

**WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace  
Questions & Answers – Week 49  
February 17, 2021**

*The following questions were asked during WorkCare's weekly webinar series on Preventing and Managing COVID-19 in the Workplace – Week 49. Anthony Harris, M.D., M.B.A., M.P.H., WorkCare's Chief Innovation Officer and Associate Medical Director, presented the webinar and provided these answers. Please refer to previous Q&As if your question is not answered here.*

*Here are links for your reference:*

- [February 17 Webinar Recording](#)
- [Questions & Answers from the February 10 Webinar](#)

**CASE AND TEST RATES**

**Q:** Why is the COVID-19 case rate dropping in the U.S. and internationally?

**A:** One hypothesis is that case rates are dropping because the prevalence is so broad. When we talk about prevalence, there is observed or verified prevalence and there is presumptive prevalence from an uncaptured standpoint. If we reflect back on seropositivity data, we saw in some cases states experiencing seropositivity of 10, 15 and even 20 percent of the population taken in samples being positive for having had COVID-19. Across the board, we now estimate that a far greater number of people – possibly eight to 10 times the number – have recovered from COVID-19. That being true, the number of people who are no longer in the susceptible pool is increasing, thus decreasing overall incidence. That may have a definitive role for getting to the number needed for herd immunity in conjunction with the tens of millions of people who have been vaccinated. We have been starting to put together some of that data to understand the difference between natural and vaccinated immunity and what that means for herd immunity in the U.S. and abroad as far as the timing.

**Q:** Why has the number of diagnostic tests performed in the U.S. declined in recent weeks?

**A:** We don't have any great answers as to why testing has decreased. When we looked at the rate of increased number of tests months ago, it seemed like we were going to hit the numbers we desired – 2-3 million tests on a daily average. We just never got to that. Instead, we saw contractions. From a manufacturing and supply standpoint, we may have outstripped the resources needed in laboratories. For example, the reagents needed for PCR testing are not available. Another reason may be associated with individuals not showing up to be tested. If we presume a far higher number of people are contracting COVID-19 and recovering, they are not getting tested because they felt symptomatic and now feel better. If concern around contracting COVID is not as great, testing numbers will be lower. Number of tests performed does not necessarily reflect our actual capacity to test. I believe that may be important for us to examine.

**Q:** How do you explain the effectiveness of infection controls in India? Data show case rates in India are relatively low compared to other countries.

**A:** When you speak with professionals in India, the suspicion is that not that India is doing a tremendous job at prevention. It's rather that they are not actually capturing the number of infected individuals...the broad testing is just not there per population compared to other countries. It's most likely accuracy in understanding incidents and prevalence.

**Q:** Does the testing data you present include all types of tests, including home tests, or just tests that are conducted in a lab?

**A:** The data only include those tests that are conducted in laboratory settings by organizations that are obligated to report.

#### **QUARANTINE**

**Q:** What is your opinion regarding requiring quarantine of employees who tested COVID-positive within the last 90 days when they are identified as a close contact of a COVID-positive person? Is quarantine excessive or warranted?

**A:** We agree with the recommendation that within 90 days after recovering from COVID-19 an individual should not require quarantine with any subsequent exposure within that time period. After that time period, it is recommended to have quarantine because of the increased risk of infection. A period of five to eight months is what we believe is imparted with natural immunity at this time. We may see a lengthening of that recommended of 90 days, but right now that 90-day window after recovery or after vaccination is recommended.

#### **VACCINE**

**Q:** I understand that vaccine effectiveness is related to a short-term measure, but shouldn't safety be evaluated? What are the long-term impacts regarding safety of the vaccine?

**A:** Speaking of the vaccines authorized for emergency use in the U.S., you're right, we do not have any long-term safety data. The short term is obviously understood from immediate response after vaccine administration within 30 minutes as being equivalent to or less than 1 percent of placebo. But over a long-term period of time, a year or more, we just don't have that data yet, but we will soon for the phase 2 and 3 clinical studies that kicked off at the beginning of last year.

**Q:** Is there a schedule for vaccine rollout?

**A:** Refer to the [CDC's Vaccine Rollout webpage](#) for recommendations and related information.

#### **VARIANTS**

**Q:** How does the CAL.20C variant compare to the other variants? It is up to 40 percent of all cases in Southern California and has been detected in at least 19 states. It doesn't seem to be getting as much hype as the other variants. Why is this since it is already here in the U.S. and is a major proportion of cases in California, which leads the nation in cases?

**A:** We have evidence to show that there is not necessarily increased risk for infection nor evidence that points to a poor outcome determination. In terms of the CAL variant, we haven't seen any data that points toward increased transmissibility and severity. That may be why it is not getting as much press compared to other variants that have higher transmissibility and severity.