CDC Partner Call – Update on the COVID 19 Response
Agriculture Workers and Employers
Transcript created by Western Growers
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>> Hello and thank you for joining us. My name is Dr. Tamika Smith, and I would like to welcome you to today's CDC Partner Update Call on COVID-19. This call serves as a way for CDC to share weekly updates on COVID-19 and our latest resources and guidance, especially for the private sector and other partners. Our topic of focus today is on Considerations for the Agriculture Industry, but we will also cover more general updates and information from CDC. Our plan is to hear an update from our Chief Medical Officer about everyone, about what everyone should know about protecting themselves and others. We'll then hear from three of our experts about CDC's new guidance for agriculture workers and employers.

Afterwards, our speakers will take questions from the audience. This call is not intended for media. Media can direct their questions to media@cdc.gov. Again, that's media@cdc.gov. This call will be recorded and later posted on the CDC COVID-19 website as well as on YouTube. Similar to last week, our call today is at 3 PM Eastern Time as opposed to our usual 4 PM time slot. We are considering shifting the time of these calls in the future. We will deploy a poll while transitioning from presentation to Q&A to ensure a strong contingent of participants are able to participate. During the poll, you'll be provided two time slots: Mondays at 3 PM or Tuesdays at 4 PM. Both times are Eastern Standard Time.

I would like to remind all participants that the CDC website has the latest information, guidance, and communication resources. There are now close to 1800 documents providing information and guidance for individuals, businesses, and the public on our website. In addition to the tools we'll highlight today, some resources posted within the last two weeks include When can you be around others after you had or likely had COVID-19? COVID-19 in Racial and Ethnic Minority Groups. Household living in close quarters. Stress and coping considerations. Workplace decision tool. Testing strategy for Coronavirus in high-density critical infrastructure workplaces after a COVID-19 case is identified. An overview of testing for SARS CoV-2. Thank you to those who sent questions in in advance.

We have teed up some of those questions, and I'll also be keeping an eye on the Q&A box, so feel free to, so feel free and welcome to submit questions there as well. Note: we will not be viewing the chat box, so please utilize the full functionality of Q&A. I am pleased to be joined today by four CDC experts. Dr. John Brooks, who is the Chief Medical Officer for the COVID-19 Response here at CDC, Dr. Jennifer Lincoln who is the Associate Director of the CDC's National Institute for Occupational Safety and Health also known as NIOSH. Officer of Agriculture Safety and Health, Dr. Megin Nichols who's a veterinary epidemiologist on the Food Systems Working Group, and Captain Kenneth Dominguez, a medical epidemiologist in the US Public Health Service, serving on our Minority Health and Rural Health Team. For those of you logged into the webinar platform, there will be very few slides used today, so don't be worried if they don't seem to be advancing. However, a transcript will be provided along with this video when it's posted online to YouTube. You now see a very quick agenda. I'd like to now turn it over to Dr. Brooks for some updates. Thank you! Dr. Brooks, it's over to you.

>> Dr. Smith, thank you so much for that kind introduction. As Tamika mentioned, my name is John Brooks, and I'm the Chief Medical Officer right now for the CDC's COVID-19 response, and what I want to

do when we get started with this presentation today is just bring everybody up to speed where we are nationally by giving you a brief update on the COVID-19 response at CDC and also just some of the latest scientific developments and guidance that I think you might be interested in.
So, as I'm sure all of you know, we are very deep into this global pandemic. As of yesterday, there were 6.6 mil-- over 6.6 million cases globally diagnosed, and over 425,000 deaths. We've made progress in the United States at flattening the curve, so to speak, and just to give you a sense of where things stand, this, we'll give a couple of points.

The first is that nationally levels of COVID-like illness and mortality or deaths continue to climb and generally remain at stable or declining levels so that in the United States, as of yesterday there were a total of 2,063,812 cases, and 115 million, 115,000-rather, -271 deaths. In addition to this stable or declining trend in diagnoses and deaths, the percentage of lab tests performed coming back positive has increased very slightly. We're not sure exactly what that means yet. We're watching it closely, but that's the kind of thing that would give us pause, and we obviously want to give it a lot of attention. And we also know that although the trends are generally going down or stabilizing that's not true when you start to hone in on individual parts of the country. The virus has not affected everyone the same way, and some jurisdictions are seeing important increases in the daily number of reported infections.

In the coming weeks, we expect that we could see other, other increases in COVID as states continue to reopen, and we get America back to work. It's too soon to tell right now if this is going to happen for sure, but as I noted, we watch the data very closely for early signals and work with our state and local health departments and other entities to monitor activities so we can make sure we know what's going on. So, looking forward as we head into the summer months, many of us are sort of there already, but we know that this is a time of year that Americans really look forward to reconnecting to family and friends and doing things together, and we want these events to be as safe as possible.

The first thing I want to emphasize therefore is that this epidemic and this pandemic globally has not ended. You know, we are beginning to emerge from lockdown and stay at home, but we're in a new normal until there is some kind of a vaccine or other intervention that can protect all of us against this infection. Right now, we're going to have to keep doing many of the things we've been doing, but find ways to do them in a way that lets us get back together and reopen society. And we want to provide you the information you need so you can help decide which activities you'll resume, and what level of risk you would be willing to accept. The general rule of thumb in all of this is the principle that the more closely you interact with other people, and the longer that that interaction lasts, the greater the risk of acquiring COVID.

So social distancing and limiting time very close to people within that six-foot bubble are some important ways that you can reduce your risk. Last Friday we released two new resources to help people conduct their daily activities while protecting themselves and others. We've released this information on our website to help people decide whether to go out and when to take precautions if they do. It's hard to obviously anticipate every single way that people interact. We're a very complex species in a remarkable country, and we all have different ways of celebrating together, but these do have sort of practical tips and principles of guidance that can help you with things like is it safe to go dining out right now at a restaurant, and what do I need to consider? Or visiting the gym or having folks over for a family cookout? We've also added a page on our website with suggestions that could help people who are planning or attending an event or gathering thing about ways that they can make that event or gathering as safe as possible.

So, having shared this information, now I want to shift gears just a little bit and spend a few minutes updating you on what we know on a couple of scientific hot topics. And the first one was in the news a lot last week, and that is asymptomatic transmission, and I'll talk about presymptomatic transmission as well. I imagine some of you heard the press conference that took place at the World Health Organization where the speaker suggested that asymptomatic transmission is a rare thing. But really can, let me come back to this a minute and ask the first question which is what do we know? Can you get COVID from someone who doesn't have symptoms, and what's that level of risk? So, the bottom line here is absolutely yes. We have good evidence that people without evident infection, with no symptomatic illness have transmitted the infection to others either before they developed symptoms, so that would be the presymptomatic period, or also in persons who have never shown symptoms. We call those asymptomatic cases. Now we don't know exactly how often that happens, and I want to clarify -- let me clarify one thing we hear a lot in the press. Asymptomatic, when we use the term asymptomatic as an epidemiologist, that means we're referring to people who retrospectively never had symptoms while they had the infection. And presymptomatic refers to those who appeared healthy without symptoms, but then later developed symptoms.

So, the question that people heard from the, the question people had related to the statement made by WHO has to get broken down into two parts. The first part is how many people who are infected will not show symptoms. Will either have, will be truly asymptomatic throughout the course of their infection, and the second question is okay, among those people as well as people who are presymptomatic, before they get ill, how likely are they to transmit the infection compared to someone who is symptomatically ill? So, the regard of the first question, sort of how many people appear to be able to get infected and never develop symptoms, the range is quite wide, but a safe estimate, and this is part of a review published in the Annals of Internal Medicine last week, a safe estimate is that probably somewhere between 30- to 35% of people infected with COVID will never show symptoms. Now we know that these people from the small amount of data that's available probably are, have lower viral burdens, and may recover, they may clear the infection a little faster, but we really don't yet have an exact figure for how often and how much more or less infectious those persons are compared to symptomatic persons. This is something that's of intense interest to us. It's very important.

It's something unusual about this infection which keeps surprising us at every turn, and we're paying close attention and really trying to really hone in on that, that figure. We've had a couple studies out there doing that. But this is why we often, you'll hear us often stressing the importance of wearing a cloth or a fabric face covering. We know that face coverings, masks, respirators, all of these were originally developed to detect our lungs from getting personally infected by bacteria and also to prevent inhalation of harmful particles like ash and dust and things like that. But you know, we, we're now advising the use of fabric face coverings more for preventing what we call source control, to prevent a person who may be infected and not know it yet, or may never know it because they never get sick from inadvertently transmitting infection to somebody else although we don't know, we don't know how perfectly these fabric factor coverings work. We know that they offer some reduction in the exhalation of potentially infectious particles. And so we really recommend those for everyone.
And part of the principle here, and I think our Surgeon General, Jerome Adams, really summed it up nicely recently was that the more that each of us wears a fabric face covering in public when we may be within six feet of someone else, the more we are all helping protect each other. You know, the more of us that do it, the more of us it protects.

And just, you know, I think I when this-- when we first made this recommendation, I had some misgivings as to how acceptable it was going to be as sort of an extreme thing for us. It's not something

we've done traditionally, but we have some news now that shows that Americans actually are doing it, and, and following other of our recommendations to help slow the spread of the virus. This is a survey conducted in May, looking at adherence to public health recommendations in New York City, Los Angeles, and other parts of the United States. And we learned that in addition to the majority of folks reporting that they always or often wore a fabric face covering in a public area, we also saw that a majority of persons supported stay-at-home orders, supported limiting non-essential business closure and travel, and believed that their state's restrictions at that time struck the right balance between protecting the public and not being too restrictive. So, I really want to say how gratifying it is for all of us in public health to see that everyone is really helping together to fight this problem. I take my hat off to all the American people for helping us get through the last few months. This is really a terrific achievement, and we need to begin thinking about now how are we going to sustain this? Because as I said, this is part of a new normal we're learning how to live with until we get that big solution.

So, we're going to also ask for your continued efforts, and I know it's hard to make changes in your daily life because I've had to make a lot of changes in my daily life. My patients have had to learn to make changes. My friends, family, neighbors, and I'm sure all of you as well. This is something that's affecting each one of us, and we're not quite out of the woods yet. But it's getting easier to walk through those woods. As I mentioned in the coming weeks, we might see a surge in COVID-19. Not, it's not, it's too soon to know when it will happen, but know that we're working closely with health departments across the country to monitor activity, and the more we can do these efforts that I just mentioned, the more we'll help reduce that risk of it coming back. There may be new challenges like protecting seasonal farm workers and other workers and people living in close quarters. And I know that Dr. Lincoln who's coming up has some important information to share on that front, so I'll pause here, now, and ask her to speak. But before I do, I just want to also say we really look forward to your questions. I'm going to keep an eye on the Q&A box and see if I can respond to some in person. And now it's my great pleasure to turn this over to my good colleague, Dr. Jennifer Lincoln. Jennifer, would you like to go ahead?

>> Yeah, sure. Thank you, Dr. Brooks, for that excellent introduction and overview. Hi, everyone. My name is Dr. Jennifer Lincoln, and I'm the Associate Director of NIOSH's Office of Agriculture Safety and Health here at CDC. Today I'm pleased to share information on CDC's guidance for agriculture workers and employers. This guidance is co-branded with the Occupational Safety and Health Administration, or OSHA, and was published just last week on June 2, on CDC's Coronavirus webpage. I just thought it was two weeks ago, wasn't it? Time flies when you're on the response. We also have an agriculture employer checklist. Now this was posted last week, and this checklist is, was created to basically operationalize the, the guidance, the agriculture guidance that was published. It's the work plan or this checklist is to assess, is to help assess and write the control plan, and that, that corresponds with the guidance.
The link for this is located here at the bottom of the slide. The guidance is meant to assist those in the agriculture industry in efforts to decrease the spread and impact of COVID-19 at agricultural worksites, farms and ranches and other production agriculture worksites are an important part of America's food supply chain, and ensuring this critical infrastructure can continue operations while remaining safe and healthy. And this is a priority for CDC.

The agriculture guidance was written with many types of agriculture workplaces in mind, including produce growers and processors, ranches, orchards, and other production ag worksites. This guidance is intended to be a tool to help owners and operators to respond in flexible ways, to varying levels of disease transmission across our agriculture communities. US Agriculture worksites, shared worker housing, and shared worker transportation vehicles present unique challenges for the prevention and control of COVID-19. And, and we believe that those of you involved in the work can best set priorities

and assess how realistic these recommendations are for specific situations at your facilities. So, I'd like to go over a few things that are in the guidance document. The document encourages that management conduct worksite assessments to identify COVID-19 risks and infection prevention strategies.

And in addition, these prevention strategies implemented in the worksite should also be considered to be implemented in employer-provided worker housing and transportation. The control strategies included in the guidance follows the hierarchy of controls which is a fundamental method of protecting workers, workers from hazards. And our application of the hierarchy of controls in the guidance document, we grouped actions by their likely effectiveness in reducing or removing the pathogen. Our preferred approach is to eliminate a hazard or hazardous process. So, for example, in our scenario, excluding sick workers or visitors from the worksite is our first level of protection. Our next set of guidelines focuses on installing feasible engineering controls that would isolate the worker from the pathogen, and finally, in administrative controls, we suggest things as implementing appropriate protocols for cleaning, disinfection, and sanitation to further reduce exposure to the pathogen. And until such controls are in place, or they are not effective, the other administrative control measures are needed as well as personal protective equipment. Under the elimination of the hazard that this is the preferred approach to the hierarchy of controls, and this includes screening and monitoring of workers prior to entry into the worksite or if possible, prior to boarding shared transportation and encouraging workers who have symptoms to self-isolate and to contact a healthcare provider, or when appropriate, provide them access to direct medical care or telemedicine.

If a worker becomes or reports being sick, clean and disinfect the work area, equipment, common areas used by the person such as the break areas, the bathrooms, the vehicles, et cetera. And any tools handled by the symptomatic worker. If a worker is in employer-furnished housing, consider providing a dedicated space for the worker to recover away from others, and then clean and disinfect the living quarters, cooking and eating areas, bathrooms, and laundry facilities. And don't allow other workers to use these areas until they've been cleaned and disinfected. Employers should follow the CDC's critical infrastructure guidance when determining when a worker can return to work after being exposed to COVID-19 but who remains symptom-free. In the engineering control section, these, these types of controls isolate employees from a pathogen at a worksite and are the next approach in the hierarchy of controls.

Some examples of engineering controls include adjusting workflow to allow for a six-foot distance between farm workers, installing shields or barriers such as plastic between farm workers when a six-foot distance between them is not possible. And our guidance also includes a special section on cleaning, disinfection, and sanitation. It discusses hand hygiene and encouraging farm workers to wash their hands often with soap and water for at least 20 seconds. Disinfection and sanitation also discuss that farm owners and operators should develop sanitation protocols for daily cleaning and sanitation of worksites where it is feasible to disinfect the worksite, as well as cleaning and disinfecting procedures for high-touch areas such as tools, equipment, and vehicles used by farm workers following CDC guidance on cleaning methods. Also conduct targeted and more frequent cleaning and disinfecting of high touch areas of shared spaces such as time clocks or bathroom fixtures, vending machines, railings, and door handles.

Lastly, administrative controls are also important elements to include in your control plan. All communication and training for workers should be easy to understand and should be provided in languages appropriate to the preferred languages spoken or read by those receiving the training. Training should also be delivered at the appropriate literacy level and include accurate and timely

information. We also recommend examining leave and sick leave policies to make sure that ill workers are not in the workplace or are not penalized for taking sick leave. Make sure that workers are aware and understand these policies. We can also promote social distancing by reducing crew sizes, staggering work shifts, mealtimes, and break times, and having farm workers alternate rows and fields to facilitate that six-foot distance between each worker. The guidance discusses the option of grouping workers together into separate cohorts who work, sleep, and/or travel together, and this cohorting practice may slow the spread of COVID-19 among agriculture workers by minimizing the number of different individuals who come into close contact with each other over the course of a work week. It may also reduce the number of workers quarantined because of exposure to the virus
and therefore, be less disruptive on the overall operation.

My colleague, Dr. Dominguez, will speak more to shared housing considerations in a minute, and so I won't go into the topic right now, but I would like to briefly mention a couple of ideas listed under the special considerations for shared transportation. The guidance talks about providing as much space between riders as possible, and to group or cohort workers in the same crews or those who share living quarters together when transporting. Also increasing the number of vehicles and the frequency of trips to limit the number of people in the vehicle is also an option. We know that farm operations vary across regions of the country, and our challenge was to write guidance that could be applied to all of these operations. These guidelines provide a template of action to protect agriculture workers from COVID-19 and should be applied as applicable to specific operations. The consistent application of specific preparation and prevention and management measures contained in the guidance can help reduce and risk-- can, can help reduce the risk of transmission of COVID-19. I'd like to now turn it over to Dr. Nichols for some testing guidance that's applicable to agriculture and other high-density workplaces. Dr. Nichols?

>> Thank you so much, Dr. Lincoln, and I'm really honored to be here today. My name is Megin Nichols, and I'm a veterinary epidemiologist, and I've been working alongside the food systems working group at CDC. I'm here today to add a little bit to Dr. Lincoln's guidance by speaking briefly about some testing considerations in high-density critical infrastructure workplaces, such as worksites for workers in really close contact or long periods of time, and for example, that might be an eight- to twelve-hour shift. So, this might include those who are in agriculture facilities, distribution centers, meat and poultry processing facilities and others. So, the CDC received some new guidance on this over the weekend. Recent outbreaks of illness among workers in our critical infrastructure food producing facilities has really highlighted the need for a testing strategy as a tool that might be used to augment existing disease control measures, and aid in identifying infectious individuals who might require either isolation or quarantine to reduce transmission and prevent outbreaks in these workplaces.

Workers in high-density settings in which they're in the workplace for a long period of time, and I mentioned that eight- to twelve-hour shift and have long, prolonged contact, so again, our definition being within six feet for 15 minutes or more with other coworkers might be at risk, increased risk for exposure to SARS CoV-2 and early experience from these outbreaks in a variety of different settings has suggested, and as Dr. Brooks also mentioned, that there can be asymptomatic or presymptomatic workers with the virus in the workplace. And testing is really important to identify some of these individuals as they might not know they're infected. So, SARS could lead to transmission from asymptomatic or presymptomatic people can result in additional illnesses and transmission of the virus, and even potentially outbreaks of COVID-19.

Critical infrastructure employers also have an obligation to manage the continuation of work in a way that helps protect their workers and the general public. And so that's part of the reason this team at CDC has come together to develop this testing strategy to again, aid and identify the infectious individuals so that if they test positive, they can be excluded from the workplace with the goal of reducing transmission of SARS CoV-2. There's two tests that are currently available for COVID-19. Viral tests to detect current infections and antibody tests that can help identify previous infections.
The testing that is most useful and that is described in this particular guidance for this testing strategy is viral testing because it can be used to inform actions that are really necessary to keep the virus out of the workplace, to detect COVID-19 cases quickly, to exclude them and stop transmission. So now I'm going to talk a little bit about the testing strategy, and I highly encourage those of you that are interested, there's a screen shot of it up on the slide, but I really encourage you to go to the website to read through the testing strategy and take a look at the diagram. So, our prioritization of risk is really based on the likelihood of exposure in the workplace, workplace characteristics, and contact investigation that can be done when a COVID-19 case is identified.

And once this is done, there can be a progressive, tiered approach to testing of coworkers, and you can see on the slide that we have some graphic representation of what that could potentially look like. So, this testing strategy is optional, and again, designed to augment existing guidance, but not replace any existing guidance to help reduce transmission in the workplace. So, when a case of COVID-19 is identified, a review of facility and work records, conducting facility walk-throughs and employee interviews may add in categorizing workers according to the risk of exposure, and then subsequently prioritizing them for testing in what we're calling a tiered approach. The tiered categorization is based on the likelihood of exposure given this workplace assessment with those who are most likely to have exposure to the COVID-19 case in tier one, those less likely to have exposure in tier two, and those least likely to have exposure to the case in tier three. And the way we're looking at tier-one workers, and again, I encourage you to look at the strategy online, is that those workers can be identified in two ways. The first is through contact investigation, finding out if the case of COVID-19 carpooled, worked on the same line in the same room, or other characteristics that would identify them as a potential close contact.

So, contact investigation, and then again those working during the same shift, or overlapping shifts in the same area, for example, the same line or the same room as one or more of the workers with COVID-19. Now, this does include other factors that employers would want to take into consideration in terms of kind of looking at this tier one, and that might include the layout and size of the room, and the design and implementation of design and engineering controls and adherence to administrative controls of which Dr. Lincoln mentioned. So, once the workers are categorized into tier one, two, or three, or even those that are not exposed, the next step is to look at a potential strategy for testing. And again, looking at this the way we've designed the strategy is there in the lower right-hand, so workers in tier one who've had close contact or been exposed to a coworker with confirmed COVID-19 should be tested and quarantined, and then various strategies can be considered for when these critical infrastructure workers in tier one would return to work.

So, in looking at this testing strategy, the most protective approach for workforce health and to keep those who might be shedding the virus out or might be exposed and then subsequently become ill out of the workplace is for tier one critical infrastructure coworkers to follow the existing recommendation regarding exclusion, exclusion from work, meaning these workers who are exposed would ideally be excluded from work and quarantined for 14 days. Now we know that in many critical infrastructure workplaces, employers are also considering how to maintain continuation of operations given there

might be an exposure in the workplace, so this testing strategy comes into play because there can be a serial test-based approach that can be used for earlier return to work.

So, this would be basically looking at your tier of coworkers or that cohort of coworkers who were exposed and applying a testing strategy to those who were exposed which if you identify positive workers, they could be quickly excluded from the workplace. And then we recommend serial testing of those workers every three days until there's no more positives in that group of cohort of exposed workers. Workers who test positive or become symptomatic should be excluded from the workplace, and that's again discussed in the guidance. So, this is a tool that can be used which will aid with these specific workplaces to identify a cohort or group of people who they think might be exposed and then provide a test-based approach that would help to detect somebody who's infectious and then remove them from the workplace more quickly which might help reduce transmission in the workplace. And that's our goal, to protect worker health and safety. Again, the link is there on the website. So next I'd like to introduce Dr. Ken Dominguez to talk a little bit more about worker housing and guidance. Over to Dr. Dominguez.

>> Alright, thanks Dr. Nichols. This is Dr. Ken Dominguez, and I'm a medical epidemiologist and a Captain in the US Public Health Service, and I serve on the Community Interventions At Risk Task Force, and I'm part of the Minority Health and Rural Health Team, and so I want to talk a little bit about special considerations for shared housing since it's an important topic for agriculture and many other industries. So, there are a few general considerations. First, family members should be kept together in housing facilities. In addition, grouped or cohorted workers can be considered a single household or family. Farm workers that are in the same shared housing unit should follow the housing, living in close quarters guidance that can be found on the CDC website. This guidance can be found on the, on the link that's posted on the slide. Most importantly in employer-furnished housing, the owner/operator should provide a dedicated and segregated space for sleeping quarters, kitchens, and restrooms for farm workers with confirmed and suspected COVID-19 to recuperate without infecting others.

So, what happens if a household member becomes sick? Recommend to provide a separate bedroom and bathroom for the person who is sick if possible. If you cannot provide a separate room and bathroom, try to separate them from other household members as much as possible. Keep people at higher risk separated from anyone who is sick. If possible, have only one person in the household take care of the person who is sick, and this caregiver should be someone who is not at higher risk for severe illness and should minimize contact with other people in the household. Identify a different caregiver for other members of the household who require help with cleaning, bathing, or other daily tasks. If possible, maintain six feet between the person who is sick and other family or household members. And what about sharing bedrooms and bathrooms? If you need to share a bedroom with someone who is sick, make sure the room has good airflow.

Open the window and turn on a fan to bring in and circulate fresh air if possible. Maintain at least six feet between beds if possible, sleep head to toe, put a curtain around or place other physical divider-- for example, it could be a shower curtain, a room divider, a large cardboard, cardboard poster board, quilt, or large bedspread to separate the ill person's bed. If you need to share a bathroom with someone who is sick, the person who is sick should clean and disinfect the frequently touched surfaces in the bathroom after each use. If this is not possible, the person who does the cleaning should open outside doors and windows before entering and using ventilating fans to increase air circulation in the area. Also wait as long as possible to enter the room to clean and disinfect or to use the bathroom. If you are sick, do not help prepare food. Also, eat separately from other members in the household. Those are

some quick recommendations, but I'm happy to take more detailed questions later if they come up. With that, I'll hand it back to Dr. Smith.

>> Thank you so much to all of our experts for sharing such wonderful updates. Very, very informative. Before we transition to Q&A, as I mentioned at the top of the call, we are considering changing this call's day and time. Racine, could you please deploy the poll? As you can see, there are two options.
Please indicate the day and time you would prefer. The two options are Mondays at 3 PM, or Tuesdays at 4 PM.
Note both of these are Eastern Standard Time. Your opinion is welcomed and appreciated, so please, please, please make sure you click one or the other. The next part of the call is our Q&A. We received some questions in advance, and we will start with a few of those. You're also welcome to submit questions via the Q&A button in Zoom, and it looks like you guys are very comfortable with that.
Please keep those coming in. I'd like to start with some general questions that I think may be relevant to everyone on the call, including the business audience. So, we'll start with you first, Dr. Brooks. Can you give us an update on who was most at risk for COVID-19 at this stage in the epidemic as well as who is getting sick, and who is suffering severe illness?

>> Thanks, that's a, a great question. I appreciate answering that. I want to alert folks that MMWR was published today reporting some of our early surveillance data which contains some information around this question. But just let me start by giving you some of the general information about what we know. So, what we know with this disease is that among the, there are a certain set of medical conditions which we have evidence for now that increase a person's risk for either more severe disease or increasing the risk of death, and there are also some other factors that can alter the risk, increase the risk for infection and for poor outcomes, severe infection and poor outcome. In terms of the medical illnesses, those generally fall into a list of categories you may already know or you've heard of with regard to other diseases. So, in this case, cardiovascular disease. That includes hypertension, severe obesity, which is defined as a body mass index greater than 40 kilograms per square meter.
Chronic liver disease or chronic lung disease, active immunocompromising conditions, and autoimmune conditions.

Oh, there you go. Sorry, my screen just got obscured by something. There we go. And then persons with chronic kidney disease. So those are the main underlying medical conditions that we know increase risk for COVID being more severe or having a very poor outcome, fatal outcome. In addition, increasing age has a very strong effect on your risk for severe disease and poor outcome. We typically have been saying that people over the age of 65 are higher risk than others, but as I hope all of us recognize, there's nothing magic that happens the day you turn 65, and in fact, it's more of a spectrum that starting around age, maybe late 30', late 40's, it sort of depends a little bit on the population that you look at, the risk for severe disease and for death continues, steadily increases. Where that biggest flex point occurs has so far been mostly around the early 60's to the middle 60's. But I think we will soon be having some additional clarification of these risk factors coming out, and you may see that it speaks more broadly about age without so much of a distinct cut-off related to just one specific age.

To give you a sense of how these differences play into a person's risk, I want to share with you some of the data that was in today's MMWR. And so for instance, if we are looking at the risk, how many people were admitted to the ICU, what percent of people who were hospitalized-- sorry, if a person who's diagnosed were admitted to the ICU, considering people who had no underlying health condition versus those who had one of those underlying conditions I just mentioned, and possibly a few others that I didn't mention that were included for part of the study. So, if among people who had no underlying

health conditions, about 1.5% of them ultimately ended up in the ICU. Now that compares to 8.5% for people with an underlying medical condition, and the difference is even more stark when we look at the number of people who died. So, among persons in the ICU who died, those without any medical conditions, that was 1.6% versus those with underlying medical conditions, 19.5%.

So, this is the reason we want people to pay attention to the underlying medical conditions is for two reasons. First, so they recognize that they need to be especially careful to make sure to the best of their ability that they don't get exposed to this virus and infected with it, and secondly so that if they do have any concerning symptoms, or they think they might have had a serious exposure and need a test, that they seek out that healthcare as soon as possible because this is not a disease where you want to delay. And I want to reassure everyone that our health system is now safe for you to go to. It's early in the, in this epidemic you heard the message over and over, stay at home, stay at home. Don't go to the doctor, call the doctor ahead of time. Call the ER ahead of time, and we recommend you doing that if you have the luxury of time to do it. But if you are having chest pain, a cough, you can't breathe, call 911. They will come and they will get you and bring you to the hospital, and if you have to go to the hospital on your own, they are ready to receive you safely and take care of you so that you don't get, so in case you don't have COVID you don't get infected from someone, and if you do, that everyone is protected against that.

The last two things I want to say about risk factors really are a bunch of broader risk factors related to bigger issues, and first is the effect of sex. So, it turns out that men have a slightly more difficult time with COVID than women. They're a little bit more likely to get infected, 15.6% of infected men were hospitalized versus-- sorry, were hospitalized. I didn't mean to say infected, I meant to say hospitalized, that among people who are hospitalized, 15.6% of men who were diagnosed were hospitalized versus 12.4% of women. Another thing we look at is race/ethnicity. I'm certain that if you haven't heard already that you need to know that there are differences in terms of race/ethnicity in who is affected by COVID. The bad news here is that it is very clear that people of minority race/ethnicity are at higher risk for becoming infected, and there's a lot of complex reasons for that, and we now have a Chief Health Officer for Health Equity who's working with us to address these, better understand the disproportionate burden of this disease on people of minority race/ethnicity, and to address that.

The good news is that when you get to a hospital and get into care, and if you get the care you need, that there is no very big difference in terms of outcome. The biggest difference in terms of outcome is if you're in a group that's more likely to get sick, then as a whole, you're more like, there are likely to be more deaths in that group. So, it all really starts with reducing the risk for getting exposed, and to the extent that you're able to help us share the message with people that to the extent they can do it, how to protect themselves, that's very, very useful and would be welcome. So, let me stop there, and if there's a follow-up question or anything you want to ask, otherwise, we'll go on.

>> Thank you so much, Dr. Brooks. The next question I'll grab from the Q&A. in developing outbreaks in an agriculture facility, do negative tests of workers need to be retested to avoid false negatives and a restart of the outbreak? I'm going to shoot this over to Dr. Megin Nichols. Dr. Nichols, are you on mute?

>> Thank you. I do hope, I saw Patrick's question and thought it would be a good one to address as well, so I do hope that our guidance or our strategy for testing is helpful. If there is an outbreak, first definitely making sure you're working with your state or local health department I think is, is very key, and the second thing I would say is this testing strategy may help you to kind of look at where you might be having cases in the agriculture facility, and potentially look at prioritizing some of those workers who

were potentially exposed for testing, and then taking some concrete action based on that. So, in this particular testing strategy, if you do have workers who were exposed and meet that tier one description where they were most likely to have contact with the person who has the COVID-19 case, those would be good people to consider testing, and in this particular case, it could be serial testing, meaning that you're testingat three-day intervals, and that's based on when we believe people would be likely to develop symptoms and to test positive.

The other thing to make sure you're doing, and this is something that is in Dr. Lincoln's guidance is screening. So not only can testing be used as a tool, but that even more critical is potentially screening workers for symptoms and monitoring body temperature so that those workers in the event that they have symptoms or feeling ill are excluded from the workplace, and that should happen before the testing strategy is employed. So great question, and I hope our testing strategy helps you to address some of those issues as well.

>> Awesome, thank you. Dr. Dominguez, I just found a question that seems like it might be perfect for you. Many businesses, especially in agriculture and food industry have a very diverse workforce. Many of these workers, English-- excuse me, for many of these workers, English may not be their first language. Does CDC have COVID-19 health information in different languages as well as different levels of, of interpretation?

>> Great question. It's really critical that we communicate health information in a way that your audience can understand, and so this includes providing critical COVID-19 health information in languages your workers actually use. So, in light of that, CDC provides fliers and health information on its website in over 60 languages and in various formats including videos, recorded PSA's and posters that are free and available for sharing and downloading. For additional COVID-19 materials in other languages, we invite folks to visit the CDC print resources page. Also, much of our web information on COVID-19 is available in Spanish, Chinese, Vietnamese, and Korean, and at the top of each webpage, there's a drop-down list for you to select other languages. However, note that the website is updated very frequently, and information may be available in the English before it's available in other languages. For more information in Spanish, please visit the CDC in Espanol, which is CDC's dedicated hub for all Spanish content. CDC also has a dedicated COVID-19 communications toolkit for migrants, refugees, and other limited English-proficient populations. Thank you!

>> Okay, thank you for that. I've seen a couple of questions regarding face shields and cloth face coverings and humidity, so I'm actually going to hop over to Dr. Lincoln. Dr. Lincoln, what if it's too hot or uncomfortable for workers to wear cloth face coverings? Can workers wear a face shield as an alternative? Dr. Lincoln, are you on mute? Okay, we may have lost Dr. Lincoln. Okay, we'll come back to that question and Dr. Lincoln. Alright, let me ask Dr. Nichols, another question for you. One of our most frequently requested topics for discussion week after week is screening workers for symptoms of COVID-19. What are your recommendations for the agriculture industry and other high-density workplaces including how to make sure temperature readings are accurate and the right questions are asked during screening?

>> This is a great question, and you're right, it does seem to come up week after week. So, as I mentioned, screening workers and others entering the workplace for symptoms of COVID-19 such as an elevated body temperature is really a key component of preventing transmission and protecting workers, including those in high-density critical infrastructure workplaces. Uniform policies and procedures for screening workers should be developed in consultation with state and local health

officials and occupational medicine professionals, and that really helps you tailor this approach to the workplace. This might include guidance on how to protect personnel who are conducting the screening. Making sure you're conducting the screening in a confidential manner, manner that is in compliance with the Equal Opportunity, Equal Employment Opportunity Commission and OSHA guidance, and the other applicable laws and regulations. And there is more information on this on our business frequently asked questions page as well as the agriculture guidance. There's possible options to screen workers for COVID-19 symptoms such as again, screening prior to entry to the workplace, or if possible, before boarding any shared transportation. Checking temperatures of workers at the start of each shift to identify anyone that might have a fever of 104, 100.4 degrees Fahrenheit or greater. And then asking workers in appropriate languages per Dr. Dominguez' recommendations that to see if they have a fever, respiratory symptoms, or other symptoms of COVID-19 in the past 24 hours. And then CDC's website, if you have questions about what are the latest symptoms associated with COVID-19, we're working to make sure that the website is up to date.

So, with regard to temperature screenings, it's really important to train temperature screeners to use those temperature monitors according to manufacturer instructions, and this might include calibrating devices before use or taking steps to validate the temperature readings, and then employers should provide temperature monitors that are accurate under conditions of use. So, this includes extremely hot temperatures or cold weather, and we're headed into the summer, so this is an important consideration, and making sure those conditions are properly accounted for when developing any of the standard policies that I mentioned. And of course, any workers who become sick either during their work shift or if they have a positive screen for symptoms or fever at the arrival to the workplace, they should be sent to their home or healthcare provider as appropriate and referred for further evaluations. So just a note there. Thank you.

>> Alright, thank you. Alright, back over to Dr. Lincoln. As I noted before, there's a number of questions about cloth face coverings versus wearing face shields. So if it's hot and humid or just uncomfortable, just too uncomfortable for workers to war cloth face coverings, can workers wear a face shield as an alternative?

>> Thank you for that question, and I'm so sorry about before. I'm coming to you from a one-room little farmhouse, and I have puppies in the background that get out of hand sometimes. [Laughter] Full disclosure: I'm sorry I was unavailable a few minutes ago. This is a really important question, and I actually get this quite a bit, even from my family as they're working. So, cloth face coverings may be difficult to wear, as you already mentioned. Whether it's for a long time, but especially in hot and humid environments. These environments require, you know, sometimes touching your face which is not what you want to do if you-- sorry, I'm going in here-- which is not what you want to do if you're, if you're wearing a cloth face covering. That's the whole reason you're wearing it, so to keep things off of your face.

So, social distancing will be very important when using cloth face coverings, and when that's, especially when if that's not available, you really need to be wearing cloth face coverings. Employers may also consider providing workers with alternatives, as you mentioned, face shields. So, face shields may serve both as source control which is what we talked about earlier. It's preventing other workers or other people from respiratory droplets produced by the person wearing the shield. Face shields are also PPE, so they can protect, face shields will protect the eyes and the face of the wearer from hazardous splashes. It's really important to note that cloth face coverings are not PPE, and neither cloth face

coverings or face shields are appropriate substitutes for PPE such as respirators, like N-95 respirators, or medical face masks like surgical masks in workplaces where respirators or face masks are recommended or are required to protect the wearer. So, thanks very much for the question. I'm sorry about the distraction, and I welcome any other questions that I can answer.

>> No problem at all. As noted on some of the Q&A, people would actually love to see your puppies, so it's quite okay. [Laughter] Quite okay.

>> Okay, thank you [laughter].

>> Yes, yes. Oh gosh, we've actually reached the end of this wonderful time with you. We've only got four minutes left, and we've got to close up. So, I want to thank everyone for joining, Dr. Brooks, Dr. Lincoln, Dr. Nichols, and Dr. Dominguez. Do any of you have any last closing remarks you guys may want to add or any last thoughts to share?

>> Well, I'll take the opportunity. This is Dr. Brooks, and I'll just say I first want to thank you guys for being on this call. It's encouraging to know so many people are interested in this, and if you have ideas for topics, is there a place where they can submit them, Dr. Smith?

>> Now, now I had the problem with getting unmuted. [Laughter] Sure. They, they can submit them to EOCEvents337@CDC.gov. EOCEvents337@CDC.gov.

>> This is Ken Dominguez, and I also wanted to leave a couple of parting thoughts, and one is really for folks to remember to really work to be proactive in terms of implementing a lot of the mitigation strategies for agricultural workers who are, are essential workers. And also, to remember that according to the National Agriculture Worker Survey, 82% of farm workers are non-migrant workers. Only 5.2% follow the crop, so this has important implications on mitigation strategies both for, for workers who travel, and those who are in our local areas. So please keep that in mind as you develop your mitigation strategies. Thank you. That was the perfect ending. Thank you, Dr. Dominguez. Alright, hearing no further questions and/or comments, I again want to say I appreciate you guys for filling out our poll this afternoon. We will make our decision soon regarding the final time for our future meetings. And lastly, thank you again. Please, please, please join us next week for yet another exciting time with CDC and our update on COVID-19 with you. Okay, have a wonderful day. Bye-bye!