

**WorkCare Briefing: Preventing and Managing COVID-19 in the Workplace  
Questions & Answers – Week 52  
March 10, 2021**

*The following questions were asked during WorkCare's weekly webinar on Preventing and Managing COVID-19 in the Workplace – Week 52. 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. **Please Note:** The webinar is moving to a monthly schedule. The next session will be April 7, 2021, from 1-2 p.m. Eastern time. If you have already registered, you do not need to re-register. To register for the monthly webinar, please use the form on WorkCare's COVID-19 webpage.*

Here are links for your reference:

- [March 10 Webinar Recording](#)
- [Questions & Answers from the March 3 Webinar](#)

#### **KEY TAKEAWAYS**

**Q:** A lot has happened in the past 12 months. You have presented 52 consecutive webinars covering topics ranging from coronavirus basics, to case and fatality rates, to complexities involved with symptom screening, testing, quarantine and isolation, and distribution and administration of vaccine in the context of the U.S. workplace. As a clinician, what have you gleaned from your experience with the COVID-19 pandemic in terms of how you practice occupational medicine?

**A:** What I have learned is that we really need to have a broader perspective and understanding of trends abroad. Had we paid attention to what was occurring abroad early in this pandemic and took it more seriously regarding potential harm and impact to us domestically, we may have made some different decisions – not just at the political leadership level, but also at the workplace level. As a clinician, I think about sounding the alarm, perhaps sooner, of a potential pandemic coming. This journey has definitely deepened my resolve to look for macro trends from a health and wellness perspective, and from an epidemiological standpoint. I've also learned to let that broader perspective inform how we practice occupational medicine here domestically and how we advise those who may be at risk abroad.

#### **VACCINATION**

**Q:** What are your thoughts on the recent CDC guidance for fully vaccinated people to meet with others indoors? Is it prudent?

**A:** I think it is prudent. If we talk about absolute risk or even relative risk, once you are fully vaccinated it is level in regard to a risk of transmission in the household setting. This was what Dr. Fauci was speaking to regarding being able to enjoy meeting in the household with friends and family who have been vaccinated. At this point, both the Moderna and Pfizer vaccines have been found to be up to 85 percent efficacious against the majority of the variants we are seeing. Being fully vaccinated myself, I would attend a family gathering as outlined in the recommendations.

**Q:** If you are fully vaccinated but have COVID-19 symptoms and get tested, would you automatically test positive even if you are not infected?

**A:** No. The test for COVID looks for genetic material in the virus. It would be negative if you do not have COVID and because your system is only primed to recognize viral particles when they are presented from a potential immune challenge not from vaccination. If you are fully vaccinated and are infected, then you may fall into the demographic that did not seroconvert and acquire immunity to SARS-CoV-2.

- Q:** If an employee has had an adverse reaction to a previous vaccination, is advised against getting the vaccination but their employer mandates it, how would that situation be handled? Are companies going to be held legally liable?
- A:** In regard to that mandate and those who have medical exceptions to vaccinations, we deal with that currently in the workforce, especially in health care settings. If you are going to work in a hospital, you must have a set of vaccines and proof that you've been vaccinated. Those who cannot be vaccinated are evaluated for a reasonable accommodation under the Americans with Disabilities Act. That allows a clinician to review a document, as we do on a regular basis at WorkCare. Then a company should allow that individual to be gainfully employed under those reasonable accommodations.

## IMMUNITY

- Q:** If people are vaccinated and we are approaching herd immunity, what impact will mutations or variants play when we reach that point? Will variants have an influence on herd immunity?
- A:** If we look at the most dramatic impact, it underscores the notion that we must have a global effort at combating SARS-CoV-2. To achieve herd immunity here in the U.S., we will need to have 80 percent of the population vaccinated and not susceptible to the virus. This includes all types and variants. Other nations, particularly socio-economically challenged nations that do not have as much access to vaccinations, will continue to have higher levels of infections and higher levels of mutations that could potentially be imported to the U.S. and escape the acquired immunity, even from vaccinations. That would have a dramatic impact on herd immunity globally and at that point affect nations that have international travel, which could import vaccine-resistant viruses.
- Q:** I am trying to understand how the same immune system that is supposed to provide immunity after vaccination somehow does not provide immunity after illness. T-memory cells provide long-term immunity. What scientific studies do we have that support this?
- A:** One of the contributing factors that we understand today is that an individual who recovers from an infection of COVID-19 is imparted with a level of immunity against a certain form of the virus. They do not gain immunity to the same level against all variants across the board. The variants that you see in the media are variants that have enough mutations to achieve components (i.e., the receptor binding site of the S spike protein) to minimize the effectiveness of natural immunity. We're not talking about all variants that occur through genetic drift. The immune system is recognizing and protecting us from these types of variants, except for those that have become more prominent. We also know that there is a quantity factor to immunity, meaning that the acquired immunity from a vaccine can produce up to 40 times the immunoresponse to the natural immunity pathway. These factors play out in natural immunity not being as effective for these variants, as opposed to acquired immunity through vaccination.
- Q:** We were quarantining all ill employees per our protocol, and now are getting employees with illnesses who have already had COVID. We continue to quarantine them, but what is the likelihood they have another COVID infection?
- A:** According to the National Institutes of Health, recent findings from a study of thousands of workers in England show that those who got COVID-19 and produced antibodies against the virus were highly unlikely to become infected again, at least over the several months that the study was conducted. In the rare instances in which someone with acquired immunity for SARS-CoV-2 subsequently tested positive for the virus within a six-month period, they developed symptoms. Some earlier studies have shown that people who had COVID-19 [continued to produce protective antibodies](#) against key parts of the virus for several months, but how long those antibodies last and whether they are enough to protect against reinfection have remained open questions. The following CDC guidelines apply to fully vaccinated employees of non-

health care congregate settings and other high-density workplaces (e.g., meat and poultry processing and manufacturing plants) with no COVID-like symptoms: They do not need to quarantine following an exposure; however testing following an exposure and through routine workplace screening programs is still recommended. Refer to [www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html).

#### **TRAVEL**

**Q:** Can you comment on states revising travel bans (testing/isolation) from mandatory to recommended? What should companies do?

**A:** When we talk about recommended vs. required, if you can require it, you have a legal stance to do so. At this point the question is: Is there going to be enough risk to support it? We're still at levels that were alarming early on the pandemic. We're lower than we were, but these levels last year were alarming. There is still support for mandating these precautions for travel, which certainly we would recommend. If you have the leadership support to do so, it would be prudent to mandate until we get to the point where we have enough people in the United States vaccinated to approach herd immunity. That is conservative in regard to protecting the workforce.

#### **TESTING**

**Q:** You mentioned the downward trend in testing in the United States. What is your opinion as to why we are seeing this trend?

**A:** When we talk about the downward trend of testing, it is likely not the result of testing not being available or accessible, but rather individuals not participating in testing to the extent they used to. Again, that's a result of the exposure, transmission and recovery from COVID-19. If we look at positivity rates in the U.S., some states only have a 2 percent positivity rate. Those individuals are not showing up to be tested because they are either not symptomatic or have recovered. We see this playing out in the U.S. with decreased testing adjacent to decreasing cases, and we see it playing out in other nations, as well. That is likely the genesis of decreased testing. In the UK, we see more surveillance testing being conducted, which is why their testing rate is going up versus here in the U.S. where surveillance testing has not been relied upon substantially. I think that may be to our peril if we continue to see upward trends of the variants play out in which we still have susceptible populations, because they have only enjoyed a natural immunity to this point versus acquired immunity through vaccinations.

#### **SYMPTOMS**

**Q:** Can you address loss of taste and smell as a distinguishing symptom of COVID vs. the flu vs. allergies and how they would be applied in workplace screening?

**A:** We have incorporated loss of taste and smell as one of the symptomatic metrics to put you in a high-risk category for SARS-CoV-2 infection. Moving forward it will likely continue to be a trigger for required isolation if an individual presents with a loss of taste or smell.