

WorkCare Briefing: Trending Beyond COVID-19
Questions & Answers
August 4, 2021

The following questions were asked during WorkCare's monthly webinar series on Trending Beyond COVID-19. Anthony Harris, M.D., M.B.A., M.P.H., WorkCare's Chief Innovation Officer and Associate Medical Director, presented the session and provided these answers. The next webinar in this series will be Sept. 1, 2021.

Here are links for your reference:

- [August 4 Webinar Recording](#)
- [Questions & Answers from the July 7th Webinar](#)

EXPOSURE RISK

- Q:** Is there a number of attendees for a group gathering, like a conference, that can serve as criteria to help define exposure risk? In other words, are there different risk management protocols depending on the group size, say 10 vs. 100 vs. 1,000? In all cases, assume we don't know the vaccination status of the attendees.
- A:** To answer this, we can look back at our approach when we didn't have a subset of the population vaccinated. The recommended approach was to limit the number of people at your gathering. It is all tied back to what we have covered previously, the R-naught (R0) number, which is the reproductive rate of an illness and a predictor of the risk of transmission based on population size. The number of contacts an individual has at any given time increases the risk of transmission as their number of contacts goes up. So, we can easily conclude that a greater number in your gathering would present a greater risk of transmission. It is reasonable from a numbers standpoint to suggest a different approach for various sizes and various levels of risk in the workplace. But from a practical standpoint, we've seen it not play out well when there are different protocols for different population subsets in large workforces. If you have a population or workforce with several thousand individuals, having two to four messages around how to protect yourself, depending on your actual scenario that day or month, could be complicated. We've been dogmatic about using a one-size-fits all approach to our COVID-19 prevention recommendations because of the complexity in communicating multiple approaches. For example, Centers for Disease Control and Prevention (CDC) mask recommendations have changed again; based on new data about the Delta variant, they are now recommending wearing a mask indoors regardless of vaccination status. We have consistently recommended continuing to wear masks. Because of the complexity of messaging and the need to ensure compliance, we suggest having a one-size-fits-all approach for your workplace guidance, again, not taking into account the messaging for a vaccinated population vs. an unvaccinated population, since the question stated that would be an unknown.
- Q:** Should we start requiring office employees to wear masks at least within cubicles?
- A:** Masks are recommended when indoors and there is a likelihood of close contact with other people regardless of vaccination status.
- Q:** Understanding COVID will be around for some time, are there other indicators we should be monitoring with regard to workplace safety and risk such as hospitalizations and not just the number of cases? Should we also consider risk by age, co-morbidity or other indicators?
- A:** Other risk considerations provide insights for protecting vulnerable people or populations, but the current recommendations call for protecting everyone in your workforce by following prevention measures

regardless of an individual's or group's exposure risk. This include masks, social distancing, hand hygiene and vaccination for those who do not have medical or religious reasons not to get vaccinated.

VACCINE

Q: When will Pfizer have a booster for the Delta variant?

A: Pfizer and BioNTech announced in July that they are developing a COVID-19 booster shot intended to target the Delta variant, with related clinical studies expected to begin once regulatory approvals are received.

Q: Would a booster shot (3rd dose) increase the effectiveness of the vaccine against Delta variant infections?

A: If boosters under development target Delta, such as the one mentioned in the previous question, we presume they will increase effectiveness against Delta variant infections. However, clinical data are not yet available.

Q: What is the difference between a booster shot vs. initial vaccination? If an initial vaccination is a two-shot series, would a booster be just one of those shots or is it a completely different dosage?

A: An initial vaccination provides a level of immunity against a virus. A single booster further strengthens the body's immune system response to a pathogen. The booster formula may be the same as the first dose or it may be modified in response to variant strains.

TESTING

Q: Are we seeing any trends toward standard antibody titer testing to ascertain who has enough immunity against SARS-CoV-2?

A: In a [May 19, 2021, announcement](#), the U.S. Food and Drug Administration (FDA) reminded the public and health care providers that results from authorized SARS-CoV-2 antibody tests should not be used to evaluate a person's level of immunity or protection from COVID-19 at any time, and especially after the person has received a COVID-19 vaccination.

Q: If your staff is fully vaccinated, should you still test (PCR or Antigen) for COVID-19 regularly? If so, how often?

A: At this point, there is no data yet to suggest that a surveillance program for a vaccinated population is effective at preventing transmission in the workplace. We know that surveillance for an unvaccinated population is effective. If incidents in the vaccinated population rise to the levels we saw previously with unvaccinated individuals, or near that, then surveillance would be very likely to become an effective tool in that scenario. That's not the case yet. Testing with only at-risk individuals who have a positive test or exposure regardless of vaccination status, or who are symptomatic, should be your approach at this time.

VARIANTS

Q: How worried should we be about the Lambda (L) variant?

A: This ties in well with the previous question. The Lambda variant has demonstrated resistance to vaccination and has increased its prevalence in several countries. We will report next month on its prevalence here in the U.S. For now, just recognize that there's another variant already showing resistance that may be even more resistant than the Delta variant.

Q: It looks like the Delta variant has about the same transmissibility for vaccinated and unvaccinated people. Is that supported by published data?

A: The CDC recently cited a combination of [unpublished data](#) from outbreak investigations and outside studies showing that vaccinated individuals infected with Delta may be able to transmit the virus as easily as those

who are unvaccinated. The data also suggest that vaccinated people infected with Delta have measurable viral loads similar to those who are unvaccinated and infected with the variant.

Q: How do these variants start?

A: Viruses constantly change through mutation and become more diverse. Changes are expected. A variant may be detected by changes to spikes on the surface of the virus or other mutations. There are currently 11 COVID variants named in accordance with the Greek alphabet.

Q: If emerging variants are resistant to the vaccine, what is the strategy to convince those that are choosing not to get vaccinated that they need to get the shots?

A: Some people will refuse to get vaccinated for various reasons no matter what the science tells us. For others who are undecided or reluctant to get vaccinated, the strategy is to continue to educate them about vaccine safety as well as exposure risk, vulnerable populations, sickness, hospitalization and death rates that could be dramatically reduced with vaccination.

Q: What is the current death rate per 100,000 for Delta?

A: It is estimated at least 80 percent of current COVID-19 infections in the U.S. are caused by the Delta variant. The number of related fatalities has not yet been unconfirmed due to lag times in reporting. You may find [related data in this report](#) of interest.

VACCINE MANDATE

Q: In a case where staff is mostly working from home and/or unvaccinated wearing a mask in the office, how relevant is a vaccine mandate in the workplace?

A: A vaccine mandate should be in place if we have a total worker health mentality. Our role as EHS professionals is to reduce workplace and overall health risks that may impact the business. Therefore, individuals who are not vaccinated are still very much at risk of a poor outcome and death vs. someone who is vaccinated. That's why we're suggesting that no matter what, mandating a vaccine in the workplace is the right thing to do if we're talking about total worker health. That's why we want to shift to that mindset and hopefully get leadership on board. There have been several articles that have stated that vaccination mandates are good for business. I think we can lead the way and back it up with data. We will discuss this next month. As a preview: An individual in the workplace who contracts COVID-19, on average, if they are a poorly controlled diabetic, can cost nearly \$70,000 in health care expenditures. If they are a well-controlled diabetic, that cost can go down to \$30,000. If they don't have diabetes and have symptoms, the cost goes down to \$16,000. For self-insured employers, mandating a vaccine that can limit the impact of a COVID-19 infection in the workforce is good for total worker health and business. This is why we recommend it no matter what.

Q: Are there any recommendations for employers to use to launch a vaccination mandate? Any lessons learned?

A: Here are some recommended resources:
[Seyfarth Shaw Vaccine Resource Center for Employers](#)
[Society for Human Resource Managers](#)
[Workplace COVID-19 Vaccine Toolkit](#)

Q: How will exemptions regarding mandates be handled? Currently fielding questions from employees regarding concerns surrounding this. Specifically, those who have developed GBS, anaphylaxis or other severe allergic reactions post-vaccination. But also, those with religious or conscientious exemptions.

A: Refer to the [Equal Employment Opportunity Commission](#) for guidance on this topic.

TRAVEL

Q: What is your guidance on travel for vaccinated people?

A: Many companies that we serve at WorkCare have said that they are going to dial back on traveling as the number of cases has increased. We've also seen a number of those companies say employees can only continue to travel domestically or internationally if they are vaccinated, and they have created a policy to confirm it. That is a reasonable approach to help mitigate the risk of transmission. The most conservative approach would be to reduce travel to what we saw last year, which is for strong business necessity only and as allowed by host destinations. As we continue to see Delta cases increase, we are likely to see that trend going forward. That is not to suggest that we have any data that air travel is riskier as a result of the Delta variant. We know that the Delta variant is far more transmissible, but we haven't seen any studies regarding the Delta variant and airline travel, because masks are still required at this point. For airline travel, we are likely to see transmission rates continue to be low, even with the new variant, because protective measures are in place. (Refer to the CDC for recommendations on domestic and international travel.)

MASK REQUIREMENTS

Q: We all know that vaccinated individuals can get COVID and pass it on to others. Why are they not required to wear masks?

A: The pulling back of the mask requirement came at a time when there was a lot of COVID fatigue and economic stress. The guidance that we saw for vaccinated individuals to not have to wear a mask came from data that suggests there was a 95 percent chance that individuals who were vaccinated would not transmit COVID-19. At the time we didn't fully understand the extent to which transmission would occur with vaccinated individuals. Because there is a higher percentage of people not wearing masks compared to those that are vaccinated, we are seeing businesses and venues going back to mandating masks. The CDC language has changed to now suggest that it is prudent to wear your mask even if you are vaccinated. Now we have the data with the Delta variant being more contagious and resistant to back that up.

SIDE EFFECTS

Q: Do we have a better understanding of what COVID-19 is as a disease? For example, what systems does it affect the most? What types of co-morbidities result in the worst outcome? What percentage of adults experience COVID brain fog with the Delta variant compared to the original strain?

A: To answer the first part of this question, it affects the vascular system tremendously. It also affects the respiratory system. The worst outcome is death with the respiratory system being overwhelmed and causing respiratory failure. We've also seen damage to the liver, kidneys and the brain because of the micro-vascular effect of COVID. Stroke was also a phenomenon that we saw early on. It was all the result of hypercoagulation in the blood vessels themselves. Platelets would glob together. Regarding COVID brain fog, it's because of the micro-vasculature in the brain, specifically cells called megakaryocytes that are sitting in vessels that normally don't exist. They are causing the vessels in the brain to be clogged. That could lead to deficits in memory and trouble with recall. I have not seen any updated literature pointing to the Delta variant causing an increase in COVID brain fog. We are seeing similar rates in regard to those that are being hospitalized from the Delta variant and those who have severe cases and are in the ICU. Up to a third of people are having some type of COVID brain effect, similar to what we saw with MERS and SARS-CoV-1.

VACCINATION STATISTICS

Q: Why don't the vaccination statistics (49.7% in the U.S.) include natural immunity?

A: The statistics show the number of vaccinations given. Natural immunity is difficult to track because many so cases have never been confirmed with testing or were asymptomatic.

Q: What's the status of testing the vaccination for children under the age of 12? Do statistics on total number of vaccinations include those children who in clinical trials?

A: The FDA has said mid-winter is when the vaccination will be available for children under the age of 12. This was reported in mid-July. The CDC is not reporting data on the population under 12 who are vaccinated, only the percentage of the population over the age of 12.