WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace
Questions and Answers
May 27, 2020

The following questions were asked during WorkCare’s weekly webinar series on Preventing and Managing COVID-19 in the Workplace – Week 11. 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 27 webinar recording
- May 20 webinar recording
- Questions and Answers from the May 20 webinar

SCREENING

Q: What is the value of self-reporting (screening for symptoms) if no testing is involved?
A: We know that screening is essential, including IR thermography to measure body temperature and screening for symptoms other than fever. That’s going to be the front line of defense when we talk about who is safe to be at work and who’s not. It relies on the honor system and participation. After doing over half a million daily screens, we have found that participation is substantial because it’s being mandated to gain entrance on the premises for employees by employers. And, we know that we’ve only had a very small fraction, far less than 1 percent, trying to game the system. Testing is still essential with inevitable reopening and the sustainability of reopening, to limit the spread of disease. We can’t rely only on testing as a primary means of detection. For example, in Wuhan, China, where testing was widely available, they estimated that only 41 percent of those with the disease were actually tested. That’s what we’re up against when we talk about the level of testing and burden of disease.

Q: Can you please review WorkCare’s recommended return-to-work screening process?
A: We refer to our comprehensive screening approach as the COVID Clear Zone. It starts with screening up front to keep symptomatic people out of the workplace and have them remain at home. If you don’t do this, then the utility of doing testing and surveillance decreases dramatically. We offer a digital platform, as we have for the last 2½ months, so our clients can quickly scale up. We have also been delivering onsite staff with IR thermography screening on site, with well over 300 locations where we have personnel helping out. The next piece is a COVID Surveillance Program. It starts with baseline testing for a return-to-work scenario. Once you have a baseline test, individual risk is stratified using a behavioral and geographic-based COVID risk appraisal survey instrument. Determined risk – high, medium or low – predicates needed scheduling for testing until we get to the other side of this pandemic with vaccines and herd immunity. We’ve already been able to roll this out with employers in different geographic locations, helping them focus on where their greatest need is.

TESTING

Q: How effective is the LAMP test you referred to in your presentation? (LAMP refers to loop-mediated isothermal amplification techniques used in the diagnosis of infectious diseases caused by bacteria and viruses.) What is the cost for this test?
A: The LAMP test included in this presentation today is sensitive to 95.6 percent, which means it’s only going to miss 4.4 percent of those individuals who test positive. When we talk about specificity, only .6 percent of people that have a positive test will have had a positive test because of a cross-reaction with another virus, so those are very solid numbers when we talk about accuracy. I am not aware of information about the potential cost.

Q: Which brand of tests do you recommend?
A: At WorkCare we are test manufacturer brand-agnostic. We want to make sure we’re vetting the technology and clinical approach so we can assure our partners that the accuracy of the test is based on the best data available. This allows us to scale rather quickly because we aren’t locked into a particular single test and can provide tests with comparable accuracy across our service areas.

EXPOSURE RISK
Q: How soon after exposure does someone become contagious?
A: After exposure an individual can become contagious within 48 hours because of build-up of the virus in the system – exponential replication of the virus. That’s the window in which we’re trying to capture those individuals who are pre-symptomatic. When they test positive, we can get them safely isolated from others.

Q: Is aerosolization of the virus in workplace restrooms something we should be concerned about?
A: In general, aerosolization of the virus is a concern. It’s like an Oort Cloud of particles around an individual. Within the breathing zone particles smaller than 5 microns are suspended in the air. Those are the particles that are carrying enough virus to be infectious. They typically exist in a radius of 3 feet. So, the 6-feet social distancing buffer provides a safe zone. Heavier particles from a cough (20 microns or greater) fall to the ground more quickly, so they’re not as much of a concern beyond this radius. Tiny particles in air can be suspended for up to three hours, studies have shown, so we want to make sure that we are following proper precautions to help prevent the spread of infection. If you are in public as an asymptomatic carrier and are not wearing a face covering, you have a higher likelihood of transmitting the virus. That is why we recommend face coverings across the board. Regarding hand drying in bathrooms, some studies have recommended against use of aid hand dryers because of the risk of aerosolization. Virus particles are substantially smaller than bacteria and thus pose greater risk for becoming airborne from air hand dryers compared to bacteria. I have yet to see any fecal or oral studies looking at aerosolization exposure risk, but I hope over time we’ll see more studies come to publication. Currently, there’s nothing we’ve seen to suggest an increased risk of infection from aerosolization in the lavatory as opposed to other confined spaces.

Q: Is there any new information about the risk of exposure associated with spirometry tests?
A: There is no new information or recommendation across the board regarding the recommendation to suspend spirometry testing or when it should be resumed. Clinics have stopped screening processes such as spirometry and audiometric testing across the board to limit transmission from a social distancing standpoint.