

**WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace
Questions & Answers – Week 42
December 30, 2020**

The following questions were asked during WorkCare’s weekly webinar series on Preventing and Managing COVID-19 in the Workplace – Week 42. This week’s topic was “Year in Review.” 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. If your question is not answered here, it was answered in a previous Q&A.

Here are links for your reference:

- [December 23 Webinar Recording](#)
- [Questions & Answers from the December 23 Webinar](#)

KEY LESSONS

- Q:** As a clinician who has been following coronavirus developments since day one, what are the key lessons that you have drawn from this experience? Which of these lessons are especially applicable as we move into the New Year with respect to how employers will manage COVID fatigue, vaccine distribution and other ongoing preventive measures?
- A:** What I’ve taken away from this year at a macro level of understanding, and looking at anecdotally, is that employers who have weathered the pandemic better than others took a very proactive stance early on to put in place measures and procedures that were scalable. It’s not necessarily that the majority of employers lacked forward movement with regard to a preventive strategy – I’m drawing a sharp distinction between those who put in place scalable processes that allowed them to weather the duration of this pandemic and those who did not. In 2021, we are going to need to double-down on that strategy. If you don’t have a scaled process in place at this time, meaning that you haven’t dialed into automation or the use of digital platforms, that’s going to be paramount with regard to continuing to keep the workforce safe. From a preventive standpoint, it includes tracking, social distancing and contact tracing. When we talk about vaccinations, it’s going to be about tracking those individuals who have or have not been vaccinated. With contact tracing, it will be identifying how people are being exposed and whether they should be in quarantine. That’s going to be complex. Having a scalable process – hopefully partnering with us to do that – will be the key to maintaining safety as well as preventing burnout for those human resources and environment, health and safety professionals who have been doing a lot of the heavy lifting. For me personally, it has been not to just solve the problem, but solve the problem with scalable solutions as early as possible so that the workforce is safe and the company doesn’t experience burnout with the frontline HR and EHS folks.
- Q:** What can we glean from the past to be better prepared in the event of another pandemic?
- A:** One of the interesting historical perspectives I want to share with everyone is that we’re part of organizations that we want to be able to weather the storm of an occurrence like this in the future. Hopefully, at this point, everyone is thinking about the long-term game and about how to keep our workforce safe. This is the historical reference: If we look at the first recorded pandemic in 400 B.C. and we track the occurrence of global pandemics since then, and we look particularly at the last eight to 10 pandemics, we see a dramatic decrease in the time scale and frequency of these types of events. Meaning, right now, we are looking at a time horizon of every 15 to 20 years, and in some instances as little as every eight to 10 years depending on the years you’re analyzing. Certainly within our lifetime we may experience

this again. We need to have processes in place that are scalable and sustainable for organizations so that we are on the front end of primary prevention rather than doing secondary prevention only.

VACCINE

Q: Is the U.K. going to begin vaccinating with the normal dose or a lower dose of the AstraZeneca vaccine?

A: It looks like it's going to be the normal dose, and the reason why I mention that is because if you look at the AstraZeneca Phase 3 clinical trial, there was a group of individuals who received two full doses of the vaccine and had an efficacy of around 90 percent, and the individuals who received one and a half doses had an efficacy of 64 percent. Erring on the side of trying to maximize efficacy, a full dose is what I anticipate will be the next move in the U.K. I can't confirm that with any substantial data at this time, but based on the clinical trials, I don't anticipate them deviating from that.

Q: Do you think the CDC or FDA will approve giving only one dose of the Pfizer and Moderna vaccines to increase the number of people who can be vaccinated?

A: That's a good question. I don't know. The strategy that the U.K. has with the AstraZeneca vaccine may be predicated on the vaccine's initial efficacy; I'm not certain. I can dig into that more in the days and weeks to come. I have not seen any indication or any reports from the FDA that they would adopt a similar strategy in regard to trying to increase the number of people in that first tranche of vaccinations because it would be a dramatic deviation from how vaccines have historically been administered. It will be an interesting conversation, an interesting small case study that the FDA might do, but I'm not familiar with anything that points to heading in that direction at this point.

Q: How long do you think it will be before vaccines are available to the general public?

A: If everything goes well, I anticipate April will be the timeline for vaccine distribution to the general public. If we have some tremendous successes with continual approval of additional vaccines, then it may be a little bit sooner. However, April is the date in which our general population will likely receive – at the earliest – their vaccine. It won't be until end of next year fourth quarter that we'll have enough people vaccinated to get close to that herd immunity number. Again, that's predicated on who actually signs up to be vaccinated.

Q: If someone had just been vaccinated and then gets tested for COVID, would they test positive because of the vaccination?

A: The question is, can a PCR test detect proteins that were created de novo from a vaccine circulating in our systems? The answer is no when we talk about PCR because we're referring to nucleic acid, not spike protein. You shouldn't test positive using a PCR that amplifies nucleic acid when we're testing individuals because the body is not producing nucleic acids, only the protein that is displayed on the SARS-CoV-2 virus. If you test an individual using serology, meaning an antibody test, yes, you hopefully will have a positive antibody test to SARS-CoV-2 whether you have gotten it through acquired immunity with the vaccine or natural immunity from having recovered from COVID-19.

CASE RATES

Q: It is difficult to extrapolate hospitalizations and ICU admission rates, specifically the Los Angeles County case rates you mentioned. What percentage are COVID related? What is the current mortality rate?

A: If we look at that data, you will see the percentage of confirmed COVID-19-related cases occupying normal hospital beds, not ICU beds, was 48 percent (on Dec. 29, 2020). If we look at ICU census, it's 45 percent. That's the association from a COVID-specific standpoint. Here is the Jan. 3, 2021 daily update for Los Angeles County:

COVID-19 DAILY UPDATE

Los Angeles County*

January 3, 2021

12,488

NEW CASES
(818,639 to date)

91

NEW DEATHS
(10,733 to date)

7,544

CURRENT
HOSPITALIZATIONS

*includes Long Beach and Pasadena Health Departments
For more information, visit: publichealth.lacounty.gov/coronavirus

