

WorkCare Briefing: Trending Beyond COVID-19
Questions & Answers
February 2, 2022

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. Please refer to previous Q&As if your question is not answered here.

Here are links for your reference:

- [February 2 Webinar Recording](#)
- [Questions & Answers from the January 5 Webinar](#)

TESTING

Q: I live in New Mexico. We have the BA.2 Omicron variant here. What are the chances of this variant affecting rapid test detection?

A: We know that rapid tests can have sensitivity as low as 50 percent in some cases. It comes down to not just BA.1 versus BA.2. There's not enough evidence to show that rapid tests are less likely to detect BA.2 versus BA.1 at this point. With the presumption that these tests are only for Omicron, at worse they're 50 percent efficacious. This is one of the unintended consequences of having rapid tests more widely available. I am not saying that we should limit the number of tests that we get in the hands of workers. It comes down to *when* people are testing. The first instinct of individuals, especially with the free tests when they are symptomatic, is to reach for that test. Usually, that happens on day one. That is when the sensitivity is very low with rapid tests. If individuals are testing on day three, the rate of detection of infection goes up significantly, which we have seen anecdotally and in evidence-based studies. That is key to making sure we're not exposing individuals who are negative on days one and two but are positive on day three. Day five is now the threshold for return to work with a negative test, according to CDC guidelines. Rapid tests in that case would come back positive, especially with a higher sensitivity rate.

Q: How effective are the various COVID tests at detecting the Omicron variant? We are experiencing some questionable results.

A: At WorkCare, we frequently discuss the dependability of diagnostic tests. The best way to address the practice that should be in place is to go back to the beginning of our thoughts around when to test. Here's the approach. Only do a diagnostic test when it's going to change the outcome or intervention for that individual. We got here because we blended diagnostic with screening. We want to go back and redefine what the end goal is, and then re-establish the approach that we have in terms of decision-making. A clinical diagnosis is what should be our approach first and foremost with workers and the return-to-work process. This is where we were at the beginning of the pandemic – we didn't have rapid tests. We barely had PCR tests that were able to detect COVID early on. We were resigned to using clinical diagnosis to determine whether someone had COVID. Over time that shifted to testing. If you tested negative then you didn't have COVID. Now we're at a point where the reliability of testing is such that we don't have high sensitivity and thus need to go back to clinical diagnosis first. Confirmation with tests increases the post-test probability that a positive test or a negative test helps you make a decision. That's what we want to revert to in terms of when to test and who is getting tested, because when we're testing to return to work, it's most likely after a known exposure or after a symptomatic onset. We can make that clinical determination first and then only test and rely on that diagnostic test as supporting evidence. This has helped us in determining when an employee can return to work, and move forward more quickly with

regard to determinations with a lower risk of introducing someone who may have transmission risk in the workplace.

Q: Are we able to return to work on day five without a test?

A: In California, the answer to that is no. There's a mandate that you have to test. I believe that there will be other jurisdictions that will follow suit and require testing to return to work. It's similar to what we saw early in the pandemic where you had to have two negative PCR tests to return to work. At this point, the answer is yes. You can return to work without a test on day five if there is a low clinical diagnostic likelihood that you have COVID. If there is any question, then the test is warranted to support a clinical diagnosis of COVID or to support that the individual likely does not have COVID to get them out of that gray area. We know that approach deviates from the CDC, which recommends a test when it is available but does not require a test. We want to clarify that gray area to suggest testing when there is not a clear clinical diagnostic criteria for whether or not the person has COVID.

Q: My employer is moving forward with weekly testing for employees who are not vaccinated. We implemented a mandatory vaccination policy with exceptions based on religious and medical accommodations. Do you believe there is value in this testing action given the fact that Omicron infects vaccinated individuals? What value do you place on weekly testing for people who have not been vaccinated in an effort to keep the workplace free of COVID?

A: There is a lot of value that comes from weekly testing. Data from South Africa demonstrates that unvaccinated people are more likely to transmit COVID-19 than someone who is vaccinated and boosted. It's not just the risk of the individual having, contracting and having a poor outcome from COVID-19. It's the fact that they are more likely to transmit it to someone else. Thus, testing on a weekly basis or having a screening protocol for the unvaccinated would still yield greater returns on investment in terms of prevention of transmission in the workplace compared to vaccinated individuals.

MASKS

Q: As states are dropping local mask mandates due to political pressure, what is the guidance for employers? Should we continue to keep our company mask mandates? If so, what is the trigger for when we can loosen restrictions?

A: There has been data to suggest that mask mandate, because the high prevalence of Omicron, could have very little effect on its spread, meaning that there is only a 1-5 percent effect on transmission rates as a result of a mask mandate at work. Most of the transmission of Omicron is not happening in the workplace. It's happening in the household. There is little evidence to show that people are walking around their house with masks on. We know that Omicron is being driven by household exposure. A mask mandate in the workplace may only have a modest impact on the prevention of Omicron transmission in the workforce. That's the first part. The second part is whether additional protection, although modest, warrants a mask mandate in the workplace. That's going to be an individual corporate decisions. Do we do everything we can to prevent workplace transmission or do we suggest something that we may have to negotiate with a union? We still recommend mask-wearing to help prevent transmission in the workplace, although it may not prevent all of your workforce from experiencing the high impact of Omicron.

Q: What type of mask would you recommend for everyone to wear in a conference room of 40 people? The length of the conference would be eight hours: N95, KN95 or surgical?

A: We've seen attention being paid to the type of masks individuals are recommended to wear. The cloth masks are not being recommended as much as they were under the surgeon general of the past administration. Moving toward a surgical mask or N95 is the trend that we're seeing and certainly the

recommendation that we would make in that setting. You refer to having 40 people in a closed indoor space for a long period. We know that a properly fitted N95 mask will protect to a significantly higher degree than a cloth mask. In terms of surgical masks, double- masking is something that still should be practiced. It doesn't mean that you have to wear two surgical masks, but if you wear a surgical mask and a cloth mask over that, it increases the protection factor up to 96 percent in terms of limiting transmission from one person to another, according to CDC data. That is also a strong recommendation if N95 masks are not available. At this point, we've seen an increased availability of N95 masks because the Biden administration has sent out millions of N95 and KN95 masks.

RESPIRATOR FIT TESTING

- Q:** What do you think about the safety of conducting quantitative respirator fit testing at this time? (Not so much for the person conducting the test, but for the people getting tested.) We disinfect the facepiece adaptors, but there are the hoses that connect the adaptors to the machine.
- A:** In terms of overall risk, we know that for a period of time doing respiratory diagnostics as well as quantitative fit testing was paused. I have not seen any data that suggests it increases the potential rate of transmission or risk for individuals being tested. That may be because extra attention and care is being paid to disinfect hardware used during testing. With the clinics that I work with, I have not seen an increase in risk. However, it would warrant a specific study. Unless we see an outbreak in a particular setting, it would be difficult to collect data because of the broad community spread of Omicron, whether the increased transmission or risk was a result of the testing.

Note: A webinar participant shared this related document: [Hygienic Security and the Portacount Respirator Fit Tester](#). (WorkCare does not endorse/sell specific products.)

OSHA GUIDELINES

- Q:** Do you have any information regarding OSHA's COVID-19 workplace safety requirements and the implications if its not followed?
- A:** Without an enforceable Emergency Temporary Standard, OSHA's general duty clause applies, so consequences would be associated with violation of general duty provisions. There is nothing more to add until more information is given by OSHA around the permanent rule-making they're trying to propagate. Once we have that, we will have a clearer understanding of what they intend to impose in terms of repercussions for any violation.

TREATMENT

- Q:** Can you comment on anti-virals in the pipeline for COVID treatment?
- A:** We know that Pfizer and several other companies have their five-day regimen for treatment as well as post-exposure. Merck had data early on showing that their treatment was very efficacious, but later only showed 33 percent efficacy in preventing or decreasing symptomatic illness from COVID-19. Pfizer's treatment, I believe, is over 89 percent effective. These are treatments that we will see used particularly in nations that have less access to IV and monoclonal antibody treatments. While they are good for helping prevent poor outcomes from COVID, we're likely not going to see them relied upon as means to help us get out of the pandemic. They're not geared toward shortening the duration of COVID or decreasing the transmission of COVID. They're more geared toward helping an individual through their experience with COVID in terms of the prevention of severe illness and death. Of course, we want those treatments, but from a prevention standpoint, they are not likely to be a key factor in our strategy.

LONG-TERM COVID

Q: Are there any additional publications on the long-term impacts of COVID? Do we see long-term impacts if it is an Omicron infection?

A: We do know that we're seeing long COVID with Omicron. We're seeing less severity with Omicron in general, but we're still seeing a persistent cough and shortness of breath. We're also still seeing some of the mental fog exist with Omicron, as well. In terms of new data on long COVID, I haven't seen a lot of studies examining the overall outcome of long COVID in terms of endpoints. We still know that it's occurring and not just a phenomenon of Alpha, Beta and Delta variants of COVID. In regard to the long-term, nobody knows what the effects are in terms of years down the road, because we haven't had the time to examine it. Some of the most interesting evidence is studying how COVID affects the brain from an MRI perspective and how it causes inflammation. It also causes inflammation in other organs such as the heart. I think we will see more evidence cropping up from individuals with long COVID to help us understand the potential for long-term implications for the general population. The subset of the population that experiences long COVID may be somewhat representative of those potentially broader long-term effects.