

WorkCare Briefing: Trending Beyond COVID-19
Questions & Answers
March 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., a WorkCare consulting 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:

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

MASKA

- Q:** The CDC guidance changes made last Friday feel a little pre-mature and potentially politically motivated. The new rule is that you only need to mask indoors if you're in a high-risk area. What are your thoughts about this change? Is it appropriate for an employer to use this methodology when determining masking requirements indoors? I am suggesting to leadership that it's not appropriate for a workplace because case rates are given little value. Our job is to keep COVID out of the workplace and our staff well. To me, the use of the CDC's data tracker is more appropriate.
- A:** Let's take a look at [county-by-county data](#) from the CDC. Counties are put into categories of high, medium and low risk. They are looking at cases per 100,000 over the last seven days, new COVID admissions per 100,000 and the percentage of staffed inpatient beds occupied by COVID-19 patients. I agree, because of the way we have approached risk mitigation, that you should still be factoring in local incidence rates. Let's break this down a little in terms of the arguments of why you should or should not pay attention to incidence. This all came about because of the Omicron variant. With Omicron, we saw a far more infectious virus, but we also saw a less severe virus (compared to prior strains). What that meant is that we drove up the number of cases, but overall we didn't have the impact in terms of severity and hospitalizations that we had previously. Looking at incidence alone became less effective in determining whether individuals were at risk for severe outcomes as a result of COVID-19. What happened is that the criteria were broadened but still inclusive. If we look at risk profiles for COVID-19 at the beginning of the pandemic performed by different institutions, they all incorporated some level of incidence data. They added to that severity factors such as hospitalizations and those who were admitted to the ICU. It also included the use of supplemental oxygen. Multiple factors affect community risk levels. If we compare those models to what the CDC is proposing, we see a difference in comparison to data models that include incidence. My suggestion is to still include incidence locally as a factor in assessing the risk level for your workforce. By not doing so, we may be missing an opportunity to protect the workforce in a meaningful way compared to if we eliminate that data. When and if we have another variant, which could be even more severe in terms of poor outcomes than Delta, then incidence data will again be incorporated into the CDC's rubric of high, medium and low risk from a community standpoint.

CONTACT TRACING

- Q:** Do you think that the pandemic will reach endemic levels and companies will be able to stop contact tracing, and if so, do you have any sense of when we might reach that point?
- A:** As we had talked about previously in our other presentations, there is no consensus around the threshold of when the pandemic becomes endemic. However, death rate is a factor. For example, can compare the COVID-19 death rate to the death rate of other endemic diseases such as the flu. We know that the death rate from COVID-19 is still multiple factors higher than what we experience from the flu. To answer the

question, it will not be until we see the death rate closer to what we see from the flu. Is that an absolute? Absolutely not. We may experience a steady state and seasonality to COVID at a significantly higher rate of death compared to the flu, and it may just be something that we have to live with. Hopefully, because we have vaccinations that are effective against the severity of COVID, we will have a comparative endemic picture of COVID closer to that of the flu.

LONG COVID

- Q:** When we talk to employees about persistent symptoms of COVID (long-haul COVID), what should we be telling individuals who think that want to try and “get it” because they think this provides them better protection? Many seem to think that getting it means they have better protection but neglect the fact that there are serious health consequences for some people who get COVID.
- A:** Many individuals who don’t have any underlying conditions can still experience poor outcomes and death from COVID, not just long COVID itself. Exposing yourself knowingly and willingly to COVID is not recommended whatsoever. There is no evidence to suggest that natural immunity is better than acquired immunity through a vaccine. On the contrary, we have data to show the immune response to vaccination is multiple-times more robust, in some cases up to 40 times more robust than natural immunity. But we do recognize that individuals, after a COVID infection, will have some level of natural immunity at a minimum of 90 days, and in some cases longer. We also know that vaccinations are far safer than exposing yourself knowingly to COVID to try and get immunity long-term.
- Q:** Were long-COVID effects found to affect people who received one of the vaccines but did not experience a COVID infection? My understanding is that many of the symptoms presented were attributed to the spike proteins, and those were also produced by vaccination.
- A:** There are no data to suggest that the spike protein is a cause in of itself through vaccinations of the long COVID symptoms that individuals are experiencing from an active or past COVID infection. Long COVID symptomatology is not a result of the spike protein. It is a result of the virus causing inflammatory changes, damage to the epithelium that causes blood clots and other conditions, and organ damage as a result of the viral response. We’re starting to understand more in terms of the bio-accumulation of the spike protein. There is a plausible mechanism that bio-accumulation of spike protein may cause long-term adverse effects from vaccination. But again, it’s a big maybe. There is no current evidence to suggest that there are poor health effects from vaccination secondary to bio-accumulation of the spike protein.
- Q:** How do you think long-COVID will affect Family and Medical Leave (FMLA), short-term disability and long-term disability determinations?
- A:** As I mentioned during the presentation, the clinical community has been under-educated on the parameters clinically around long COVID - under-educated around clinical recognition and certainly under-educated around the disability impact of COVID. Consequently, individual employees may experience issues and denial of their disability secondary to a clinician not giving credence to the symptoms that they’re having and attributing that to their past COVID infection. The result in that scenario could be an individual who should not be working, being put back to work, and introducing risk in the workplace that is above and beyond what that risk would be otherwise. On the other side, individuals who experience symptomatology secondary to long COVID are underdiagnosed as a result and are out on FMLA, maybe causing prolonged absence and delays in reaching an endpoint of the process. We will likely find that individuals just simply leave the workforce. It’s something that we will likely see more of because if you look at projections, half of the U.S. population will have contracted Omicron before it’s gone. We will see more demands on disability processes and systems, in general, and clinicians as a result of long COVID disabilities. There will also be delays in getting people what they need to recover, and delays in getting people back to the workforce.

ASYMPTOMATIC COVID

Q: How would someone know if they have recovered from COVID-19 if they are asymptomatic? Is there a way to determine how long ago a person was infected?

A: Refer to the CDC for information about [post-infection antibody tests](#) with or without vaccination.

VACCINE BOOSTER

Q: Will be a need for another booster?

A: The CDC has recommended a second booster for immunocompromised people but not for the general population at this time. The need for another booster is being studied.