WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace
Questions and Answers
June 3, 2020

The following questions were asked during WorkCare’s weekly webinar series on Preventing and Managing COVID-19 in the Workplace – Week 12. 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.

Here are links for your reference:
- June 3 webinar recording
- May 27 webinar recording
- Questions and Answers from the May 27 webinar

EXPOSURE PREVENTION

Q: Should an employer require an employee to self-quarantine at home for 14 days after traveling out of state for vacation? (For example, an employee lives and works in Illinois and wants to travel to Florida or Tennessee.)

A: We encourage employers to reply on our clinicians to walk them through the same evaluation that we use for all employees regardless of travel. It’s going to be a case-by-case scenario of understanding potential exposures and that individual’s actual risk. So, the short answer is “no,” you shouldn’t require it merely based on the fact that they’ve traveled. However, it should be a factor in consideration as part of the process for evaluating their actual risk. Now that we’re in phase 2 and 3 of re-opening the workplace, you’re going to see more and more travel as a potential exposure risk.

Q: Should I remove employees from the workplace if they have any of the COVID-19 symptoms, even if it’s only a sore throat or headache?

A: No, it’s an individual determination – albeit a complex one. If you have an across-the-board process that says, “any symptoms whatsoever means you’re going home,” you’re going to have a mess with absences on your hands, which is what we saw early on with managing COVID. With that being said, we’ve found the best approach has been a comprehensive one, looking at the multi-factorial assessment of an individual’s risk of actually having COVID, as well as other infectious diseases. This means that a sore throat could be associated with seasonal allergies, or a chronic cough could present itself in a way that does not necessitate an individual being home and starting self-quarantine. Partnership is necessary with clinical support. That’s how we’ve been able to get a good response managing workforce presentations.

TESTS

Q: Why are walk-in clinics giving a patient a note to stay home from work until test results are received if they do not have any symptoms? (In this example, the person is a contact of another contact who may have been exposed to the virus.)

A: WorkCare does not operate walk-in clinics, so I can’t speak to the specifics of that scenario. However, I can speak to what we always see as occupational health professionals – those who aren’t trained in our specialty and taking care of the workforce have a predilection to take individuals off work, whether that be for a sprained ankle or a sliver in a finger. We are very likely seeing that continue into COVID-19 response from those clinicians who aren’t well-versed in whether someone who is asymptomatic should be at work, or someone who has a cough due to a chronic illness or seasonal allergies should be at work. Across the
board they’re removing people from work because it’s the easy thing to do when there is a lack of or gap in clinical knowledge.

Q: Are employers legally allowed to require COVID-19 testing prior to returning an employee to work or as part of a pre-employment screen?
A: While I’m not giving legal advice, yes, the Equal Employment Opportunity Commission, which enforces the Americans with Disability Act, has published guidance that allows employers to test their employees before they can return employees to work. We’ve been a part of that testing in Texas, Florida and Massachusetts, so we know that is the current status. As to whether that will change as we move forward, that is yet to be seen.

Q: Is there any reason to get an immunity test if you’ve been well-quarantined without much contact and not sick, or is this a waste of time and should instead be only taken after being sick?
A: So far, the recommended approach has been not to test those who are well unless there is a specific reason, such as needing to return someone to work or establish a baseline for the worker population. If you are not part of that scenario, and you have been in quarantine, a molecular or antigen test would be unwarranted. In medicine, the classic retort to diagnostic tests is, “Don’t perform the test if it won’t change the outcome.” And certainly, that is the case with this scenario.

Q: What do you tell employers who want to test their entire workforce?
A:

TREATMENT
Q: Are you familiar with Germany’s protocol for treating patients with ozone instead of intubating?
A: I am not familiar with the ozone treatment for COVID-19, specifically. I would love to learn more about it, and I will shortly after this presentation. There haven’t been any third party or peer reviewed ozone treatment studies in the U.S. that would move us in that direction.

TRAVEL
Q: Is the U.S. considered a Level-3 Health Notice like other international countries? Does that make the U.S. a travel-restricted destination?
A: Yes, every major country has been at Level 3 for some time. I am not aware of when that status will change.

Q: If an employee gets COVID after work-related travel, would that go on the OSHA log?
A: Potentially. OSHA has specifically stated that disease as a result of travel could be a recordable event. However, there are exceptions to that depending on where an individual resides during their travel. So, it is really a specific, case-by-case determination.

Q: If someone travels to the U.S. from the United Kingdom for business, is a quarantine period in a hotel required?
A: It’s a case-by-case scenario. It should not be a policy to quarantine anyone who travels without considering the specifics.

Q: Do you foresee people who have survived COVID-19 being given some sort of “travel-free” card, meaning they won’t be hampered since they aren’t likely to get the disease again or be contagious to others?
A: That’s less of a clinical question and more of a policy question, and one that I am not credentialed to answer. Could it be? Absolutely. Will it be? Who knows? From an absolute immunity standpoint, we still
don’t know how long COVID-19 immunity lasts, but studies will be continually ongoing to try and answer that question more fully.

GENERAL

Q: Are you seeing long-term health effects or permanent damage among those who have had COVID-19?
A: Individuals who have had severe illness and been hospitalized can have permanent effects such as kidney failure or respiratory failure. There may be some permanent impacts to an individual’s overall health and wellness as a result of COVID-19. Is it solely because of COVID-19? Perhaps not. It is typically associated with secondary events that can compound what an individual experiences from a clinical perspective.

Q: China, Russia and India seem to be doing better at containing and eliminating COVID-19 than we are in the U.S. I see that case rates have also dropped off in Australia. Is this due to under-reporting, or is there something we can learn from them?
A: For those locations mentioned in this question, declines in case rates could very likely be associated with under-reporting due to lack of testing. If we look at some of the statistics of number of cases vs. tests conducted, we’ll see India, one of the locations in question, has drastically less per capita number of tests performed, which could lead to under-reporting. This would not be attributed to poor actors in terms of hiding cases, but more likely the amount of positive cases has been underestimated due to the limitation of testing per capita. There are also gaps in terms of geography and government intervention.