From: sgreenmd@pdxn.org <sgreenmd@pdxn.org>
Sent: Monday, July 13, 2020 3:39 PM
To: FILSINGER Cara L * DCBS <Cara.L.Filsinger@oregon.gov>
Cc: VANWINKLE Theresa A * DCBS <Theresa.A.VanWinkle@oregon.gov>
Subject: Re: MLAC Covid analysis

Dear Cara,

Thanks. I had some time to read the materials on the MLAC website - I wish I had done so before writing - and wanted to add a few comments to my earlier email. The term COVID-19 is being used loosely in these discussions, as we usually do. I think it may be useful to define terms precisely in any rule making - exposure is not the same as infection; infection is not necessarily the same as disease. I was interested to see what other states are doing, and agree whole-heartedly with Rep. Warner regarding the need to protect workers in general. As the insurers have pointed out, some evidence of exposure is appropriate in a work claim.

Additional notes:

Although there have been only a small number of SARS-COV2 related claims to date, the likelihood is that cases will continue to occur into 2021, and the possibility of a seasonal surge or spike in caseload for other reasons will remain present throughout this time.

It may be helpful in distinguishing three different circumstances in any rule-making or presumption:

1. Occupational exposure to SARS-COV2 (the virus that causes COVID-19 disease)

Individuals in this category need ready access to testing, contact tracing, and quarantine coverage. The latter is especially important where testing is a limited resource – a situation that may recur. A presumption or low threshold may be essential here. Individuals in this category may never become infected, or may transition to #2 or #3 below.

2. Infection with SARS-COV2, asymptomatic

(this is not COVID-19 disease if there is no objective or subjective evidence of illness, just as not everyone with HIV has AIDS)

Individuals in this category need timely isolation/quarantine coverage and contact tracing. A presumption or low threshold for acceptance seems appropriate. In my opinion, any presumption must not obviate the need for some evidence of workplace exposure, or should be rebutable.

3. Infection with SARS-COV2, symptomatic (this is the disease called COVID-19 by the WHO).

Individuals in this category may require medical care in addition to isolation; such medical care may be prolonged; permanent impairment may result. While I favor a low threshold for

acceptance, I do believe that some reasonable evidence of exposure must be present, or that a presumption is rebutable.

I believe that any presumption or similar rules should apply to workers in general, as we now know that a wide variety of work can result in significant workplace exposure to SARS-COV2. Workers in settings where there is a generally higher prevalence (such as hospitals, jails, or nursing homes), workers in facilities that have outbreaks, workers that are routinely exposed to the public, and workers that have inadequate PPE/protection measures are all at increased risk of occupational exposure to SARS-COV2.

Thanks again,

Sean

M. Sean Green, MD, FAAN

sgreenmd@pdxn.org

From the WHO technical guidance:

Naming the coronavirus disease (COVID-19) and the virus that causes it

Official names have been announced for the virus responsible for COVID-19 (previously known as "2019 novel coronavirus") and the disease it causes. The official names are:

Disease

coronavirus disease
(COVID-19)

Virus

severe acute respiratory syndrome coronavirus 2
(SARS-CoV-2)

Why do the virus and the disease have different names?

Viruses, and the diseases they cause, often have different names. For example, HIV is the virus that causes AIDS. People often know the name of a disease, but not the name of the virus that causes it.

There are different processes, and purposes, for naming viruses and diseases.

Viruses are named based on their genetic structure to facilitate the development of diagnostic tests, vaccines and medicines. Virologists and the wider scientific community do this work, so viruses are named by the International Committee on Taxonomy of Viruses (ICTV).

Diseases are named to enable discussion on disease prevention, spread, transmissibility, severity and treatment. Human disease preparedness and response is WHO's role, so diseases are officially named by WHO in the International Classification of Diseases (ICD).

ICTV announced "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" as the name of the new virus on 11 February 2020. This name was chosen because the virus is genetically related to the coronavirus responsible for the SARS outbreak of 2003. While related, the two viruses are different.

WHO announced "COVID-19" as the name of this new disease on 11 February 2020, following guidelines previously developed with the World Organisation for Animal Health (OIE) and the Food and Agriculture Organization of the United Nations (FAO).

- *WHO Director-General's remarks at the media on 11 February 2020*
- *WHO Situation Report on 11 February 2020*

WHO and ICTV were in communication about the naming of both the virus and the disease.

On Jul 13, 2020, at 6:29 AM, FILSINGER Cara L * DCBS <Cara.L.Filsinger@oregon.gov> wrote:

Dr. Green –
We will submit your email for the record and note you would like to speak on Wednesday, if your schedule permits. Thank you for your interest.
Cara

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From: sgreenmd@pdxn.org <sgreenmd@pdxn.org>
Sent: Friday, July 10, 2020 6:00 PM
To: FILSINGER Cara L * DCBS <Cara.L.Filsinger@oregon.gov>
Cc: VANWINKLE Theresa A * DCBS <Theresa.A.VanWinkle@oregon.gov>
Subject: Re: MLAC Covid analysis

Thanks Cara,

No need to try to carve out a time-certain, I'll attend as long as I can. My primary interest is in making sure that the committee hears briefly the IME perspective, and it doesn't matter if it is written or verbal. I'm sure there are an enormous number of considerations here, and that optimal policy-making - for a situation unlike anyone living has ever seen - will be difficult. I do think that policy decisions here can have a substantial impact on the physical, emotional, and economic health of working Oregonians, and the viability of Oregon businesses. So thank you for your service, really!

Regards,

Sean

M. Sean Green, MD, FAAN

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On Jul 10, 2020, at 2:10 PM, FILSINGER Cara L * DCBS <Cara.L.Filsinger@oregon.gov> wrote:

Dr. Green:
Thank you for your comments, we will forward them to members for their review and put them in the committee records. Unfortunately I do not know if we can provide a specific time certain for testimony, but the meeting starts at 1 p.m. If you have a specific time availability, I can relay your request to the committee co-chairs to see if they can accommodate your schedule.
Cara

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From: sgreenmd@pdxn.org <sgreenmd@pdxn.org>
Sent: Friday, July 10, 2020 1:36 PM
To: FILSINGER Cara L * DCBS <Cara.L.Filsinger@oregon.gov>
Subject: MLAC Covid analysis

Dear Ms. Filsinger,

In reference to the upcoming MLAC meeting seeking public input - I am not certain whether I will be able to attend part or all of the virtual meeting, but wanted to pass on a few comments from the perspective of a medical expert asked to provide causal analysis in occupational illness claims. If possible, could you enter this into the record as written comments or provide an estimated time for joining the meeting to provide verbal testimony?

I am a forensic neurologist who has provided IME in Oregon since 1996. The following opinions are mine alone, although I believe that a few of my colleagues hold similar views.

1. Can SARS-COV2 exposure or infection be an occupational illness?

Yes, absolutely. From a scientific medical perspective, a relevant exposure may either necessitate quarantine or directly cause illness. I believe SAIF's position here is correct; it is certainly supported by the science.

2. Can the workplace environment be an important cause of SARS-COV2 exposure?

Briefly, yes. There is increasing evidence that the virus is transmissible via aerosol and that initially-recommended protections (largely aiming at fomite transmission) are inadequate. In my own work, some elements of medical examination or procedure are high-risk and are likely to occasionally result in transmission of infection EVEN when suitable protection - new N95 mask, face shield, gown, gloves - are available. Of course, suitable protection is most often NOT available outside of the ICU setting. My front-line colleagues have told me during ECHO conferences that they do not have adequate equipment, some having a single N95 expected to last until the pandemic is over, and others having only flimsy disposable surgical masks (again for constant reuse). Although our federal partners such as CDC have suggested what emergency protections can be used in the absence of suitable protection, we should not pretend that inadequate employee protection is equivalent to what we would ordinarily consider minimum reasonable protection.

Similar factors are present in many different lines of work - indeed, medical workers are usually better protected than those in lower-wage work or involved in low-margin industries. When an outbreak occurs in a workplace with a combination of close-quarters and inadequate protection, the risk to workers can quickly become very high.

3. Can employers protect workers from SARS-COV2?

Yes, to a degree. Employers that allow 100% remote work, for example, have reduced the risk to the same level as the general population, and risks at that point are largely related to personal circumstances and behaviors of the worker in their off-work life.

Some work requires physical presence at the workplace; some work necessarily involves exposure to the public. Decisions to restrict availability of scarce PPE have been and will continue to be necessary: this does not mean that a cloth mask is a magical talisman protecting workers. In these situations, there will be varying degrees of protection. Both employers and workers may support or undermine these protections in various ways.

The circumstances of this pandemic - including political opinions and antisocial personal behaviors - mean that many, many employers will simply not be able to provide adequate protection from occupational SARS-COV2 exposure.

4. Will there be cases requiring IME, and will they exceed capacity?

Yes, some cases will require IME. We can expect that most cases will be mild - a substantial minority will be asymptomatic, a majority will have mild symptoms, some (perhaps 20%) will require hospital care, and a few will die. We know that the virus can directly infect brain, among other tissues. Systemic effects of serious illness may result in permanent impairment of several types, including symptoms such as disabling fatigue that often require IME (and which may be litigated).

Policy decisions will define whether IME capacity is exceeded. For example, if insurers are required to automatically accept exposure and pay for quarantine costs, none of those cases will need IME. Similarly, if there is a presumption that disease (COVID-19) in an exposed individual is compensable, IME regarding causation will not be needed at all. If there is an intermediate "bar" for considering COVID-19 compensable, the IME burden will probably be intermediate. The medical community might strain to meet that burden, and the quality of IME is likely to suffer. If there is a high threshold for finding COVID-19 compensable, I anticipate that there will be a commensurate high demand for IME services. In my estimation the medical community will not be able to meet such a burden.

5. What should the threshold for compensability be?

This pandemic is un-precedented and distinct from the usual infectious diseases we see: nearly everyone is susceptible to this new virus, and humans are the vectors for this infection. A very large number of infections can be expected over the next few years, and I expect that an unusually large number of occupational claims will be coming. My own belief is that a forward-looking, systematic approach by MLAC/WCD to this whole class of claims will be better for all stakeholders (rather than deciding every single case individually until a body of precedent is built up).

I personally favor a low threshold for compensability, or even a presumption of compensability wherever there is relevant exposure, because of the factors mentioned in 1-3 above. Such a threshold would reduce the need for neurologic IME (my own specialty) to complex cases with

serious and permanent impairment - a burden that the medical community is likely to be able to meet.

6. Economic impacts

Because the economic impacts of enacting (or failing to enact) policies discussed here may eventually be large, I encourage MLAC/WCD to consider reaching out to both economic advisors and any relevant government agencies at the state and federal level.

Respectfully,

Sean Green

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