



GOVERNMENT + POLITICS HEALTH

Hospitals battling the COVID-19 surge sought state help for weeks. They haven't gotten it.

Internal emails show Northam administration won't reinstate previous emergency waivers

BY: **KATE MASTERS** - OCTOBER 5, 2021 12:03 AM



 Health care workers with the Carilion Clinic in Roanoke wear enhanced personal protective equipment inside the health system's facilities (Photo courtesy of the Carilion Clinic).

In mid-August, as the delta variant was surging across Virginia, hospitals reached out to Gov. Ralph Northam's administration for help.

“This rise in infections is once again placing significant stress on general hospitals and nursing facilities within the commonwealth,” wrote Sean Connaughton, president of the Virginia Hospital and Healthcare Association, in a letter to Health Commissioner Dr. Norman Oliver and Health Secretary Dr. Dan Carey. At the time, the seven-day average for new hospitalizations mirrored that of March, when Virginia was still recovering from a massive holiday surge.

Connaughton asked the administration to reinstate emergency waivers that had given hospitals the ability to quickly add bed capacity and hire out-of-state providers, among other regulatory changes that could provide flexibility.

“Staffing levels at these facilities are severely strained by a shortage of health care workers and trained health care professionals, exacerbated by fatigue, personal illness and family needs stemming from this long-term pandemic event,” he wrote. “It is further anticipated that COVID-19 will continue to place increased demands on the commonwealth’s health professional workforce.”

It was far from the only communication between health systems and the Northam administration. Emails from Carey’s office, obtained through a Freedom of Information Act request, show multiple hospitals began raising concerns over increasing caseloads around the same time. An Aug. 13 email from James Moss, the state hospital coordinator with the Virginia Department of Health’s Office of Emergency Preparedness, noted that facilities in Eastern Virginia were already “getting close” to exhausting their bed space.

“Sentara asked VHHA to have the governor reissue [executive order] to allow operating above their licensed capacity,” Moss wrote. “Given what we’re seeing statewide,” he added, “suggest we prioritize and proactively push up asap.”

More than a month later, though, there’s been no action by the administration to relieve hospitals in Eastern Virginia or anywhere in the state – frustrating many health systems and providers as they continue to struggle with a sharp rise in patients. New infections and hospitalizations have declined slightly since their peak in mid-September, the state’s worst surge since last winter. But the current COVID-19 hospitalization rate, at close to 2,000 weekly patients across Virginia, is still dramatically higher than it was this summer, when the weekly average dropped to [an all-time low of 220](#).

Clark Mercer, Northam’s chief of staff, said reimplementing the waivers would require the governor to declare another state of emergency at a time when not all hospitals were experiencing the same needs. He also said the administration had been in close contact with both the hospital association and individual health systems across the state, where hospitalizations correlated strongly with low vaccination rates.

“The numbers have been high, but they haven’t been unmanageable, that we’ve seen,” he said. And it’s true some of the earliest warning signs were among health systems – including Ballad in Southwest Virginia – where less than half of the service population has been fully

vaccinated against COVID-19 (so far, the system [hasn't mandated vaccines](#) for its own employees, either).



📷 *Carilion, a hospital system in Southwest Virginia, erected a tent outside one of its emergency rooms in preparation for a growing spike in visits. (Courtesy of Carilion Clinic)*

But the ongoing pandemic isn't the only challenge that hospitals are confronting. Across the state, emergency rooms [have been overwhelmed](#) by an influx of sicker-than-normal patients – driven, doctors say, by delayed care throughout much of the pandemic. And as [pediatricians struggle to keep up with exposures at school](#), many families are flocking to their local hospitals for testing.

The demand for medical care is continuing to reverberate across Virginia, even in areas with higher vaccination rates. Dr. Cameron Olderog, president of the Virginia College of Emergency Physicians, said Inova Fairfax was diverting patients last week as the system struggled to keep up with demand (nearly 74 percent of the county's adult population is fully vaccinated). The same week, Mary Washington Healthcare in Fredericksburg became the latest system to postpone elective procedures, even with close to [60 percent of adults](#) fully vaccinated in the city and surrounding counties.

“At this point, we’re still awaiting potential action by the administration,” said Julian Walker, vice president of communications for the hospital association. “Many of our members are struggling right now. And whether it’s scaling back visitation or postponing elective procedures, all of these are in response to the pandemic surge and the strain on both hospitals and the team members who work there.”

Hospitals want the reinstatement of waivers that were in place for much of the pandemic under an [emergency order](#). In early 2020, Northam allowed Oliver to [authorize new hospital beds](#) without requiring facilities to go through the state’s lengthy licensing process. The order eventually included more than half a dozen additional waivers, including [liability protections](#) for medical professionals and allowing out-of-state providers in good standing to practice in Virginia.

Those provisions expired on July 1, when Northam’s emergency order came to an end. But Connaughton pointed out in his letter that, at the time, both cases and hospitalizations were as high as they were in March, when the waivers were still in place. Even with the recent drop, metrics remain far higher than they were at the start of the pandemic, when Northam himself ordered a statewide pause on elective procedures and [mobilized the National Guard](#) to respond to an anticipated surge.

“It is further anticipated that COVID-19 will continue to place increased demands on the commonwealth’s health professional workforce that will require additional personnel, including for the ongoing administration of COVID-19 vaccines,” Connaughton wrote. Staffing is currently [a huge problem](#) facing hospitals in Virginia and across the country, heightening the competition for nurses, respiratory therapists and other much-needed medical providers.

Olderog said any flexibility that would allow more practitioners to enter the field – from waiving state licensing requirements for out-of-state providers to re-expanding telehealth or [easing practice regulations](#) for nurses – could be helpful. COVID-19 hospitalizations and high ER demand are putting an additional strain on staff, as is the drive for new treatments such as [monoclonal antibody therapy](#).

“At any point we that we can allow somebody to practice at the full extent of their abilities, it frees up other providers,” she said. “Right now, the biggest resource we’re running out of is people.”

According to Mercer, though, those staffing needs likely wouldn’t be met by reinstating emergency waivers. “Some of the requests they’ve put in aren’t going to address the fact that there just aren’t enough nurses right now,” he said. The administration has suggested state legislators could be taking a more active role to assist hospitals, from promoting vaccines in their home districts to taking up legislation that could allow the state health commissioner to independently waive regulations during a public health emergency.



📷 Clark Mercer, chief of staff to Gov. Ralph Northam, discusses an investigation into the Virginia Parole Board at a news conference in 2020. (Ned Oliver/Virginia Mercury)

“That would probably be a good thing for the General Assembly to look at,” Mercer said. Northam, for his part, has also continued to emphasize vaccinations as the single biggest solution to relieving hospitals and ending the ongoing pandemic.

“We’re fighting a virus and we’ve all got to step up to the plate and be part of the solution,” Northam said at a news conference last week. “We’ll do everything we can to keep the staffing, keep the beds open, but it’s getting to the point where we don’t have as many answers as we’d like.”

At least internally, though, there’s been acknowledgement that state leaders may have to consider other solutions to significantly reduce COVID-19 hospitalizations. In a Sept. 1 email, one VDH staffer raised the possibility of establishing clinics for monoclonal antibodies – a laboratory-designed drug that can temporarily help the immune system ward off severe symptoms of COVID-19 – at both local health departments and at more hospitals across the state.

“With about 45 percent of Virginians not fully vaccinated and the delta variant showing no current signs of slowing down, I believe we need to work with our private sector partners to discuss planning,” wrote Dr. Brooke Rossheim, a public health physician specialist for the

department. Some individual hospitals have submitted their own requests for assistance, including [hard-hit Augusta Health](#), which requested National Guard support from both the state and federal government.

“So many other hospitals find themselves in similar situations to ours, and resources are strained everywhere (compounded by recent developments calling for those same limited resources to help with Haitian refugees in Texas and Afghani refugees in Northern Virginia),” Augusta Health spokeswoman Lisa Schwenk wrote in a Monday email. “We appreciate there is a lot of competition for these same resources.”

It’s not clear how the current strain will evolve in the coming months. Modeling from the University of Virginia, widely relied on by state officials, suggests the state [could see another peak](#) through the week of Oct. 17. More pessimistic projections suggest cases could rise steadily through the holiday season even as vaccination rates continue to increase – something Connaughton said many hospitals are expecting.



 Health care workers screen a patient for COVID-19 at a drive-through coronavirus testing site on March 18, 2020 in Arlington, Virginia. (Photo by Drew Angerer/Getty Images)

Even without a continued spike in patients, higher-than-normal numbers of COVID-19 hospitalizations could complicate efforts for facilities, especially amid the current staffing shortage. Mercer suggested that not all hospitals are collaborating to transfer patients when there’s a shortage of space. But Olderog said a lack of fully staffed beds has been the real

problem. Transferring patients can be complicated, and often can't occur if an open facility can't meet the person's medical needs.

“If a patient is vomiting blood and needs a gastroenterologist, they probably also need an ICU bed,” she said. “And finding both those things – a GI doctor and a place with an available bed – can be really difficult.

“There's a fair amount of head-in-the-sand right now,” she added. “I understand people want to keep things open as much as possible, but there's a lot of stress on the medical system.”



[REPUBLIC](#)

Our stories may be republished online or in print under Creative Commons license CC BY-NC-ND 4.0. We ask that you edit only for style or to shorten, provide proper attribution and link to our web site. Please see our republishing guidelines for use of photos and graphics.



KATE MASTERS [✉](#) [🐦](#)

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

[MORE FROM AUTHOR](#)

RELATED NEWS



Across cultural lines, home schooling has boomed...

BY **JEFF SOUTH**

January 3, 2022

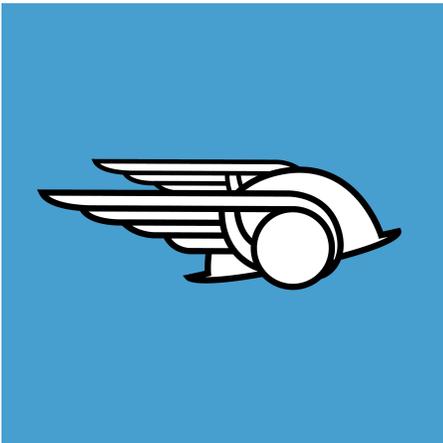


Pandemic deaths fail to shake loose a legislative...

BY **KATE MASTERS**

March 25, 2021

A NEW LOOK AT THE OLD DOMINION



From the push to remove Confederate statues to big shifts in healthcare and energy policy, the Old Dominion is changing; fair and tough reporting on the policy and politics that affect all of us as Virginians is more important than ever. The Mercury aims to bring a fresh perspective to coverage of the state's biggest issues.

[Ethics Policy](#) | [Privacy Policy](#)



Our stories may be republished online or in print under Creative Commons license CC BY-NC-ND 4.0. We ask that you edit only for style or to shorten, provide proper attribution and link to our web site.





COVID-19 HEALTH

Virginia health officials race to shift their sequencing strategy as omicron cases emerge

Right now, the state lab isn't sequencing enough COVID-19 samples to confidently pick up on new variants

BY: **KATE MASTERS** - DECEMBER 3, 2021 12:03 AM



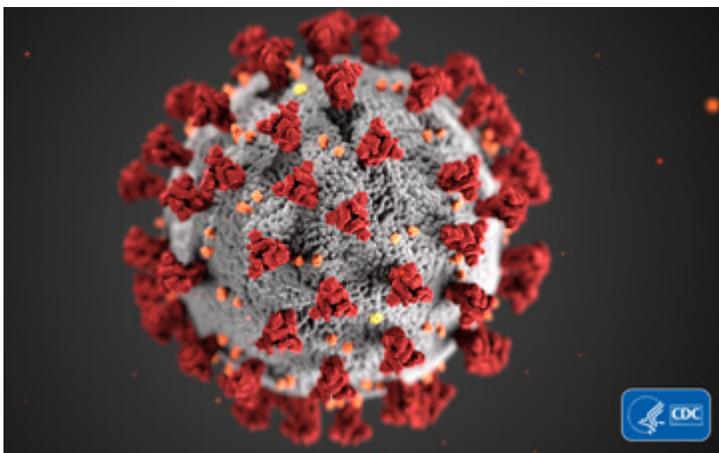
📷 A woman is tested for COVID-19 in a parking lot in Richmond where the health department set up a temporary walk-up testing center. (2020 photo by Ned Oliver/Virginia Mercury)

For months, whenever a lab in Virginia sequences a sample of the virus that causes COVID-19, it's almost unfailingly been linked to the delta variant.

“It’s been really hard to see anything but delta,” said Dr. Amy Mathers, director of the clinical laboratory at UVA Health. Nationally, it accounts for [99 percent of new coronavirus cases](#). Over the month of September, Mathers’ lab analyzed more than 1,000 samples from Virginia and didn’t find a single other variant. But after months of concern over the highly infectious form of the virus, public health experts have a new variant to worry about.

There’s much that’s still unknown about omicron, a new version of the SARS-CoV-2 virus first detected in South Africa and now identified in [two U.S. states](#). Virginia has yet to report a case. But the emergence of the lineage – classified as a “[variant of concern](#)” by the World Health Organization and U.S. Centers for Disease Control and Prevention – is forcing Virginia to revamp its detection strategy. That responsibility largely falls to the state’s public health laboratory, which has been analyzing samples of the virus since [early in the pandemic](#).

More accurately known as whole genome sequencing, it’s a way of unraveling the entire genetic code of the virus. And as SARS-CoV-2 has evolved into new and sometimes more dangerous variants, it’s been a crucial tool in identifying cases linked to those lineages. COVID-19 tests can verify if a person’s contracted the disease, but only sequencing can confirm whether it’s a version of the virus caused by a variant of concern.



This illustration, created at the Centers for Disease Control and Prevention (CDC), shows a coronavirus virus virion, or virus particle, including the spikes that adorn the outer surface, which impart the look of a corona surrounding the virion. (CDC Public Health Image Library)

But Virginia, like many states, is still limited in its sequencing capacity. While there have been improvements over the course of the pandemic, the state has only sequenced around [2.7 percent](#) of its total coronavirus cases, according to data from the CDC. It’s higher than some neighboring states (Kentucky and Tennessee, for instance, have sequenced less than 2 percent of their total cases), but lower than neighbors like West Virginia and far lower than national leaders including Vermont and Wyoming, which have each sequenced more than 20 percent of their cumulative cases.

Virginia, of course, has a much higher population than either state and has recorded more than eight to 10 times the number of COVID-19 cases. But Dr. Denise Toney, director of the state’s public health lab, has acknowledged she’d like to boost Virginia’s sequencing numbers.

Currently, the state has the capacity to sequence between 800 and 900 samples a week through its public health laboratory and two contracted partners – Mathers’ lab at UVA and Virginia Tech’s Fralin Center. However, Toney said Virginia would need to sequence between 1,100 and 1,400 samples a week to be 95 percent confident that it could pick up omicron if it was circulating in the community.

“That’s based on some of the UVA modeling that’s been shared with us,” she said. And while the public health lab is sequencing every positive COVID-19 test result it processes, it’s also conducting far less testing than it’s able to. The state’s laboratory network, including UVA and Virginia Tech, has the capacity to test more than 5,000 samples a day, according to Toney. Currently, though, it’s only running between 500 and 600.

“Many hospitals now have the capacity to do their own testing so they don’t need to send it to us,” Toney said. “Lots of school systems, correctional facilities have all brought on the point-of-care tests. There’s so much testing out there that there’s not a need to send samples to the state laboratory anymore.”

In some ways, it’s a major advancement over the early days of the pandemic, when Virginia’s public health lab was the only source of COVID-19 testing in the state. But as officials increasingly recognize the importance of detecting new versions of the virus, the abundance of at-home tests has, in some ways, become a barrier to variant surveillance.



📷 Dr. Denise Toney, the director of Virginia’s state laboratories, answers questions at a briefing on the spread of COVID-19 in Virginia. (Ned Oliver/Virginia Mercury)

Omicron, for example, has multiple mutations along its spike protein, a target of some PCR-based tests. When a sample linked to the variant is tested through those platforms, it can register as a target failure, or [S-gene dropout](#) – a key clue to send the sample for sequencing.

The state lab is currently conducting all of its testing on a platform that targets the S-gene to better isolate potential cases of suspicious variants (the B.1.1.7 lineage, sometimes better known as the UK variant, had the [same testing failure](#)). Over time, though, PCR tests have increasingly been supplanted by antigen or at-home test kits, with samples (and results) that generally aren't passed on to the state.

“A lot of community testing is now antigen-based, for example,” Toney said. “And those don't have residual samples to be used for genetic sequencing.”

Even with those limitations, expanding capacity is largely a function of funding. Mathers said the CDC has recognized the importance of better variant surveillance, but her lab doesn't currently have the funding to significantly boost its numbers. The state's public health lab has added additional sequencing equipment over the pandemic, including, most recently, a robotic system that will automate much of the prep work. Still, Toney said it will likely only boost capacity by around 100 samples a week.

“Of course, if we could spend a lot of money to get 20,000 samples sequenced a day, that would be even better,” said Madhav Marathe, director of the Network Systems Science and Advanced Computing Division of UVA's Biocomplexity Institute. Responsible for much of the pandemic-related modeling and predictions across the state, the institute helped develop target sequencing numbers based on an equation that includes the prevalence of new cases across Virginia.

Still, Marathe said a fundamental shift in strategy could be just as helpful as boosting capacity. Like many states, Virginia has largely focused its sequencing efforts on cases with potential public health consequences – including those linked to fast-spreading outbreaks or vaccine breakthroughs. Those can be a useful indicator of possible variants, but with little real information on how the omicron lineage behaves, detecting it might require casting a wider net.

“We're shifting attention from prevalence and outbreaks to a variant detection program,” he said. “So, what gets sent in has to change in some form.” Both the state lab and the Virginia Department of Health have asked testing providers to send in any samples that register as an S-gene dropout on PCR platforms. They've also asked hospitals and commercial labs to submit at least 50 percent of their positive samples to the state's laboratory network for sequencing. (The state lab first made the request in July, as the delta variant was becoming prevalent, but the number of samples has dropped off over the last few months, according to Toney.)

“We're also looking to expand our capacity by bringing on new partners or establishing partnerships with other laboratories,” she said. “So if there were an instance where we had to ramp up significantly, we would have that in place.”

Better sequencing – in Virginia and nationwide – can offer essential information on how new variants behave once they're circulating in a community. Omicron has attracted global attention for both the number and location of mutations along its genetic sequence, which have been associated with increased transmissibility and the potential to evade existing

immunity through vaccines or previous infections. But Mathers said it's still unclear if the variant will actually demonstrate those traits, or if it's transmissible enough to outpace the delta variant.

"I don't know if I'm a big fan of the level of hype it's getting," she said. "I think it's a little early." But expansive sequencing could help answer fundamental questions if the virus begins to circulate widely, such as whether omicron might be linked to more severe symptoms of disease.

"If you were to predict how this virus might behave, without much data, you would say it's going to misbehave," Mathers said. "But right now, we can't say anything for sure."

REPUBLIC

Our stories may be republished online or in print under Creative Commons license CC BY-NC-ND 4.0. We ask that you edit only for style or to shorten, provide proper attribution and link to our web site. Please see our republishing guidelines for use of photos and graphics.



KATE MASTERS  

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

MORE FROM AUTHOR

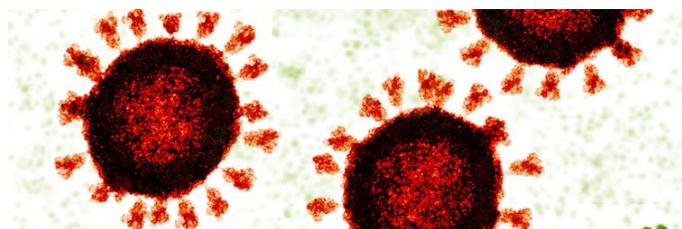
RELATED NEWS



How effective are vaccines against omicron? An...

BY GUEST COLUMN

December 17, 2021



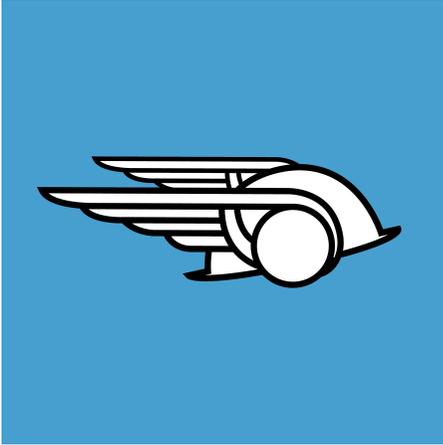
How can scientists update coronavirus vaccines for omicron?

BY GUEST COLUMN

December 3, 2021

A NEW LOOK AT THE OLD DOMINION

DEMOCRACY TOOLKIT



From the push to remove Confederate statues to big shifts in healthcare and energy policy, the Old Dominion is changing; fair and tough reporting on the policy and politics that affect all of us as Virginians is more important than ever. The Mercury aims to bring a fresh perspective to coverage of the state's biggest issues.

[Ethics Policy](#) | [Privacy Policy](#)



Our stories may be republished online or in print under Creative Commons license CC BY-NC-ND 4.0. We ask that you edit only for style or to shorten, provide proper attribution and link to our web site.





COVID-19 HEALTH

Virginia's breakthrough case numbers are likely an undercount

Issues with data reporting made it difficult to report and verify cases among vaccinated people

BY: **KATE MASTERS** - AUGUST 27, 2021 12:04 AM



 Health care workers screen a patient for COVID-19 at a drive-through coronavirus testing site on March 18, 2020 in Arlington, Virginia. (Photo by Drew Angerer/Getty Images)

Earlier this week, the Virginia Department of Health updated its [public reporting](#) on breakthrough COVID-19 cases to “more accurately represent the impact of vaccinations on infection rates in the commonwealth,” according to a release from the agency.

As the [Mercury reported](#), the data illustrates the higher risk for infection, hospitalization and death among unvaccinated Virginians. But the way it's presented makes it tough to calculate the [prevalence](#) of breakthrough infections in the weeks since the Delta variant began to account for the vast majority of cases across the country.

In other words, VDH isn't reporting the percentage of breakthrough cases out of all total known infections week-by-week. That makes it hard to know exactly how many of those cases are occurring among immunized Virginians amid the rise of a highly infectious variant that's been shown to [reduce the effectiveness](#) of available vaccines.

Even without that data, though, recent state reporting has seemed to suggest that Virginia's breakthrough infection numbers are curiously lower than other states – and even localities within the commonwealth. Before VDH changed its dashboard, the department was reporting that less than two percent of all reported COVID-19 cases between January and early August were among vaccinated Virginians. At the same time, some local health departments were reporting numbers that would ostensibly drive up that total.

Prince William, for example, announced that between [25 to 30 percent](#) of its recorded cases throughout the first half of July were breakthroughs.

“And I don't think Prince William is an outlier,” District Epidemiologist Sean Morris told the Mercury. But even national reporting has described Virginia as strangely immune to infections among vaccinated residents. Last week, The New York Times reported that data from seven states – including Virginia – reflected a rise in breakthrough cases. Virginia was the “[outlier](#)” of the bunch with 6.4 percent of its recorded infections among the fully vaccinated. In the other six states, they accounted for 18 to 28 percent of total cases in recent weeks.

It turns out the discrepancy has less to do with Virginia's good luck and more to do with a likely undercount of breakthrough cases. And VDH officials say that determining the actual prevalence of breakthrough cases from week to week is “discouraged.”

'HARDER TO VERIFY'

Prior to Aug. 19, VDH relied on laborious manual reporting to confirm an infection occurred in a fully vaccinated person. According to Dr. Julia Murphy, VDH's state public health veterinarian (who, in the midst of the pandemic, is also assisting with the state's overall epidemiological response), multiple things had to happen before a breakthrough case could be identified.

“First, the person needs to be tested for COVID-19 and test positive,” Murphy wrote in an email. Once a positive case is registered with VDH, it's assigned to a local case investigator. Before last week, that investigation was an important – and sometimes critical – part of verifying a breakthrough infection. The investigators are tasked with asking more than two dozen questions to help determine the severity of a case and potential exposures – including whether the patient was vaccinated.

The details of a patient’s vaccination status are important. For an infection to count as a breakthrough, there needs to be proof the person completed a full vaccine series (two doses in the case of the Pfizer and Moderna vaccines and one in the case of Johnson & Johnson) in the [time frame recommended](#) by federal health officials. There also needs to be confirmation that the patient completed the series at least 14 days before the positive test.



 *Syringes are prepped with the Moderna COVID-19 vaccine before being administered at Richmond Raceway in Richmond, Va., Feb. 2, 2021. (Parker Michels-Boyce/ For the Virginia Mercury)*

In Virginia, public reporting includes infections among partially vaccinated people, as well. Confirming those cases requires verification that the patients hadn’t completed a full vaccine series, completed it outside the recommended time frame, or got sick less than 14 days after they received their full vaccine course, the time it takes for someone to be considered “fully vaccinated.”

Positive COVID-19 test results are reported in VEDSS, the Virginia Electronic Disease Surveillance System. Before Aug. 19, though, there was no integration between VEDSS and VIIS, or the Virginia Immunization Information System, where vaccinations are recorded.

“The process of comparing data in these systems used to be performed manually by a COVID-19 case investigator,” Murphy wrote. If those investigators couldn’t reach a patient to confirm vaccination status – which happened around 35 percent of the time in the last week of July, according to [VDH data](#), and roughly 53 percent of the time from Aug. 13 to 19 – they would

have to find that person in the state's vaccination registry and manually transcribe the information into its disease surveillance system.

And while some local health districts took that step, it didn't always happen.

"If a case investigator could not contact a case, that case's vaccination status information was harder to verify and, therefore, may not have been captured as a breakthrough," Murphy wrote.

For much of July and August, there were other factors complicating the reporting. The lack of automation made vetting fully vaccinated cases more challenging at the state level. Before the two systems were integrated, VDH's central office in Richmond manually reviewed every identified breakthrough infection before reporting it on the public dashboard. Murphy said that contributed to the data lag and the apparent discrepancies between state and local data.

"Now that cases are being automatically cross-referenced between VIIS and VEDSS, more cases will be reported that have not been individually reviewed by Central Office," she wrote. "The data will more closely match what local health departments are reporting."

'THERE MAY BE LESS OF A MARGIN FOR ERROR'

But even now, it's likely breakthrough cases are still being underreported. The majority of those infections are mild or asymptomatic, making it less likely a patient will seek out testing. And at this point in the pandemic, the market is inundated with at-home testing options, which generally aren't passed on to VDH unless patients disclose their results to a medical provider or local health department.

It's nearly impossible, then, to confirm exactly how many breakthrough cases occurred in Virginia over the last month and a half, as Delta became the dominant variant across the country. From the available data, it's clear rates of known infections among the fully vaccinated have nearly quintupled between early April – when vaccines became widely available – and Aug. 14, the state's most recently available data. VDH's new public dashboard also includes the total number of known breakthrough cases, but it's not clear how they compare to all new COVID-19 infections from week to week.

Trying to calculate that prevalence is "discouraged," Murphy wrote, "for several reasons." As the Mercury reported earlier this week, state health officials have been concerned that a growing focus on breakthrough cases will minimize the success and importance of vaccines. Dr. John Swartzberg, a clinical professor emeritus of infectious diseases and vaccinology at the University of California, Berkeley School of Public Health, pointed out that an "infection" doesn't correlate with actually getting sick.



GET THE MORNING HEADLINES DELIVERED TO YOUR INBOX

SUBSCRIBE

“Infection just means you have the virus that’s replicating in you,” he said. “It doesn’t say anything about whether you have symptoms or not.” Vaccines that prevent the development of severe disease, including hospitalization and death, are a public health success. And currently available vaccines are still so successful at preventing those outcomes that some public health experts argue booster shots [aren’t really necessary](#).

As more and more people get immunized, and cases continue to rise, Murphy pointed out that a higher number of breakthrough infections is an expected outcome. In an interview earlier this month, state epidemiologist Dr. Lilian Peake gave the example of a 2006 mumps outbreak at the University of Virginia. The college required students to be immunized, so 100 percent of the cases were in a fully vaccinated population. But the high level of vaccination still meant very few people contracted the virus.



📷 Virginia State Epidemiologist Dr. Lilian Peake spoke at a press conference on Capitol Square. (Ned Oliver/Virginia Mercury)

“It was a highly effective vaccine, but once you have a high proportion of the population vaccinated, the data is skewed,” she said. Still, some public health experts have criticized the overall lack of data on breakthrough infections, especially when it comes to mild cases. [For researchers](#), knowing the true number of infections is important for parsing out [the reasons why they’re occurring](#) and whether some people are more vulnerable than others. But obscuring those numbers can also minimize the risk of transmission for vaccinated people.

“I think what we’re seeing is that viral loads can get very high with Delta,” Dr. Michael Mina, a Harvard epidemiologist, told [New York Magazine](#) earlier this month. “The idea that we’re going to vaccinate our way to true herd immunity – that idea has to be put to bed for a moment.”

And while Virginia’s data highlights that the relative risk of infection, hospitalization and death is much greater for unvaccinated residents, prevalence can help underscore the importance of continued mitigation measures like mask-wearing, social distancing and continuing to exercise caution about potential exposures.

“We know that if you get vaccinated, you prevent yourself from the worst outcomes,” Morris said. “But there may be less of a margin of error than with less transmissible versions, which means you really have to be on top of it and make sure you’re doing what’s recommended.”

SUPPORT NEWS YOU TRUST.

[DONATE](#)

[REPUBLISH](#)

Our stories may be republished online or in print under Creative Commons license CC BY-NC-ND 4.0. We ask that you edit only for style or to shorten, provide proper attribution and link to our web site. Please see our republishing guidelines for use of photos and graphics.



KATE MASTERS [✉](#) [🐦](#)

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

[MORE FROM AUTHOR](#)

RELATED NEWS



What is a breakthrough infection?

BY GUEST COLUMN

July 30, 2021



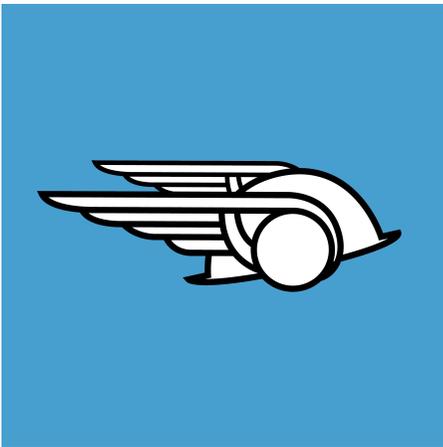
How common are breakthrough infections in Virginia?...

BY KATE MASTERS

August 24, 2021

A NEW LOOK AT THE OLD DOMINION

DEMOCRACY TOOLKIT



From the push to remove Confederate statues to big shifts in healthcare and energy policy, the Old Dominion is changing; fair and tough reporting on the policy and politics that affect all of us as Virginians is more important than ever. The Mercury aims to bring a fresh perspective to coverage of the state's biggest issues.

[Ethics Policy](#) | [Privacy Policy](#)



Our stories may be republished online or in print under Creative Commons license CC BY-NC-ND 4.0. We ask that you edit only for style or to shorten, provide proper attribution and link to our web site.

