

**WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace  
Questions and Answers – Week 24  
Aug. 26, 2020**

*The following questions were asked during WorkCare’s weekly webinar series on Preventing and Managing COVID-19 in the Workplace – Week 24. This week’s session featured a retrospective look at the pandemic to date and how employers and public health officials are responding to it. Anthony Harris, M.D., M.B.A., M.P.H., WorkCare’s Chief Innovation Officer and Associate Medical Director - Onsite Clinical Operations, presented the webinar and provided these answers.*

Here are links for your reference:

- [August 26 webinar recording](#)
- [August 19 webinar recording](#)
- [Questions & Answers from the August 19 webinar](#)

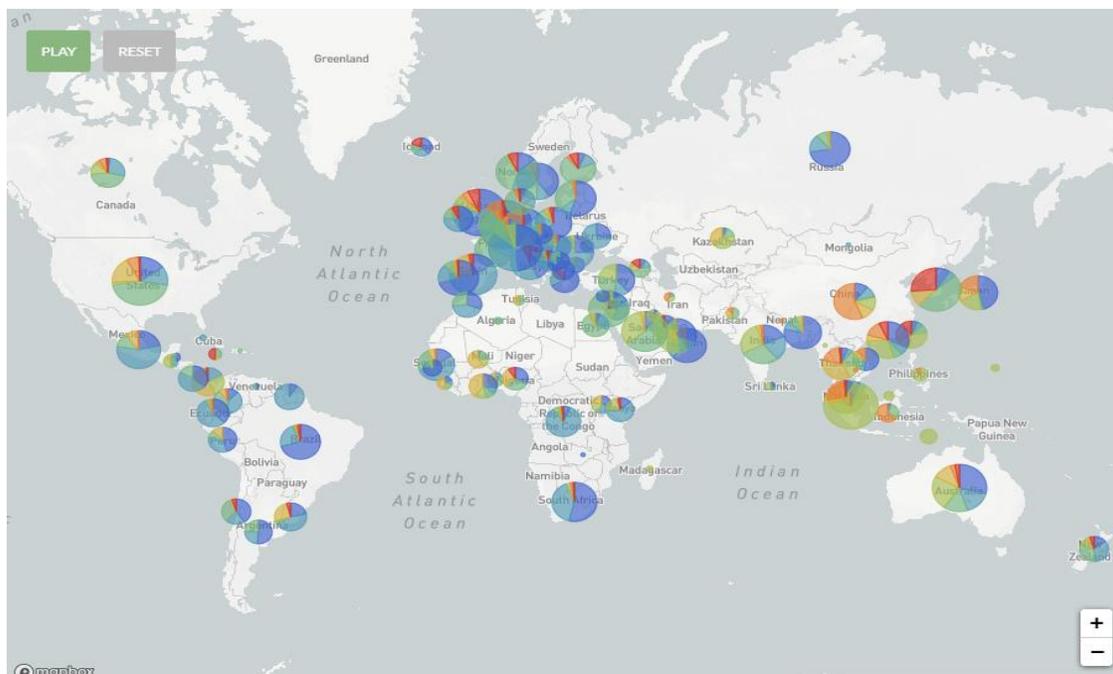
**RE-INFECTION AND VIRAL STRAINS**

**Q:** Regarding the case Dr. Harris presented on the Hong Kong man who was tested and found to have had COVID-19 twice, the second time without any symptoms – is it possible he was asymptomatic because the mutated virus strain that re-infected him was sufficiently different from the strain that infected him earlier?

**A:** Yes, that is the rationale as to why he was asymptomatic. There is literature from 2003 and 2005 that looked at immunity of individuals for SARS-CoV-1. Today there is 85 percent estimated SARS-CoV-2 immunity for people who had SARS-CoV-1 in 2003.

**Q:** Have we observed any particular commonality between a given strain of the virus in different countries? Is each country experiencing outbreaks of one particular strain more than another?

**A:** Refer to the world map (below), which illustrates the proportion of genomes of SARS CoV-2 by country. To see a full list of genomes, visit [www.gisaid.org/epiflu-applications/hcov-19-genomic-epidemiology/](http://www.gisaid.org/epiflu-applications/hcov-19-genomic-epidemiology/)



**Q:** What are your thoughts on the recent report that one strain of COVID-19 caused a large number of cases at a biotech convention in Boston? Are some strains more contagious than others?

**A:** I have heard about it. We do know it's not so much about the strain itself than it is about the event. We presented earlier in this webinar series on super-spreaders, a term used to define an individual or event where broad transmission occurs. What we know now is that it's less the strain and individual, and more the circumstances and event that caused the broad transmission. Obviously in a convention-type setting, you have individuals who are not social distancing well. Similarly, we looked at super-spreading events at church and singing in the choir, and we've seen those episodes occur many times over. So, it's more about the nature of the event and less about the genetics of the virus.

### **CDC RECOMMENDATIONS**

**Q:** Can you comment on new CDC guidelines that "you do not necessarily need to test" people who have had a close-contact exposure but do not have symptoms?

**A:** (Refer to the CDC's [Overview of Testing](#) webpage for recommendations). This recommendation and similar ones based on other scenarios come at a time when the general clinical wisdom is that those individuals who are asymptomatic and have had close contact with an infected individual should be tested. We want to know if these people are transmitting the disease. This is the sentiment of leading epidemiologists and infection control experts. So, there is a backlash regarding this recommendation. I struggle to understand what advantages these recommendations will provide us in terms of preventing illness. If we look at predictive models on decreasing transmission in the workplace, the factor that saw the best result was the frequency of testing. To suggest now that individuals should not be tested at all is not reflected in these types of models. More understanding is necessary as to why the CDC made these recommendations.

**Q:** Does the recent change in CDC recommendations regarding no longer requiring a 14-day quarantine after travel mean a possible change at the state level?

**A:** No, each state still determines the need for quarantine for persons returning from out of state.

**Q:** Is it true that scientists think the 6 feet social distancing guideline is not enough? Will we see a change in those recommendations?

**A:** The 6-foot range is a buffer zone to help prevent particles that are smaller than 20 microns from contacting those around you. Those particles that are larger than 20 microns typically fall to the ground due to gravity within one meter or 6 feet. Aerosolized particles <5 microns may remain suspended in air for greater distances than 6 feet, however, the number of particles is inversely proportional to distance. With good cough etiquette and use of face coverings, social distancing of 6 feet should be sufficient to limit spread of COVID-19.

### **SCREENING**

**Q:** Why is an emphasis still being placed on temperature screening when asymptomatic carriers have a normal temperature?

**A:** Temperature screening continues to be necessary but not sufficient. An individual may be most infectious during the time they are feverish, so it's important to make sure those individuals do not come into your facility.

**Q:** How can we differentiate between a cold, the flu and COVID-19 during the upcoming cold and flu season?

**A:** It will be difficult from a screening standpoint to differentiate whether someone has COVID-19 or the flu. We are establishing clinical protocols that you can use in partnership with clinicians to evaluate those cases. We do something similar for the common cold and allergy symptoms. We are also looking at

increased access to testing. A dual test for both the flu and COVID during the acute phase of infection recently received FDA Emergency Use Authorization. (Refer to [the CDC's webpage on the Influenza SARS-CoV-2 \(Flu SC2\) Multiplex Assay](#), which detects and differentiates RNA from SARS-CoV-2, influenza A virus, and influenza B virus in upper or lower respiratory specimens.)

## **VACCINE DEVELOPMENT**

- Q:** Is there a plan to distribute COVID-19 vaccine once one is approved? What is that process?
- A:** Details about the process have not been widely published. However, we know the vaccine will likely go first to the military. In China they have approved a vaccine going to their military. Next would be individuals who are most vulnerable, for example, health care personnel and first responders, and individuals who are most at-risk due to their age or medical condition. Individuals who are otherwise healthy would likely be last in line for distribution of the vaccine.
- Q:** The fastest that a vaccine has made it through FDA approval is upwards of six years. Is the priority with the COVID-19 vaccine speed or safety?
- A:** The accelerated pathway for FDA approval of vaccines for COVID-19 is driven by both speed and safety. The vaccine characteristic that is likely to be least validated is effectiveness because it is significantly influenced by observations over time among various populations.
- Q:** Why aren't medical professionals talking more about prevention by building up immunity vs. vaccine as the only solution?
- A:** Healthy people with no pre-existing illness are getting COVID-19. There is no evidence to suggest immunity can be obtained through diet, exercise, stress management, and other physical or behavioral health factors. However, a healthy person who exercises, eats nutritious foods, has a normal weight, effectively manages stress and doesn't smoke may improve their chances of having a better outcome if they get the virus.

## **FLU PREVENTION**

- Q:** Can you address the efficacy of receiving a flu vaccine during the pandemic? I recently read that the flu vaccine can actually present an increased risk of COVID infection by reducing non-natural immunity?
- A:** Outcome data from Brazil indicate that flu vaccination reduced mortality among individuals who contracted COVID-19, suggesting that the flu vaccine can be protective against severe impacts of COVID-19. I am not aware of any clinical evidence that the vaccine reduces immunity or increases COVID-19 infection risk.
- Q:** When should people get the regular flu shot with flu season approaching?
- A:** Flu vaccine is already available in some markets. Workplace flu prevention campaigns typically gain traction in September and October.
- Q:** How many studies have been conducted on how the flu vaccine impacts COVID-19 risk?
- A:** The primary study that has examined the effects of 2020 trivalent flu vaccination on COVID-19-positive individuals concluded that mortality is decreased among those who have received flu vaccination. There are not many studies that we have seen that examine the impact of flu vaccination on COVID-19-positive individuals. There are studies that suggest immunity to the flu may have cross-immunity to COVID based on previous studies that looked at such cross-immunity with SARS CoV in 2003.

### **MORTALITY RATES**

**Q:** Now that we have more mortality data, how does COVID-19 compare to the seasonal flu or chronic illnesses such as heart disease, in terms of relative mortality?

**A:** The case fatality rate for seasonal flu in the U.S. is 0.1-0.2 percent. COVID-19 has a case fatality rate of 0.9 percent for those without pre-existing conditions, and as high as 10.5 percent for those with pre-existing cardiovascular disease. COVID-19 mortality rates cannot yet be compared to annual compilations of case rates for other conditions.

### **RETURN TO WORK**

**Q:** When do you think full integration back into the workplace is possible?

**A:** Full integration back into the workforce depends on the environment in which work is begin conducted. For example, those work environments that permit physical distancing (6 feet or greater), frequent hand hygiene and wearing of facial coverings are currently undergoing a return to work en masse scenario (given state restrictions). This is compared to those jobs that require close proximity and have limitations with regard to wearing a mask due to other potential health hazards such as heat exhaustion.