where they survey/call parents and ask about the status of vaccination of their children and then follow up with their healthcare provider to confirm that the children have received the vaccines. Notice that for the most part, Texas is trending closely across vaccines with the U.S. In Texas, the HepB birth dose coverage is higher than the U.S. We are likely not going to see the impact of the pandemic in this NIS, but rather in the 2021 NIS; then we will be able to tell how large of an impact the pandemic had on vaccination coverage.
  - Texas Vaccines for Children (TVFC) doses administered for non-flu childhood vaccines – we see data for 2021, 2020, and 2019. 2019 is used as a benchmark for before the pandemic. In March of 2020, the pandemic hit in Texas and we saw a steep decrease in doses administered.
  - NIS Flu – for the 2019-2020 and 2020-2021 flu seasons (from the end of September of one year to the end of May in the following year). We see a decrease in flu vaccine uptake across pediatric age groups. However, in the adult age groups, we see increases in the 65+ ages and 50+ and 64+ age groups. There was a lot of messaging to vulnerable populations and we have seen increases in flu vaccine coverage.

Dr. Hellerstedt:

- There are almost 10 million individuals that are still not vaccinated. It is a matter of fact that these individuals that will be at the highest risk for severe disease, hospitalizations, and death due to COVID. Lower percentage of flu vaccination: the fact that there were marginal changes in vaccination rates, but a profound rate of decreased influenza circulation can be pointed to the non-pharmaceutical interventions working. The omicron variant may have some aspects that make it riskier or more dangerous, but we don't know, but prevention tools like vaccination and personal infection prevention behaviors work.

### **Agenda Item 6: Respiratory Viruses Update**

Dr. Jennifer Shuford, Chief State Epidemiologist, provided an update on respiratory viruses (Influenza/Respiratory Syncytial Virus) and referenced a PowerPoint presentation entitled "Respiratory Viruses Update". Highlights of the update and task force member discussion included:



- Respiratory Syncytial Virus (RSV) is an RNA virus that is primarily spread through respiratory droplets when a person coughs or sneezes, but also can be transmitted through surface fomites. RSV is the most common cause of bronchiolitis and pneumonia in children under one.
- RSV usually circulates in the fall/winter months. RSV season is defined as antigen test >10% and/or PCR tests are >3% positive for two consecutive weeks.
- RSV is not a reportable disease in Texas, but there are providers that report voluntarily. There is a monoclonal antibody treatment available, but it is about \$2,500 per dose and requires multiple doses. Insurance/Medicaid rely on the start of an RSV season.
  - 2017-2018 RSV season lasted between October and March
  - 2019-2020 season started at the end of September and peaked in November, so that was a bit shifted.
- There was a steep decline and drop-off in activity as soon as the pandemic hit, and schools closed, and people began working from home.
- 2020-2021 RSV season – there was very little activity from August 2020 through April 2021 when individuals starting relaxing pandemic measures and then we saw increase starting in May 2021, which is an interseason increase of RSV.
- 2021-2022 RSV season saw high rates in July that decreased in September but is currently increasing again.
- Because of this off-season increase in RSV, many providers were not aware that RSV was highly circulating so CDC released a health alert to inform providers that children may present for RSV and should be tested. DSHS also released an alert to providers in Texas.
- Influenza – infection caused by influenza virus. It is a huge cause of morbidity and mortality since about 10-20% of the population becomes infected. In Texas, flu is not a reportable disease but there are a few situations that are reportable, which include a pediatric influenza-associated death, flu outbreaks, and novel influenza infections.
- Influenza like illness (ILI) activity during 2017-2021 – since influenza isn't a reportable disease, we track activity through providers reporting ILI – which is an illness like influenza. 2017-2018 was a severe season, 2018-2019 was a mild season, 2019-2020 season was severe with an early peak and was very long, however when the pandemic hit in March 2020, we saw a steep decline in influenza activity. In 2020-2021, influenza activity was almost non-existent and was low throughout the season.
  - 2018-2019 – 144 pediatric deaths across U.S.
  - 2019-2020 – 199 pediatric deaths across U.S.
  - 2020-2021 – 1 pediatric death across U.S.
  - 2021-2023 – 0 pediatric deaths across U.S.
- Looking at pediatric deaths in Texas:
  - 2018-2019: 17
  - 2019-2020: 20
  - 2020-2021: 0 influenza deaths but 71 COVID deaths reported
- 2021-2022 ILI activity is currently increasing but is still low.

- Across the U.S., flu activity has been low except for New Mexico and Georgia, and in a normal season, this is what we usually see – low except for a few states and then increases across all states.
- U.S. Clinical Flu Testing – 1.0% positive in the last week; mostly seeing influenza A.
- In Texas, we are still seeing less than 1.0% positivity.
- We know that there have been multiple outbreaks across the country, and they have been caused by influenza A(H3N2).
- CDC released a health advisory to alert healthcare professionals of the increase in influenza A(H2N3) and the need to test for influenza and not just COVID-19.

### **Agenda Item 7: Update on Other Infectious Diseases**

Ms. Imelda Garcia, Associate Commissioner, Laboratory and Infectious Disease Services, provided an update on other infectious diseases and referenced a PowerPoint presentation entitled "Update on Other Infectious Diseases". Highlights of the update and task force member discussion included:

Other Notifiable Diseases in Texas:

- Within our NEDDS system we have reportable disease. For the NEDSS data; we do not have an overall denominator for positive tests.
- Notifiable conditions that have been reported to the state and to NEDSS: there was a peak in 2019 at 32,758 cases, including zoonotic diseases, respiratory diseases, and vaccine preventable diseases.
- In 2020, we see a sharp decline to 16,262 diseases and we know that there was a decline in people going to the doctor. There was an additional decline in 2021, but there were changes to the notifiable conditions at the beginning of 2021. We added candidiasis and tickborne diseases. The shifts in the numbers and decline can be attributed to the reduced number of conditions as notifiable.
- 2019-2021 Notifiable Diseases – salmonellosis, campylobacteriosis, shigellosis, streptococcus pneumoniae, carbapenem-resistant Enterobacteriaceae (CRA), shiga toxin-producing E. coli (STEC), varicella, and pertussis.
- We have about 90 conditions that are notifiable. Some of these are very rare and are only seen every few years.

Dr. Hellerstedt:

- I am wondering if there are multiple reasons if some people didn't report or whether some of the personal infection prevention measures are the result of the reduced number of notifiable diseases.

*Discussion*

Dr. Hellerstedt:

- Would like to hear what people think is ahead of us and comments from the members.

Dr. Lakey:

- Question on the last presentation: We know that DSHS saw an increase in congenital syphilis, are we still seeing this? I am also interested in seeing data on HIV and late-stage identification of HIV.

Ms. Garcia:

- Didn't include these rates in this presentation because there haven't been significant changes in cases since the last season. They did just close out their HIV data for 2020. Do not know if Texas will remain number 1 for congenital syphilis. Have not heard of late diagnosis for HIV.

Dr. LeDuc:

- Thank you for your focus on prevention measures. I have been disappointed in the low uptake of the COVID-19 vaccine. With the omicron variant I wonder if the state should have an aggressive campaign that focuses on the need for vaccination.

Dr. Hellerstedt:

- We have a budget and have messages that have been well researched and messaged for groups. We know that messages from trusted sources are the best way to reach individuals that are still unvaccinated. We are doing the best we can. It's not like we have the budget for a Superbowl campaign, but we have messages that are seen and are out there.
- We do feel like messages can come from everyone to encourage vaccination. I think to overcome this vaccine hesitation – I know there is a certain group of individuals that believe the vaccine is not safe – that overtime, they have seen their friends/family get vaccinated with no bad effects. Since there are over 10 million individuals that are eligible but are not vaccinated, and this is disappointing and a real risk to these individuals and those at risk in our community. And to emphasize right now we are seeing not omicron but delta killing people in our communities.
- Over all weeks we have seen thousands of people get their first dose. I hear from lots of people that they just won't get vaccinated and it is not a matter of safety or protection and I do not know what is the right message for those folks. But to your point, one of the biggest challenges for public health is credibility and to be trusted by the people and the people to believe you are telling them the truth. And in part, what has eroded that is as the science has evolved the recommendations have evolved and for those that are not familiar with science and public health, this has looked like to them that we do not know what we are doing.
- How to bridge that communication gap and that gap in trust. Like the change in the recommendations for boosters – that was complicated and to finally come down to everyone getting a booster. We are stuck because if we have a too negative message or too pessimistic message about the risk of omicron, people will think we are trying to manipulate them.

Dr. Hotez:

- I think that one of the things that I have seen among public officials that say that they support vaccines but what they will often do will qualify their statements like “I have been vaccinated but everyone has their choice to be vaccinated” so what I think happens is that people think they can get the vaccine or they can have their freedom. It is really important, whenever we can, to educate our officials that when they say these things it’s dangerous and not to go back to this freedom of choice and medical freedom. I think that this is causing the loss of life.

Dr. Hellerstedt:

- It is disappointing to me that the safety and effectiveness of the vaccine, and the minor risk/inconvenience, can convince individuals to not get vaccinated. Everyone is tired of the pandemic. And we need to end this pandemic. We need people to focus on prevention and reducing the circulation of the virus in our communities.
- How quickly do you think we will be able to get data about omicron?

Dr. Hotez:

- I think within the next week we will have information about neutralization of the virus by vaccines. This is not a vaccine effectiveness study but will give us an idea of how this will be affected. If it is the same as beta or lambda, then it might not be that big of a deal, but if it is higher, we will have an issue. I think it is important for everyone to get their booster.

Dr. Hellerstedt:

- We are now saying everyone should be boosted and I wonder how long it will take for us to change our definition of fully vaccinated.

Dr. Hotez:

- CDC has remained firm in their assertion that 2 doses of mRNA is enough to be called fully vaccinated, but I have come out publicly that I do not agree and believe everyone needs 3 doses to be fully vaccinated/protected.

Dr. Hellerstedt:

- We just received information that a third case of omicron has been detected in the U.S. and it is international travel related.

**Agenda Item 8: Public Comment**

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office, Facilitator, stated that there were no registrations for public comment and no requests for public comment were received during the meeting.

**Agenda Item 9: Planning and Discussion of Future Meeting Topics**

Commissioner John Hellerstedt, M.D., Chair, led the discussion and asked task force members to provide future meeting dates and topics. Highlights of member discussion included:

Dr. Hellerstedt:

- I bet we will be talking about COVID-19 for a while. I think it is a matter of when we revisit the pandemic. Valentine's day sticks out in my mind as a good time frame. I personally find the summary of other diseases to be useful, but I do not think that by February there will be any meaningful updates for these diseases. There was a mention of congenital syphilis.

Dr. Hotez:

- Would like an update on neglected tropical diseases.

Ms., Garcia:

- We have contractors that are working on this and we can provide an update on their work at the next meeting.

Dr. Hellerstedt:

- Hearing no objections on February 14, we will have an update on the COVID-19 pandemic, congenital syphilis, and neglected tropical diseases. There is flexibility to change the date, but there is a deadline of 10 days prior to a meeting to post the meeting information publicly.

**Agenda Item 10: Adjournment**

Commissioner John Hellerstedt, M.D., Chair, adjourned the meeting at 3:36 p.m.

Below is the link to the archived video of the December 2, 2021 Task Force on Infectious Disease Preparedness and Response that will be available for viewing approx. two years from date of meeting posted on the website and in accordance to the HHS records retention schedule.

[Task Force on Infectious Disease Preparedness and Response](#)