

**WorkCare Briefing: Trending Beyond COVID-19**  
**Questions & Answers**  
**September 1, 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 webinar and provided these answers. Please refer to previous Q&As if your question is not answered here.*

**NOTE:** Questions about ivermectin, a medication used to treat parasitic roundworms, head lice and some skin conditions, will be answered separately to allow time for additional research. Ivermectin is not an anti-viral drug and is not approved for the prevention or treatment of COVID-19.

Here are links for your reference:

- [September 1 Webinar Recording](#)
- [Questions & Answers from the August 4 Webinar](#)

#### **FLU SEASON**

- Q:** We are beginning to roll out our seasonal flu vaccination clinics. We hope our employee population will be interested in participating but are fearful the recommendation of a COVID vaccination booster at the same time might make employees reluctant to get both vaccines. What recommendations do you have as employers start to prepare for flu season?
- A:** There is no data to suggest that there is a downside or risk associated with being vaccinated for both flu and COVID at the same time. There is still a strong recommendation to get both. Due to the high emotions surrounding vaccinations, WorkCare physicians recommend a 14-day interval to alleviate patient concerns about feeling sore or feverish in the 48 hours following vaccination, but for those individuals who want to get their booster and flu shot on the same day, that is fine, as well. Having both vaccinations makes it easier to determine someone's exposure risk level if they have symptoms. If you've been vaccinated for both, there may be a different pathway regarding your return-to-work process that is less arduous than if you are not vaccinated for either or only one. Those are things we should consider and communicate. In addition, during the last flu season we saw that because we were wearing masks and washing our hands, the instance of flu went down. There's likely a causal association.

Here is related guidance from the Centers for Disease Control and Prevention (CDC) on [coadministration of COVID-19 vaccines with other vaccines](#):

Although data are not available for COVID-19 vaccines administered simultaneously with other vaccines, extensive experience with non-COVID-19 vaccines has demonstrated that immunogenicity and adverse event profiles are generally similar when vaccines are administered simultaneously as when they are administered alone. COVID-19 vaccines were previously recommended to be administered alone, with a minimum interval of 14 days before or after administration of any other vaccines. This was out of an abundance of caution during a period when these vaccines were new and not due to any known safety or immunogenicity concerns. However, substantial data have now been collected regarding the safety of COVID-19 vaccines currently approved or authorized by FDA.

COVID-19 vaccines may **now be administered without regard to timing of other vaccines**. This includes simultaneous administration of COVID-19 vaccine and other vaccines on the same day, as well

as coadministration within 14 days. It is unknown whether reactogenicity of COVID-19 vaccine is increased with coadministration, including with other vaccines known to be more reactogenic, such as adjuvanted vaccines or live vaccines. When deciding whether to co-administer an(other) vaccine(s) with a COVID-19 vaccine, vaccination providers should consider whether the patient is behind or at risk of becoming behind on recommended vaccines, their risk of vaccine-preventable disease (e.g., during an outbreak or occupational exposures), and the reactogenicity profile of the vaccines.

- Q:** Is the summer peak we experienced with COVID-19 this year comparable in scale and impact to the usual uptick of flu during the summer?
- A:** The flu season in North America begins in the fall and lasts until spring. We have not seen any comparable data.
- Q:** What is the survival rate comparing influenza vs. COVID for 18 years of age and under?
- A:** CDC data show COVID-19 and the flu account for less than 1 percent of all pediatric deaths since the start of the pandemic.

#### **VACCINE AND BOOSTERS**

- Q:** Is there any new data showing the incidence of COVID-19 in vaccinated vs. unvaccinated people? In other words, is this still a pandemic of the unvaccinated?
- A:** The CDC monitors hospitalizations and deaths from any cause among fully vaccinated individuals with COVID-19, but it stopped monitoring break-through infections on May 1. In a United Kingdom-based [study published Sept. 1, 2021 in \*The Lancet\*](#), 1,240,009 COVID Symptom Study app users reported a first vaccine dose, of whom 6,030 (0.5%) subsequently tested positive for SARS-CoV-2, and 971,504 reported a second dose, of whom 2370 (0.2%) subsequently tested positive for SARS-CoV-2. The study period was Dec 8., 2020 to July 4, 2021. A study published Aug. 24, 2021, in the *Morbidity and Mortality Weekly Report* found that unvaccinated people were about 29 times more likely to be hospitalized with COVID than were those who are fully vaccinated, and that unvaccinated people were nearly five times as likely to become infected. The study was based on 43,127 infections in residents of Los Angeles County, California, that occurred between May 1 and July 25, 2021. The Kaiser Family Foundation published data on cases associated with vaccinated versus unvaccinated Americans on July 30, 2021. It found that the share of COVID-19 cases among those not fully vaccinated ranged from 94 percent in Arizona to 99.8 percent in Connecticut. Hospitalizations for those not fully vaccinated ranged from 95 percent in Alaska to 99.9 percent in New Jersey (although COVID may not have been the reason for hospitalization). The share of deaths for those not fully vaccinated ranged from 96.9 in Montana to 99.9 percent in New Jersey. (Again, the cause of death may not have been due to COVID.)
- Q:** Are all vaccines faring about equally as each other to protect from infection and transmission?
- A:** All of the vaccines offer strong protection against severe disease. To learn more, refer to this Aug. 26, 2021, article, [Comparing the COVID-19 Vaccines: How Are they Different?](#) published by Yale Medicine, which features findings from studies on the efficacy of the Pfizer, Moderna and Johnson & Johnson vaccines approved for use in the U.S.
- Q:** Has there been any new data about transmission of the Delta variant outdoors? Is it still not a concern, as we were considering for the original strain or earlier variants so it would be okay to hold outdoor work events, e.g. lunches, etc., without masks?
- A:** The CDC recommends wearing masks in public indoor places in areas of substantial or high transmission. It has not issued similar guidance for outdoor events while awaiting further data on transmissibility of the

Delta variant. In the U.S., many outdoor venues are requiring proof of vaccination or a negative COVID test to gain entry because of the highly contagious nature of Delta. We recommend postponing outdoor workplace social events or requiring employees to wear masks regardless of their vaccination status out of an abundance of caution.

**Q:** In Israel, does the 39 percent effectiveness of the Pfizer vaccine include those with a booster?

**A:** Israel recently reported the booster significantly lowers infection risk among older adults.

**Q:** Regarding vaccine demographics, are numbers/percentages available by religious background for vaccinated vs. non-vaccinated individuals?

**A:** You may find these survey results from the Public Religion Research Institute of interest: “Religious Identities and the Race Against the Virus: Successes and Opportunities for Engaging Faith Communities on COVID-19 Vaccination,” July 28, 2021); [www.prrri.org/research/religious-vaccines-covid-vaccination](http://www.prrri.org/research/religious-vaccines-covid-vaccination)

**Q:** What is the prevalence of SIRVA associated with COVID-19 vaccines?

**A:** Prevalence is low. You may find this case report published in *Skeletal Radiology* of interest: [Subacromial-subdeltoid bursitis following COVID-19 vaccination: a case of shoulder injury related to vaccine administration \(SIRVA\)](#).

**Q:** What types of side effects can we expect with the booster shot? What if you get a flu shot close to the time you get a booster or your first COVID vaccination?

**A:** The most common side effect are soreness at the injection site and feeling tired. The rarest side effect is severe anaphylaxis. If you have experienced a strong response to any vaccine, particularly COVID, talk about it with your physician. The impact of the COVID vaccine that we all have seen play out in terms of knocking you down for 48-72 hours may still come into play. There is no limitation in receiving the COVID and flu vaccine from a side-effect perspective, and there is no increase in risk if you are getting both vaccines in close proximity to each other.

**Q:** Do you have an update on the booster for the Johnson & Johnson vaccine? We have a large number of employees in Waco, TX, who received it.

**A:** Even though the FDA has given a clear date of September 20 for mRNA vaccines boosters (Pfizer and Moderna), they said they need more data around the J&J vaccine before they give a recommendation on it for boosters. There is no date yet published by the CDC or the FDA. They are likely to recommend boosters for J&J once the data they need is provided.

**Q:** What clinical trials have been conducted for boosters? How do the booster’s contents differ from the ingredients and dose? How are boosters studied and approved?

**A:** It’s the same process as the original approval for Pfizer and Moderna. At the one-year mark for the individuals who participated in the Phase 3 trials, which was December of last year, clinical trials began for the Pfizer booster. It was conducted similarly to the original phase 3 clinical studies in terms of looking at safety and efficacy. All of the data has been beneficial in terms of minimal risk from a safety profile and benefiting individuals in terms of susceptibility, re-infection, severe illness and hospitalization. There is no difference in the formulation. The boosters, it appears, are coming from our stockpile. That will likely be the case abroad, as well. In terms of the pharmaceutical test, its efficacy is still the same as we’ve seen for the Delta and Lambda variants from a standpoint of hospitalization and severe illness.

- Q:** Can you get Moderna or Pfizer vaccine as a booster if you had the J&J vaccine?
- A:** Any type of booster for the J&J vaccine has not been recommended pending receipt of additional data. Mixing vaccine types is not recommended.

## TESTING

- Q:** We are managing COVID per federal government requirements and CDC guidelines. CDC recommends that fully vaccinated people who have close contact with a known COVID case should not quarantine but should have a test 3 to 5 days after exposure and should quarantine if the test result is positive or if they experience symptoms. Should the test be a rapid results test authorized by the CDC or should it be a test that requires lab analysis? Is there a consistent approach as to what type of COVID-19 test should be used and when?
- A:** I will answer the question in terms of what we are recommending to our clients because the CDC does not go into detail as to which test should be used. We recommend PCR tests for any positive or known exposure of an individual, on a case-by-case basis. On a broader scale, let's say if you have an exposure of an individual in a workforce of 50 individuals in a room, we have seen rapid tests utilized for a large number of people to be screened for potential infection after a positive exposure. In general, on a case-by-case basis, a positive exposure would require a PCR test. It says 3-5 days, but we've seen a lot of breakthrough infections of individuals who become positive after the 3-day window. Because of that, we've changed our recommendation to 5 days. At 5 days, doing a PCR test to rule out infection is the best practice that we are recommending at this time. There are a lot of PCR tests – we don't go as far as to specify which one. You should try and understand the efficacy of a particular test because there is a lot of variability in terms of false positives, false negatives, etc. That, in brief, is our recommendation.
- Q:** Why did the CDC say testing should be 3-5 days after exposure for vaccinated people vs. 5-7 days for unvaccinated people (as we were using before)? Are there medical reasons to use a different time period for testing after exposure for vaccinated versus unvaccinated people?
- A:** Here is the current CDC guidance: Fully vaccinated people who have a known exposure to someone with suspected or confirmed COVID-19 should get tested 3-5 days after exposure and are to wear a mask in public indoor settings for 14 days or until they receive a negative test result. People who are not fully vaccinated should be tested immediately after being identified, and, if negative, tested again in 5-7 days after last exposure or immediately if symptoms develop during quarantine. Because of the potential for asymptomatic and pre-symptomatic transmission, it is important that individuals [exposed to people with known or suspected COVID-19](#) be quickly identified and quarantined (if unvaccinated) or wear a mask in public settings (if fully vaccinated). Regardless of vaccination status, persons with positive results should remain in isolation until they have met the criteria for discontinuing isolation. Unvaccinated persons with negative results should remain in quarantine for 14 days unless other guidance is given by the local, tribal, or territorial public health authority. Fully vaccinated persons can discontinue wearing a mask in public places once they receive a negative test unless they live in an [area of high transmission](#).

## VARIANTS

- Q:** Are there any updates on the Lambda variant? Should we be concerned?
- A:** Delta is responsible for most of the cases occurring in the U.S. It is also in the U.K. and multiple other countries. Lambda is starting to emerge in the U.S., but Delta remains the most prevalent variant. The Lambda variant does not appear to be as easily as transmitted as the Delta variant. The question is, is it likely to blossom as the Delta variant has? That's still pending. We know that Lambda does have some features of resistance to the vaccine, but that might be offset by the decrease in ease of transmission. We will continue to follow the impact of Lambda and see how it's going to go.

**Q:** We know Delta is more transmissible. Has the survival rate of COVID-19 changed due to the Delta variant? Seems the recent focus is on case rates, not death rates.

**A:** Although the Delta variant is more transmissible and causing a spike in cases and hospitalizations, the survival rate in comparison to the Alpha variant is not yet clear.

#### **MASKS**

**Q:** Is there any indication of the relative protection factor of masks for the Delta variant? Assuming it transmits less readily among masked people vs. unmasked, are there any updated studies on the effectiveness of masks we could reference?

**A:** We have not seen any mask data specifically related to the Delta variant. A large, randomized trial led by researchers at Stanford Medicine and Yale University has found that wearing a surgical face mask over the mouth and nose is an effective way to reduce the occurrence of COVID-19 in community settings. The findings were released Sept. 1, 2021, by [Innovations for Poverty Action](#) prior to publication in a scientific journal. You may find this Nexstar Media compilation of interest: [Do face masks work? Here are 49 scientific studies that explain why they do](#). An epidemiological study published March 17, 2021 (not peer-reviewed) examines [face-mask usage as an effective strategy to control COVID-19 spread](#).

#### **OSHA**

**Q:** Regarding mandated COVID vaccines in the workplace: If an employer requires vaccines and then a vaccinated employee becomes infected and misses work/gets sick, can this be considered an OSHA recordable?

**A:** COVID can be a recordable illness if a worker is infected as a result of performing work-related duties. [Refer to OSHA regulations](#). They do not address mandates.

#### **TRAVEL**

**Q:** What are your thoughts on the safety of work travel at the moment?

**A:** We recommend following CDC guidance on domestic and international travel.

#### **DEMOGRAPHICS**

**Q:** What are the demographics of COVID deaths, age, co-morbidities, etc.?

**A:** Refer to the [COVID Data Tracker](#) and [Our World in Data](#).

**Q:** You mentioned that the R-naught number was 3.5 at the beginning of the pandemic. What is it now?

**A:** As of today, the R-naught number is just under 1.5. If we continue to trend up in terms of cases, we will likely to see this number go up.

#### **HERD IMMUNITY**

**Q:** Is it appropriate for a company to make changes to precautions for an office once that staff reaches herd immunity? What percentage of the population should be used in the calculation of herd immunity?

**A:** Masks are recommended when indoors when there is a likelihood of close contact with other people regardless of vaccination status. Social distancing and hand hygiene are also recommended. Protection afforded by herd immunity does not apply in this case because people who are vaccinated can still get break-through COVID-19 infections and be contagious without realizing it. At a minimum, it has been estimated at least 70 percent of a population needs to be vaccinated or have natural resistance to create herd immunity. However, it is now estimated up to 95 percent of the U.S. population would need to either have had COVID or been vaccinated against it to achieve herd immunity. Herd immunity calculations for a

given population, such as office staff, depend on how contagious a virus is, and the Delta variant has been found to be highly contagious.

**FORECAST**

- Q:** The previous spike (January timeframe) seemed to slow and decline with a combination of vaccine roll-out and keeping some COVID restrictions in place. With vaccine administration somewhat stale and a hesitancy to go back into restrictions, what would cause the current spike to decline? How long might it last?
- A:** It's difficult to predict how long we will trend in the wrong direction without a significantly higher percentage of the population getting fully vaccinated.