WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace
Q&A
May 20, 2020

The following questions were asked during WorkCare’s weekly webinar series on Preventing and Managing COVID-19 in the Workplace – Week 10. Anthony Harris, M.D., M.B.A., M.P.H., Chief Innovation Officer, Vice President Onsite Clinical Operations and WorkCare Associate Medical Director, presented the webinar and provided these answers.

The following are links for your reference:
- May 20 webinar recording
- May 13 webinar recording
- Questions and Answers from the May 13 webinar

Please refer to Q&As from the previous nine weeks if you don’t see answers to your questions here.

TESTING

Q: The Abbott Lab COVID-19 test got some bad press this past week regarding its accuracy. How does the Abbott test compare to the many other tests out there?
A: We agree that the data we’ve seen on the Abbott test does not compare to some other tests with higher sensitivity and specificity. At this time, we are not using the Abbott test at WorkCare.

Q: With an incubation period, how does 24 hours relate to re-opening cities if test results are not yet turned around quickly? The Maryland numbers you cited during your presentation seem to have already been increasing before re-opening.
A: The Maryland study didn’t look at the specific test and the turnaround time. We know that there are point-of-care tests that can produce results more quickly than several days – in as soon as 30 to 90 minutes – so it just depends on which tests are used. Yes, there does need to be additional studies on the cause of increased numbers of COVID-19. I did point out that correlation doesn’t necessarily mean causality. There needs to be additional studies to show that the re-opening was the cause of increase in cases; there is no data to strongly suggest causality at this point. Correlation yes. Causality, perhaps not.

Q: As far as pre-screening when returning to work, do you think employees should be screened for COVID-19 on a monthly basis?
A: Our approach and guidance to employers for timing of testing in a surveillance-type program is all predicated on relative risk. Meaning, if you are low-risk because you are in a geographic that has little impact from COVID-19 in terms of prevalence and incidence, then your testing regimen would perhaps look different from someone in a geographic area like New York or Chicago, where prevalence is far greater, incidence is far greater and your relative risk may be greater, as well. As far as practicality of testing, it should be based on risk. The actual frequency may be monthly, it may be bi-weekly. We strongly suggest against daily testing or anything beyond a clinical resolution. If the test would not change the actual outcome or behavior, there is really no need to test. Testing daily or weekly may not impact your ability to mitigate transmission.
Q: Does testing require a CLIA waiver?
A: There are a number of tests for which a CLIA waiver can be used by a lab. CLIA is a guidance for conducting lab studies in the U.S. It stems from the '70s, when physicians could test in their own labs. There were few controls, and that resulted in a lot of disproportionate results. There are three levels of CLIA: waiver, medium and high level for different tests that have different levels of complexity. There are a few tests that only require a CLIA waiver. Those tests may be the finger prick test for antibodies. But the majority of tests available require a CLIA certification, not a waiver, of at least medium, and a number of them require high. CLIA waiver can be used for testing, but only for a select few FDA emergency use authorized tests.

Q: Can you share what brands of COVID-19 tests WorkCare uses?
A: We don’t want to endorse a particular brand in this forum. However, we perform due diligence on a number of manufacturers to understand which tests have the highest accuracy. These are the tests we employ with our clients.

RETURN TO WORK

Q: In light of the Korean study findings you presented, do you think the Centers for Disease Control and Prevention (CDC) will update its return-to-work protocols? Maybe people can't test "negative?"
A: We believe it’s coming. We are seeing it anecdotally in the testing that we’re doing already. In Texas, I spoke with a young man about a week and a half ago, and he, along with 60 percent of his co-workers, tested positive for COVID-19 in a meat-packing facility. But when I spoke with him and asked, “Hey, how are you feeling?” he said, “I had a mild cough three weeks ago.” Again, that’s three weeks before he tested positive for COVID-19. His mild cough lasted 24 hours and he’s been asymptomatic since then, so we know he fell into that group that was continuing to test positive and may no longer be shedding the virus sufficiently to transmit it. I think we’ll continue to see that trend and more data pointing to this phenomenon, and just as Korea did, we’ll likely have some changes in requirements as a result. (Refer to COVID Patients Testing Positive After Recovery Aren’t Infectious, Study Shows, Bloomberg, May 18, 2020)

Q: What is risk stratification as it relates to employees returning to work?
A: There are two approaches to risk stratification, the individual and the organization. For individual risk stratification, we bifurcate that into geographic risk and behavioral risk. We call it the COVID-19 risk appraisal. It’s a survey that puts an individual into a high-, medium- or low-risk category for potentially being exposed to COVID-19. So, with geographic being the first piece of that - are you in the middle of Wyoming or in New York or New Jersey? With the behavioral aspect, are you in an uncrowded area or community setting where social distancing can be practiced readily, or do you frequent areas where social distancing might not be as achievable? When we talk about organizational risk stratification, relative risk is based on location, for example, widespread, sustained community transmission, which is a county- and state-specific reported designation.
Q: With regard to testing, what is the best way to address potentially exposed employees who are returning to work? For example, an employee who worked near a confirmed COVID-19 case but is not exhibiting any symptoms. When can this employee be permitted to return to work? Should testing be required first?

A: Testing should be part of a comprehensive program to mitigate risk in the workplace. Our approach has been to implement testing only after a robust pre-screening program has been instituted for an organization. Once an organization is broadly screening out those individuals who become symptomatic, then testing is appropriate to further delineate those who are potentially at risk for contracting and transmitting COVID-19.

PREVENTION

Q: What do you recommend for cleaning workplaces: How many times per day? Should cleaning be done mid-day while employees are still onsite?

A: We are seeing cleaning regimens with employers that are multiple times a day, cleaning a facility three, and in some cases four, times a day. It depends on the traffic. If traffic is high, cleaning more frequently would provide a better opportunity to prevent fomite or contamination. We recommend deep cleaning at least once a day above and beyond just a routine cleaning during the day. We believe that cleaning while employees are at work is beneficial. The EPA has published a comprehensive list of commercially available cleaning solutions that have the ability to readily kill the virus.

DEATH RATES

Q: There have been reports that doctors in the U.S. are recording COVID-19 as the cause of death in some cases rather than influenza or an influenza-like illness because reimbursement rates are higher for hospitals. How accurate are these reports?

A: I have not seen any studies that have looked at or substantiated mis-incentives for coding in terms of health practices for COVID-19. However, when we talk about what has been predicted in regard to deaths from COVID-19, we do not see skewed number in studies showing a disproportionate increase from COVID-19, which one could hypothesize if we were skewing the data to the right to suggest there was an increased number of deaths from COVID-19. We’re actually seeing less deaths from COVID-19 than predicted in earlier models, which forecast 1.1 million deaths in the U.S.

Q: Excess deaths attributed to COVID-19 seem to be about one-third of the total number of deaths previously and typically reported. Not to minimize the severity, but the actual number of deaths because of the virus might be less panic-inducing if presented more broadly. Are the excess death numbers used in models/strategies or total numbers?

A: The excess numbers are real, current death total numbers based on historic metrics as comparison.

GENERAL

Q: Is there any link between vitamin D and the severity of COVID-19 cases?

A: Not that I’m aware of at this time.

Q: Are there any new recommendations for pregnant women who are returning to the workplace beyond following guidelines for social distancing, hygiene and screening practices?

A: Pregnant women are advised to follow general population best practices in the workplace for preventing COVID-19 transmission.