

WorkCare Webinar: Trending Beyond COVID-19
Questions & Answers
January 5, 2021

The following questions were asked during WorkCare's monthly webinar series on Trending Beyond COVID-19. 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.

Here are links for your reference:

- [January 5 Webinar Recording](#)
- [Questions & Answers from the December 1 Webinar](#)

TESTING

Q: Regarding at-home tests, quite a few folks are initially testing negative, even while symptomatic, and then later testing positive. We have heard tests are more accurate if you swab your throat and then your nose. Should we be encouraging employees to do this when they test to get a more accurate result?

A: I am not aware of any manufacturer literature around improving the accuracy of rapid antigen tests from a dual method of collection. The method of collection for a test has FDA emergency use authorization. I have not seen any evidence to suggest that doing a throat swab and then a nasal swab on the same sample would provide better sensitivity for that particular test. Can it hurt? No, it can't. But will it lead to better accuracy? That is a big question mark and not something that we can stand behind right now. We know that different rapid tests have different levels of accuracy and sensitivity, and we know that there are even some PCR tests that are on the FDA's list that are not as sensitive because of Omicron, but the vast majority of PCR tests detect Omicron.

Q: What guidance is there on testing symptomatic or positive individuals at the end of their isolation/quarantine period to confirm they are no longer shedding the virus?

A: That question goes back to when the pandemic first started. To return to work it was recommended by the CDC to have two negative PCR tests 24 hours apart. Then we learned after a period of time that individuals were not likely shedding sufficiently to produce a transmission, therefore they did not require testing. In addition to the supply issue on the testing side, as it stands now it is still clinically valid to clear someone to return to work without testing being a necessary part of that return-to-work process 10 days after a positive test. That logic and clinical reasoning have not changed. However, what has changed is how do you get workers back to work sooner and minimize the risk of transmission in that scenario before 10 days have elapsed? As of right now, that methodology still does not require testing but is suggested in the new CDC recommendations at day five. Will that change? I think it might. Rumbblings in the clinical community suggest that the CDC may change its recommendation to require testing for an early return to work. There are still jurisdictions that don't agree with the CDC recommendation of the five-day return with masking, if not testing. At the end of the day, testing is not a requirement for a return to work at this time, because the risk is still minimal if it's been 10 days.

Q: What guidance is there on testing individuals who have had COVID in the past 90 days when they have close contact or start experiencing symptoms?

A: It is still a consistent recommendation that you're presumably not positive for COVID if you've been exposed unless you have symptoms. That's the threshold. Exposure by itself does not require you to quarantine if you have recovered in that time period from COVID. Same with regard to being fully vaccinated. You are not required to quarantine from exposure. This is just a one-off exposure, not someone

who is living in a household with someone who tested positive; that's a different scenario. But it is best practice for any individual with symptoms who has been exposed regardless of when they recovered previously to get tested to make sure they are not positive. I don't want you to think that if you are symptomatic, but are within that 90-day window, you're in the clear.

- Q:** Is weekly testing adequate? It seems like the timeframe from exposure to contagion is greater than five days, making weekly testing ineffective.
- A:** Data from Columbia University on workplace transmission show that doing more than weekly testing can provide additional protection for your workforce. Columbia University looked at testing three days a week, testing weekly and testing daily. The more testing that was done, the lower the workplace transmissions. We know you can do more and provide more protection. However, is the cost worth the return on investment? The basis for doing more at this point because of the impact on productivity and success of a business is now back in question since companies have entire lines of workers out due to COVID. It's now shifting more toward doing more at a higher cost since there will likely be a return on investment.
- Q:** Are antigen tests less reliable for Omicron?
- A:** The FDA collaborates with the National Institutes of Health's (NIH) RADx program to study the performance of antigen tests with patient samples that have the omicron variant. RADx recently performed preliminary studies evaluating the performance of some antigen tests using patient samples containing live virus, which represents the best way to evaluate true test performance in the short-term. Early data suggests that antigen tests detect the Omicron variant but may have reduced sensitivity. Refer to [Omicron Variant: Impact on Antigen Diagnostic Tests](#) (as of Dec. 28, 2021).

CDC Guidance

- Q:** What are WorkCare's recommendations for quarantine and isolation employees? Are they consistent with CDC guidelines for the general population?
- A:** WorkCare will be publishing a briefing on our recommendations.

VACCINE

- Q:** Are there fewer deaths from Omicron because of vaccination protection and/or is the Omicron variant less severe in general?
- A:** There is clinical suggestion of both. Populations that have experienced previous high rates of infections in the past may have some level of protection from an immunological standpoint. This is what we have theorized in South Africa and here in the U.S. If we look at CDC laboratory reports, seropositivity rates are approaching 40-50 percent in some states, meaning 40-50 percent of the population has had COVID. We know that imparts some protection against high severity and hospitalization. Even among the unvaccinated population and those who are naïve to the virus, we are still seeing less hospitalization across the board and less dependence on ICUs and oxygen use. We saw that first in South Africa where fewer individuals who were admitted to the COVID ward required oxygen as a result of Omicron infection. We've seen this play out in multiple nations and hold that Omicron presents a lower risk for severe illness because of the nature of the virus itself in addition to existing immunity in the community.
- Q:** If the vaccine does not prevent contraction or transmission of the disease, what is the purpose of vaccine mandates?
- A:** Vaccination reduces risk of serious illness, hospitalizations and deaths, and it helps slow the spread of contagious disease.

CASE AND FATALITY RATES

Q: Do you have an explanation as to why case rates in India are lower than they in other countries?

A: Logic would say that in India, due to lack of access to testing, the numbers are under-reported. By comparison in the U.S., we are reporting higher numbers, but if you look at the data on seropositivity, we know the true number of cases may be almost double and in some cases triple to what we're picking up through testing.

Q: Are COVID deaths counted as people who died *with* COVID or as people who died *from* COVID?

A: Died from COVID is the definition of a COVID death. I know that there's been an ongoing debate around how individual deaths are coded by the clinical community at the time of death. By far and away the clinical logic for declaration of the cause of death should be from COVID, not just died with COVID. For example, if you had metastatic cancer and liver failure, succumbing to that along with having a positive test for COVID when you were admitted to the hospital for your underlying condition, it would not be the same from a coding standpoint, as if someone died just from COVID-19. It would be the individual who was admitted for an underlying clinical condition consistent with a COVID-19 infection, which would oftentimes involve the respiratory system. It is a distinction that I think does not pose any admixing or misrepresentation of true COVID deaths versus deaths from other causes.

Q: Do you have data comparing more open states, like Florida, to more closed states, like California and New York?

A: Refer to the U.S. COVID-19 state/territory maps on this [CDC webpage](#) for comparisons.

BREAKTHROUGH CASES

Q: Is there any current data on the COVID breakthrough rates for fully vaccinated and boosted individuals?

A: I have not seen updated data on breakthrough rates. In terms of symptomatic illness prevention numbers, we know that even after a booster the risk of symptomatic illness goes down substantially. If we look at Israel's data, the protection factor goes from 37 percent up to 92 percent. It's still a question of how long after a booster that number is maintained and the extent to which it wanes over time. Anecdotally, it still looks like immunity wanes over time in terms of exposure risk going back up. We just don't have enough data to suggest how low that waning immunity goes. Certainly, with new variants, that throws the entire equation off in terms of waning immunity, because new variants such as Omicron escape the immunity from natural immunity or acquired immunity through vaccination.

WORK-RELATED TRAVEL

Q: In your opinion, should businesses limit work-related travel, air in particular, to essential travel only for the next week or two or even more?

A: We recommend following CDC guidance for domestic and international travel. Many employers are delaying non-essential travel as an added precaution during this current surge.