

Transcript for CDC Media Telebriefing: Update on COVID-19

Press Briefing Transcript

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Key Metrics:

- › [Daily Update for the United States](#)
- › [COVID-19 by County](#)
- › [Variant Proportions](#)

Moderator:

Welcome and thank you for standing by at this time, all participants are in a listen mode until the question and answer session of today's conference. At that time, you may press star one on your phone to ask a question, I would like to inform all parties that today's conference is being recorded. I want to turn today's call over to Jason McDonald. Thank you, sir. You may begin.

Jason McDonald:

Thank you, Denise. And thank you to all who have joined us today for today's COVID 19 update. We are joined by CDC Director, Dr. Rochelle Walensky and Dr. Kristie Clarke. Dr. Walensky will provide opening remarks followed by Dr. Clarke, who will give an overview of a new report being released today in CDC's MMWR. After remarks, Dr. Walensky, Dr. Clarke, and Dr. Meyer will be happy to take your questions. This is an on the record briefing and embargoed until 1:00 PM Eastern. At this time, I will turn the call over to Dr. Walensky.

Dr. Rochelle Walensky:

Thank you, Jason. And good afternoon, everyone. Thanks for joining this call today. I'll start by giving you an update on the state of the pandemic, and then turn it over to Dr. Kristie Clarke, who will provide some details on a report we are releasing in the MMWR today. Overall, we continue to have some mixed trends as seen on slide 1, deaths fortunately are continuing to trend downward with a 70 average of about 300 per day, which represents an, um, estimated 18% decline from the prior week. Hospital admissions also remain low at about 1600 per day, but we should note that for the second week in a row, they are slowly trending upwards and increase of about 9%. this week from the prior week. Cases also remain comparatively low to where we were even a month ago at about 44,000 per day. Though, this too has represented an increase of about 25%

Dr. Rochelle Walensky:

in the past week. We are aware that many are using rapid antigen tests that may not be reflected in the total daily case counts. Our data show that we are still doing over 650,000 PCR tests daily. And while this is about a fivefold reduction in PCR testing then was done during the omicron peak in January and February, we are now recording 70 fold fewer cases suggesting that our reported cases counts do reflect a true and reliable drop in our overall cases. We're of course, continuing to follow trends in positive PCR tests and have also looked at data on a selected share of rapid tests. The

trends are largely similar, and we continue to believe that our PCR testing data, especially when we corroborate it with information from our other surveillance systems like wastewater surveillance and emergency department and hospital surveillance provide us a reliable picture of the trajectory of COVID-19 across our country.

Dr. Rochelle Walensky:

Last Thursday, CDC updated COVID-19 community levels shown on slide 2. I'd like to call your attention to upstate New York and the Northeast region where we have an increased number of cases in hospitalizations, the counties in orange or high COVID-19 community level reflect just a small subset of counties and of the United States population. But these are areas CDC recommends people should wear a mask in public indoor settings due to an increasing level of severe disease and the potential for significant healthcare strain. Similarly, the counties in yellow or medium, many of which are in the Northeast and Puerto Rico are areas to watch carefully and where those who are immunocompromised or at risk of severe disease might consider wearing a mask in public indoor settings and where screening testing, and other prevention strategies may be implemented at the individual or community level. I wanna move now to slide 3 and the latest on our genomic surveillance of variants and their lineages and sub lineages, we're sequencing thousands of viruses per week through our national SARS-CoV-2 strain surveillance and contracts with diagnostic and sequencing groups across the country to understand what is out there in the United States. Essentially, a hundred percent of what we're finding now is Omicron though different lineages or sub lineages may be more common in each region. This means that if a new variant were starting to spread, we would identify it quickly. As a reminder, it was the BA.1 Omicron sub variant that caused the surge early in the year. Right now, BA.1 is only about 3% of the sequences identified. We are now more commonly finding the BA.2 Omicron sub variant, which makes up about 68% of circulating virus. More recently, we're finding the BA.2.12.1 sub variant, which was first identified in upstate New York, and which makes up nearly 30% of sequences identified nationally. We are just starting to learn about the impact of BA 2.12.1.

Dr. Rochelle Walensky:

It appears it might have a transmission advantage of about 25% over the BA.2 sub variant. Additional evaluation is currently underway to understand the impact of BA.2.12.1 on vaccine effectiveness. But importantly, we continue to believe that those who are vaccinated and especially those who are boosted continue to have strong protection against severe disease, even from BA.2.12.1. Today, CDC will release a report in the MMWR that looks at the proportion of the United States population with infection induced antibodies. And we're fortunate to have with us on this call, Dr. Clarke, the lead author of that study, to answer your specific questions about those data. Before we take your questions, I'd like to turn it over to Dr. Clarke, to say a few words about the study and its key findings. Thank you, Dr. Clarke.

Dr. Kristie Clarke:

Thank you, Dr. Walensky, good to be with you all. Today, we will release a report in the, MMWR that looks at the percentage of the US population with evidence of prior infection with SARS-CoV-2, the virus that causes COVID-19. This study was conducted on clinical blood samples from all parts of the country and looked at the percentage of the US population that developed antibodies to the nucleocapsid protein. This antibody develops in response to infection from SARS-CoV-2, but not in response to vaccination. By February 2022 evidence of previous COVID-19 infections substantially increased among every age group compared, especially to December 2021. And this is a period where we would expect to see it reflecting the increase in cases that we noted as Omicron surge in this country. The highest jump of antibody detection was among children and adolescents. Now overall between December 2021 and February 2022 thorough seroprevalence, in other words, the presence of antibodies to the virus in the bloodstream increased across all US age groups from 34% in December 2021 to 58% in February 2022.

Dr. Kristie Clarke:

Again, this study was only looking at the presence of antibodies from prior infection and did not detect antibodies from prior vaccination, whether it be primary series or boosting. The largest increases were observed, as I mentioned, among children and teens, those 17 and younger of whom by February 2022, roughly 75% or 3 in 4 had developed antibodies due to prior infection. Having infection induced antibodies does not necessarily mean you are protected against future infection. We measured the proportion of the population with any detectable level of these antibodies, and this type of antibodies stays positive for at least two years after infection. We did not look at whether people had a level of antibodies from prior infection that provides protection against reinfection or severe disease. Previous infection has been shown to provide some protection against severe disease and hospitalization. And vaccination either before or after infection provides additional protection.

Dr. Kristie Clarke:

Additionally, we still do not know how long infection induced immunity will last, and we cannot know from the study again, whether all the people who tested positive for SARS-CoV-2 antibodies continue to have protection from their prior infection. What we do know is that vaccination is a safe and effective way to get robust immune protection. For specific amount of time, CDC continues to encourage all Americans to stay up to date with their COVID-19 vaccinations. And while those who are under the age of five are not yet eligible for vaccination, the best way to protect them is to make sure that they are surrounded by people who are taking preventive measures, like staying up to date with their vaccines. With that. I'd like to turn it back to Jason for any questions.

Jason McDonald:

Thank you, Dr. Clarke, Denise will start with our first question for the reporters on the phone. We will do one question and one follow up. Go ahead.

Moderator:

Thank you. The first question comes from Erika Edwards with NBC news. Your line is open.

Erika Edwards – NBC:

Thank you so much for doing this briefing and for taking our questions. You know, clearly you're seeing this dramatic increase in kids with COVID. Given what we know about increasingly contagious sub variants and the fact that the youngest children do not have access to the vaccines. Are you concerned that these sub variants will continue to plow through, you know, these most vulnerable pediatric populations, perhaps leading to long term consequences? And I'm also curious really how parents should interpret this study. Should they bother getting vaccines for kids who are eligible given this high seroprevalence? Thank you.

Dr. Rochelle Walensky:

Dr. Clarke, do you want to take that question?

Dr. Kristie Clarke:

Oh, of course! Thank you so much for that question, Erika. So there are a couple of aspects to your question. First, you talked about the increased seroprevalence among children, which was quite striking over this Omicron time period. And I think that some of the important things to note here are that these findings and seroprevalence reflect some of the things that we saw in terms of clinically and through our other surveillance systems during Omicron, where during the Omicron wave compared to Delta peak hospitalization among kids was 2.9 times higher, with ICU admission rates 1.4 times higher, and five times increase in the hospitalization rates among kids aged at zero to four. But at the same time, there was no difference in the proportion of those hospitalizations where the primary reason for admission was COVID-19.

Dr. Kristie Clarke:

So, this really reinforces some of our previous findings, and then to your second point regarding parents, now I'm a pediatrician and I've talked to a lot of parents who, you know, have questions about vaccination over the years. And the first thing I always do is just to listen to them. I know they're coming from a place of wanting to make the absolute best decision for their child. I have a four year old myself and I have in common with every parent everywhere. I just want my kid to grow up happy and healthy. And so after, you know, hearing their concerns and I can see that some people would wonder with this high seroprevalence regarding, vaccination. So that's why I wanna be really specific in responding to this question. So first of all in kids, COVID can certainly be quite severe.

Dr. Kristie Clarke:

We see, you know, among those that are hospitalized, 20 to 30% going to the ICU, and that's especially among our very important population of kids with special healthcare needs. And then multisystem inflammatory syndrome in children, that happens 60 to 70% of the time in previously healthy kids. We also know that post COVID conditions can occur. And

so, and there is evidence that all of these outcomes can help to be protected by vaccination. And we also know that there is an impact of vaccine among those that are previously affected in terms of a subsequent infection leading to hospitalization. Another important thing to consider is that when we see a new variant, like we did with Omicron, that is when we start to see more cases of reinfection. And so when you're looking at whether to vaccinate a child, you need to also think about giving them broad protection. And so not just to, you know, an infection might effect with Omicron, but also to the vaccine, it really maximizes the protection to their kids. So overall we know SARS-CoV-2 infection can cause severe disease, whereas COVID-19 vaccination is safe and effective at preventing it. So as a pediatrician and a parent, I would absolutely continue to endorse that the children get vaccinated, even if they have been previously infected. Next question.

Moderator:

Next question is from Lena Sun with the Washington Post, your line is open.

Lena Sun – Washington Post:

Hi, thanks for taking the question and for doing the briefing. Either Dr. Walensky or the Dr. Clarke could you perhaps for the general public and also my editor, explain what is the takeaway? What is the significance of knowing that nearly 60% of the American population have these antibodies that mean that there was a previous infection and what does that mean? Does it just reinforce what we know? Does it tell us that more people were infected than we previously knew? And also not just for the kids, but a lot of adults, as you know, don't want to do any more mitigation measures or even get vaccinated and would they interpret this to mean we don't need to bother because we already have natural immunity.

Dr. Kristie Clarke:

Hi there. Yeah, absolutely. Thank you so much for that question. So in terms of what this means it's important to look at all of different ways that we can track COVID-19. And we know that the reported cases are just the tip of the iceberg. We all know that there are some infections that go unreported either because they're, you know, asymptomatic, mild, the person didn't get tested, or it didn't get reported. So seroprevalence is an important piece of the puzzle and it helps us to really understand more kind of the public health picture for COVID-19. And then, you know, in terms of what this means in terms of infection rates, we have done another study which will be released in pre-print soon. We look at the number of estimated infections per reported case.

Dr. Kristie Clarke:

And we know that that it's going up and that now there are a bit over three estimated infections for each reported case, which is the highest level that it's been. So that's why this is sort of an important part of the puzzle in terms of contextualizing our case data. If you're asking a second part of your question, I believe was regarding kind of some thoughts about no need to take, to continue to take measures, because of high population level seroprevalence. So it's important to note that there's, first of all this could not be accurately understood as a proportion of people who have protection against reinfection. We know that that is not what this means reinfection happens and infection after vaccination can happen.

Dr. Kristie Clarke:

And, you know, infection and protection from vaccination and protection from previous infection due wane over time. There's also no known threshold of the population where once we get above X percentage, we'll completely stop community transmission of SARS-CoV-2. So all of that is really important to know. And in terms of, you know, maybe adults who have been infected and may not, you know, have been infected I think it's important to reference the recent MMWR, that among adults with previous infection vaccine added protection against a reinfection that would lead to hospitalization. We wanna keep all people in our country as healthy and safe as possible. So it is important for, you know, either adults or child who have been previously infected to get vaccinated if eligible.

Lena Sun – Washington Post:

Okay. So could I just with a follow up, sorry.

Jason McDonald:

Go ahead, Lena.

Lena Sun – Washington Post:

Sorry. So is this 60%, is this more or less than you previously thought?

Dr. Kristie Clarke:

That's an interesting question. I definitely expected that we were going to see an increase continue. We had 43% in January and I did expect it to increase. I didn't expect it to increase quite this much, but we follow the data and we look at the data and this is what the evidence is showing us and so this is why we wanted to get this message out to the US population as soon as possible. This was the first time that population seroprevalence is over 50%. Next question.

Moderator:

That comes from Mike Stobbe with the Associated Press. Your line is open.

Mike Stobbe – Associated Press:

Thank you for taking my question and thank you for doing this briefing. Could you repeat Dr. Clarke, did you say that just the limitations of this did detectable levels of antibodies you could detect them for up to two years? I mean, like if someone was infected in early 2020, would they have enough antibodies in their blood that it would've been detected here? Or is this really just a snapshot of the last year? I'm just wondering if there are any limitations about that and could you just speak plainly to the public about, just simple explainer, why infections were more common in kids and adolescents? Why was it 75% in them, but just 33% in people 65 and older. Why the difference among these ages? Thank you.

Dr. Kristie Clarke:

Okay. Thank you so much, Mike, for that question. So it seems like the first part of your question was regarding the length of time for which people have this type of detection on this test. So we use for the specific study a type of test that detects anti-nucleocapsid antibodies, but detects a very low level of anti-nucleocapsid antibodies. It also gives us a yes or no answer either the antibodies are detectable or they're not and so we do know that this test will be positive in someone who has been previously infected for at least one to two years after infection. And so this is a good measure of how what proportion of our population has been previously uninfected, but not a good measure of what is the level of antibodies that you know each person has with this particular type of test.

Dr. Kristie Clarke:

Now in the future with this surveillance system, we are moving to also including a quantitative test and we'll be looking forward to doing more work on the amount of antibody, and how long that takes to wane and other additional things that are important at this stage in the pandemic. There are a couple of limitations here. First of all this type of methodology cannot detect reinfections, and there's some emerging data that suggests that infection after vaccination might be less likely to result in detectable antibodies. So we'll continue to follow those data. And we'll also continue to advance on our work to use some quantitative tests or in other words, tests that give us, you know, a number in terms of the precise level of antibodies. But I think there was another aspect to your question, which I maybe slipping did I get a point?

Mike Stobbe – Associated Press:

I mean, even it's well known to you, could you explain to me in the readers why the infection prevalence was so much more common in adolescents and kids. 75% compared to 33% in people who are retirement age?

Dr. Kristie Clarke:

Sure, absolutely. So one of the important things that we saw in this study was that the greatest increases in seroprevalence over this time period occurred in age groups with the lowest vaccination coverage. So the proportion of the population that was fully vaccinated by April 2022, it increased with age whereas, you know, our seroprevalence

decreased with age. Now some of that may also be due to in some of the older adults they may be more conservative in terms of, more consistent in terms of using other preventive measures.

Jason McDonald:

Next question

Moderator:

Up next is Spencer Kimball with CNBC. Your line is open.

Spencer Kimball – CNBC:

Hi, thank you for doing the call. My question is what does this potentially mean anything for the future trajectory the pandemic in other words? So we know now that 58% of people have antibodies against COVID. There's also a lot of vaccination out there in the population. So can we expect to see the lower burden of severe illness, at least as long as you know, the circulating variants are still within the Omicron moving forward?

Dr. Rochelle Walensky:

Yeah. Thank you. I'll start with that one and say, you know, this is among the reasons why we roll out our COVID 19 community levels, because we do believe that there is a lot of protection in the community, both from vaccination, as well as from boosting and from prior infection that said, we, I can't underscore enough on what Dr. Clarke said, which is those who have detectable antibody from prior infection, we still continue to encourage them to get vaccinated. We don't know how long that, when that infection was, we don't know whether that protection has waned. We don't know as much about that level of protection than we do about the protection we get from both vaccines and boosters. And Dr. Clarke.

Dr. Kristie Clarke:

Yeah. Another thing I think is important to keep in mind here is that we know that the Omicron surge in cases came at a time of high population seroprevalence with anti-spike antibody, which we saw in our blood donor seroprevalence study, which you also can see on the COVID data tracker. So we do know that reinfections happen as does infection in people who have been vaccinated. We know that from other studies that vaccination, including booster doses offer added protection against severe disease including that caused by Omicron. But, you know, I think it's important to take into consideration that when we saw a new variant, even in the context of that higher seroprevalence, we still saw an increase in cases. And so that's important in terms of thinking forward.

Jason McDonald:

Next question.

Moderator:

Next question is from Sheryl Stolberg with the New York Times, your line is open.

Sheryl Stolberg – New York Times:

Thank you for doing this call and taking my question. This is for Dr. Walensky, based on what you've learned about case rates and transmission over the last two weeks, would you be recommending dropping the mask mandate if it was still in place today? The transportation mandate.

Dr. Rochelle Walensky:

Thank you, Sheryl. Maybe, I'll just back up a little bit and say that although the mask requirement is not in effect and we were of course, disappointed by the ruling this past week. I wanna just emphasize that CDC continues to recommend that people wear masks in all public indoor transportation settings. We've said before wearing a mask is most beneficial in crowded or poorly ventilated locations. Many of those are in our travel corridors like buses, busy subway trains, jet waves on airplanes and in the airport. When we know that when people wear a well-fitting mask over their nose, mouth, and or

when they wear a respirator that they protect themselves and they protect those around them. Of course, as you noted, we are continuing to closely follow cases, hospitalizations, our COVID-19 community levels, but we fully intend to continue our recommendations right now that people wear masks in public indoor settings. Thank you.

Sheryl Stolberg – New York Times:

And just a quick follow up. You had extended it until May 3rd, which is a week from today, I believe. Will you be making any announcement on May 3rd about whether you are going to recommend continuing masking or whether you would recommend dropping masking?

Dr. Rochelle Walensky:

Sheryl we're having those conversations right now, and of course they have legal implications as well. But what I do wanna emphasize is regardless of, well maybe I'll just say we're continuing to have those conversations now, but I do wanna re-articulate that we could also continue to recommend masking in public indoor settings. And I don't expect that to change.

Jason McDonald:

Next question.

Moderator:

That comes from John Woolfolk with San Jose Mercury News. Your line is open.

John Woolfolk – San Jose Mercury News:

Hi. Thank you. If you could hear me, just to clarify, you were just saying a moment ago that you're continuing to recommend masking in public indoor settings. Is that, did you just mean in the transportation setting or is that because that seems to be contrary to what the guidance has been for 98% of the country that isn't having hospital pressure. And my main question was just if you could tell us what we're supposed to make of the rising, the obviously rising cases and some uptick in hospitalizations. We now have this new study indicating that half or more of the country has been infected and has some protection for that, is that, do we have a wall of immunity and we don't have to worry about the rise in cases or is that not known?

Dr. Rochelle Walensky:

John, maybe I'll just take the first part really clearly and say my response to Sheryl in the prior question was all about transportation settings. If that wasn't clear, it was all about transportation settings. So we as CDC continue to recommend that people wear masks in all indoor public transportation settings. With regard to your question about where are we in this moment? I think, you know, there are some areas in the country, particularly in the Northeast where we're seeing a higher number of cases, and we're starting to see some hospitalizations tick up, you know, we're watching this carefully, this, we haven't seen them tick up as much as we might have expected in prior times during this pandemic, thanks to, I believe a large amount of protection in the community, both from disease and infection as Dr. Clarke has articulated as well as vaccine protection you know. But this is something that we need to watch carefully. And, we also are looking at not just the hospitalizations, but the character of those hospitalizations. We're seeing less oxygen use, less ICU stays, and we haven't fortunately seen any increase in death associated with them. So we are hopeful that positive trends will continue, that we will not see as a result of these increase in cases, any further severity of disease. And in places that we do, we are again, recommending that people follow our instruction from our COVID 19 community levels, that if they are in orange, that people mask in public indoor settings, and if they are yellow, that people take extra precautions as well. Thank you.

Jason McDonald:

Next question.

Moderator:

Next question is from Marie Rosenthal with Infectious Disease Special Edition, your line is open.

Marie Rosenthal – Infectious Disease Special Edition:

Thank you for taking my questions. I have two, but they're related. Are you seeing a difference in severity of disease from the different Omicron sub variants and did the actual immunity development depend on the severity of disease?

Jason McDonald:

I'm sorry. We had a very hard time understanding that cuz you were breaking up. Can you try again?

Marie Rosenthal – Infectious Disease Special Edition:

I'm sorry. Sure. Hold on a second. The first, seeing a difference, the severity of disease from the different Omicron sub variants does it matter, which sub variant you get, how sick you become? And secondly, does natural immunity development depend on how sick you're?

Dr. Rochelle Walensky:

Maybe I'll take the first and Dr. Clarke can take the second. We are starting to study now BA.2.12.1 as well as BA.2. What I can tell you is the original omicron variant has demonstrated decreased severity as we saw from prior variants that we've had here in the United States, what I call this decoupling of cases and severe disease. Now there was a lot of it. And so that of course is what worked to overwhelm many of our hospital systems and lead to deaths, but case for case, it generally was less severe. We now are collecting data from places that had an initial surge of BA.2 as well as BA.2.12.1 on severity of disease. Epidemiologically, it doesn't appear as if we're seeing more severe disease in places that are having more cases. So we are not anticipating more severe disease from some of these sub variants, but we are actively studying it.

Jason McDonald:

Dr. Clarke did not hear the second question. Are you still there?

Moderator:

I have muted her line. Would you like me to open it back up?

Jason McDonald:

Yeah. So we can hear the second part again.

Marie Rosenthal – Infectious Disease Special Edition:

I'm sorry.

Dr. Kristie Clarke:

Was this regarding, I just wanna make sure I understood the question before I answer, but was this regarding antibody levels and severity of disease?

Marie Rosenthal – Infectious Disease Special Edition:

Yes. Yeah

Dr. Kristie Clarke:

Thanks. Just wanted to make sure I was focusing on what you're looking for here. So more severe disease is associated with higher antibodies, which may be associated with higher protection. However, people with risk factors for disease are at increased risk for severe disease from reinfection. So all of that is important to keep in mind and just reinforces the

message that for all people it's important for folks to you know, not only think that because they've been infected they can skip vaccination or boosters. We encourage people to stay up to date completely on their vaccination regardless of their history of infection.

Jason McDonald:

Next question

Moderator:

That is from Alexander Tin with CBS. Your line is open.

Alexander Tin – CBS:

Hi, thanks for taking my question, for Dr. Clarke, can you just follow up on something you mentioned earlier? You said that there was a, I think an estimate of the kind of true count of total cases from zero positivity. Can you tell us more about that? Forthcoming estimate, and then Dr. Walensky, just to follow up on an earlier answer, can you tell us more about kind of travel masking? It sounded earlier, like there was a framework coming. Is that still the plan and what did you mean by framework? Thanks so much.

Dr. Kristie Clarke:

Hi. yeah, thanks so much Alexander. So in terms of the emerging study, so we have a study that's gonna be coming out in pre-print within the next couple days where we looked at for each reported case, how many estimated infections based on our seroprevalence data does that represent? So we've refer to those as case infection to case ratios. And what we found was that this varies over time, we looked at it over various time periods, depending on the amount of transmission that was going on, as well as, the predominant variant. And we did find that there tend to be more in infections for each reported case during times of increased transmission. And we also found that now this was a period that covered December, January, February. So that kind of the Omicron period, we found that over that time period, the infection to case ratio was the highest that it's been at over three estimated infections per reported case. And that varied by region, so depending on which US census region the estimates were, you know, the ratios were higher or lower. There is a previous study that was published in open foreign infectious diseases that showed also an increased ratio of estimated infections per reported case among the pediatric population as compared to the all ages population. So that's also something to keep in mind in the context of these data.

Dr. Rochelle Walensky:

And to your other question, Alexander, maybe I'll just give you a sense of some of the things that we're looking at especially in our travel quarters, which I feel like are characteristically different because of the international component. So we are of course, looking at our COVID-19 community levels, where we are as a nation in terms of how we're doing in terms of cases and certainly severe disease. We're looking not just at the absolute numbers, but also the trends in those numbers. We also because of the international nature of specifically air travel, we are looking at whether there's other variants that are emerging around the world, whether other places around the world are having challenges with variants of interest or variants of concern, new or novel emerging variants. And then of course, we have a stellar team of epidemic modelers and we're looking at the anticipated forecast of where we might be in the future. So many things are going to come into our decision as to our recommendations for indoor public transportation masking. Thanks.

Jason McDonald:

Next question.

Moderator:

Next question is from Julie Steenhuysen with Reuters, your line is open,

Julie Steenhuysen – Reuters:

Thanks for taking my call. So I just kinda, I know this you've hit on this a couple times. I just really wanna understand it, but, you know, based on what we're seeing in the slide on the increase in cases, it looks like cases are up 22.7% over the past seven days that fell by 13.2%. And then we have this overlaying, seroprevalence data, which is now rising, can we, you know, help us to understand, you know, is that a reflection of the higher seroprevalence within the population? I know that your study didn't look at levels of antibodies, but, you know, I mean, do you think it's more related to the severity of illness caused by the virus or are we seeing some benefit from a large proportion of people in the United States with prior infections to COVID. Thanks.

Dr. Rochelle Walensky:

Thanks, Julie. Maybe I'll start and, and just sort of say the data that you see on slide 1 are data that are pretty well up to date to the minute, to the day. And the data that Dr. Clarke has reported are antibody data that are ended essentially February of 2022. So it is essentially a look backwards as to how much disease or infection that we have seen historically. So I think that if we wanted to understand where we are today, we would look at, you know, the data on slide 1. If we want to understand where we are, sort of how many people been seeing previous disease in the country. And then we layer on top of that previous vaccination and previous boosters. This gives us both a nice window of cases we might have missed historically, but also how much population immunity is out there.

Moderator:

I am sorry, sir. One more time.

Jason McDonald:

We have time for two more questions.

Moderator:

Thank you. And the next question comes from Drew Armstrong with Bloomberg News. Your line is open.

Drew Armstrong – Bloomberg News:

Hi. I have one quick technical question and then an actual one. Could you guys, this is for Dr. Clarke, could you tell us exactly what the survey period was on the February seroprevalence, and then another technical question, the antibody detection time frame, you mentioned that it's about one to two years. Is that time frame because that is how long we have had these COVID antibodies to test for, or is that kind of a standard thing for a test like this?

Dr. Kristie Clarke:

Thanks so much for that question, Drew. Your first question regarding the surveillance period. So for this February data collection period, the data were collected over the period I believe from January 27th to February 26 and there were 18 jurisdictions in which the data collection period was less than two weeks. And there are correspondingly slightly lower sample sizes for those jurisdictions. We're posting the data on COVID data tracker today with you know, specific asterisks on those dates. You'll be able to see the exact data collection dates as well as sample sizes.

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[U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES](#)

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