Australasian College for Emergency Medicine

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COVID-19 Vaccine Webinar Timelines and Impacts

Q&A summary

2 February 2021

Disclaimer

This document is a summary of a question and answer session of the COVID-19 Vaccine Timelines and Impacts webinar that occurred on Tuesday 2 February 2021 with:

- Professor Allen Cheng – Deputy Chief Health Officer, Victoria
- Dr Kerry Chant – Chief Health Officer, New South Wales
- Professor Julie Leask – NSW Nursing

Every effort was taken to answer as many of the questions as possible as accurately as possible based on information known at that time and as circumstances permitted at the time of the webinar.

Some questions and answers have had some minor editing for clarity and to minimise repetition.

The vaccination program has not started in Australia and New Zealand and there is still much uncertainty.

The logistics of involvement of emergency departments is an example of something that may vary between jurisdictions and will need to be clarified at a local level as the vaccination program starts.

At the time of publishing new information is emerging regarding the relative efficacy of the various vaccines against the new COVID-19 and its variants. Current advice is that there are no head-to-head comparisons of the vaccines making it too early to claim better efficacy of any one over the other in the Australian and New Zealand context. We intend to keep our members as up to date as possible and as soon as is practicable as information (on the vaccination program) becomes known to us, including requesting further comments from our expert panel.

Questions and answers

Asked prior to and during the webinar

Q: What is needed for a COVID-19 vaccine to effectively prevent infection (i.e. like the measles vaccine)?

We need to understand current vaccines better – all we currently know is that asymptomatic infection seems to still occur, but it isn't clear if these people are infectious and how likely they are to pass on infection compared to those who are not vaccinated. Hopefully, when this is better understood – along with the underlying immunology – this will be addressed in second generation vaccines. (Allen Cheng)

Q: Why does Stage 1A of the Commonwealth Government vaccine roll-out plan not include immediate family members of high-risk workers?

It is a numbers game with diminishing returns. We have about 600,000 people in the first line groups. If we included their family members it would mean up to 1.5 million people are in that stage. (Allen Cheng)

Q: Is there data on use of vaccines in people who have had previous COVID-19 infection?

A paper about this was published today (2 February 2021) – it looks like a single dose may be effective in these people. See this pre-print. (Allen Cheng)

Q: Is there any point in vaccinating people who have had COVID-19 but did not mount an IgG conversion?

We don't know the correlate of protection – whether IgG or IgA and how much – or T-cell responses. In the absence of knowing more they should probably get vaccinated. (Allen Cheng)

Q: Is there benefit of a single dose of vaccine, especially for people who had adverse reactions to the first dose?

A single dose of the Pfizer vaccine has been shown to be about 52% effective (top line) but there is limited data on duration of protection. (Allen Cheng)

Q: We don't know if the vaccine blocks transmission, there is no information about vaccine use in large groups of people (e.g. pregnant women) or how long immunity lasts for. The media is selling this as an end to COVID-19 but I don't see that. Will we get our life back or not? If so, how?

We don't know yet. It is unlikely (hopefully) that we will be able to assess effectiveness of these vaccines in Australia as we won't have many cases, but information from other countries that have a large case load will inform what public health control policies are needed, and what response is proportionate to risk once we have broad vaccine coverage. (Allen Cheng)

Q: Do we have a government communications plan to stop people from presenting to emergency departments to request vaccination?

There will be vaccination hubs that are separate to emergency departments, although some of these clinics will be based at hospitals. (Allen Cheng)

Q: Once the Pfizer vaccine is defrosted from –70°C, what temperature does it get stored at? Does it go in the usual immunisation fridge? How will it be transported to regional/rural centres?

The Pfizer vaccine has a shelf life of six months at –70°C. Once defrosted, it can stay in the fridge for five days. Once diluted it lasts several hours. The five-day window will allow transport. The Astra Zeneca vaccine is stored at fridge temperature so transport should be much easier. (Allen Cheng)

Q: Is there evidence of vaccine hesitancy in healthcare workers?

No – but obviously we haven't vaccinated anyone yet. (Allen Cheng)

Yes, there is direct evidence from overseas and it will occur in Australia to some extent. Vaccine intentions and concerns in healthcare workers are similar to the general population. Currently, for the general population, 60 per cent intend to have a COVID-19 vaccine, 26 per cent are unsure and 13 per cent say they will not. Hesitancy may reduce as the program rolls out and becomes more established and familiar and in the absence of any major issues. (Julie Leask)

Q: Is promoting vaccination considered within the emergency department scope of practice?

We usually discuss vaccination with parents of children presenting to emergency departments. (Attendee)

All healthcare workers should recommend vaccines to their patients if they need them. Taking a vaccination history is standard in paediatrics. Routine screening of vaccination status among adults in emergency departments is likely to increase coverage among adults and reduce their risk of specific diseases (and potential return to emergency departments). This article makes the case for recommending vaccination in emergency departments. (Julie Leask)

Q: How much difference will the vaccines make to our day-to-day lives?

I believe the vaccines will make a meaningful difference to our lives that will be felt gradually. We will have more confidence to return to doing some things that are difficult now. If we can sort out the border risks, the chance of the virus entering Australia is much lower and that will have flow-on effects for many facets of our lives. I also think it is good to keep people in touch with this motivation. We can't over-promise, but equally we shouldn't under-promise. (Julie Leask)

Q: How do you envisage the process for reopening Australia's international borders, in particular with New Zealand, the Pacific and other near neighbours?

We will need to know more about the impact of vaccines – particularly the degree to which they reduce infection and infectiousness, and how protected the Australian population is from serious disease. First aim is to protect from disease and get higher coverage. New COVID-19 variants are a wild card. (Allen Cheng)

Q: Which vaccines are coming to Australia? In what quantities and in what timeframe?

The supply schedule is not clear at this stage. What is on paper is:

- Pfizer – starting delivery of 80,000 doses per week, with 10 million doses by the end of 2021 (i.e. 200,000 per week);
- Astra Zeneca (pending TGA approval) – three million doses in March and 50 million doses over 12 months; and
- Novavax – 50 million doses over 12 months.

However, vaccine production is a fraught process and we are in a global market. (Allen Cheng)

Q: Are jurisdictions seeking one vaccine over another?

Each jurisdiction will get supply according to population. (Allen Cheng)

Q: How will the process be managed across Australia and jurisdisctions? What is the role of the Commonwealth and State/Territory governments? What will be the impact on the emergency department workforce?

There are two processes. States and territories are responsible for healthcare workers and hotel quarantine workers, including emergency department staff. The Commonwealth is responsible for aged care and community sector healthcare workers. There is likely to be some crossover using cross-contracted services. (Allen Cheng)

Q: Are any vaccinations planned to be delivered by emergency department staff to patients in emergency departments? How will emergency departments be involved in management of adverse reactions?

Emergency department staff will not be involved in routine vaccine delivery – there will be a specialist vaccination workforce, at least initially. Emergency departments will be involved in management of adverse outcomes per usual processes (e.g. for anaphylaxis). Reporting adverse events will be important. (Allen Cheng)

Q: What are the arrangements for timing of second dose vaccinations? Is a delayed second dose (per the UK) planned?

The intention at this stage (per TGA approval) is Pfizer 21 days apart, Astra Zeneca four to 12 weeks apart. (Allen Cheng)

Q: What public messaging is being planned to encourage take-up of the vaccine?

There is a Commonwealth Government communication strategy in development. Victoria is coordinating a program for communications with vulnerable/CALD populations and presumably similar processes are in place in other jurisdictions. (Allen Cheng)

Q: Is there a plan to stagger vaccination of healthcare workers to mitigate sick leave due to vaccine side effects?

Yes. We expect that around one-third of people who are vaccinated will need to take the following day off work, so we won't vaccinate more than one-third of workers at a time. (Allen Cheng)

Q: Will healthcare workers be prioritised to receive the Pfizer vaccine?

Emergency department healthcare workers are in Phase 1A of the roll out, which is first, and Pfizer will be the only vaccine available. Beyond that, plans for who gets which vaccine are not yet clear, and are dependent on TGA approvals. (Allen Cheng)

Q: Is it common to see post-vaccination side effects?

Yes – one-third of people experience fever, aches, malaise for up to 24 hours. The proportion of people with side effects is higher with the second dose of the Pfizer vaccine and in younger people. (Allen Cheng)

Q: Does the Pfizer vaccine have higher clinical efficacy than the Astra Zenca or Oxford vaccines?

Headline results from studies include the following statistics: Pfizer/Moderna 95%, Novavax 90%, Janssen/Astra Zeneca 60-70% effective in prevention of severe infection. There are no head-to-head studies. All vaccines seem less protective against mild infection – and the studies included very few severe infections (and there were also small numbers of severe infections in the control groups). It is worth noting that the choice is between waiting a year or more for the general population to receive the Pfizer vaccine or getting the Astra Zeneca vaccine much sooner. There is evidence that all vaccines have good efficacy in prevention of serious disease resulting from COVID-19. (Allen Cheng)

Q: What is the indication to isolate and test people who have post vaccination fever?

Clinical advice will be developed. In general, if someone has fever and myalgia (without respiratory symptoms) for up to 24 hours that would be consistent with vaccine side effects. Prolonged fever, respiratory symptoms or other epidemiological risk factors will indicate whether COVID-19 testing is required. (Allen Cheng)

Q: How have vaccine purchases been negotiated in Australia?

The government has been in discussion with all major manufacturers and has explored potential for on-shore production or fill/finish. Advice from SITAG has been to diversify to reduce risk. We are competing for supply in a global market. ACV provides advice to the TGA, ATAGI and to the COVID-19 task force and program. (Allen Cheng)

Asked during the webinar but answered following its conclusion

Q: What arrangements will be made for vaccinating emergency department healthcare workers in the private sector or working as locums?

I'm not sure but the policy is "setting" based (i.e. everyone who works in the emergency department) rather than "workforce" based (e.g. only doctors or nurses). (Allen Cheng)

Q: Which vaccine is associated with anaphylaxis to the polyethylene glycol additive?

Anaphylaxis has been reported with the Pfizer vaccine at a rate of 1:100,000. It isn't clear what the allergen is – the AZ vaccine also contains polysorbate 80, and this is also contained in a number of other vaccines. (Allen Cheng)

Q: Which vaccines are TGA approved? If not, why not?

Only Pfizer so far, but others are under evaluation. (Allen Cheng)

Q: Can patients who have had severe reactions to other vaccines (eg Pneumovax) receive a COVID-19 vaccine? What are the risks of having similar reactions?

Not clear. Those who have had severe allergic reactions to any injected drug/vaccine, or who carry adrenaline for severe allergy should seek expert advice. It may still be possible to get vaccinated under close supervision or receive a different vaccine when available. (Allen Cheng)

Q: Should we remain cautious with use of nebulisers and NIV, even after COVID-19?

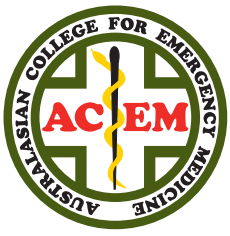
Yes, for now until we know more about how good the vaccines are and there is good coverage. (Allen Cheng)

Q: Is vaccine efficacy changed by use of paracetamol as an anti-pyretic for post-vaccination fever?

Not known at this stage. (Allen Cheng)

Q: Will the COVID testing clinics move from swabbing to vaccinating?

Exact model will depend on the state/territory, but noting that we will need to maintain good testing capacity to respond to outbreaks. (Allen Cheng)



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