

WorkCare Briefing: Trending Beyond COVID-19
Questions & Answers
December 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.

Here are links for your reference:

- [December 1 Webinar Recording](#)
- [Questions & Answers from the November 3 Webinar](#)

OMICRON VARIANT

Q: We just learned the first case of Omicron in the U.S. has been detected in California. How many cases do you think need to emerge within the coming weeks to determine how prevalent the Omicron variant is going to become?

A: I think this variant of concern is following a trend similar to the Delta variant. Delta became the prevalent variant within weeks. I anticipate that Omicron is likely to do the same because of similar mutations it shares with Delta. This is why it only took the World Health Organization (WHO) less than 48 hours to declare it a variant of concern after they received a sample on Nov. 24.

VACCINATION

Q: The Centers for Disease Control and Prevention (CDC) recommends getting a booster six months after completion of full vaccination. What are the consequences to employees who wait longer than six months to get their booster? At what point should they be considered unvaccinated or at increased risk? When do you think the CDC will change its definition of being fully vaccinated?

A: As long as you have received a full series (two doses of Pfizer or Moderna or one dose of Johnson & Johnson), you are considered fully vaccinated under the CDC's definition. For the purposes of OSHA's emergency temporary standard (ETS), which would require vaccination or weekly testing/masks in private companies with more than 100 employees (pending further public comment and court rulings), any WHO-approved vaccine is allowed. The definition of risk and being fully vaccinated are not associated. If you wait longer than six months to get your booster, your risk is going to go up, but your status without the booster remains as fully vaccinated until the CDC changes the definition. From a clinical standpoint, let's use the definition that the Food and Drug Administration uses to grant emergency use authorization – the level of efficacy would need to be at least 50 percent. If a vaccine's efficacy is not 50 percent or higher, it would not receive emergency use authorization. I suggest that anyone who has a susceptibility at lower than 50 percent would clinically be considered unvaccinated. I believe that the CDC may change its definition after we receive a verdict on the ETS. If the CDC changes the definition of fully vaccinated to include a booster, then our numbers don't look so great: only 19.1 percent of eligible Americans have received a booster to date.

Q: Does a booster make the host more prone to antibody-dependent enhancement (ADE) if exposed to Omicron?

A: No, in theory, it should make the host less susceptible. Here's why: There are two scenarios that set you up for ADE. One, your antibodies don't bind well enough to the virus to eliminate it. Two, you don't have enough antibodies in your system to effectively neutralize the virus. The booster addresses both, in a way.

After a booster, your immune response is far greater than after the initial two doses. Efficacy also goes up to 93 percent after a booster. That means you have more effective circulating antibodies and a higher volume. Those two scenarios will reduce your risk, in theory, of ADE. However, whether you have gotten a booster or not, having antibodies in your system may still pose a risk for ADE with the Omicron variant, but I don't want you to walk away thinking you're at high risk for ADE because of Omicron. We still don't have enough data to determine if ADE is occurring because of Omicron. I only pointed it out based upon the mutation of the virus itself, the potential risk being greater as a result of Omicron's genotype versus Delta and other variants.

Q: Now that we've had more run time with the COVID shots, has there been a better understanding of the near-term risks or negative consequences of the vaccine itself? Are there any increased (or decreased) concerns mid- or long-term?

A: Refer to the [CDC for a clinical review](#). Public health authorities continue to report vaccines authorized for emergency use are safe and effective. Long-term effects are not yet known.

TESTING

Q: Are variants detected in rapid test samples?

A: Rapid tests detect SARS-CoV-2 infection but not variants. Widely used PCR tests that are analyzed in labs can detect infection by variants such as Delta and Omicron.

Q: Is it reasonable to use rapid diagnostic tests until more information about the ability of these tests to detect the Omicron variant is determined?

A: Absolutely. We strongly advise you to use the tests that you currently have available. We want to just caution that in the future leveraging rapid tests may change. Not all rapid tests are equal, but the ones that have been approved can still be very effective. Just to be safe, you may want to confirm any positive tests using a PCR test. Researchers around the world are working to better understand the nature of Omicron transmissibility, severity of infection (including symptoms), performance of vaccines and diagnostic tests, and effectiveness of treatments.

Q: If you have a rapid test that uses an app to confirm test results, would you still need a proctor under the OSHA ETS?

A: It depends on automation of reading the results. If the results of the rapid test are analyzed and recorded in an automated fashion, then that would meet the definition of *not* being self-read, and based on my interpretation of the ruling, the test would not be subject to proctoring. If it requires input from the employee into the app, that is a scenario in which the results are self-read and would be subject to proctoring.

EXPOSURE RISK

Q: We don't hear much any more about asymptomatic transmission. Is this still an issue with Delta or other variants?

A: Yes. We know that asymptomatic cases still occur. If we look at the evolution of the virus with different variants, I believe that because of the severity that we first saw with the UK variant, and then with Delta, the percentage of the asymptomatic population has decreased. I haven't seen any data saying so, but anecdotally I believe that is because the virus is becoming more virulent from a severity standpoint, increasing the likelihood of symptoms. I think Omicron will fit in that bucket, as well.

- Q:** With the increase of the number of vaccinations administered, how do we explain the greater number of cases in 2021 versus 2020?
- A:** We believe that it's a function of the decline in the efficacy of the vaccine and behavioral change of the population. We need to consider the metric of mobility. We saw that as mobility increased, so did transmission rates. A component of the reproduction rate of the virus is proximity. As more people changed their behavior, they came into closer proximity of each other. Because of the vaccination status of some of the population, the risk of transmission is higher than the effectiveness of the vaccine. This has led to the overall increase of positive cases.

ANTIBODY TITERS

- Q:** Have you heard anything new about antibody titers? Are we any closer to assessing immunity levels or is that out the window in light of the Omicron variant?
- A:** Antibody testing is [not currently recommended](#) by the CDC to assess for immunity to SARS-CoV-2 following COVID-19 vaccination or the need for vaccination in an unvaccinated person, nor to determine the need to quarantine after a close contact with someone who has COVID-19. Some antibody tests will not detect the antibodies generated by COVID-19 vaccines. Refer to the [CDC's](#) anti-body test guidelines and the [FDA](#) for additional information.

TRAVEL

- Q:** Do you think the U.S. is going to close its border to Europe?
- A:** For now, the U.S. is controlling entry into the country with diagnostic testing 24 hours in advance of travel from international destinations regardless of vaccination status.