U.S. DEPARTMENT OF LABOR

+ + + + +

ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

+ + + + +

MEETING

+ + + + +

WEDNESDAY
APRIL 15, 2020

+ + + + +

The Board met telephonically at 11:00 a.m. Eastern Daylight Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN M. DEMENT
GEORGE FRIEDMAN-JIMENEZ
MAREK MIKULSKI
KENNETH Z. SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
ROSE GOLDMAN
STEVEN MARKOWITZ
CARRIE A. REDLICH

CLAIMANT COMMUNITY

KIRK D. DOMINA
RON MAHS
DURONDA M. POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICIAL

MICHAEL CHANCE

CONTENTS

P-R-O-C-E-E-D-I-N-G-S

11:11 a.m.

MR. CHANCE: Good morning everyone. My name is Michael Chance and I would like to welcome you to today's teleconference virtual meeting of the Department of Labor Advisory Board on Toxic Substances and Worker Health. I am the Board Designated Federal Officer, or the DFO. I -- I think obvious to everyone today, as you are aware, this meeting will be completely virtual as a precaution against the COVID-19 pandemic.

I am joined virtually by Carrie Rhoads from DOL and Kevin Bird from SIDEM. He is our contractor. And I want to welcome everybody. I want to tell everyone that we appreciate the work that the Board members have put in preparing for today's meeting, and for the upcoming deliberations today and tomorrow. We are scheduled to meet today. We -- again, at 11:00. We are slated to 5:00 Eastern Time with the public comment period to commence at 3:30. As we began this morning, I think that you will see

that there have already been a few growing pains on protocol and how we proceed. So just bear with us and be patient as we try to get through the first of this type of meeting. And we will try to help anybody who has any kind of technical difficulty. You can reach out to Kevin or Carrie as we move forward. I want to make sure that everybody is heard, so just bear with us.

Regarding the operations of today's meeting, again, I believe that you have all seen the agenda. Today is a lengthy proceeding. So there are breaks that are set up already in the -- in the meeting. But if -- you know, as -- as Dr. Markowitz proceeds forward, as he feels that there is a break in the flow and people need a break, we can certainly be liberal with that.

I wanted to let everyone know that copies of all meeting materials and the written public comments are -- are -- or will be available on the Board's website under the heading Meetings and the listing there for the committee meetings. So the documents will also

be up on the Webex screen, I believe. So everyone can follow along with the discussion. The Board's website can be found at DOL.gov/OWCP/Energy/regs/compliance/board.htm. If you haven't already visited the Board's website, I strongly encourage you to do so. After looking on today's meeting date, you'll see a page dedicated entirely to this meeting. The web page contains publically available materials submitted to us in advance of the meeting.

We did obtain a few things late -- late last evening. So bear with us. I believe that everything should be up on the site. We will publish any materials that are provided to the committee. There are -- there you should also find today's agenda, as well as instructions for participating remotely. If you're having a problem, as I said, you can email the Energy Advisory Board at dol.gov, or just reach out to Kevin or Carrie, or just -- if you're having -- having a problem, this is -- this is kind of uncharted territory.

If you're joining by Webex, please note that the session is for viewing only and will not be interactive. The phones will be muted for all non-Advisory Board members. Please note that this is a new way of conducting these meetings and we ask you to be patient as we work out any old and new technological issues. As I said, you may contact Ms. Rhoads or Mr. Bird for technical assistance throughout this meeting if needed.

About meeting transcripts and minutes -- the transcript and minutes will be prepared from today's meeting. During Board discussions today, as we are on a teleconference line and all -- everyone is remote, please speak clearly enough for the transcriber to understand. When you begin speaking -- especially at the start of this meeting -- please state your name so we can get an accurate record of this discussion and attribute to the proper speaker. Also, I'd like to ask our transcriber to please let us know if you're having an issue with hearing anyone or

with the recording.

As the DFO, I see that the minutes are prepared and ensure that they're certified by the Chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today per FACA regulations. But if available sooner, they will be published. Also, although formal minutes will be prepared, we will also be publishing verbatim transcripts which are, obviously, more detailed in nature. Those transcripts should be available on the Board's website within 30 days.

I would like to remind the Advisory Board Members, there are some materials that have been provided to you in your capacity as special government employees and members of the Board which are not for public disclosure and cannot be shared or discussed publically, including in this meeting. Particularly, as you are aware, we will have the public on later on -- this afternoon. So please be circumspect. Please be aware of this as we are continuing with the meeting today.

These meetings can be discussed in a general way which does not include using any personal identifiable information such as names, addresses, specific facilities if a case is being discussed, or a doctor's name.

On top of my usual opening statement, I was asked to reiterate a discussion that I -- took place with on April the 2nd of this year with Dr. Markowitz and Douglas Pennington, who is the Deputy of the Energy Program. I'd like to spend a moment discussing an issue that was raised in the last meeting. This is my second one, and I remember it being raised in the last meeting, and that was on April 2nd. And that discussion was primarily regarding resource allocations and requests for resources. I believe that Dr. Markowitz wanted me to just kind of go over that quickly so that everybody understands what was said in that meeting and -- and where we are with regard to resources so that -- that at least that has been -- that loop has been closed and everybody is aware that we have

gone ahead and -- and done that.

We discussed at length the matter of resources and outlined some of the challenges that must be overcome. Just briefly, I outlined the conversation as thus. I mean, depending on the specifics of what the Board is envisioning -- and currently, I think as everyone knows with the COVID pandemic, there are a great deal of -- there's a great deal of competition -- probably more heated than ever for -- for vital government resources.

The Board -- and it would be incumbent upon the Board, as a full body -- would need to determine what the mission would be of -- of this -- of this -- of these resources that are -- that are desired. There would be a need to ascertain those -- the proper tasks. Obtain hourly rates of contractors from the general -- General Services Administration Schedule, based on job titles. And the Board would need to estimate the workload needed for any -- any contractor that -- that you envision that would be needed.

The Board must determine what resources it needed by a labor class category. It would need to design a comprehensive statement of work outlining all required duties and tasks. I -- I want to -- I cannot stress enough, the contracting process is extremely complex. I am not a contract law expert -- specifics in requirements are -- are necessary to be able to bring any contract vehicle online. All requirements would need to be -- would need to be met for each request.

Another issue that was raised by Mr. Pennington is a good point. If any -- any potential to create records that would devolve out of a contracting group -- a group of contractors evaluating data -- this might require some sort of federal system of record. So there's more to it than just the contract.

The budget for FY 2022 is being discussed within the next few months. Usually, those submissions are put forward in the fall. 2021 formulations are already complete. I know

that Dr. Markowitz asked a bit about that. It would be very -- I mean, very, very difficult to get (telephonic interference) in for 2021. Even if it could be requested, as I said, it is not likely to be granted given the current situation -- budget under COVID-19 pandemic crisis. Everything that (telephonic interference) be. And there is a huge crunch on all government resources. So -- you know, just to outline that. It would be something that -- that would be, again, incumbent upon the Board to develop a working business case to demonstrate the need for funds. And be able to demonstrate a compelling reason to go forward when such funds are already in great demand for high priority matters throughout the entire government -- outside of the Department of Labor. So it -- it is a -- it is a big challenge.

And so I wanted to -- I hope that I -- I hit all of the high points of the discussion that Doug and I had with Dr. Markowitz. And -- so that everyone knows that that -- that was

done. And that those considerations have been evaluated and communicated back to Dr. Markowitz. So -- with that, I apologize for the long monologue, but I needed to get through all of that. And with nothing else on my list, I now convene the meeting of the Advisory Board on Toxic Substances and Worker Health and turn over the microphone to Dr. Markowitz. Thank you.

CHAIR MARKOWITZ: Thank you, Mr. Chance, for that welcome. I would like to welcome Board members back for -- to this board meeting. Welcome also to the leaders of the staff of the Department of Labor, members of the public who are on the Board or are attending the meeting today. I know that for the Board members -- for all of us actually work had been dislocated, and I realize there's some very important competing priorities with today's times and tomorrow's times. And so we're going to try to address the various issues as expeditiously as we can in order to get through the agenda.

It may be that the public comment

period -- if there aren't that many people who want to make public comments, we may continue the Board meeting during that time period, however, to concentrate the -- our -- the time that we spend on this. But we'll -- we'll see. We'll see as that goes along. Okay, so I -- next, I'd like to do introductions. I think maybe if -- if you need to do a roll call of all the Board members, maybe the easiest way to do this would be if someone were to call on the Board members and they could indicate that they're present, and also introduce themselves. Is that suitable?

Okay. I can't hear anybody.

MR. BIRD: Carrie -- Carrie or Mike, do you guys want to do a roll call?

MS. REDLICH: I can start. This is Carrie Redlich.

(Simultaneous speaking.)

MS. REDLICH: Can everyone hear me?

CHAIR MARKOWITZ: Yes, go ahead.

MS. REDLICH: Just for the record, I was the very first person on the call today.

(Laughter.)

MS. REDLICH: Yes, this is Dr. Carrie Redlich. I am the director of the Occupational and Environmental Medicine Program at Yale. Also a pulmonary physician and it actually will be a pleasure to think about something other than COVID and personal protective equipment and ICU beds. So I am looking forward to this meeting.

CHAIR MARKOWITZ: Carrie Rhoads, do you want to call people out?

MS. RHOADS: Sure, I can do that. Dr. Berenji?

MEMBER BERENJI: Yes, good morning. This is Mani Berenji. I am an occupational and environmental medicine physician, assistant professor at Boston University School of Medicine.

MS. RHOADS: Okay, Dr. Dement?

MEMBER DEMENT: John Dement, Professor Emeritus in the Division of Occupational and Environmental Medicine at Duke University Medical Center. I am a -- an industrial hygienist and

epidemiologist.

MS. RHOADS: Thank you. Mr. Domina?

MEMBER DOMINA: My name is Kirk Domina. I am the Employee Health Advocate for the Hanford Atomic Metal Trades Council in Richland, Washington. We currently represent about 2800 active members. I've been out here 37 years and I'm a member of the United Steel Workers Union.

MS. RHOADS: Thank you. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Hello, I am George Friedman-Jimenez. Occupational and Environmental Medicine physician and Epidemiologist at NYU School of Medicine and Bellevue Hospital in New York City.

MS. RHOADS: Thank you. Dr. Goldman?

MEMBER GOLDMAN: Hello, I am Dr. Rose Goldman, Founding Director of Occupational and Environmental Medicine Program at Cambridge Health Alliance and is currently Director of Faculty Affairs here and Associate Professor of Medicine at Harvard Medical School and Harvard

School of Public Health.

MS. RHOADS: Thank you. Mr. Mahs?

MEMBER MAHS: Mahs -- Ron Mahs. I am a construction worker. I retired from Oak Ridge, have been in the trade 45 years. Representing the claimants and the national building trades.

MS. RHOADS: Thank you. Dr. Mikulski?

MEMBER MIKULSKI: Hello, good morning. This is Marek Mikulski and I am an occupational epidemiologist with the University of Iowa. Former life training was an occupational physician. I currently direct a former nuclear weapons workers medical training program for Iowa sites.

MS. RHOADS: Thank you. Ms. Pope?

MEMBER POPE: Good morning, Duronda Pope. I am with the United Steelworkers and the emergency response team. I am a former worker of Rocky Flats. Worked there 25 years.

MS. RHOADS: Thank you. Dr. Silver?

MEMBER SILVER: Ken Silver, Associate Professor of Environmental Health in the College

of Public Health at East Tennessee State University. And I was finishing my doctorate, focusing on Los Alamos historical emissions, I worked very closely with the Los Alamos workers and their families. Followed through to work pro bono on actual EEOICPA claims for the people out there. And have written and published a little bit on uses of historical information around the DOE complex.

MS. RHOADS: Thank you.

(Pause.)

MS. RHOADS: Sorry?

CHAIR MARKOWITZ: Did you call Calin Tebay?

MS. RHOADS: I did --

(Simultaneous speaking.)

MEMBER TEBAY: I can barely hear you.

MS. RHOADS: Oh, sorry. Okay, go ahead.

MEMBER TEBAY: Good morning, Calin Tebay, Buildings Rights and Sheet Metal Worker. I am the current site-wide beryllium health

advocate at Hanford and I am also the Hanford Workforce Engagement Center representative.

MS. RHOADS: Okay, thank you. All right, I think back to you, Dr. Markowitz.

CHAIR MARKOWITZ: Okay. Steven Markowitz, the -- the Director of the Barry Commoner Center at City University, New York, Occupational Health physician and epidemiologist. I run the biggest former-worker medical screening program, which is suspended, now, for the time being. Could we have the introduction for the Department of Labor folks on the line? That would be great.

MS. RHOADS: Rachel, are you on?

MS. POND: Yes. This is Rachel Pond. I am the director of the program. It's formerly Leiton, and you'll see that the agenda says Leiton, but it currently is Rachel Pond. And I will be talking with all of you shortly.

MS. RHOADS: Is anyone else on yet? John or Doug?

MR. VANCE: John is here. Can

everyone hear me?

MS. RHOADS: Great. Yes.

MR. VANCE: Good morning, everyone. This is John Vance. I am the Policy Branch Chief for the Energy Compensation Program. I am looking forward to chatting with you all today.

(Simultaneous speaking.)

MR. PENNINGTON: Yes, this is Doug Pennington, the Deputy Director of the Energy Program.

MS. RHOADS: Thank you, Doug. Okay, that's the Department of Labor folks.

CHAIR MARKOWITZ: Okay, and any members of the public, if you want to volunteer your name, that would be great.

MR. BIRD: Dr. Markowitz -- sorry, can you say that again?

CHAIR MARKOWITZ: Sure. If there are members of the public on the phone, if they want to just introduce themselves by name, that would be great.

MR. LEWIS: Dr. Markowitz, before you

get the Public, this is Greg Lewis from the Department of Energy.

CHAIR MARKOWITZ: Oh, okay. Yes. Thank you Greg.

MR. BIRD: Hold on one second, Dr. Markowitz, I'll just un-mute everybody.

(Pause.)

MR. BIRD: Hello, if there are any members of the public on the line who would like to introduce themselves, feel free to do that now.

MS. MEDINA: This is Sandie Medina from the Worker Health Protection Program in Las Vegas, Nevada.

(Simultaneous speaking.)

MS. VLIEGER: Good morning, this is Faye Vlieger.

(Simultaneous speaking.)

MS. BARRIE: Good morning, this is Terrie Barrie.

CHAIR MARKOWITZ: Okay, we heard -- this is Steven. We heard Sandie Medina, Faye

Vlieger, Terrie Barrie. Is there anybody else we didn't catch?

(Simultaneous speaking.)

MS. NELSON: This is Malcolm Nelson, the Ombudsman for the Energy Program.

MS. CISCO: Jeanne Cisco from the Portsmouth Workers Health Protection Program.

MS. QUINN: Trish Quinn with CPWR and the PTMed Former Worker Program.

CHAIR MARKOWITZ: Okay, that's great. Thank you. Thank you for attending. And I -- Kevin, I don't know. Maybe you'd want to un-mute the public at this point so they can say whatever they want while they listen in. Let me --

MR. BIRD: Dr. Markowitz -- can you say that again? You broke up a little bit.

CHAIR MARKOWITZ: Yes, sorry. If you want to un-mute -- I mean, sorry, do you want to mute the public?

MR. BIRD: Yes, absolutely.

CHAIR MARKOWITZ: Okay, so I want to review the agenda. And then we'll get back to

whatever Mr. Chance wants to say under the Status of Recommendations, Solicitation of Nominations. So that occurs in conjunction with the report of the Department of Labor Staff.

So we start off with reports, information, updates from Department of Labor -- both on the program overall as well as on the interaction with the Board. And those are listed in the Agenda. I will review those now. And then later in the morning -- or early afternoon, I guess, we're going to be discussing Parkinson's-related disorders. And after a short break, we will be discussing the Department's request to us to address -- actually, on the Webex you just keep going up the -- to 1:30, that's where I am at. Discuss the requests around the Board considering the status of certain cancer-causing agents and how they might be viewed in the SEM. After which we'll discuss -- have a discussion about the part of the Board's tasks that -- which is to evaluate the CMC, industrial hygienist performance.

We'll discuss additional DOL requests to the Board around B reading, around provider outreach, and then have a discussion about the current occupational questionnaire. At 3:30 we'll have a public comment period. We welcome the public to make comments. Right now on the website -- on our website, today's meeting, we have one -- a one-page comment from Ms. Vina Colley. And if -- if the public comment in -- before 5:00 p.m., then we're probably just going to continue the meeting.

Day two -- tomorrow, right now we have listed for 11:00 a.m. a discussion of the recommendation, the DOL's response -- of that response around site-wide job titles. We have a discussion about changes in the Procedure Manual and bulletins that are going to come out since the last meeting. A brief update on expanding asbestos job titles. We can review public comments. And then, we need to get into any new issues that arise.

So then we need to discuss -- this

board's term is up mid-July. Then we have, I think, three months to -- to finish or to continue our work. And what I think we ought to do as we go through today's meeting is -- have in the back of our minds what we're going to be able to complete within the next three months. I think we should have a telephone meeting the second two weeks of June -- the latter part of June -- just so we can close out any recommendations, and official communications we want to make to the Department.

And so -- so -- I hope to get as far as we can get on discussions today. Any items we can't quite close out today, we have another opportunity during this fourth term. Any questions about any of this? Or any other items anybody wants to add to the Agenda?

Okay, so let me turn it back to Mr. Chance to discuss the status of recommendations and solicitation accommodations.

MR. CHANCE: Thank you, Dr. Markowitz. The -- I am trying to pull up the document here.

The -- regarding the nominations -- everybody on the call is certainly eligible to go ahead and participate. I believe that I want to make sure that I have the date right. The open nomination period, everyone is eligible to re-nominate for the next term on May 1. So that is an ongoing issue that is -- is coming with regard to the -- but we -- but we are prepared to take any nominations that nominations that we receive and evaluate those and pass them forward by May 1.

The status of the latest recommendation on asthma, I believe, is with the Secretary's office for clearance and is due out on May the 5th. Carrie Rhoads, are you on?

Carrie, can you hear me?

MS. RHOADS: Yes, that's right. May -- the next recommendation response is due out in early May. That's the one on asthma from the January meeting.

MR. CHANCE: Right. Are there -- is any outstanding issues other than that that I'm missing?

MS. RHOADS: No, that was the one. And the rest of the recommendation responses have been posted on the web.

MR. CHANCE: Okay, all right. So I just wanted to make sure that I didn't miss anything. I -- you know, bear with me, Dr. Markowitz, I am still kind of new at this. So I wanted to make sure that I didn't leave anything out. But I believe that that's all that we would need to cover with -- with recommend -- outstanding recommendations and the nominations. Is there anything else you would like for me to discuss?

CHAIR MARKOWITZ: No, no. We can just continue -- continue on the Agenda. That's fine.

(Simultaneous speaking.)

MR. CHANCE: Okay.

CHAIR MARKOWITZ: Let's into some of the --

(Simultaneous speaking.)

MR. CHANCE: Thank you.

CHAIR MARKOWITZ: -- the funds -- the

updates? The program highlights?

MS. POND: Yes, hello everyone. I do want to start off by saying thank you to the Board members for taking time out of your schedules, particularly during this period of emergency, to be here with us and to go through this agenda and all the work that the Board has been doing for us.

Today I am going to walk through just some overview items. Just kind of generalities of what we're currently doing, our recent accomplishments, some items that cover COVID and the types of things we doing for that. A few other things that will just kind of give you a broad overview. And then after that, I am going to turn it over to John Vance who is going to cover some of the more details that are on the Agenda, as well as to Doug Pennington. So we should be able to cover all the topics this morning that are on the Agenda through the -- up until the 12:45 discussion. That -- we'll turn it back over to -- to Dr. Markowitz and they can

move on to the next topic.

Dr. Markowitz, I am going to go through this -- the overview, and then John is going to talk a little bit. When you -- and then we'll switch it over to the 12:15, we'll try not to run past the 12:45. But if you need -- you know, if there are questions in between, you'll probably want to work out a mechanism for how people want to ask those questions. I will try to pause in between subjects a little bit and see if there are questions as I move through what I am talking about. And I am sure John and Doug can do the same.

So I am going to start out with just some statistics, you know, this is about our recents, but we've paid almost $18 billion in over 300,000 claims since inception of the program. Interestingly, now almost $6 billion of that is medical benefits. That's where we're seeing a steady increase in the last five years -- in the amount of money that we're spending. Large part is due to the fact that we've -- our -

- our population is becoming a little bit more elderly. There are more consequential conditions. There's more need for services, like home healthcare. So that is becoming more of what we're doing is optimizing medical benefits and ensuring people are getting the equipment they need, the services they need and that sort of thing. And that's part of the reason that we've -- we've talked briefly about -- we've centralized some of our medical bill authorization processes into the national office.

But I want to talk a little bit about recent accomplishments. We -- effective, like I think April 1st, we started a new case assignment process. It's just something that we did in the final adjudication branch in 2018. Basically we used to assign cases by jurisdiction. Meaning this is the last place that the employee worked was in a particular location, where that location was, they were assigned to a particular district office. That process was beneficial and worked really pretty well at the beginning of the

program. However, as we have evolved, we get more cases from one particular area, like Hanford, and less from some other areas like the AWEs and -- and the -- the Cleveland jurisdiction. So in light of that and in order to kind of even out the workload across our district offices, we have now moved to an assignment process that is a round robin across the country. It works pretty well for our Final Adjudication Branch. And so far, in the first couple of weeks of this, it has been working pretty well for our district offices.

When we made this transition, we did do some training -- cross training across district offices regarding particular facility issues. We have place of contact in each of our district offices for facility issues so that if somebody in Jacksonville has a question about a Hanford facility, they can go to that POC. We also have reference materials. There's a lot of materials that have been collected over the years that we -- our claims staff utilizes to

familiarize themselves with facility issues.

So we're going to continue to monitor that, but I think overall it's going to assist us in balancing workload, in hiring across the country, and those sorts of things. Another thing that we started last year -- well we've always done pretty robust sampling, but we've got to -- more of a -- let's say consistent process for sampling work in that throughout the country, both in our final adjudication branch and our medical benefits examiner branches and in our -- our district offices, we have instituted each to provide their reviews of a certain percentage of the work that's randomly selected on a monthly basis, on the workload of the claims examiners. We talk about that work, make sure that they're aware of -- of where they're doing well, where they're not doing well, where there are issues with the cases -- things that we can fix on the spot.

And in conjunction with that, we also

started this year -- we hired some quality review analysts in each of our -- that work for our national office. And what they're doing is they are evaluating cases -- in addition to our -- our annual accountability reviews, they -- they produce a spreadsheet that contains a series of questions in each and every area of the work that we do. That would be development letters and recommended decisions and final decisions and ancillary medical benefits. And each one of those categories are being evaluated on a weekly basis by these accountability review analysts. They are looking at work -- not that was done six months ago, but work that was done recently. And this will give us a feedback that will provide our supervisors and our claims staff with immediate feedback. It will give us an idea of where we need to do additional training. What -- you know, if there are particular pockets of -- of subjects that we need to change our policy on. Those sorts of things will be a lot more acceptable for us to make changes to the program

overall where we need to as we move through the year.

We still are going to do our accountability review, which are the annual assessments that are conducted by a team of employees throughout the country. Those will still happen this year. They may not happen in person, as they usually do, because of the COVID pandemic. But we will be doing those. So we're going to have a pretty robust quality review process in addition to what we used to do. We also continue to evaluate 10 percent of our claims after they've gone out -- or, before they've gone out as a result of recommendations that were made several years ago by the Government Accountability Office.

And so those all together will be put into spread sheets at -- by -- in 2020. For some of them, 2021. But the rest of them that we can compare and contrast, we'll be able to look at what we -- what areas we need improvement based on all four of these categories. The sampling,

the accountability reviews, the quality review analysts, and the GAO audit. And we continue to conduct some, still hoping that this is going to enhance our current quality review process.

As I indicated earlier, we centralized our medical benefits. That is going well. It's probably going to have to be consistent in the way we respond to all of the additional home healthcare and ancillary medical benefits that we see.

I wanted to talk a little bit about the impact of the current pandemic and the kinds of things that we've been looking at. We've been pretty busy trying to make sure that we are able to maintain the safety of our claimant population as well as provide the benefits that they (telephonic interference) need. So there is information, FAQs, on our website that provide some of these details about what we have done and what we're moving forward in terms of flexibility for people that cannot leave their homes. And particularly considering the fact that our

claimant population are susceptible to this particular virus.

One of the things is that we're being a little bit more flexible on deadlines. For example, we have physicians that can't see patients -- or don't feel that the patient should come into the office right away, or they have to delay providing us information. So we are very flexible on those deadlines. We -- one of the areas that we have set up a bulletin, it's Bulletin 20-03, is about home healthcare. We have certain changes that we've made during this period of pandemic emergency for home healthcare.

Normally we require face-to-face examinations for any expiring home healthcare authorizations, any new requests, any requests for new care. During this time we are allowing for home healthcare extensions can be done through a letter of medical necessity by a physician if the physician feels that it would be unsafe for the claimant to go into the office for a face-to-face examination, and that's on

existing levels of care.

For levels of care that are greater than what they've already got, for the new requests, we are allowing for telemedicine under certain circumstances. Those circumstances are outlined in our bulletin.

One thing that we do need to account for in our -- in how we respond and what -- what information we can obtain is that the Department of Energy is not fully staffed right now. Not everybody can telework. They can't get access to some of the verification records that we would need to verify employment. Therefore, we are looking at -- we have to take that into consideration when we're developing a case until such time that they can provide us with that information, we will likely have to hold some of those cases.

We also are no longer doing in-person hearings at this time. We do have the ability to conduct hearings through phone calls and Webex. And that is where we are -- where we stand with

that at this time.

Resource centers are not open to the public at this time, but they are continuing to work. They are able to telework. They have started to answer -- you know, a couple of years ago or last year they started answering initial phone calls. They can still do that from home -- transfer calls.

We do have them coming into the office -- or going into a resource center once a week to collect and scan mail. And so we are still able to intake claims. We're getting weekly reports from them regarding how many claims we're getting. So it's still pretty robust in terms of the number of contacts we're getting and the number of claims that we're taking in.

The other thing is that we have -- you know, some doctors -- claimants need their medications. There are pharmacies that will allow mail order. Doctors are able to extend their prescriptions beyond sometimes 30 days -- now, you know, is up to 90 days. And that is not

a problem for us.

We are continuing to reach out to the public where we can in terms of -- calls with providers, email blasts. But we are not doing outreach right now. We had to cancel our outreach events for March, April, and May as a result of this. We hope, obviously, when this is all over we will go back to that and continue our authorized (telephonic interference) workshop from the town hall meetings and other outreach events that we believe are important to continue to do when we can.

We did -- we are still updating our training. Our basic -- our basic claims examiner training is being updated by a contractor with oversight by a federal employee. And so those are -- those are the big things that -- that we're -- well, there is one other thing I wanted to mention with regards to ongoing activities is the new medical bill -- contractor.

We have a new contractor that will be handling those issues effective April 27th of

this year. We have in -- this is an OWCP workers-compensation-program-wide contract, and so mailers are going out to all of the claimants for all of the divisions and to the providers to let them know of this change. Again, our conference call was provided -- will provide this information to them, and we have email blasts that people prescribe to that will have this information as well as other types of information we'll put on the website.

So before I move on to some of the updates on board issues, are there any questions about any of that?

CHAIR MARKOWITZ: This is Steven Markowitz. I have a question. You talked about the various activities relating to quality review. -Did any of those new activities or renewed activities pertain to the CMC or the industrial hygiene evaluations?

MS. POND: No these are -- well, they touch on them. In terms of what they'll be reviewing, is the types of information that's

submitted to CMCs, types of information submitted to IHs, whether we're asking the right questions. We will be reviewing the responses that come back, but not as an audit for the CMCs or the IHs. These are really a review of the claims examiner's work.

CHAIR MARKOWITZ: Okay, thank you. Another question I have is the -- there's a transmittal document that was issued by the program April 3rd that summarized changes to the Procedure Manual. Were there any -- or maybe you're going to get to this. Maybe I am jumping the gun. But I'm just wondering if either now or if you -- and if you could just briefly review any changes that are pertinent to the kinds of issues that the Board gets involved in. to here

MS. POND: Yeah, I will -- and John is going to go through the Procedure Manual changes and the bulletins that have come out. So when we get to him, I'll have him go through those.

CHAIR MARKOWITZ: Okay, great thank you. Other questions?

(Simultaneous speaking.)

MEMBER DOMINA: This is Kirk Domina. I have a question on -- for Rachel on Bulletin 20-03.

MS. POND: Yeah?

MEMBER DOMINA: I guess what my question is -- and I understand and appreciate that on the letter of medical necessity that -- like on a new claimant who is trying to get coverage out here, specifically, in Hanford, you know, we have some people that are really, really vulnerable. And then you also have nurses that work in other facilities, not maybe just for a home health to be able to come and help with that evaluation.

And it's -- you know, the families are -- you know, people are scared. And I understand you guys are doing the best you can, but trying to, you know, let somebody into their home or stand six feet, or ten feet, or 20 feet away to do a video to try and get something approved, I was just wondering if there's a little more

leeway or something that we can do to try and help people.

Because, you know, it's kind of -- it went through the nursing homes and stuff out here in the Tri-Cities pretty quickly and bad. And it still continues. And, you know, people are just trying to protect their loved ones. And I am just trying to figure out if there's a way that we can do this on -- I am talking specifically on brand new coverage for home health.

MR. PENNINGTON: Rachel, can I speak to that real quick?

MS. POND: Sure.

MR. PENNINGTON: This is Doug.

MS. POND: Introduce yourself --

(Simultaneous speaking.)

Mr. PENNINGTON: This is Doug Pennington, the Deputy Director of the program. Kirk, specifically to your issue, that is kind of why we developed the process that we did was on a new request where, in essence, the doctor will be asking to introduce people into the claimant's

home on a -- up to a daily basis, all the way up to 24 hours a day, where you could have as many as 10 people coming into the home and as few as one on a regular basis, we felt it was necessary to ensure that the physician had all the tools necessary to adequately assess the risks of bringing those people into the home.

And part of that was making sure that the physician could conduct an examination that provided them all the information necessary to be able to truly assess the claimant's medical need and weigh those risks versus bringing people into the home on a regular basis. So by bringing in a trained RN, physician's assistant, or advanced practice nurse who have expertise in being able to essentially protect themselves and their claimant from exposure to COVID through appropriate protective equipment and gear, as well as standard medical knowledge and expertise, we felt that was the best way to mitigate the exposure risks by bringing an individual into the home while also assuring that we had the

opportunity to provide the physician with eyes, hands, and ears at the claimant in order to conduct that face-to-face examination so it's not just a two-dimensional person on a video screen.

That they're able to assess the vital signs. They're able to essentially make sure the claimant's physical needs are going to be appropriately met by the home healthcare. And like I said before, balance the risk of them bringing in home healthcare aides into the claimant's home during this pandemic. Does that answer your question?

MEMBER DOMINA: Yeah, kind of. But I'll think of rephrasing a few things. Thank you.

MS. POND: So just to follow up on that, I -- I -- we are constantly and continually, throughout this, looking at ways that we can be as flexible as possible. So this is what we have come up with and been able to publish bulletin on currently. And as we continue to look at these things, if there are

additional flexibilities we can make, we will publish additional information on it.

Okay, I am going to move on -- oh, go ahead. Sorry.

CHAIR MARKOWITZ: I am sorry. It's Steven. I just want to ask a question. Has the program received any claims for -- specifically for COVID infection or disease?

MS. POND: No, I don't believe so. They -- you know, it would have to be tied -- I think that if COVID were to come in, it would obviously be some sort of a consequential condition because of their preexisting. I am not aware of any. Doug or John, have you heard of any that we've received?

MR. VANCE: Not that I am aware of. This is John Vance. But, you know, with this program, I am sure we'll see them at some point.

MR. PENNINGTON: Yeah, this is Doug Pennington. We have not yet identified any consequential claims requests. But since they're not, as Rachel pointed out, not occupational,

somebody would have to actually tie the receipt of the disease specifically to the existing accepted condition as a consequence of it in order to -- for us to cover it.

CHAIR MARKOWITZ: Thank you.

MS. POND: Other questions before I move on? I just have a couple more things, and then I will turn it over to John.

Okay. So one of the -- just a couple updates on Board issues that I am going to address. Some of the other items will be addressed by either John or Doug. But with regard to the ability for IHs to speak with claimants, we do have a process for that already. It is -- we do require that the claims examiner be on the phone. But if an IH believes that it's appropriate to speak to a -- a claimant, they can do so. We've only had that happen once so far, but that ability to do that is out there.

There was a question about cases -- being available through the public portal. We -- you know, I think that the Board's original

request was that certain people have access to the case files. And we talked about the fact that, long term, we plan to have an ability for our claimants to be able to look at their case files directly. That is something that we still plan to do.

However, we needed to ask for, you know, resources from OMB and a budget to make that happen. There are some contractual -- things that contractors have to do with regards to our technology to make that happen. We're going to be piggybacking on some technology that's currently being developed for our sister program, the Federal Employees' Compensation program that we are hoping to move into place in 2021, in the Fiscal Year 2021.

So once we get our new budget, we do hope that that capability will happen in 2021. There are some caveats, as I said, depending on what resources we get, but that is our plan.

OHQ revisions, we've got -- had some feedback back and forth in conversations about

the OHQ. We are moving this into a -- a database format that the resource centers can complete easily, taking into consideration a lot of the recommendations that the Board has made to how we can change this.

I think there was a follow-up question from one of the Board members just last week or the week before that was responded to. And at this juncture, I think we've responded to everything, and we're in the midst of finalizing it. It's -- I noticed this was on the agenda for the Board to discuss during this -- the course of this meeting. And of course, if there are more recommendations for it, we will be -- we will take those into consideration. But we are in the midst of trying to move forward with a revision to that now.

There was also a question about data requests. I think there was a lung cancer claims data request, post-1995 data request for claims -- post-1995 claims with industrial hygienist report. That requirement was clarified, also, in

a discussion with, I believe, Dr. Markowitz within the last several weeks. So we are working on that and hope to have that to you, particularly now that we have a little bit more of a clear plan for those two requests for data.

And then there was also a very recent request for development letters. We have those. I just looked at about ten of them. I want to make sure that we have what we need to -- that will give you a pretty good sampling. So those should be coming to you in a week or so. That is what I have before I turn it over to John. Are there questions about those last two items before I do so?

CHAIR MARKOWITZ: This is Steven. I have a question about the -- the interview by the industrial hygienist. So could you just -- I know it's in the Procedure Manual, which I haven't yet committed to memory -- could you just refresh our memories about how that interview is initiated? How it is that the program decides to conduct an interview?

MS. POND: Well, it's -- there are -- there are two ways that actually it can happen. I think that we've had requests from a claimant to speak to an IH. And that is, I think, what we've facilitated with the claims examiner on the call. Please correct me if I am wrong, John or Doug. But -- and the alternative is an industrial hygienist has a case file, they believe that they need to have more information, or their discussion with the -- with the actual claimant would be beneficial, they -- they can request that. But the claims examiner will facilitate it. John, I don't know if you want to go into a little more detail about how that works?

MR. VANCE: Yes, I mean it -- hold on. Yeah, this is John Vance. Rachel is correct. So it's basically, you know, the initiation of this can be under any real circumstance where an industrial hygienist, either one of our contractors or an internal, you know, federal industrial hygienist has looked at a case and

just has determined that it really is something that -- that we need to talk to the claimant to get a better understanding of what the circumstances are with regard to a particular work activities or exposure.

And that was sort of the issue that came up in one case where there was some contention over the way that the industrial hygienists were characterizing as an exposure, and a claimant was offering a contradictory viewpoint on that so that we ended up having to, you know, talk to the claimant.

It was something that is coordinated and administered by the claims examiner that's overseeing the case, and then an industrial hygienist has an opportunity to ask questions about the circumstances where the employees work and their exposure. And then that information is recorded and incorporated into the case file. And then it's also reevaluated by the industrial hygienist to determine whether or not it in some way is going to modify their exposure analysis

output.

CHAIR MARKOWITZ: This is Steven again. Thank you. So how long has this been that these interviews have been able to be conducted -- when -- when -- more or less, what was the start date? Trying to figure out what -- what the dynamic is.

MR. VANCE: I am looking now. It was in our -- one of our releases for our Procedure Manual. So it was -- I don't have the exact date, but it was not in our most recent one.

MS. POND: Yes, maybe about three to six months. Maybe three months.

CHAIR MARKOWITZ: The -- okay, thank you. So has the -- the claimant community, whatever that consists of, has there been any notification that the claimants can request to have such an interview?

MS. POND: There isn't a formal notification that we sent off to all of our claimants. But we've got the information on the website. It's included in the -- I believe it

would be included in the changes that was -- are defined in the transmittal. If a -- you know, we do have -- claims examiners do talk to the claimants pretty regularly, and, you know, if -- if an issue like that comes up, then the claims examiner would definitely allow the -- tell them, you know, there is this option. But we haven't sent out a specific mailing or anything like that.

CHAIR MARKOWITZ: And how about the -- this is Steven again, just the -- I think the last question. So the industrial hygienists, whether the contractor or the in-house people, they're all aware that if there is some uncertainty they think they can resolve, they're able to communicate with the claims examiner or request an interview. Is that right?

MS. POND: Yes, yes.

CHAIR MARKOWITZ: Thank you.

MS. POND: Okay, so that's all --

(Simultaneous speaking.)

CHAIR MARKOWITZ: Any other questions

-- I am sorry, any other questions from Board members?

Okay, thanks.

MS. POND: Okay, I am going to be -- I will be on the phone the rest of the day today if there are additional questions. I will be here this morning, as will John. I am going to turn this over to John to cover some of the other issues with regards to changes in the Procedure Manual, new bulletins, SEM issues, and a couple of other things. So thank you all for your attention, and I will send this over to John for now.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: All right, well good afternoon, everyone. This is John Vance again. It's a pleasure to get an opportunity to speak with everyone again. So on the agenda, I am going to speaking to the Procedure Manual and some bulletin updates. And then I think we move into some responses directly to the Board issues. So let me try to stick to the agenda. I've got

five minutes, apparently, to talk a little bit about the Procedure Manual. But if we go over, I think we'll just sort of play it by ear here. So --

(Simultaneous speaking.)

CHAIR MARKOWITZ: Well, you can have a little bit more time. Don't worry, John.

(Laughter.)

MR. VANCE: That's what I figured. So let me start by just saying, for everyone that's on the Board or on the call, the Department of Labor does maintain a huge volume of information about our policies and procedures online. We have a tremendous amount of resources available to allow people to understand how claims examiners and our appeal board goes about doing their day-to-day work. And our Procedure Manual is basically the epicenter of that policy and procedural guidance. So it is available online.

And I also want to encourage folks to sign up for our program or policy updates. There is a link on our main page that talks to email

notifications on updates because we do update our procedure manual fairly frequently. And that email will just alert you to when changes have occurred. We also update our website with notifications on our program highlights when we have updates or changes to the policy. So I just wanted to make a plug for those two things.

With regard to the process of Procedure Manual editing, again, this is a claims examiner and -- you, know process guide. It's for staff. It's directed to staff, but it helps the public understand sort of how staff go about doing their work in conjunction with the evaluation of claims. So it's a very important document. And we take input from staff, from, you know, stakeholders, from the Advisory Board, in how we modify our -- our procedural guidance.

And I also want to say our procedural guidance is framed within the context of the law and our regulation. So this is just merely guidance as to how we best can administer, you know, our legal requirements for adjudicating

cases.

So we do issue publications that -- that encompass the entire Procedure Manual. If we have interim updates that we want to make based on either a very specific change, or a expedited issue, we will issue interim bulletins. And so what I am going to do is talk a little bit about some of the more recent things that have been going on and cover our most recent release that went out on March 31st.

So let me just start by going to our -- our March 31st release. So we had a major update to our Procedure Manual. It went from Version 4.0 to 4.1. For the most part, I think it -- it represented a lot of administrative and technical updates. But we did have some important changes.

We incorporated a bulletin -- there had been an interim bulletin that had updated some guidance from Version 4.0. We have replaced an instruction about who was responsible to process and adjudicate medical benefit claims.

That has now been centralized into a medical benefit adjudication unit. So we had put out a bulletin explaining that change. That bulletin was subsequently incorporated into the official Procedure Manual as part of this 4.1 release.

The update also included changes in guidance that we had to incorporate into the Procedure Manual about reporting to the National Instant Criminal Background Check System instances or evidence, or we have information that relates to people that could be potentially prohibited from purchasing or obtaining firearms. This would be like us receiving information regarding someone who has recently been -- you know, imprisoned as part of a, you know, a felony. So that -- that was a requirement that we had to update. And that has gone into our Procedure Manual.

We had updated guidance relating to the centralization of our customer service interactions with the resource centers. So we had provided some guidance with regard to how

phone calls are handled by the resource centers. We had -- this is something specific that the -- to the Board, we have updated our Exhibit 15-4, which speaks primarily to the presumptive standards that -- that the program applies in adjudicating Part E cases. We had the addition of two new presumptive standards relating to non-Hodgkin's lymphoma. That has actually been released as part of a bulletin, Bulletin 02-02. So that was an interim update to Version 4.0, and we merely formalized it into the -- into the Procedure Manual as part of this 4.1 release.

The -- the big change that did occur for 4.1 was the elimination of recommended decision cover letters. This again is sort of like something that originates from staff where we look at comments and feedback that we receive from staff and stakeholders with regard to changes to our process.

We received a lot of feedback saying that our cover letters were redundant and not very helpful, and that it was something that a

lot of folks deemed as unnecessary because the decision itself provides a lot of relevant information about the nature of the decision and what's -- what's going on. It also already identifies the people that are involved in the decision.

So we made a determination that the cover letter was really unnecessary for recommended decisions. So we've removed that from our process, and now we won't be going -- or have gone to a process where we will be sending all the parties to a decision just a copy of the decision itself, along with any relevant attachments.

We also simplified our waiver process. We have gone to a single waiver, versus the two different types that existed prior to the release of Version 4.1. So hopefully that will simply the process, will get rid of some of the confusion that people were having with regard to our waiver that was a bifurcated waiver between people that wanted to agree to part or all of a -

- a particular recommended decision. And that again was feedback that we'd received from the District Office and also from a claimant about the confusion about our waiver process.

We also had updated guidance regarding reimbursement for costs for eyewear. We have also memorialized guidance regarding medical marijuana. We have basically stipulated that it is still a federally controlled substance and we as a federal agency cannot accept it as having any kind of medical value. So it's not a reimbursable medical benefit.

So those are the big changes that went into the last edition of our Procedure Manual. We are currently working on the next version, which is going to encapsulate the changes that Rachel mentioned with regard to our transition to a new medical bill processing contractor. So we're hoping to get that out as close to April 27th as we possibly can.

So, as I mentioned, we have incorporated two bulletins into this last release

of the Procedure Manual. Our other bulletin that was issued recently was our telemedicine bulletin that just talks about the increased flexibilities that the program has released with regard to how we will allow certain telemedicine interactions to occur. And, you know, as Rachel mentioned, we're continuing to look at that. That's something that we will be continuing to revise based on input from stakeholders and our own internal experience in trying to administer, you know, that policy.

So that is the -- that is the -- the update I have for policies and procedures. And again, for folks that are -- that are online or on the call, just remember, all of our policies and procedures are available through our website. We actually also archive prior editions. So if you do want to do any kind of review of prior versions of our Procedure Manual, it's all available through our public reading room link. So please avail yourself of those -- those options and links.

CHAIR MARKOWITZ: Thank you. Were there any questions for Mr. Vance?

Okay. Anything else, Mr. Vance, you want to discuss?

MR. VANCE: Not on the policies and procedures. We can move on with the agenda.

MS. POND: I think that -- okay, sorry. I think that we're going to -- John can continue but -- so, yes, there's another section, so I'll let you move forward with that.

CHAIR MARKOWITZ: Okay, I think we're going to come back to Mr. Chance's notification about our request for resources, but we can do that at the end of the next session, so I guess you all can continue.

MR. VANCE: All right, well, that's what I was waiting for. I was waiting for Dr. Markowitz to give me permission to continue.

So, I'm going to move on into the agenda for the next item which is talking about some of the responses to issues that have been raised since the last meeting.

So, we do get lots of input from the Board that's not really encompassing into formal recommendations, so we do want to try to be responsive to, you know, all of the concerns that are raised.

And we have received some input with regard to the Site Exposure Matrix and some other issues with regard to the application of policy by Dr. Redlich, and so I just had some quick comments that I wanted to make in response to those concerns.

And I think it can be something that maybe the Board would want to continue to discuss if there are continuing concerns, but it has to do primarily with the way that we present information in the Site Exposure Matrices with regard to pulmonary disease, and so let me just sort of walk through my notes.

So, I think the concern had been about how COPD is listed in the Site Exposure Matrices and, you know, for those of us that are very familiar with the Site Exposure Matrices, it

provides information about known medical conditions that have a connection to toxic substance exposure.

And so our Site Exposure Matrices lists out conditions that are basically known to science to be somehow associated with exposure to particular toxins, and so we do have chronic obstructive pulmonary disease listed in the Site Exposure Matrices. It's listed under pulmonary disease, chronic obstructive.

It has multiple aliases, so that means that we would look for COPD or any of the conditions that are known to be an alias in our research of those toxins that an employee may have encountered during their work because that's critical in evaluating the causative relationship between an exposure and development of that disease.

So, we do have COPD listed in the Site Exposure Matrices to avoid any confusion about that, and there are multiple aliases for it, chronic bronchitis, emphysema, and just the

acronym COPD.

Then what I think has raised some concern and I just wanted to speak to it, is that the Site Exposure Matrices doesn't apply separate determinations that the program makes with regard to the application of procedural guidance with regard to how to do certain things with some of the conditions.

So, the Site Exposure Matrices doesn't speak to this, but we do have instruction to our staff that talks about the use of how to go about evaluating clients for interstitial lung disease and pulmonary fibrosis.

So, we have specific procedural guidance that instructs our staff that when they're looking at a claim for interstitial lung disease or pulmonary fibrosis, they're then to go to the Site Exposure Matrices and use pneumoconiosis, other as the health effect for those two conditions.

So, this is not something that you would see or communicate -- it wouldn't be

communicated in the Site Exposure Matrices. This is merely procedural instruction that staff are to adhere to when they're evaluating cases for interstitial lung disease or pulmonary fibrosis.

And a similar situation exists for individuals that are identified as having an idiopathic pulmonary fibrosis. This was an issue that had come up some time ago where physicians would identify a condition like pulmonary fibrosis or lung fibrosis as idiopathic, which just means of unknown origin.

We clarified in our procedure that a claims examiner is not to treat an idiopathic pulmonary fibrosis or lung fibrosis as being, you know, unrelated to work, but they would still have to look at that as potentially work-related, as the underlying condition, and not just necessarily as idiopathic.

So, in other words, if I'm a claims examiner and I have a physician diagnosis of idiopathic pulmonary fibrosis, I'm going to treat that condition as pulmonary fibrosis in my

evaluation of that client without any -- you know, without discrediting it as a potentially work-related medical condition.

And then finally, there were some concerns about how we report sarcoidosis in the Site Exposure Matrices, and again, that is not something that we have any known health effect for.

That's certainly something that the Board can continue to look at is, you know, is there known, you know, exposures linked directly to a diagnosis of sarcoid or sarcoidosis?

What we do have is guidance in our procedural manual speaking to the fact that sarcoidosis can represent a misdiagnosis of chronic beryllium disease under our evaluation criteria for chronic beryllium disease.

And again, that is a procedural instruction that we have an allowance for when claims examiners are evaluating claims, but that's not something that is captured or communicated in the Site Exposure Matrices.

Finally, with regard to Dr. Redlich, there had been a request, and I think that this was something that the Advisory Board had identified or mentioned as to why asbestos has not been added to the pneumoconiosis health effect profile in the Site Exposure Matrices.

I'm happy to report that that is actually there now, so that is a toxin that is listed under pneumoconiosis, and we did make that update based on the input that we received.

Any other questions with regard to some of that information that I've just provided?

CHAIR MARKOWITZ: This is Steven. So, Kevin, could you put up from our meeting briefing book, the SEM fixable file just so we can be looking at that?

And then -- because I think maybe Mr. Vance addressed these, but I just want to make sure that the issues that were raised in that file are the same ones that we're discussing now or to make sure there are no residual issues as well.

Okay, so if you go down to the next page? Go down to the next page, Kevin.

MR. BIRD: Yeah, which page? Here, let me.

CHAIR MARKOWITZ: It's page -- you can go to page two and then page -- page two briefly and then page three.

MR. BIRD: It doesn't seem to be showing correctly in the -- I'm just going to try --

CHAIR MARKOWITZ: Dr. Redlich, I don't know if you want to address this. Oh there, okay, fine. So, yeah, so this is entering through the Paducah site in the SEM. And so Dr. Redlich, given what Mr. Vance just said, does that address some of the issues that you were looking at here?

MEMBER REDLICH: Well, you know, I want us to retest it to see if -- and I was just doing that now. I did miss a few of his comments because of a problem with the phone line.

As far as sarcoidosis, it just seems

like it would be much simpler, since we know that clinically, sarcoidosis and beryllium disease are indistinguishable, that one would link beryllium to sarcoid in the SEM, but that link doesn't mean that that's what the final adjudication is, but I'm still confused why one wouldn't link those two.

You know, if A equals B and, you know, can be caused by, if both of those -- you know, if those are indistinguishable and beryllium can cause them, we know that most clinicians have very little experience recognizing or diagnosing chronic beryllium disease. It seems that the obvious thing to do would be to provide that link in the SEM.

There are different ways. You know, COPD, emphysema, chronic bronchitis, I think as you recognized, that those are interchangeable terms for basically the same chronic obstructive lung disease, you know, granuloma and lung disease.

You know, sarcoid and beryllium really

being indistinguishable, it would make sense to have them linked.

MS. POND: This is Rachel. You know, usually we do. The doctors oftentimes can tell us that this is sarcoidosis based on what they see, at least in our experience on the exams, on the tests that they take, and those sorts of things.

If we automatically assume that sarcoidosis is beryllium disease and put a link to beryllium in the SEM, then we're really not making that distinction that can be made in certain circumstances in certain cases.

We don't want our claims staff to go in the SEM and say, oh, okay, this person has sarcoidosis. We're going to go ahead and assume that that's really related to beryllium and it's really beryllium disease and not sarcoidosis.

It's not an assumption we want to make without a doctor's input until we really ask those questions on a case by case basis to a doctor.

MEMBER REDLICH: Yeah, I guess it's just that I've now reviewed, you know, a number of claims where, because the SEM did not link, you know, recognize that there was beryllium exposure, an obvious case of chronic beryllium disease was, you know, that diagnosis was missed.

So, the linkage in the SEM, that -- one still takes into account the duration or the timing of exposure, you know, the onset of disease, and all of those factors.

So, I haven't seen any situation where the SEM acknowledging a disease exposure association immediately led to that diagnosis because it appeared to me that there was still input from the, you know, claims examiner or from the contract physician to then take that information and use that information as part of their decision making.

I mean, there were other -- you know, I've often reviewed cases that I thought were sarcoid and were sarcoid, so to me, that's just -- you're using that information, but by not

providing it, I just don't think that that improves the accuracy.

MS. POND: Well, our procedure manual and our training to our staff explains to them that when they see sarcoidosis, they should be looking for beryllium, so beryllium tests, beryllium, you know, a possible diagnosis for beryllium, to do (telephonic interference) beryllium in certain circumstances, and that's where that comes in.

Putting it in the SEM, I think for our purposes, would just be making an assumption. Since beryllium doesn't cause sarcoidosis and they are two different conditions, we don't want to put beryllium in the SEM for that purpose.

We have training materials and our procedure manuals that captures what the CE needs to look for when looking at a particular case, particularly for sarcoidosis and the possibility that that's beryllium disease.

MEMBER REDLICH: No, that all makes sense and I agree, but in cases I reviewed, the

question was sometimes that maybe the SEM was queried in the wrong way, but there was a query, were there any exposures at this workplace that could cause sarcoid? So, that is always going to come up with, no, there are no exposures, because -- so that, and then that information is given to the, let's say the contract medical physician and saying, look, there is no exposures at this workplace that could cause sarcoid, and the clinician recognizes that this is likely beryllium disease.

And, I mean, I reviewed a case such as that and then the claim examiner said that, you know, the physician didn't know what he was talking about because he didn't answer the question.

You know, it's partly the question that the -- maybe another way to solve this would be that the question that is posed because it creates these scenarios where the question is, you know, were there any exposures at this workplace that caused the patient's sarcoid, and

that's always going to be a no.

MS. POND: Yeah, there are case by case situations and we have to look at it on a case by case basis at this point. Yeah, there are cases where you're going to see maybe they put it wrong and maybe they didn't ask the right questions, but a lot of times they do.

So, I don't want to get into a discussion about what all could go wrong in the case on sarcoidosis right now, but, you know, we believe at this point, putting beryllium in sarcoidosis is not the best route for our, you know, for the direction we're going in this.

Again, if the Board comes up with a recommendation on this, we're happy to evaluate it.

MEMBER REDLICH: Okay, I mean, sarcoid is a relatively rare disease. It's not like COPD or asthma.

MEMBER GOLDMAN: This is Rose Goldman. Could I just ask a question here about the SEM then? Because if you have interstitial fibrosis,

you would have a link there, for example, to potential asbestos so that the examining physician could see or somebody could ask the question, is this interstitial fibrosis, could this be asbestos?

So, you're not making it 100 percent that it is asbestos, but you're putting that link, potential link out there so that one could then pursue that further.

So I thought that was sort of the model that's out there in terms of using the SEM, and if that's the model, then why wouldn't that apply to something like sarcoid which is very similar to beryllium, and you're just saying there could be a linkage because it's not really sarcoid; it's really beryllium lung disease?

Just like interstitial lung disease, UIP or something, if somebody isn't looking closely or see that there's been an asbestos, heavy asbestos exposure, could be missing that. So, it seems like that is the pattern for other conditions, so I'm not quite sure why that

doesn't apply here.

MR. CHANCE: Everyone, this is Mike. I think that Rachel, you know, she made it clear. If you guys have, if the Board has a recommendation, please deliberate and bring that forward. I don't think that this is the forum to debate these specific case-specific issues.

CHAIR MARKOWITZ: Okay, that's fine. This is Steven, just a quick question relating to this slide. Where does the claims examiner find interstitial lung disease, or interstitial pulmonary fibrosis, or pulmonary fibrosis in this 26 health effects from Paducah?

MR. VANCE: Well, I don't have specific -- I'm not looking at that right now, but I do know that our procedure manual has specific instructions, and I can find that and send it to Ms. Rhoads talking to the fact that, if a claims examiner does identify a diagnosis of interstitial lung disease or pulmonary fibrosis for any claim, whether it's at Portsmouth, Paducah, or elsewhere, they're to search in the

Site Exposure Matrices under that pneumoconiosis, other health effect that's listed in the Site Exposure Matrices, and as I mentioned, that has been updated to include exposure to asbestos now.

MEMBER REDLICH: Yes, and I will confirm that. As long as it's clear that if you get pulmonary fibrosis, that you look under pneumoconiosis, other, that is correct that asbestos is now listed, which it hadn't been, so I appreciate that.

CHAIR MARKOWITZ: Okay, I think the other slides that you have, Dr. Redlich, on this same issue pertain to other pneumoconiosis and asbestos, so I think that's the example.

MEMBER REDLICH: Yeah, I don't --

CHAIR MARKOWITZ: Yeah.

MEMBER REDLICH: Okay, we might go through -- we could address that as maybe a recommendation as far as what would be appropriate exposures to have under that other pneumoconiosis.

CHAIR MARKOWITZ: Okay, so we'll take

note of that and the Board can come back to that. If it wants to formulate a recommendation, then we can. Thanks. Any other final comments on the matter or can we move on?

MEMBER REDLICH: No, I think that that's reasonable to do. I just think that another easy solution would be to use the clinical terms that are, you know, clinicians are familiar with, but if there's a way to translate that into a term, you know, as long as that's happening reliably, then that should work.

MEMBER DOMINA: This is Kirk. I got a question for Mr. Vance. I believe at one of our meetings, the one in the spring, I think we talked about, and I just want to clarify this, that the claims examiners have access to a different SEM than we do that has some other drop-down boxes in it. Is that correct?

MR. VANCE: Yeah, I mean, the filtering functionality is a little bit different, but the data that is in the Site Exposure Matrices is the same except for that

exception that we talk about with regard to the functionality where we have to freeze it.

The version that the claims examiners receive is frozen, and then it has to go through a security review by the Department of Energy, and then that's updated, but the search criteria is a little bit more advanced for the claims examiners, but the same data is available to both the public and claims examiners.

It's just that the public variant is a little bit behind in the data because what we're building is, you know, our contractors, subcontractors continually updating the Site Exposure Matrices, but the same basic filtering functionality is there that is used by the claims examiners.

MEMBER DOMINA: Thank you.

MEMBER REDLICH: You know, it would, just would be helpful, not for now, but if you could just -- this is Dr. Redlich again. If you could just let us know which clinical diagnoses are now linked to the other pneumoconiosis, that

would be helpful.

MR. VANCE: Okay, and as I'm sitting here, which is nice about working from home, is I can look things up very quickly.

So, our guidance with regard to pneumoconiosis and how we treat that with regard to the diagnosis of pulmonary fibrosis or interstitial lung disease is actually on page 187 of our version 4.1 of our procedure manual.

So, that's the specific procedural reference to how we do that in evaluating claims for pulmonary fibrosis and interstitial lung disease.

MEMBER REDLICH: Okay, I can review that. Thank you.

MR. VANCE: Yes. Okay?

MEMBER REDLICH: Okay.

MR. VANCE: Any other questions on that particular topic? And then I'll move onto the next one, which hopefully won't be as controversial.

Okay, hearing none, the next one that

I had on the agenda was Exhibit 18-1. There'd been a question raised about the importance or the relevance of asking individuals when evaluating pulmonary conditions about smoking, and the question just is that, you know, we generally don't consider smoking as part of an occupational evaluation for pulmonary disease.

So, we took a look at the exhibit in its entirety and decided that, yes, there was a problem with that exhibit, but we also had other concerns with that exhibit that has raised questions about whether or not we should even be trying to offer diagnostic criteria that are generally characteristic of particular types of diseases.

So, after looking at it very carefully and considering it, the Department of Labor has decided to go ahead and review that entire exhibit just because we really need to rely on the expertise of a qualified physician in evaluating whatever clinical or diagnostic evidence exists that they interpret as supporting

a diagnosis.

And so any kind of framework that the Department of Labor could utilize in sort of identifying general characteristics or considerations of what should go into a diagnosis, we've determined that that's just not something that we need our team to be adding into the procedure manual and potentially causing confusion with our claims staff.

So, we really want to make sure that our claims staff are evaluating cases based solely on the input of qualified physicians in interpreting whatever available clinical or diagnostic evidence exists in a case.

So, the decision has been made that we're going to go ahead and remove that exhibit. That will be added into our agenda for one of our next reviews of the procedure manual update.

CHAIR MARKOWITZ: This is Steven. I just have a short comment. All I can say is, I'm sorry, hallelujah.

MEMBER REDLICH: Thank you.

MR. VANCE: All right, well, that was the final comment that I had, and thank gosh it was a noncontroversial one, and it made everybody happy, so I'm done unless there are any other questions.

MS. POND: Thanks, John. I'm glad that we did -- we've gotten a lot of input on this 18-1, so I'm glad that the Board is a lot happier about this, so I think it is probably the best decision.

So, with that said, I'm going to turn it over to Doug Pennington to talk about some of the issues, the rest that's on the agenda here.

MR. PENNINGTON: All right, hello, this is Doug Pennington again. So, I'm going to start with the question regarding our contract medical consultant contract. The contract ends in August of 2021.

So, typically after August of 2020, we would begin working with, usually at the beginning of the next fiscal year, our contracting office to develop a statement of

work.

It would usually be based similarly on the existing statement of work unless there are specific needs or changes that we identify as beneficial to the government, and that is always how we characterize contract changes, is they should be beneficial to the government.

And so the expectation would be that we would have that statement of work in place and enough time based on what the contracting office sets as the time table for recompetition of the contract, and so it's very much driven by our contracting office and we work at their time tables that they set for us.

So, that's pretty much what I can share on that. Are there questions regarding that?

CHAIR MARKOWITZ: This is Steven. So, you start working in August of this year on various aspects of the contract, including statement of work, and how long does that process take roughly?

MR. PENNINGTON: Anywhere between three to nine months depending on a number of factors from our needs, to the contracting office's reviews, to the Solicitor's Office's reviews, and so it can range based on a variety of factors.

CHAIR MARKOWITZ: Thank you.

MR. PENNINGTON: Again, government contracting, you know, this is how I'll say it and I think Mr. Chance said it at the beginning of the meeting. Government contracting is difficult.

Most of our contracts, due to a variety of factors, get delayed in their issuance even, and so we end up often having to extend existing contracts beyond the traditional contract ending period.

It just depends on what factors the contracting office puts in front of us. So, we always do our best with the variables that are provided to us. Additional questions?

MEMBER BERENJI: Yes, this is Dr.

Berenji. Can you guys hear me?

MR. PENNINGTON: Yes.

MEMBER BERENJI: Okay, perfect. I actually had a question about this process. Do you folks actually do some sort of audit of all of the CMC reports just to make sure that you can look at quality, if they're meeting standard medical metrics?

MR. PENNINGTON: The contract currently has a provision where our medical director, our staff medical director performs regular audits of a sampling of the work, and those are published on our website when completed, and so we make them publicly available in non-case specific redacted iterations, but we still provide the results of the CMC audits on our website.

MEMBER BERENJI: Thank you.

MR. PENNINGTON: Does that answer your question? Okay, any other questions? Okay, hearing none, I will move on to the contract industrial hygienists' quality control language.

So, the contract industrial hygiene contract is -- that's a mouthful. It is a 100 percent reviewed contract. So, what that means is every IH referral that is sent to them, the contractor, is quality controlled by their staff on a variety of bases.

They do not do a 100 percent quality control themselves because of the variety of certifications and credentialing that their staff have, but when it comes to us, we have certified industrial hygienists on our federal staff who review 100 percent of the reports that we receive for compliance, for accuracy, for consistency, and we actually sign them.

So, if you noticed in the industrial hygiene reports that you've reviewed, every one of them has been signed by a federal employee. So, we have a 100 percent review of all of the reports already for our quality control. Any questions?

CHAIR MARKOWITZ: Yeah, this is Steven. I've got a question. So, on the medical

side, you have your medical director who, every quarter, takes a sample of claims and then performs kind of a fresh-eye look, an independent look at the CMC work on particular claims, and you have nothing quite comparable to that on the industrial hygiene side, is that right?

MR. PENNINGTON: No, because we have 100 percent reviews, so why would we need to then do a second percentage review? If 100 percent of all reports done by our contractors are reviewed by certified industrial hygienists on staff, why would we then do an additional percentage review on top of that?

CHAIR MARKOWITZ: Sure, the Board is going to talk about that later. That's fine. Thanks.

MR. PENNINGTON: Any other questions?

CHAIR MARKOWITZ: So, if there are no questions on the IH side, I just want to come back while we still have the DOL on the agenda here.

I just want to come back to the

information about the resource request because I just want to give the Board the opportunity to ask any questions or get any clarifications on that side.

And if you could just briefly summarize kind of the time table for any requests and how that time table plays out? Because it takes a long time to turn things around and to get things approved, and so I want to make sure that the Board is clear about that.

MR. PENNINGTON: Mike, do you want me to do that or would you like to do that again?

MR. CHANCE: I can, well, maybe we could both do that. Let me start off and, you know, again, as I indicated in my opening monologue, I am not a contract law expert, but I do have my own, you know, my own experience with this, you know, and as Doug pointed out, you know, contracting is not easy.

It's always a lengthy process, and it's painful, and it requires a great deal of precision to lay out exactly what it is you want

to do and who it is you want to do it.

You know, building basically your business case, writing out the narrative for your statement of work, you know, what --

CHAIR MARKOWITZ: I'm sorry, Mr. Chance?

MR. CHANCE: Yes?

CHAIR MARKOWITZ: I'm sorry, I don't mean to interrupt. So, we got that.

MR. CHANCE: Okay.

CHAIR MARKOWITZ: My question is much more targeted.

MR. CHANCE: Is this about timing?

CHAIR MARKOWITZ: Yeah, the time table, and that's all.

MR. CHANCE: Okay, right, and let me try to get into that, and if I miss anything, Doug can help me out, but, you know, basically as I said, 2021, you know, is a done deal. We've already formulated the budgets for that.

You know, there are instances where you can request, I mean, you know, pretty much at

any time, you know, which would be kind of, let's call it a budget anomaly, which is --

Generally speaking, you know, it has to be a pretty compelling emergency, and that would have to be done like right now, I think, and Doug might be in a better position to be able to talk about 2021 for the Energy budget.

And then formulations for the FY 2022, as you can see, we do these things far out into the distance, will be discussed over the next few months, you know, into the summer, and finalized early fall.

And, you know, again, bear in mind these dates that I'm saying are perfect scenario dates, you know, where, you know, you're in an uncharted territory here where I don't know what these dates really are.

And so, Doug, I don't know if you can maybe help get some more precision into that?

MR. PENNINGTON: Sure, so typically in August -- we'll use this year. In August of this year, each program begins working on their -- so

this is 2020. It's the fiscal year 2020. We begin working on the fiscal 2022 budget in August of 2020.

We begin getting it ready. We make our narratives and supporting documentation. We have to get it through layers of vetting before we submit it to the budget office within the Department of Labor.

We do that in the first quarter of FY21, which would be typically the November, December time frame, sometimes October depending on the year and the issues that are occurring.

Again, those timelines are actually set by the budget office, and so we respond to their timelines. It gets reviewed, vetted, put together, and eventually submitted to OMB.

OMB reviews it, and then in February or March typically, we end up getting what's called a pass-back which basically OMB, the Office of Management and Budget, passes it back to us for review based on their comments, their questions, their edits.

We then have to respond to those. That is then done throughout the summer so that it can be presented back to OMB and eventually to Congress, so that way the President's budget can be presented to Congress for 2022 in the 2021, but the end of the 2021 calendar year, sorry, fiscal year, so that way in theory, it can be voted on at the beginning of the 2022 fiscal year, which again would be in October of 2021.

So, as you can tell, we're basically trying to build budgets more or less two years ahead of time, and so if you're trying to do anything off cycle, which would be any budget request that doesn't match that, it has to be an emergency request.

And again, as Michael pointed out several times, it requires a substantial amount of justification because in essence, most monies have to be appropriated, which is again, a congressional authority.

For those budgetary things that don't need to be appropriated, they still have to go

through OMB for apportionment, and OMB looks at everything off-cycle as an issue where the first question is why wasn't it planned for? What's the emergent need? Why can't it wait? What is the essential need that requires us to reallocate funds from potentially one project to this project in order to accomplish something? All of those things have to be taken into account.

And that's not even including the fact that all of this has to be approved through the budget office and the Secretary's office for their sign-off as well before it ever gets to OMB. Does that answer your question, Dr. Markowitz?

CHAIR MARKOWITZ: Yes, thank you. That was very clear. Any questions from the Board?

MEMBER FRIEDMAN-JIMENEZ: Yes, this is George Friedman-Jimenez. How does the budget process take account of the possible impact of COVID-19 on the worker's comp budget?

An example would be someone is on

chemotherapy for a cancer that's related to work that's funded under the program, and then they get COVID-19 and wind up in the ICU.

They come up with a big hospital bill that then would be a consequential damage because they had an underlying condition that was due to their work that caused them to incur this, to develop this medical problem most likely due to COVID-19. So, there may be some overlap cases like that.

My question is are you planning for that in any way by modeling how often you think that will happen, adding that to the budget so it doesn't completely obliterate other parts of the program, the quality controls, CMC auditing, IH parts that then would get hit hard by these additional unexpected expenses?

MR. PENNINGTON: So, let me address that in two parts. First of all, I'll address the budgetary aspect, and then I'll address the consequential condition aspect.

The budgetary aspect is all of the

budget discussion we've had so far is about what we call administrative budgets. They're the budgets related to the funding and operation of people and systems and contracts.

They're essentially everything but our benefits. Our benefit fund is a permanent, unlimited appropriation. We have whatever money is necessary to pay the bills when it comes to paying benefits. We do not have to go back to Congress. We do not go through the budget process per se.

We still go through the process of telling Congress what we believe our budgetary needs are, but it's informative. It is not decisional, and so we have whatever money is necessary to pay the bills when it comes to the benefits side.

On the consequential conditions side, if, again, somebody files a claim saying that they received COVID-19 as a direct consequence of their accepted condition or conditions, and they can outline it and we accept that, then yes, we

would begin to pay for the medical benefits associated with COVID-19.

But again, that would be something that has to be accepted as a consequential condition before we would be able to pay for it, which means there has to be a filing for it, for the condition.

There has to be the medical evidence submitted, including physician statements and such, and so it's part of our claims process. John, would you have anything to add?

MEMBER FRIEDMAN-JIMENEZ: That answers my question, in particular the first part of what you said. Thank you.

MR. PENNINGTON: Okay.

MR. VANCE: Yes, and Doug, this is John. I did not have anything else to add.

MR. PENNINGTON: Okay, thank you. Any other questions?

CHAIR MARKOWITZ: Okay, thank you. So, now let's move onto the next agenda item, which is going to be a discussion of a

recommendation on Parkinson's-related disorders.

And Marek, I'm not sure that Kevin can have this, but I just sent him your -- okay, good. Okay, so I don't know, Marek, whether you wanted to show this or not, but if you do, here it is, and if not, we can take it down. Let me turn it over to you.

MEMBER MIKULSKI: Yes, thank you, Dr. Markowitz, and thank you for the opportunity to work on this subject.

Last year, our group shared the presentation and the chart write-up with the Board that provided with the overview of the most recent clinical and research information on Parkinsonisms in general, and Parkinson's disease specifically.

This presentation included updates on the nosology of these disorders, as well as some details of clinical diagnosis and most recent information on the risk factors associated with Parkinsonian disorders.

What we intended for this presentation

and the short write-up was to provide resources for the Department of Labor on Parkinsonism in general and the process of delegating the claims, but it also answers some of the questions that the Department of Labor has asked the Board at the beginning of this term.

With this information that was included in the presentation, we put together a set of proposed recommendations that were circled around last week, and I wanted to briefly go over these and hopefully submit them for the Board's vote.

So, the first question we heard to aliases used for Parkinson's disease. We have identified several different aliases that have been used both clinically and in research over the years, and these are all listed in the recommendation.

It needs to be remembered that Parkinson's disease is the most common of all Parkinsonian disorders. However, despite having common clinical characteristics, these disorders

may differ in the clinical onset, symptomatology, the rate of progression, as well as risk factors. Can we go to the next slide, please?

MR. BIRD: Marek, do you want the document that Dr. Markowitz just sent me or the PowerPoint that you sent?

MEMBER MIKULSKI: The PowerPoint slides. I have four slides for each of the questions with the recommendations, so if we can move onto the next slide?

MR. BIRD: Great, we'll do that.

MEMBER MIKULSKI: Thank you. The next question, or actually a set of questions referred to specifically diagnosis of Parkinsonisms and Parkinson's disease, and the criteria to evaluate the medical evidence and records for appropriateness of the diagnosis.

The diagnosis of any type of Parkinson's disease is a fairly complex one, and despite all of the recent advances in brain imaging techniques, as well as research into biomarkers, it is still pretty much based on the

clinical presentation that involves neurobehavioral evaluation, as well as review of the family history, risk factors, and most importantly, a therapeutic response or lack thereof to dopamine replacement therapy.

We have provided, both in the presentation and in the write-up, the most recent diagnostic criteria formulated by the International Movement Disorders Society, but we feel that it is warranted that it is only the clinical diagnosis of Parkinson's disease that is made preferentially but not exclusively by a neurologist.

With the ICD, respective ICD codes that we have included in the rationale for the recommendation, that is used in the adjudication of relevant claims. Can we go to the next slide, please?

Questions two and three relate to exposures, toxins associated with Parkinsonisms diagnosis and any presumptions that could be offered, for example, including job titles and

work processes that put workers at higher risk for those exposures.

In addition to carbon monoxide and manganese exposures that are already included in the procedure manual and the Site Exposure Matrix, our group has identified several case reports describing Parkinsonisms' symptomatology following exposures to solvents, including carbon disulfide, methanol, and toluene.

These solvents have been commonly used throughout the Department of Energy weapons operations, and we have provided in the enclosed rationale with examples of job categories and work processes that would put workers at the highest risk of exposure.

Exposures to solvents, specifically TCE, trichloroethylene, has also been found to be associated with the increase in risk for Parkinson's disease in the epidemiological studies. We've included a brief review of those studies in the rationale.

It should be highlighted however that

TCE was one of the most commonly used solvents industrially throughout the mid-1970s and traces of it have been found in nearly all of the samples from the DOE side that were surveyed by the DOE site science program in the early 1990s.

As you see, our recommendation also includes exposures to polychlorinated biphenyls. Exposures to PCBs have been shown in the epidemiological studies, but we associate it with increased mortality rates from Parkinson's disease in highly exposed female workers, a finding that was eventually confirmed in the pathology studies. However, it has not been further studied epidemiologically.

Again, as was the case with the solvents, PCBs were commonly used throughout DOE weapons operations, and we have provided with examples of a listing of 10 congeners, PCB congeners in the rationale for the recommendation. Can we move to the next slide, please?

Finally, question number four,

referring to causality presumptions for any of these exposures. As we previously discussed and described in our presentation, the causality relationships for these toxicants are yet to be established.

Epidemiological studies are still trying to answer these questions regarding characteristics of exposures, primarily dose response relationships, as well as latency and potential susceptibility to the exposures.

We do see though, however, that taking into account the number of positive studies, as well as the strength of the association in these exposures to TCE and PCBs, these are to be considered as likely as not being contributing or aggravating to the risk of Parkinson's disease throughout the claim adjudication process.

We did not make any specific recommendations regarding latency as this information is very limited in the studies that we have reviewed.

However, based on the epidemiological

data, we do feel strongly to recommend that the duration of exposure to either substance be taken into account when adjudicating the claim.

With that, I'd like to turn it over back again to Steve.

CHAIR MARKOWITZ: Okay, thank you. That was a terrific presentation. The floor is open for comments by Board members.

MEMBER DEMENT: This is John Dement. I have just one question. We, in the past, have been given, I think, a document that really goes through the review of the studies that support the Board's recommendation. Are we going to vote on this at this meeting or are we going to have that document to take a look at again?

CHAIR MARKOWITZ: So, typically what we've done is constructed recommendation language and voted on it, and then afterwards, I write a rationale for the recommendation.

In this case, we would, with the recommendation, there are several parts of the recommendation. We would just hit those, put

those together, and then use the rest of the text as the rationale for the recommendation. I think that -- does that address your concern?

MEMBER DEMENT: Yeah, I just, I want to make sure that we've taken -- it's been a while since I've taken a look at these studies. I just wanted to have the background to look at before we vote.

CHAIR MARKOWITZ: Okay.

MEMBER MIKULSKI: And the rationale actually includes the list of all of the recent references of other studies that were reviewed for this review.

MEMBER DEMENT: Yes, thanks a lot --

(Simultaneous speaking.)

MEMBER DEMENT: -- a lot of good work.

CHAIR MARKOWITZ: I have a quick comment. I wonder whether it's worth putting in there that the VA recognizes exposures from Camp Lejeune contaminated water.

I think it was TCE was the implicated solvent. They recognized that exposure during a

certain time period at Camp Lejeune is associated with Parkinson's disorder as a matter of presumption.

You know, that's not the science, but that is a different federal agency at least recognizing the connection on a presumptive basis. Are there other comments?

(Simultaneous speaking.)

CHAIR MARKOWITZ: Go ahead. I'm sorry.

MEMBER GOLDMAN: This is Rose Goldman. I think this is a really good summary, and I think that one of the important points here is that there are certain agents such as a very bad overdose of carbon monoxide or manganese, which in and of themselves as a toxic effect, cause a Parkinsonian type syndrome.

That is different than these other possibilities, and exposures to these other solvents increase the risk of what we would normally call Parkinson's disease in the population, and so that's an increased risk for

developing the (telephonic interference)

CHAIR MARKOWITZ: Hello?

MEMBER GOLDMAN: I mean, and I think that's part of the basis of the VA and Lejeune. You know, more on an epidemiological basis, the people who have these exposures to that water or the solvents had an increased risk of what we would call Parkinson's disease.

MEMBER MIKULSKI: That's correct, and it has been added just most recently, TCE specifically.

MEMBER GOLDMAN: So for example, the reason I bring that up, and there are cases of major overdoses to TCE where people have fully collapsed and become unconscious and rescued, and they developed a particular change in their trigeminal, their fifth nerve palsy and recovered from that.

So, that was like an acute exposure to TCE as a direct toxic effect, which is really different than this which is chronic long-term exposure leading to an increased risk for

development of what would otherwise be an indistinguishable disease from other people who have Parkinson's disease, but then it's increasing the risk for that, which is what I think you're trying to put forth in this document.

MEMBER MIKULSKI: Yes, this is specifically regarding the chronic exposures, and the epidemiological studies have taken into account a lifetime exposure to TCE.

CHAIR MARKOWITZ: Other comments or questions? So, this is Steven. I have a question actually. I'm just looking at the language of the recommendation parts of this to look for, you know, clarity.

So, the first part of the recommendation, actually, Kevin, if you go up, which is the -- I think if you go to the second slide, yeah.

Okay, so the -- when we talk about differentiation between Parkinsonian disorders, is the recommendation about exposures as follows:

do they apply to all or does this say that they apply to all Parkinson's-related ICD codes? Is that what this says?

MEMBER MIKULSKI: Yes, all this is specifically to all Parkinsonism cases and including Parkinson's disease, yes.

CHAIR MARKOWITZ: Okay, so somewhere you discussed Parkinson-Plus disorders, which are --

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: -- which are distinctive clinically. So, is the intent that the causal links also could be applied to these Parkinson-Plus disorders?

MEMBER MIKULSKI: No, it's not. The Parkinson-Plus disorders are a separate group of disorders and these are hypothesized, but thought to have a genetic etiology for the most part.

So, while we talk about the clinical diagnosis of Parkinsonisms in general, we talk about ICD-9 and ICD codes that that would not apply to, our recommendation would probably not

apply to Parkinson-Plus syndromes.

CHAIR MARKOWITZ: Okay. Okay, thanks. Other comments at this point? So, let me suggest that we just, it's 1:15, that we take our very leisurely 15-minute break and come back at 1:30 where we will resume this discussion on the Parkinson's issue and see if we --

MR. BIRD: Dr. Markowitz?

CHAIR MARKOWITZ: Yes?

MR. BIRD: I'm sorry to interrupt, but just a very important note. I just sent an email to the Board members. We are going to, in an effort to try to free up some call-in lines for members of the public, we are going to undertake a little change on our end.

So, this line for members of the public will continue to operate as it has, but for Board members, please check your inboxes. I just sent some instructions for everyone to follow.

I just wanted to make sure everyone saw that and realized what to do. But again,

members of the public, nothing is changing for you. Feel free to stick around.

MS. POND: And Kevin, this is Rachel. So, I'm going to stay on just in case there are questions, and you're going to send me -- yes, I got it. Thank you.

MR. BIRD: Absolutely.

MS. POND: Thanks.

CHAIR MARKOWITZ: Okay, thank you.

MR. BIRD: With that, Dr. Markowitz, I apologize for interrupting, but should we go ahead and start our break now?

CHAIR MARKOWITZ: Yes.

MR. BIRD: Okay, thank you.

(Whereupon, the above-entitled matter went off the record at 1:18 p.m. and resumed at 1:39 p.m.)

CHAIR MARKOWITZ: Okay. So Kevin, if you could bring back up -- yeah.

We were discussing -- we were discussing this -- hold on one second. Okay. We have -- sorry about that.

We have a recommendation, a draft recommendation, and we were discussing the elements of the recommendation. Actually, there are four parts to it, which is separated into the four questions I think that the Department of Labor gave to us.

This recommendation differs from many of our other previous ones because this is specifically in response to a request from the Department for assistance looking at Parkinson's related disorders.

So if you can go to the next slide.

MR. BIRD: Dr. Markowitz, sorry. Can you speak a little more clearly into the phone?

CHAIR MARKOWITZ: Yeah. Okay. Is that better?

MR. BIRD: Much better. Thank you.

CHAIR MARKOWITZ: Okay. I'm sorry about that.

Anyway, we're -- I was just saying that this recommendation is not something that we developed on our own as much as a response to a -

- this is a request from the Department for assistance on Parkinson's related disorders. So we have language for our recommendation divided into four parts that correlate to the four questions asked of us.

Do you want to just go to the next slide? And so the floor is open for additional general comments about this issue.

MR. BIRD: Dr. Markowitz, are you going to want to edit this text? Should I be pulling up a Word version? Are we going to make changes?

CHAIR MARKOWITZ: We may, and so what you can do is you could pull up the version, the Word document that I sent you a couple hours ago.

MR. BIRD: Exactly.

CHAIR MARKOWITZ: And, Marek, I -- it -- from the last version you sent me, which I sent around to the Board last week.

Okay. So are there additional general comments about this document?

So why don't we walk through the

language of the recommendation and see if there are any amendments before we decide whether we're ready to vote on them or not?

So this first recommendation we're looking at, any comments, suggestions? Okay. So let's go to the next -- if you scroll down some you'll get to the next part of the recommendation.

So I wonder whether we should potentially put the ICD codes that we think should be included in the body of the recommendation, in other words to repeat them somewhere there in the rationale to the -- to this recommendation. We don't have to do that --

PARTICIPANT: Can someone turn off their speakerphone? Getting some echo.

CHAIR MARKOWITZ: Sorry about that. Yeah, so I was just saying that I think if we could, and we needn't do it right at the moment, but I think we should include the ICD codes in the actual body of the recommendation itself, not just in the rationale. That's something pretty

simple.

Any comments on the language of this part of the recommendation?

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. Just a very minor point. Change the word between to among. In other words, differentiation among Parkinsonian disorders, because there are more than two of them.

MR. BIRD: That's a change you want to correct, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. BIRD: Okay. Great.

MEMBER FRIEDMAN-JIMENEZ: Thank you.

(Simultaneous speaking.)

MEMBER MIKULSKI: I agree with expanding the recommendation to add the ICD-9 and ICD codes. Can be easily done within the next few days.

CHAIR MARKOWITZ: Okay. So then we can just add a sentence to the end of this that says that the following ICD codes should be

included, colon, and then we'll fill in the blanks.

Any other comments or --

MEMBER POPE: This is Duronda Pope. I was wondering, Dr. Markowitz, if we needed to include any language about that Parkinson-plus. I didn't see any of that language within the body of the summary.

CHAIR MARKOWITZ: Right. So the -- I think -- so at the end of the rationale after this is when Dr. Mikulski and the group discuss Parkinson-plus. And they have specific ICD codes.

Go down a little bit more. Yeah. So right there, you see the paragraph Parkinson-plus. So that paragraph has specific ICD codes. So I'm thinking if those are not included in the recommendation, then it'll appear that the Parkinson-plus syndromes aren't included in what we're talking about.

Does that address your point?

MEMBER POPE: Yes. Thank you.

CHAIR MARKOWITZ: Okay. So we can move on to the next part of the recommendation, which is back down where you were, Kevin. Okay.

So this is the response to a particular question from the Department, which documents are associated, and then secondarily, what presumptions did the board offer regarding exposure?

Are there any comments on this, on the language? I think the second part about presumptions actually is not addressed in the language we're looking at. It's -- the first part is addressed, and then there's a later part of the recommendation that addresses presumptions.

So the question is when we bring this to a vote, is whether board members feel comfortable with this recommendation and the rationale.

Okay, so for those --

(Simultaneous speaking.)

MEMBER DEMENT: This is John Dement. I

wonder if we could have a little discussion of the methanol issue. Now, the others I'm a little more comfortable with. I just don't know the literature on Parkinsonism and methanol.

CHAIR MARKOWITZ: Dr. Mikulski, do you want to address that, or --

MEMBER GOLDMAN: This is Rose. I don't hear him, but I discussed it with him, and I guess this was based on one case -- one or two case reports.

MEMBER DEMENT: Then I guess do we want to base a presumption on just case reports?

CHAIR MARKOWITZ: The rationale, actually, bottom of page 5 into page 6, discusses methanol and cites the case reports. It depends on how convincing those case reports are, I think.

Marek, are you back on the line?

Kevin, has Marek reached out to you at all?

MR. BIRD: No. I haven't heard from him yet, or since he dropped off.

MS. RHOADS: I just sent him an email asking if he's dropped off.

MEMBER GOLDMAN: This is Rose. I had discussed it a bit with him. I thought this was one of the weaker points on the review. Maybe we all -- we have to look at those case reports more deeply.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. It seems that some of these, or maybe all of them, are ingestion rather than inhalation of methanol. So I do think we need to look at the case reports because we're probably talking about inhalation in the nuclear facilities.

There is one case report called Progressive Parkinsonism in a young experimental physicist following long-term exposure to methanol. That could be inhalation.

So I think we need to study this further with regard to methanol. I agree with Dr. Dement.

MEMBER DEMENT: I agree. I just don't

feel comfortable with it right now without taking a look at that more closely.

MR. BIRD: Dr. Markowitz, do you want to move on? We're about 20 minutes over.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Yeah. Sure. Yeah.

Are there other exposures that are listed in this part of the recommendation that deserve additional scrutiny?

Okay. So let's move on just to the last part of the recommendation. Although if Marek is not on -- I think what we need to do, actually, is to suspend this discussion until Dr. Mikulski is able to get back on because he's really been the central person in this effort for quite a while now.

MEMBER MIKULSKI: I'm here, Steven.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Oh, you are? Okay. Great.

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: Okay. So okay. So

the last part of the recommendation --

MEMBER MIKULSKI: I agree with the previous comment. Both methanol and toluene are probably the weakest exposures in this rationale.

The methanol case report said the leading -- well, exposures by ingestion except for that one report of the physicist. This is something we need to review more closely, absolutely. I agree with that.

CHAIR MARKOWITZ: Okay. So the next part of the recommendation.

MEMBER GOLDMAN: This is Rose.

CHAIR MARKOWITZ: Go ahead.

MEMBER GOLDMAN: This is a way to move with this. Make the recommendation for the ones that we feel the most comfortable about, and then say as part of the recommendation that we are further looking into methanol and toluene or whichever ones are the ones that seem less likely.

Because some of them, with long-term exposure, it increases the risk versus these

ones, which was overdose on ingestion. And we're not that familiar with this one, because methanol has been around for a long time, and its path has been very typical and neurologic outcome has been attributed to it.

So we could do that, and that way keep moving with the ones that we feel more comfortable about.

CHAIR MARKOWITZ: Well, we could remove methanol from that text and stick with the others, and then later come back with a supplemental recommendation around methanol.

But here's my question. Do people feel comfortable enough with the other exposures and the write-up to vote today on those exposures? And I'm talking about toluene, trichloroethylene, and polychlorinated biphenyls, PCBS. Oh, also carbon disulfide.

MEMBER SILVER: This is Ken Silver. Marek, quick question. For toluene, is it mostly chronic toluene abuse cases, like glue sniffing?

MR. BIRD: Dr. Mikulski, I don't think

we can hear you. Are you on mute?

MEMBER MIKULSKI: I'm sorry. I was talking and didn't realize that I was on mute.

Yes. This recommendation is based on that one case report of a colleague over ten years in experience.

CHAIR MARKOWITZ: Well, by the same logic, if it's primarily or only based on case reports, then maybe we want to take another look at toluene.

MEMBER SILVER: A moment ago Dr. Goldman spoke from her long experience about methanol not being associated with this outcome and industrial exposures. Among the collective occupational medicine expertise here today, what about toluene? I know it's mostly chronic solvent encephalopathy, but -- Parkinsonism in your collective experience?

MEMBER GOLDMAN: For me --

MEMBER FRIEDMAN-JIMENEZ: I've seen cerebellar ataxia, but I haven't seen Parkinsonism from toluene.

MEMBER GOLDMAN: That's just what I was going to say. I think with the huffers, it was mostly cerebellar ataxia and that type of a thing. So when Marek and I talked about it, I thought toluene, that's interesting because I haven't in my experience, which is not all-encompassing of everything, but it wasn't -- a Parkinson's kind of syndrome wasn't something that I usually associated with toluene.

And again, I think that if we were going to make the case, I guess one is a sort of process issue. With some of the things, like again, manganese and carbon monoxide, are acute overexposure we know that people can come out with that.

With these others, my understanding is we are looking at long-term exposures where there was an increased risk among workers like that who had these exposures in an epidemiological -- from an epidemiological study.

So the issue here that we're facing, I think, with something like this toluene case and

also the methanol case is it's a couple of case reports that might look pretty convincing in a way, but it's only a case report. So how much faith can we put in that?

And there have been many studies of solvent-exposed workers with, you know, peripheral neuropathies and more encephalopathy, and just less familiar with long-term epidemiological studies that have come up with a Parkinson's type syndrome associated with, let's say, toluene or methanol.

But I'm open to looking at something or rethinking this.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I agree with that. I think case reports can be very strong evidence in something like occupational asthma where there's an acute response that you can observe repeatedly.

But in something that's chronic with a long latency or even a shorter latency like Parkinsonism, a case report is not as strong. So

I think we should revisit the whole recommendation after we review the studies because it's not clear to me.

I'm not familiar with the deep research literature on this enough to say that we'll make this recommendation for a pretty common disease without really understanding how strong the evidence is. And I, for one, don't really understand it well enough to make that commitment right now.

CHAIR MARKOWITZ: So -- this is Steven. So what process, then, would we go through to assure ourselves that there is or is not a relationship? Is it a question of circulating the key studies, giving time to people to review them, and then revisiting the recommendation?

MEMBER FRIEDMAN-JIMENEZ: This is George again. Maybe have a -- read the studies and do sort of a journal club discussion on the phone with Dr. Mikulski, and see if we can get a consensus on which of these are strong enough to

make the recommendations. And then make a full recommendation later rather than pulling out one or two now and then adding more later.

CHAIR MARKOWITZ: So we could expand the working group to include the -- well, anybody who wants. Not the full committee because then we couldn't meet, but expand the working group to include a subset of the board in which the specific task would be to go through some of the scientific studies and look at the quality of the evidence. Is that sort of what the proposal is?

MEMBER FRIEDMAN-JIMENEZ: Yes. And I'll volunteer to be on a subcommittee, and we'll just review the literature and come up with an assessment of how strong the evidence is so that our recommendation will be more evidence-based because this is not part of my real area of expertise, Parkinsonism. And I'd like to see the literature in more depth, and maybe others would feel similarly.

MEMBER GOLDMAN: This is Rose Goldman. I'm happy to be on that committee, too.

What I think would be also useful is perhaps, and maybe Marek can help find this, get a couple of these really good long-term studies, let's say of workers who have had toluene exposure. And see if among the conditions reported is Parkinson's, because maybe I'm not remembering well, but that is not one of my recollections as a condition because then what we could do, we would then be faced with weighing, okay, here is a case report which might be one example of an acute overexposure of whatever it is.

But then there are these three or four really large-term major studies of toluene or methanol exposure, and we don't see that. And the problem with the overdose from ingestion with methanol is it's so lethal that if you ingest it, most people die before -- many people die before you even have a chance to see how they're going to be afterwards because it's so lethal. So, anyway, that would be my suggestion for how you go -- afterwards.

MEMBER FRIEDMAN-JIMENEZ: Dr. Mikulski, do you have a -- complete literature review of the chemicals, the studies that we would need to review for these five chemicals?

MEMBER MIKULSKI: Yes. Yes, and I can send these around. Yes.

MEMBER FRIEDMAN-JIMENEZ: That would be great. And if anyone knows any other studies that are important, Rose, if you know good long-term cohort studies, so we can look at all the literature, read the abstracts, and then look at the specifics of the studies and see if we believe the evidence because we're here making a presumption on a common disease with a fairly rare exposure saying that we're presuming that it's related to the exposure. And I think we should be careful about making that presumption. Make sure that we understand the level of evidence.

CHAIR MARKOWITZ: Okay. So who wants to participate in that working group, which will consist of receiving -- well, the studies will be

sent to all board members, but people who want in four weeks or so, four, six weeks, whatever, to get together on the phone and talk through the literature?

I hear Rose. I hear George. Anybody else?

MEMBER DEMENT: This is John Dement. I would --

(Simultaneous speaking.)

MEMBER DEMENT: -- to be on that.

CHAIR MARKOWITZ: Okay. John Dement. And I also will be -- I will volunteer.

So, Carrie Rhoads, you're getting the list here, right?

MS. RHOADS: Yes.

CHAIR MARKOWITZ: Okay. So I have -- okay. So --

MEMBER DEMENT: What would be the timeline?

CHAIR MARKOWITZ: We're going to have a full-board telephone meeting during the second two weeks of June, which is two to three weeks

prior to the term expiring. And -- I think. I think it's mid-July.

Actually, maybe, does anybody know, Mr. Chance, Ms. Rhoads, what the date of the expiration of the board is?

MS. RHOADS: It's July 15th for the current term.

CHAIR MARKOWITZ: Okay. Fine. Okay. So full-board meeting, then, that last week or two of June, which means that this discussion should happen roughly four to five weeks from now towards the end of May, no later than that, I would think. Does that work?

Okay. Then let me say, in the interest of time, let's not go through the final part of the recommendation, which has to do with presumption of -- about exposures and recommendation around duration or latency. The working group can look at those issues, as well, when they review the studies. Is that fair enough?

Okay, any final comments on this

issue?

Let's move on, then, to the Group 2A and other IOM source working group. Dr. Berenji?

MEMBER BERENJI: Yes. Can you guys hear me?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MEMBER BERENJI: Excellent. Okay. So this is the SEM Work Group. We were specifically tasked for looking at the IARC 2A list of chemicals. Do we have our slides?

MR. BIRD: Yeah. I'm pulling them up really fast.

MEMBER BERENJI: -- post up our slides.

Okay. Great. So next slide. Excellent.

So just to my fellow colleagues Rose, George, Duronda, if you have any further input or want to comment anytime, feel free to do so. Okay? Excellent.

So, really, our task was to review the IARC 2A data looking at the chemicals. And at

least from my previous understanding from our last board meeting, I understood that the DOL was in progress in incorporating this information into the SEM. But I'm not sure if we actually got official confirmation on that.

If Rachel or John or whomever wants to comment on that.

MS. POND: This is Rachel. We've incorporated some -- we've incorporated IARC --- the first list. But the one that we asked you guys to look into is the one that we need to look at incorporating. So we're looking for your recommendations on this.

MEMBER BERENJI: Excellent. Okay. Just wanted to make sure that we clarified that for the record. Okay.

So we're really going to focus today on the IARC 2A chemicals for the sake of time. There are also other sources of information, most notably the National Toxicology Program, or NTP. I did do a brief review, but there was over 100 chemicals, and given the situation with COVID and

my work commitments, I wasn't able to do a full review of that.

And also, I did do a preliminary review of the Haz-Map website, and we can take a look at that in a little detail. And then I know Carrie Redlich has also done a lot of work on the SEM and looking at the exposure links. We will look at that as well.

Next slide.

So our work group met virtually on February 18th and on April 7th.

Next slide.

And I'm sure we're very well familiar with this website, but just for the folks out there, this is the website. And at least from my last check yesterday, the SEM was updated on November 15th, 2019.

Is this correct, Rachel, John?

MS. POND: Yeah, that's correct. As you know, we have a process where we go through DOE for security reasons. And so that was the last official publish date.

MEMBER BERENJI: Okay. Just wanted to make sure.

Really, the SEM is used to identify the relationship between toxic substances and illness. And we know that the claims examiners and the folks at DOL do primarily use Haz-Map, the Haz-Map database. And I believe that's the website for folks who want to check that.

So everything in SEM must be pre-approved by DOE, as Rachel just mentioned.

Next slide.

So this is just a brief overview of what the IARC has updated since 2016. Group 1 -- which is listed there -- there are 11 chemicals; Group 2A, 22; and Group 2B, 47. So for interest of time, we're going to focus primarily on the Group 2A chemicals, and we'll go from there.

Next slide.

So if you actually go to the IARC's website, you can download the Excel spreadsheet looking at all these chemicals, which I found to be very illuminating. And I actually was able to

pick out the 2A chemicals from 2016, and I created my own Excel spreadsheet.

Can you still see those chemicals?

CHAIR MARKOWITZ: Yes.

MEMBER BERENJI: Okay. So if you can see there, there are 22 chemicals from 2016 through 2019. And I last visited on the 17th of March, so this is a fairly recent update.

And you can see that there's 22 chemicals total, and the ones that I bolded are the ones that, based on my review of the IARC monograph, have the most connection to the workers that we are focusing on. So those are the ones that I'm going to briefly review.

And George, Rose, did you have any comments about this Excel spreadsheet?

MEMBER GOLDMAN: First of all, congrats on really doing a fantastic job on doing this.

The only other question we had discussed in our group is how much some of the people that work for DOE taking care of the

grounds -- which we normally haven't talked about that much, because it would be the groundskeepers, whether or not they would be spraying things like weed killers, glyphosates, or some of these other things that are pesticides.

And I think in our group discussion, we weren't very sure if those kinds of workers would be part of what our group is dealing with. You know --

MEMBER BERENJI: Duronda, do you want to -- Duronda, I think you had mentioned during our call that you had some experience when you were at Rocky Flats.

MEMBER POPE: Yes, I did. So during our discussion, I talked about how we had laborers that kept the grounds during my career at Rocky Flats. And they oftentimes used pesticides and different chemicals to keep the grounds maintained -- to maintain the grounds, rather.

So I think that that labor group

should be included in -- as far as the exposure in this -- as it relates to this case.

MEMBER BERENJI: Very well said, Duronda.

MEMBER SILVER: This is Ken Silver.

MEMBER BERENJI: Go ahead.

MEMBER SILVER: I'll second that with a case from Oak Ridge. Some of you know Dr. Rick Bird, who had a hand evaluating a large number of Oak Ridge workers. And I assisted him on a case of a groundskeeper with liver/gallbladder cancer from spraying phenoxy herbicides. So it does exist in the DOE complex.

MEMBER BERENJI: Rachel --

MEMBER DOMINA: Hey, this is Kirk.

MEMBER BERENJI: Oh, go ahead, Kirk.

MEMBER DOMINA: Hey, out -- for us out here at Hanford, it would be under the jurisdiction of the teamsters. And they continue to do it today.

MEMBER BERENJI: Go ahead.

MS. POND: This is Rachel. I think

you were going to ask me to weigh in on this. I know it's one of our job categories. So, I mean, it's definitely something we'd want to be considering.

MEMBER GOLDMAN: So is that to say --

(Simultaneous speaking.)

MEMBER GOLDMAN: --- then would we be putting in these things that are pesticides that would be used for the ground?

MS. POND: Yeah. I mean, that would be considered one of our exposures, I believe, from these workers because they'll still be considered daily workers. Really, sometimes it's going to depend on the contract if they were, you know, not on a particular contract. But we do have that as a job category. That is one of the things that we need to consider.

CHAIR MARKOWITZ: This is Steven. I have a question for the Department of Labor.

When using the SEM, I think the entry point is by DOE's site. If one were to take one of these agents like glyphosate and just ask the

question from a publicly available SEM, is glyphosate listed anywhere in the SEM at any of the sites? Is that normal for the public, or does that require some special search from your end?

MS. POND: Well, I know it's doable. I am not as familiar with the differences between the public site and the internal site. I know that you can search by chemical if that's what you're asking. I would think you'd be able to do the same thing on the public site, but I will have to fact check it. I don't go to the public site that often.

I can ask John and probably get back to you this afternoon.

CHAIR MARKOWITZ: Okay. Thank you.

MEMBER BERENJI: Any other questions?

MEMBER GOLDMAN: Oh, I just -- does that mean --- Mani, is that we might end up bolding some of those pesticides if we found out they might have been used over the last 20 or 30 years because these would have blatant success

then.

MEMBER BERENJI: Absolutely. Absolutely. I think we can definitely do that. For all intents and purposes, I did do some preliminary research on the chemicals listed in bold. So I wanted to at least take some time to review those, and then we can definitely revisit the pesticides.

Next slide.

So I know that America's gone through these polybrominated compounds, but this is really focused on the polybrominated biphenyl, otherwise known as PBB.

I did some review of the IARC monograph. For those folks who don't know what that is, IARC is this international agency that produces information on chemicals, and in conjunction with the journal The Lancet, they actually are able to compile all this information into what are called monographs. So this is where I'm getting a lot of this information from, and I have that information in case anyone wants

to take a peek at that.

So at least for this presentation, really, the main focus is to look at the last two bullets. There's really limited human epidemiological studies on this particular compound, at least based on the review I did in the monograph.

But you can actually see that despite that, there's still a lot of evidence in laboratory settings where there is evidence of carcinogenicity. And that was the basic rationale that IARC used to do this upgrade, 2B to 2A.

Next slide.

So as part of this review, I actually went ahead and looked up each one of these chemicals in the SEM just to see what would pop up. And I actually have a Word document in case anyone really wants to take a look at them. But this is just a snapshot.

So if you look at this, there is -- these chemicals do pop up in the SEM. Any

comments on that?

Okay. Next slide.

The next chemical is tetrafluoroethylene, and --

CHAIR MARKOWITZ: I'm sorry, Mani? Mani?

MEMBER BERENJI: Yeah, go ahead.

CHAIR MARKOWITZ: So, in the SEM, when you looked at PBBs from the previous slide, were there any health effects linked to it?

MEMBER BERENJI: Based on what I see here -- I can pull that up. One second. If you can see this, this is pretty much what comes up. It just comes up with a chemical name, the CAS, all the aliases, but no health effects come up when you actually look up a chemical.

CHAIR MARKOWITZ: Okay. Okay. Thank you. We can continue. Thanks.

MEMBER BERENJI: Okay. Next slide.

So I know there are a lot of chemicals here, so I know that we want to be able to save time. But looking at tetrafluoroethylene, this

is another chemical that came up in the list from IARC.

So when you look at this particular chemical, from what I could review, there's only one cohort study that was able to identify cancer risk. And I actually put that reference right there. So there's elevated risk for all cancer sites, specifically liver, kidney, and leukemia cancers.

Next slide.

Again, I went through the same process. I put in tetrafluoroethylene into the SEM, and this is what came out. There's actually a lot more information, but again, the basic idea is that it comes up with the specific chemical byproducts but no health effects when you search by chemicals.

Next slide.

Silicon carbide whiskers. So this is a particular compound that is developed and is naturally found in both fibrous as well as non-fibrous form. And if you actually look up the

term silicon carbide whiskers, it actually refers to monocrystalline forms, which are primarily used in high-technology sectors. And in relation to the primary route of exposure, it used to be fibrous silicon carbide.

There have been some studies looking at exposures among worker cohorts. I believe this reference that I mentioned in bullet point 3 was looking at workers -- I believe it was in some sort of chemical plant that I can't recall.

And if you look at the fourth bullet, this really kind of summarizes all that. So really only a few studies that have actually been able to directly link exposure to silicon carbide fibers to actual occupational cancers.

Next slide.

And again, just to reiterate, when you put in a chemical name, it spits out all these varieties of different forms that it comes in but no health effects directly linked to the chemical.

Next slide.

So methylene chloride. I know I have experience with this particular chemical when I was an occupational medical resident at UCSF. And I remember we actually had to do some site visits when I worked at Cal OSHA for folks who were actually exposed to it. And Dr. Harrison is an expert, as many of you might know.

So it's really only for our purposes today. Methylene chloride is used in the manufacturing of a variety of different products, including polycarbonate plastic, and it's also used as a solvent.

There have been two cohort studies that have demonstrated exposure to this particular chemical and development of cancers, most notably liver and biliary tract cancers.

Next slide.

So you can see here that you can see a variety of byproducts when you search for methylene chloride in SEM, but no direct health effects listed.

Next slide.

How are we doing on time? Because I don't want to take up your time going through every one of these. Are we doing okay?

CHAIR MARKOWITZ: We're okay. By the way, how many more do you have?

MEMBER BERENJI: Which slide number am I on, Kevin? I can't remember.

MR. BIRD: Let me check.

MS. POND: While they do that, Dr. Markowitz, this is Rachel. I did find out that you can search on the public SEM by outcome.

CHAIR MARKOWITZ: Okay. Great. Thank you.

MR. BIRD: We're on slide 15 of 36.

MEMBER BERENJI: Okay. So for the sake of time, I mean, we can kind of scroll through these. If anyone wants the slide deck, I'm happy to send it to you.

But you can go ahead and keep going. Keep going past 17 and 18. Great. So you can go back to the previous slide on hand. Actually, that's perfect right there, NTP. Yeah. That's

great. Thank you.

So, again, at least from my review, the IARC chemicals 2A, in our system on the non-pesticides, we can see that there is demonstrable evidence with most of these chemicals that exposure -- especially among a variety of worker cohorts -- can lead to the development of a variety of cancers. And that was the rationale for IARC chemicals list 2A.

So now, looking here to the NTP, when I actually looked into this a few months back, the NTP actually had developed -- there are four pages for it because we reached back in 2016, and we had listed non-carcinogens at 62, and if you look at the last bullet, the ones that are considered to be reasonably anticipated -- I'm sorry. I can't see. I'm not sure what just happened.

MR. BIRD: All right. Sorry. One second. All right. We're back.

MEMBER BERENJI: There you go. Thank you.

So, again, when you look at the last bullet, the reasonably anticipated to be human carcinogen, there are 186 chemicals listed in the 14th Report on Carcinogens. Ideally, if we actually had additional resources on this board, I would love to be able to take a deep dive and look at these 186 chemicals and do an extensive analysis to see, are those working at these respective plants, had they been exposed to these 186 chemicals? So far, I just did not have the time to take a deeper dive.

But does anyone have any comments on that?

MEMBER GOLDMAN: Mani, what about -- this is Rose Goldman again. What about the known 62 carcinogens on that list, the 62? How many of those are ones that we're dealing with here in DOE?

MEMBER BERENJI: That I don't know, because I didn't really get a chance to really get into it with the sheer number and the resources we would need. We would be able to do

that, but I just didn't have the time. Does anyone happen to know?

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. There is a lot of overlap between the IARC Class 1 and the NTP known carcinogens. It's not a complete overlap, but "reasonably anticipated" includes mostly the 2A and 2B. And you can't really distinguish them within the NTP reports. So it's much more difficult to decide whether it's probable or possible based on the NTP reports. IARC is more clear on that.

CHAIR MARKOWITZ: This is Steven. So, there is a lot of overlap between the reasonably anticipated, which is NTP, and Group 2A, so that if you look at Group 2A from IARC, then you will have done a bunch of the work for NTP.

But a lot of the NTP reasonably anticipated are not an occupational agents. The NTP are the much broader emissions, you know, it looks at carcinogens. So they're environmental, they're dietary, they're pharmaceutical. And so

that count is challenging but not quite as formidable as it looks from this slide.

MEMBER BERENJI: Well, that's good to know. All right. Next slide.

So Haz-Map, at least to my understanding, is the main reference for this. And they actually recently launched a new website. -So if anyone wants to take a look, you can. Next slide.

So I took a snapshot of the main webpage. So, I've got to be honest, I kind of like this layout. You can actually look at these respective tabs. You can look at hazardous agents. You call look at occupational diseases. You can look at high risk jobs. At least from a user-friendly perspective, I do like the way that they were able to do this. Next slide.

So, this is the most recent update when I last checked yesterday. It looks like they have been able to incorporate the ACGIH, which I believe is the -- I believe that's the industrial hygiene group. Is that correct, Dr.

Dement?

MEMBER DEMENT: Yes, that's correct.

MEMBER BERENJI: Okay. Do you happen to have any information on that with respect to the ACGIH update?

MEMBER DEMENT: Well, they publish a list every year that's updated. So there's a list and there's a designation of whether or not it's a carcinogen.

MEMBER BERENJI: Okay. All right. Well, you guys can read this for yourselves, but there has been additional supplements to these chemicals as listed below.

So I think this was a good starting point. I think, hopefully, at least from my perspective, I'm always trying to be able to educate the public about workplace exposures, and having a website that's user-friendly and people can look up these chemicals as an adjunct to SEM, to me, that's something that's beneficial to everyone. Next slide.

So, Rose actually had brought this up

during our discussions. And I know that we've all been kind of stretched with the COVID situation. But, Rose, I wanted to give you this forum to give some insight and give us your thoughts about what do you think the SEM process is currently and how could the SEM improved.

MEMBER GOLDMAN: So, I think -- we didn't do an exhaustive run-through on it, but it looks like some of the things we discussed where some of the chemicals that are there aren't necessarily linked to some of these outcomes, for example, the cancers, and some are missing from there. And I guess we didn't really look at pesticides, for example, to have that so much on our radar screen.

So, particularly with the carcinogens, I think you have to do sort of a deeper dive to look at the chemicals that have come to 2A from IARC and see if they're in the SEM. And if they're in the SEM, are they linked to these kinds of potential cancers?

MEMBER BERENJI: Fair point. George

or Duronda, any comment on that?

MEMBER POPE: I'm sorry. Repeat the question, please.

MEMBER BERENJI: I'm sorry. Go ahead.

MEMBER POPE: I'm sorry. I didn't hear the question. So, somebody broke up.

MEMBER BERENJI: Oh, no, I'm sorry. I just wanted to see if you guys had any additional comments about what Rose just said.

MEMBER POPE: I don't have any additional comments to that. But I appreciate the report and I think it was well done. Thank you.

MEMBER BERENJI: Thank you, Duronda. Next slide. So, I know Carrie Redlich has done an extensive review, and I know we discussed that earlier, but for those of us who are really trying to get a better understanding of the SEM, you can actually look if I hold this up. And this is just to reiterate that point. Next slide.

And, again, I know we've talked about this already, as well. So we'll skip that.

So, I know, at least with respect to our task, incorporating the 2A chemical, I will defer to Steven in terms of how to proceed. But these are just my general comments about the SEM. And I know this is up for debate.

But, generally speaking, I don't feel the SEM is user-friendly. I realize what Haz-Map has been doing recently with the update on their website. And I'm hoping that SEM can follow in that direction to make it high-touch so folks can actually learn about the chemicals, have some sort of visualization, and a way to be able to make it more palatable as opposed to just putting text. Because sometimes people don't understand all the terms, but if you make it more interactive for folks, to me, that's the step in the right direction.

And that's about it. If anyone else has any other comments in the work group, please feel free to jump in.

MEMBER POPE: Hi, this is Duronda. I just want to agree with Mani that the SEM is --

it was challenging just to get through, trying to figure out where everything was, and then try to understand it as it relates to understanding the exposure and connecting the dots, so to speak.

(Simultaneous speaking.)

MEMBER GOLDMAN: Okay, sorry. I'm also trying to understand how the SEM is used practically. And I'm sorry, I'm newer to this Committee. I know that the claimant and claim official is using it. But I'm trying to imagine it from the examining, the doctor examiner. Does the examining physician who's trying to make a determination, is that doctor going to be -- let's say a worker, they see that that worker has an exposure to a certain chemical or has asthma or some condition.

Would they be going, the doctor, to the SEM to see what's there? Or is that something that would have already happened and this is some kind of documentation that goes to the physician?

MS. POND: This is Rachel. I can jump

in on that. Usually, we will make an assessment of exposure, send it to the doctor so they will have that information. We either make presumptions or there's information in SEM and we submit a determination and it goes to something that likely caused and we extend that cause contributed to or aggravated, we send it to a doctor.

MEMBER GOLDMAN: So would the doctor themselves also be looking at the SEM or no? Or just rely on whatever you send them?

MS. POND: Normally, the doctors aren't going to have access or go to the trouble of going to the SEM. So we try to provide them with that information. But that's research that our claims examiners will do up-front.

MEMBER GOLDMAN: So it really would help for the examiners, then, to have an easier to use, more robust platform, and to have it with more information, easier to use.

MS. POND: The internal SEM is probably a little bit easier to use than the

external SEM. But, yeah, if we can dedicate resources to updating it and changing the look and feel we'd probably love to do that. I'd just have to see what resources we have for that.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I was on this committee. Due to a number of factors, I wasn't able to really do any work, and I apologize for that. But I do have a thought. The SEM is really taking on a huge challenge. It serves several different functions, and I'm not sure it's easy to put them all into one function.

For example, a doctor needs to know, given the patient presenting complaints, what they're exposed to. But what they're exposed to, what you're looking for, depends on what their diagnosis is. And, in some cases, the diagnosis depends on what they're exposed to.

So it's an iterative process that they have to look and see what the possible exposures are. And then, are there diagnoses that would be affected by those exposures or caused by them?

And then go back and see, really, what was the exposure? And then go back and see what is the causal link in the literature.

So the SEM is presumably the site exposure matrix that tells us about exposures. But to add on the functionality of determining the causal relationship I think is asking a lot, because we really want to cast a wide net when we think of, say, what are the diagnoses associated with asbestos. And you want to include pulmonary fibrosis. You want to include asbestosis. You want to include cervical cancer and all the diseases. But that doesn't mean the link is certain.

So I think that we should take a look at how to design the process using the SEM, using other sources, and possibly even creating another source that would be more user-friendly. I think the non-user-friendliness is in part because it's such a challenging function to design.

And I think our committee could work on that. I wish I had more time to be involved

and formulate this more. But I'm proposing that we try and rethink the whole process, not just looking at the SEM but other sources like Haz-Map and others, as well.

CHAIR MARKOWITZ: So, this is Steven. I have a couple comments. One is the SEM was built 15 years ago, or at least initiated 15 years ago. And we've learned, since the beginning of Board in the last four years, that it is an essential resource constructed with great effort and also routinely used in the claims evaluation process. And it's unlikely that that's going to change. I think the Department would appear to be receptive to any recommendations about how to improve the SEM.

But I want to actually address a different issue about this committee, the 2A. So one challenge, I think, on the 2A is that there's a mix of evidence that IARC uses to come to its conclusions. And a part of it's mechanistic evidence, part of it's animal evidence, part of it's epidemiology.

If there was strong epidemiology, then it wouldn't be classified as a 2A, probably; it would be classified as a 1. Which means that, more likely than not, the 2As have weaker epidemiology, which is compensated for by reasonably strong animal evidence or mechanistic evidence. So, ultimately, the Department of Labor is interested in connecting a chemical, a toxic substance, to a particular type of cancer; say, methylene fluoride and lubricants or whatever.

So in looking at the 2As, the question I have for the committee is for which 2As will it be able to make a recommendation of a connection between that agent and a particular human cancer site?

And by way of background -- many people on the Board know this, but maybe not everybody in the public -- there's not a one-to-one correspondence between the animal cancer site and a human cancer site.

So I just raise this as a challenge.

But I think it could do what we want to do in response to the DOL request. I think we probably have to sort out the two ways for which we have some confidence about a particular human cancer site. Does that make sense?

MEMBER REDLICH: Yes. This is Carrie Redlich. I just had a similar thought. I mean, Mani, this is a really impressive review, which is terrific. Because of this -- because, I guess, similar in the same vein as Dr. Markowitz, either there's an issue of duration and magnitude of exposure, and you probably have a sense from the literature which ones there is a stronger case for than others. And also which ones, considering the type of work that was done, would likely have been sufficient in the magnitude and duration of exposure.

And obviously, with cancer, that's always challenging. We don't know what a lowest dose is. But I would suspect that, of the list, that there are some that are much stronger than others.

MEMBER BERENJI: This is Mani. Thank you, Carrie, for those nice words. So, at least based on the chemicals that I've reviewed in the PowerPoint, there was strong neurological evidence for the vast majority. There were examples where there wasn't.

We could definitely come up with a tiering, or come up with a tiered system by which we can identify those 2A chemicals that have strong human epidemiological evidence, moderate, and weak. I think that might be a good way to kind of identify, at least for the purposes of DOL, which chemicals they can really get the most response.

MS. POND: This is Rachel. I just want to comment here that the SEM -- pretty much the reason we use just one is that it's causation we're kind of relying on. For the recommendations that come from the Board, we can put them in the policy as contribution or aggravation.

And that tiered approach that you're

talking about would fit into that scenario where we put this into policy as some sort of a presumption for aggravation or contribution, rather than saying as strongly as we would in the SEM or with the first list. You know, here are the presumptions, here are the tiers. Those are the kinds of things that could be really helpful in how we phrase it in our policy.

CHAIR MARKOWITZ: Okay. So shall we move on, or?

MEMBER DEMENT: This is John Dement. So I just have a question on what's the path forward of this. It seems like it's almost an agent-by-agent review to determine whether or not we feel there's sufficient evidence to pull it into the SEM based on at least some human data.

MEMBER GOLDMAN: This is Rose again. So would there be a proposal, actually, to get them to do something along the line of, if it was in 2A but a higher level of epidemiological evidence, that that could be pulled in to the SEM as an aggravating or contributing factor to the

cancer?

MS. POND: So, as I said -- this is Rachel again -- that would probably be something we put in our policy and our procedures that our claims examiners would look for, rather than putting it in SEM, which is more of a causation -- direct causation link. But it would be something we'd definitely incorporate into our process.

MEMBER REDLICH: You know, I guess -- sorry to interrupt again. We can't, obviously, create in the SEM, you know, the clinical decision-making that George mentioned. But in terms of -- obviously, there's some exposures where we have very common cancers with other common known causes, whether, you know, smoking and lung cancer or colon cancer.

And so, realistically, you're potentially opening up a large number of cases that could be attributable to potentially, you know, a variable amount of exposure at some point in time that's passed. And so it seems, then, in

thinking of the priority, it might be helpful to also think in terms of, yes, how strong is this literature, but also what are the other common risk factors? And how does the magnitude of that one compare to other factors?

I mean, something like vinyl chloride, you know, with asbestos mesothelioma, that linkage, because it's rare, but when we see it, there aren't other things that cause it. So, when you have cancers like colon or lung, it gets, I think, more challenging.

CHAIR MARKOWITZ: Okay. So, this is Steven. We need to move on. So let me suggest that these issues go back into the working group to make some progress on.

MEMBER BERENJI: Thank you, Steven. I took some notes and we'll definitely review them before June.

CHAIR MARKOWITZ: Okay, great. Thank you.

MEMBER REDLICH: Thank you for taking on a difficult subject.

MEMBER BERENJI: Thank you.

MEMBER FRIEDMAN-JIMENEZ: Yeah, I want to thank Mani for giving a great review of this question and laying out the issues. And it's a very difficult topic and I think we'll make more progress on it. So I look forward to working with you more. Thanks.

MEMBER BERENJI: Great. Thank you, guys.

CHAIR MARKOWITZ: Yeah, it would be a great contribution. Okay. So we have till 3:15 or so. What I propose is we're going to skip the free-ranging discussion about the assessments of the CMC and the IH and use some of the more time limited and specific topics, and then get back to the issue of CMC and IH.

So we're going to move ahead to the 2:30 topic. And the first is the B reading issue which I will lead.

Kevin, there's a Word document that I sent you as the file that's called "ABSTWH B read DOL." And while Kevin is finding that, let me

just set out what the issue is. I'm not even sure we necessarily need to look at this. But if we can, that would be great.

So, the Department asked us, in a letter from the Department dated February 12th, they asked us certain questions. I'm going to paraphrase for the sake of time.

The program has seen variations in how B readers are certified and how their certification is documented on test results. And that, quote, the OWCP request that the Board provide input on the certification requirements for B readers and guidance on how claims staff can verify test results that originate from a qualified B reader, end of quote.

So I prepared a draft on this issue, which I sent to the physicians on the Board a couple weeks ago to get their initial input. And I got some feedback. And let's see.

So, Kevin, you're still looking for it, right?

MR. BIRD: Yeah, that's correct. Do

you remember when you sent it to me? And does it have B reader in the title or B read in the title?

CHAIR MARKOWITZ: No. Is it easier for me to just send it again? I could just send it to you.

MR. BIRD: That would make sense, yeah, if you can.

(Pause.)

CHAIR MARKOWITZ: Okay, I sent it. But I can just walk people through it. So, the question is about the nature of the B read program and certification. And so the draft responds that the B reading is administered by NIOSH. It is very well described on the NIOSH website, and I provide the website to look at.

And then I state that the physicians become a B reader after they demonstrate competence in applying the ILO classification by completing an examination, the NIOSH B reader examination. It has to be updated every four years.

So, a physician has gone to Morgantown, West Virginia, taken the B read exam. And if they pass it, then they're a B reader. And that, again, consists of looking at a number of films and correctly identifying a certain proportion as representing various substances in the lungs, asbestosis, silicosis, et cetera. And also identifying films that don't have disease.

And the list of certified B readers is available on the NIOSH website. So this description of how you get to be a B reader and the currently certified B readers is all publically available for claims examiners or others in the Department to check.

Currently, there are 176 B readers. Okay. I was reading from my own slide. Okay, 176 B readers. And, again, they're listed. It just says that they're current. It doesn't really give a date of how current they are. But it's probably pretty up to date. So --

MEMBER GOLDMAN: Actually, it's not that up to date. This is Rose. Because we tried

contacting a number of them to do B readings at Cambridge and they --

CHAIR MARKOWITZ: So the last part of your comment dropped off. What did you say?

MEMBER GOLDMAN: This is Rose. We checked a number of the people on there for getting B readings and they weren't active. So I don't know. That was a few months ago.

CHAIR MARKOWITZ: Okay. So I guess, for the claims evaluation process, in respect to a given claim, the claims examiner is wondering whether the person, the claim that contains the B read, was actually obtained by a B reader, the physician's name is at the bottom of the B read. And they can then check the file and they can determine whether that person was on the list, at least in the recent one.

So, further, the draft comments that the B reader program is excellent and it's been invaluable for its purposes. The purposes have traditionally been epidemiologic, surveillance, and monitoring studies, not really diagnostic.

I then write up a comment that there's been some well-publicized -- meaning they've been in the media -- incidents of B reader abuse or alleged abuse over the years. And to our knowledge -- and this represents the collective knowledge of the people on the Board, so you've discussed it -- that there's no highly prevalent pattern of abuse has been documented.

NIOSH has proposed a modification of the Coal Workers' Health Surveillance Program to permit NIOSH to suspend and disqualify B readers who are persistently inaccurate. And I think that follows a scandal in the Coal Workers' Program of misreading of B reads, although I don't have the details of that. That may be the Johns Hopkins radiologist incident. Maybe someone else on the Board knows about that.

But in any event, NIOSH now has at least proposed a provision that allows them to examine an incident representing possible abuse, or a pattern of abuse, and then they can disqualify such people.

And then, finally, Item No. 3. Whether a person is a B reader, there's no standard way that a B reader labels their B read as being performed by a B reader. There is a standard form for B reading that could, perhaps should, be included, but not necessarily in the claims process.

But the fact that there's no recognized stamp for B reading that NIOSH hands out when you pass the exam is not really a problem because if there's any questions about whether the person is actually a B reader or not, that list on the website could be checked.

And, finally, we make the point that B reading is not diagnostic of itself. A B reader typically does not have information about the clinical status, about the occupational history of the person whose film their reading. And that the B reading is designed to be used, at least for clinical purposes, in association with clinical exposure and some research information or the general knowledge by the clinician to make

the diagnosis.

So, questions, comments? This is something that, if there are corrections, if we could do them now, that would be great because then we could -- well, this is not here. So this addresses the questions that OWCP asked us about how claims staff can verify test results that originate from a qualified B reader.

So, what this says here is that claims examiners can verify that it was a B reader who read the film, but cannot directly verify the reading itself, for example, by preparing a B reading to a routine radiology reading.

The B reading may because they're looking -- they're qualified and are looking for a dust-related diseases and they have a more nuanced or a more accurate reading of the film. So a simple comparison of a standard radiology reading and any discrepancy doesn't inform you that the B reader is not giving an accurate reading or not.

Other clinical, medical, occupational

information could be used in conjunction with the film. But as it says here, it's the last line, any discrepancies between a B reading result and other physicians' opinion cannot be settled by claims examiners. It's really a medical issue. And if there's a question about the B reading, that would be something that I think would have to be reviewed by a qualified CMC.

So, the floor is open for comments.

MS. POND: Dr. Markowitz, this is Rachel. I just wanted to give a little context to why we're asking the question. And, basically, you've been seeing some reports coming in. We'll have an original B reader from a decade ago and somebody new will come in and review the report as a B reader now, review the test results and tell us a certain diagnosis. And that's why we just needed to check because then we have a conflict when somebody who is treating a patient ten years ago and isn't now but is coming and saying that's it's not what the original B reader said.

So we're just trying to make sure our claims examiners are doing their due diligence in checking the qualifications, making sure that we're doing what we need to do. And as you said, obviously, they're not going to try to do any of the -- look at the reports themselves and determine which is which as far as a medical opinion. But we want to first verify that they've got the right qualifications as B readers.

CHAIR MARKOWITZ: Well, B reading work may be done by a B reader who's no longer on the list because the CMC chose not to renew their certification. So checking, frankly, the publically available lists now you can look at a reader from ten years ago. The person may not be there. So that's typical.

MEMBER GOLDMAN: This is Rose Goldman again. So, part of the issue, too, is that ten years ago people were doing a B reading on regular X-ray films. And what's happened recently is that there's been a transition to

digital film and, actually, really looking at it.

And so looking at an X-ray that either was scanned in from an analog kind of film ten years ago and re-reading it now, there could be problems with that. Or you get another X-ray now which is a digital film.

And so both really could've been accurate ten years ago and now they're on different media. And also there's a process that if there is a disagreement, I believe NIOSH -- and I would defer to Carrie. But NIOSH has a program where if two B readers disagree, they actually have three B readers then review the film, or something like that, because there could be differences, particularly at the finer levels of it.

MEMBER REDLICH: I think your point that the electronic imaging has actually, I think, improved the system. It's also made it easy to send films to a B reader to review electronically.

MEMBER GOLDMAN: I guess the specific

issue that is being raised is what?

CHAIR MARKOWITZ: That's a question, I think, for Rachel.

MS. POND: I'm sorry. Yeah, I mean, I think what we're asking for is basically what it sounds like you're going to provide to us. Some things that you can look for to make sure that we've got a B reader and the cases that you're providing now with regard to things might've been different before, ten years ago. And now we've got doctors that are coming in that are looking. They provide us with a B reading and provide us with a certain result. This result they're providing us with now is different than the one we had in our documentation from the last time or initially when the system was getting the test results. So I was just trying to provide a little context as to why we're asking for this criteria and how we would use it.

MEMBER REDLICH: Yeah, I think it is a problem that the number of certified B readers has gone down a lot. We currently do not have

anybody in Connecticut. I think the new OSHA, or not so new anymore, OSHA's silica standards, one good side effect of that is that a lot of radiologists are now getting B certified because there's an increasing need for B readers.

So, hopefully, in the future, there'll be more certified B readers. And I think radiologists are a good group to get certified.

MEMBER GOLDMAN: And I'm thinking -- this is Rose again -- we don't have any radiologists at our hospital who are B readers, and they don't seem to be that interested in it. It's the training and very relatively small level of reimbursement. And the people who tend to be doing it are people that want to do a lot of them, perhaps, for some reason. And there's just a very few number.

And there's a transition that's going on because they are transitioning from the analog film to the digital. And I think they finally made that transition this year. And the new training and testing will be with the digital

film.

So that may improve things and make it a little easier for people to get certified. But I think, from the point of view of the DOE people, that you should be able to see the actual form that is filled out by the B reader. That should be part of that record. And then you can compare it to the old one and see how big a difference there is. And if you're really concerned there's a really big difference, you could then have a third person or another person do the re-read if you could find the person.

MEMBER SILVER: This is Ken Silver. I have a question for the doctors. Will the move to digital films result in more positive readings? Is there a systematic increase in sensitivity?

MEMBER GOLDMAN: NIOSH, I think, has looked at this as far as the reading. It's a challenging issue because, from the clinical perspective, most patients with respiratory disease, the threshold for getting a chest CT

scan has gotten so low that that is what is being clinically used to diagnose whether there is any interstitial process at all.

But there's an epidemiologic and a population basis to have B reads and something you can follow at the time. Most of the charts that I've reviewed, those people that had a positive B read also had evidence of lung disease in other ways in terms of either lung function testing or a CT scan.

So I think if you had a B read, you'll have certain criteria to qualify as one. But you can also have either a Part B or E condition without having a B read.

MEMBER SILVER: Thank you. Going back to Ms. Leiton's context for this, is it fair to say that a B read of a digital film, if you still call it that, is more likely to detect pathology that would have missed ten years ago on a traditional X-ray? More sensitive?

MEMBER GOLDMAN: No, I mean, my understanding is, you know, we pickpocket NIOSH

and others that have done side-by-side comparisons. And I don't think so. I think a general radiologist, their threshold to order a CT scan is pretty low, not so much worrying about mild interstitial changes but a concern about missing a cancer.

But I think in terms of reading plaques or markings that could be asbestos or silica, I don't know of any data that supports a difference --

MEMBER SILVER: Thank you.

MEMBER GOLDMAN: -- of a systematic change in the way the reading has been done.

CHAIR MARKOWITZ: Okay. I'm sorry to interrupt. I just want to -- finish your thought. I apologize.

MEMBER GOLDMAN: No, that's it. That's it.

CHAIR MARKOWITZ: Okay. So, I want to close out this topic here. So I've added -- I've Kevin has now written in Item No. 6, the B reading has evolved over recent decades to

incorporate digital films that are currently the radiology standard. This has produced some variation of B readings between current and previous B reading. So, are there proposed changes to this draft response to DOL that we can address here and now?

MEMBER SILVER: If we back up from the technical aspects of this and return to the theme of EEOICPA as a claimant-friendly program, would we want to entertain language to the effect that discordant results between B readers ought to be resolved in favor of the claimant?

CHAIR MARKOWITZ: Oh, I would say discordant results ought to be resolved by CMCs. The issue -- I think Dr. Redlich really -- well, maybe somebody, I'm not sure who -- addressed you don't really look at the B read in isolation. We really look at it in terms of pulmonary function and exposure to make sense of it. And so that picture has to be done by a physician who's familiar with the diseases. And it should be a CMC who's familiar with that.

MEMBER GOLDMAN: This problem predates digital films. I don't know how many times that they see the quality of the film or whatever, a discrepancy. And then I think what was said is to look at that in the context of all the information.

CHAIR MARKOWITZ: So --

MEMBER GOLDMAN: So I would second what Dr. Markowitz said. I think the good thing about the digital films is, if one wanted to, one can more easily get another opinion on them. Hopefully, that would not be needed.

CHAIR MARKOWITZ: This isn't really a recommendation. This is just a response to a DOL request. But our only means of consensus is to vote on it. So I think we should probably take a vote on this. Are there any -- I guess I need a proposal to adopt this response.

MEMBER GOLDMAN: I propose that we adopt the response.

CHAIR MARKOWITZ: Thank you. Is there a second?

MEMBER BERENJI: I second. This is Mani Berenji.

CHAIR MARKOWITZ: Okay. So it's open for discussion, further discussion, including any amendments or tweaking of this language before we vote on it.

(Pause.)

CHAIR MARKOWITZ: So if there are no suggested changes, then I'd say we should just vote on it. Carries Rhoads, do you want to do this by roll call?

MS. RHOADS: Mike, do you want me to do this or do you want to?

MR. CHANCE: I'll take it.

MS. RHOADS: Okay.

MR. CHANCE: Okay. Here we go. Dr. Berenji?

MEMBER BERENJI: Yes.

MR. CHANCE: Okay. Dr. Dement?

MEMBER DEMENT: Yes.

MR. CHANCE: Okay. Mr. Domina?

MEMBER DOMINA: Yes.

MR. CHANCE: Okay. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. CHANCE: Okay. Dr. Goldman?

MEMBER GOLDMAN: Yes.

MR. CHANCE: Okay. Mr. Mahs?

MEMBER MAHS: Yes.

MR. CHANCE: Okay. Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. CHANCE: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. CHANCE: Okay. Ms. Pope?

MEMBER POPE: Yes.

MR. CHANCE: Okay. Dr. Redlich?

MEMBER REDLICH: Yes.

MR. CHANCE: Okay. Dr. Silver?

MEMBER SILVER: Yes.

MR. CHANCE: All right. And Mr. Tebay?

MEMBER TEBAY: Yes.

MR. CHANCE: Okay. It looks like we have a unanimous yes.

CHAIR MARKOWITZ: Thank you. So before we take a break, I just want to announce to the public at 3:30, we will have our public comment session. If you would like to make a public comment, if you could email Carrie Rhoads now, that would be helpful. Her email address is capital R-H-O-A-D-S dot capital C-A-R-R-I-E at DOL dot gov.

So we're going to break now and then we'll resume at 3:30. It doesn't look like we're going to need the entire public comment period for public comment in which case we'll just resume the Board meeting during this period. Thank you.

MEMBER REDLICH: Can we keep our phones on? Can we keep these phones on, or are we re-dialing back in?

MR. BIRD: If you can keep it on, that's great. But if you have to re-dial, that's okay, too.

MS. POND: Dr. Markowitz, this is Rachel. I was planning to get off at this point.

But if you need me to stay on after the comments, I can do that. Do you think you'll need me this afternoon?

CHAIR MARKOWITZ: It's hard to say. Of course, we always need you. But we're going to talk about the occupational questionnaire and then we're going to talk about the assessments of CMC and IH performance. I don't know that we'll have any more questions. I'm sure Mr. Vance or Mr. Pennington are around who could probably answer them. But --

MR. VANCE: Hey, Steven. This is John. I can barely pick you up.

MS. POND: I'll just come back on, Dr. Markowitz, and I'll be available if you need me.

CHAIR MARKOWITZ: Okay. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:18 p.m. and resumed at 3:32 p.m.)

CHAIR MARKOWITZ: Mr. Chance, do you need to say anything at the beginning of the discussion?

MS. RHOADS: No, you can present the meeting.

CHAIR MARKOWITZ: Okay. Thanks. Okay. We'll start the public comment session. We have only two comments. And normally, we limit people to five minutes. But in this case, you can take a little longer.

So we're going to start with -- oh, let me just say that if anybody is on the phone from the public and you decide you would like to make a public comment, then you should say so. Let me ask Kevin. Is the public who's on the line, are they muted or unmuted?

MR. BIRD: Every member of the public right now is currently muted. When you call on them, I will unmute them so we can hear them.

CHAIR MARKOWITZ: Okay, okay. So again, if there's any member of the public on the phone and you would like to make a comment, just email to the email address that's on the board which is energyadvisoryboard@dol.gov. Okay. We'll start with Terrie Barrie. Welcome.

MS. BARRIE: Thank you, Dr. Markowitz. I appreciate this opportunity. And, members of the Board, thank you for a lively discussion today. My name is Terrie Barrie, and I'm from the Alliance of Nuclear Worker Advocacy Groups.

I want to call your attention to a recent issue that came across my desk. The Seattle Times published an investigative report which found that the respirators Hanford workers used between 2012 and October of 2016 leaked. The Department of Energy contractor admitted the respirators did not properly protect the workers from the exposures and identified over 500 workers who were affected.

A similar situation occurred with Y-12 respirators from at least 2009 until 2012. In that situation, the respirators were not properly cleaned. I will supply the link to the articles when I submitted these written comments.

I have no idea how many claims were submitted to the OIG for these two sites during this time period. But according to the Seattle

Times, at least one claim was filed by a Hanford worker. I am worried about these workers.

The Board has expressed concerns in the past over the OIG's contracted industrial hygienist reports. Some reports seem to be written using boilerplate language which tends to assume that workers employed after 1995 would not have been exposed to toxic substances above the regulatory limit.

I ask the Board, and I actually respectfully request the Board that they get a sampling of claims from the OIG submitted from the Hanford and Y-12 workers during this time period so that you can review not only the industrial hygienist reports but also the types of documents the Department of Energy provided to the OIG when DOE was complying with our request.

Claims examiners and subsequent industrial hygienists and contract medical consultants cannot adjudicate claims in a fair manner as they do not have all the facts from the Department of Energy.

I had to admit I was quite disappointed to say the least with Department of Labor's position on the Board's request for a support contractor. This recommendation/request is more than two years old, so it's not a surprise to the OIG.

If this process was started as soon as the Board first requested assistance, they would have a contractor by now. Department of Labor just added another burden to prepare to the Board. They want the Board to prepare a formal request which would include the number of hours, the job category, and the pay rate for a future contractor.

Isn't that something Department of Labor's contracting office would have more experience with? It seems to me that the Department of Labor just doesn't want to provide the assistance the Board needs.

When it comes to -- I'm still opposed to just giving the Board ten days to review policy changes. I believe it is necessary that

the Board be consulted in the very early stages of the deliberations. The OIG says it can because the policy changes at this stage are pre-decisional and cannot be discussed in public.

However, NIOSH does it all the time. They publically discuss their pre-decisional documents with the Advisory Board on Radiation and Worker Health Work Groups. Meetings of the work groups do not need to abide by the FACA regulations to publish -- like subcommittees do to publish meetings in the Federal Register.

I think something should be done similar -- something similar should be done with the Board. The language in both -- in the statute for both this Board and the one for NIOSH is very similar.

And unless I'm missing something, the process could be easily adopted. You already have established work groups. Perhaps a work group could be formed so that all proposed policy changes are reviewed by the work group.

For example, the OIG notified the

Board five months ago that this new procedure manual change was happening in the spring. If the OIG has shared with that work group the details of what was being changed, the work group could've just determined whether or not the full Board needs to weigh in.

As explained earlier today by Mr. Vance, most of the changes in the procedure manual are administrative. And the Board doesn't need to deal with whether there should be a cover letter to a recommended decision or not.

But they should have the opportunity to say yes or no, it does fall under our purview. And especially when there are things like the changes to the presumption of non-Hodgkin's lymphoma. They should have the opportunity to weigh in on this.

And it's hard for me to understand why the OIG refuses to draw on the highly qualified expertise of this Board. It's just unfathomable that they wouldn't say, hey, what do you think?

The other issue I have is the

continuing complaint I hear that Department of Labor drags their feet in getting the claims to the Board so they can review as part of their responsibilities. There must be an option to expedite this information. And I would hope that the OIG would work on that.

And in closing, I want to thank the Board for their work these past two years. And I hope all of you will continue. Like I said, you offer so much expertise to help the OIG with this program.

And I also want to thank Department of Labor for issuing the notice requesting nominations for the Board who don't want to continue so early in the process. This will result in the continuity of the Board's work.

I thank you again and look forward to listening to more of the Board's discussion. Thank you.

CHAIR MARKOWITZ: Thank you. I hope you put some of those comments in writing.

MS. BARRIE: Yes, sir. I did.

CHAIR MARKOWITZ: Are there other public commenters?

MR. BIRD: Carrie, who do you want to go next?

CHAIR MARKOWITZ: I don't think there is anybody next.

MR. BIRD: We have one more. Hold on one second. Sorry. Yeah, I think Carrie just got dropped off for a second. We will --

MS. RHOADS: Hi, I'm back.

MR. BIRD: Is Stephanie Carroll on the line? Ms. Carroll, are you on the line. Carrie, is that the only other request that you received?

MS. RHOADS: That's the only other request. I'm sending her an email to let her know what the number is. Maybe you can find her.

MR. AVERY: I have a request.

CHAIR MARKOWITZ: Sure. Who's this?

MR. AVERY: My name is Ronald Avery.

CHAIR MARKOWITZ: Okay. Go ahead, Mr. Avery.

MR. AVERY: Yeah, I was employed at

Rocky Flats from February 1970 to March 1989. I was in the plutonium recovery for about the whole time I was out there. I was a chemical operator for the first nine years, and I was a radiation monitor for three and a half years. And then back to chemical operator and then a technical foreman.

And I was diagnosed with sensorineural hearing loss. And according to the criteria, they say you had to have ten consecutive years in one of the categories. And chemical operator is one of the categories, but I was a radiation monitor for three and a half years. And even though they were exposed to one or more of those toxins, they're not listed in the job category.

And I can't understand because they turned it down. I filed on it. But even a contributing factor or aggravated because the hearing test from the time that I started out there until I quit, the hearing loss was notable.

And I just don't understand. Is SEM -- do they actually know what the job categories

does? Because a radiation monitor works in the same room with the chemical operators right alongside of them. And I just have a little bit -- and even the technical foremen do too.

So I'm having a little bit hard trying to understand how they go about picking those job categories. I know you can talk about hearing loss today, but I wanted to say something about it.

CHAIR MARKOWITZ: Thank you. So this public comment period is not meant to be a discussion back and forth. But I do want to make a comment.

The Board did discuss the issue of hearing loss and solvents exposure at the site. And we made a recommendation several years ago that Department of Labor not require ten consecutive years of exposure to the solvents in the relevant job title. Actually we recommend that they reduce it to seven years and that it not be consecutive and also that a greater number of job titles be accepted.

And so they did not agree. They did not change the consecutive year criteria. They did open up the job titles. I'd have to look at the -- if you look at the exposure manuals to see exactly what the phrasing is. But I just wanted to give you that feedback in terms of the Board thinking about this.

MR. AVERY: Thank you. I appreciate that.

CHAIR MARKOWITZ: Are there other public commenters?

MS. RHOADS: Just Stephanie Carroll.

CHAIR MARKOWITZ: I'm sorry. Is this Ms. Carroll? And I see we accepted an email, 3:40. She just sent an email to make a public comment, right?

MS. RHOADS: That's right. Ms. Carroll, if you're on the call, we're trying to find you so you can make your comment. Kevin, do you see her number anywhere?

MR. BIRD: No, and all of the lines are open. So if she was here, she could.

CHAIR MARKOWITZ: Okay. I would just, while we're on public comment, point the Board to a site where a written comment was submitted today from Ms. Vina Colley whom we've heard from before from Portsmouth Gaseous Diffusion Plant.

And what she says summarizes a letter from 2008 actually from the contractor to the Radiation Advisory Board and SC&A and which they refer to a site profile. A review of the site profile of the plant and that there was an attachment to that report called the Summary of Site Expert Interviews which is undergoing clearance and was not included in that submission.

And Ms. Colley's point she wants to raise is that the summary may still not be available publically. So I think that captures her public comment.

Okay. So are there no other public comments? I'll make one last effort for Ms. Carroll if you're there. Ms. Carroll? Okay. So are we permitted then to close the public comment

period and go back to Board business?

MR. CHANCE: I'm fine with that, Dr. Markowitz, if you would like.

CHAIR MARKOWITZ: Okay, good. Okay. So --

MR. BIRD: Dr. Markowitz, it's really hard for me to hear you. I don't know if that's the case with others as well. But I'm having a little difficulty.

CHAIR MARKOWITZ: Is this any better?

MR. BIRD: Yes, sir.

CHAIR MARKOWITZ: Okay. I'll do the best I can. If I drop off again, let me know. So let's move back to the discussion of the occupational health questionnaire, the OHQ. We've been given revised drafts by Department of Labor. And we're going to open it up for discussion. And I think Dr. Dement has some initial comments.

MEMBER DEMENT: Yes. I'll sort of lead it off if that's okay. And others can --

CHAIR MARKOWITZ: Sure.

MEMBER DEMENT: -- join in. There's a document.

MEMBER REDLICH: Can you speak a little louder, please?

MEMBER DEMENT: Yeah. It's on page 2 of the occupational history questionnaire. If you could get it up for us, please. It was part of the materials for the meeting.

CHAIR MARKOWITZ: It should be in the meeting briefing part of our website.

MR. BIRD: The OHQ examples to cite?

MEMBER DEMENT: Well, so yes, the second page. Let me find the exact title.

MR. BIRD: Dr. Dement, could you please speak a little closer to the microphone. It's hard to hear you.

MEMBER DEMENT: Okay. Is this better?

MR. BIRD: Yes.

MEMBER DEMENT: Okay. I'm having a hard time hearing people as well. So the occupational history questionnaire is something we've been working on for a good while. And we

heard at the last Board meeting about the updated draft. And subsequently, we asked to take a look at the draft. And we were given one that was sort of a completed example. And then the other was the actual questionnaire itself.

And so what I'm trying to get up, Kevin, is the actual questionnaire. It's OHQ Interview Site-Specific page. In the briefing book materials, it's third from the bottom. Are you still on? Hello?

MR. BIRD: Oh, yeah. Yeah, I'm sorry. I had you on mute. Do you know the title of the documents you're looking for?

MEMBER DEMENT: OHQ Interview Site-Specific Question input form.

MR. BIRD: Okay.

MEMBER DEMENT: So the first page of the OHQ is just basic information -- basic demographic information, the unions that the individual might have been associated in some cases, whether or not they were part of a former worker program, and their history outside of DOE.

The second part of it is actually sort of a continuation of maybe multiple parts. And so a separate site-specific section is supposed to be filled out for each site. And it goes through a series of structured questions.

And I think this is good. And I think there are many changes to the OHQ that I think are very positive. The structure for this part is when you get into the actual work task and exposures is pretty much free text. Okay. That's the --

MR. BIRD: Sorry, Dr. Dement. I think I have it pulled up if you can look on the WebEx.

MEMBER DEMENT: Yeah. Scroll down. And so this is it right here. Scroll further. Yeah, scroll. There we go. Here's the information where it really gets to be detailed.

For each job title, the claimant isactually asked to describe the areas of work activity, the toxins, and years of employment and to give some idea of frequency. And while I think this is helpful and the example that was

completed actually is very interesting and quite good, I'm still a little concerned that workers are not going to recall this level of detail.

But another comment is I think with having more free text in this questionnaire, it really places a lot of burden on the interviewer to have a fairly consistent scripted approach to asking questions so that it's delivered appropriately and consistently to each interviewee.

And I think it really is a challenge on recall issues with regard to trying to actually recall specific tasks. But nonetheless, I think it's an improvement over before. Can you scroll down a little bit further?

So this is where exposure information is entered into the form, and it's in categories. This one starts with metals, for example. And there's some examples given in red.

I'm not sure what it might be for presenting this. But I think that script, if it's going to be used in the free text form like

this, that script and examples is going to be very important.

For example, under the welding -- under the specific category of welding and metals, you see a lot of metals listed. But we don't see anything with regard to welding or cutting and stainless steel or application and removal of paints that might contain cadmium and chromium as tasked.

So I think this part of the questionnaire in particular is going to be a challenge to write a script and train the interviewers to ask questions and then follow up with appropriate detailed questions based on the claimant's response.

So that's sort of that section. If you look down at some of the other sections, it goes by different categories. For example, in the plastics and adhesives, application of urethane paints and epoxies are important tasks to be considered.

Under dust and fibers, there's

asbestos, of course, listed. Workers might remember working with drywall and doing drywall finishing. They may or may not associate that with asbestos exposure historically.

Under solvents, for example, a lot of different solvents are listed. But there are no tasks. And so if the interviewers administer the questionnaire, they might want to ask, did you do solvent degreasing as a task?

So it's not structured -- so my comment -- overall comment, it's not necessarily structured. How I would've probably gone about it is this section is not consistent with how the Board recommended that had to be structured.

I have some concerns about it, and I think training of the interviews tend to be very important. I also think it's likely that it will be helpful prior to the interview workers were given some materials to fill out beforehand before they do the interview, sort of as a memory trigger.

And I would probably suggest that some

tasks under each one of these types of exposure categories might be appropriate as triggers for the worker themselves.

My understanding is this questionnaire was pretty close to final. So I'm not sure what we say right now is going to make much difference. I understand they're going to have a pilot and see how well it works.

I guess I'd be interested in taking a look at that and what the criteria are for that and it works like it's supposed to or not. I think it's improvement, but it's been a four-year process. Look forward to seeing what it might look like in the industry.

So for comments about it, yeah, I think it's -- I do think it's an improvement of the questionnaire that exists currently.

CHAIR MARKOWITZ: This is Steven. I have a question. Looking at those same categories that Dr. Dement, you were just going over, where by category of material they ask about form and how exposed. If they asked about

task, maybe listing some of the major tasks as triggers, maybe not.

So if they asked about tasks, wouldn't the industrial hygienist get the information that they need to weigh in about form and method of exposure from the task.

MEMBER DEMENT: Well, that was the original recommendation from the working group on the OHQ to be more task oriented. That would be my preference. I think the alternative here is the part you see in red which I assume is some script that will be used. That script in this format is going to be extremely important.

For example, there's nowhere in here in any of these categories that welding is actually mentioned as an exposure. I see soldering. But welding is an important exposure for a lot of reasons and a lot of the conditions we discussed today.

So unless there's some -- a more work-related trigger. For example, did you do welding as opposed were they exposed to chromium or

nickel or cadmium? I think it's probably not going to achieve the objective. But I'm open minded, and I think this -- how it's presented by the interviewer is going to drive how successful this is.

I also think by having it structured as it is and not having sort of specific tasks that individuals are asked. I think it's more -- you're going to see a lot more variability by the interviewer -- between interviewers in particular and how this thing is administrated. Some may drill down very deeply in some of this and some may not drill so deeply at all without some scripted process.

CHAIR MARKOWITZ: So here's a devil's advocate question. This is Steven. Where it says, how did you use the substance, won't the person being interviewed come up with their tasks?

MEMBER DEMENT: That's what they have to do now. They have to describe how they were exposed to beryllium, chromium, whatever. I

think it's a challenge for -- just a recall challenge, I think, for older worker population.

CHAIR MARKOWITZ: So you're suggesting thing to have some short examples of tasks with metals and then having the interviewer ask about those specific tasks?

MEMBER DEMENT: Well, if they don't ask specifically, I think sort of working in the background, the questionnaire has to be some information about work tasks that are related to these exposures. And I think the interviewers and the interviewees need to be working from the same page in terms of what these tasks might be.

I'm suggesting that in our BTMed program, we put these tasks on a single page. So there's about 55 to 60 of them. A single page of information might be very helpful to give to the interviewer before they come for their interview.

CHAIR MARKOWITZ: I'm sorry. Is that page administered to the DOE worker?

MEMBER DEMENT: The page is -- we mail it out to them before they have their -- most of

the interviews are by phone now. But they're given this questionnaire beforehand, a few weeks beforehand usually. So they have it and they've had a chance to think about it. They've had a chance to read it, to digest it. And when they come to the interview, they're better prepared to try to respond to questions.

CHAIR MARKOWITZ: So I'll open this up to other people. But just one last question. So how specifically -- looking at this form, how specifically would you change it?

MEMBER DEMENT: Well, it would be without sort of redoing substantially, I think the part in red which I think is intended to be the triggering questions need to be thought out very carefully.

For example, I'm looking at the dust and fibers thing that's up, and it has asbestos, pipe wrap, and asbestos board. But there's some other less obvious tasks. Did you do brake work? Some of them did. Did you work with packing and gaskets? The pipe fitters certainly did.

I think in some of this, there's some tasks that really need to be incorporated in and the introduction to the worker, they describe their task. They describe their work.

CHAIR MARKOWITZ: Are there other comments, or --

MEMBER POPE: This is Duronda Pope. I think that this is so critical. Thank you, Dr. Dement. By saying that -- by putting the task down there and making it specific, having those recall triggers there.

You have to keep in mind most of these claimants are sick and they're trying to recall where they worked, what they worked with. It's a very challenging process that they have to go through.

So by making it more specific, you are enabling that claimant to better be able to formulate this form because it's in the developing stages of building this case.

MEMBER DEMENT: Well, I guess it's targeted to go for a pilot. And the Board will

have an additional chance, I hope, to take another look at the pilot and the pilot results and make recommendations to change it.

My recommendation right now is these scripted questions need to be thought out very carefully to make sure that everybody in the administers the questionnaire in a consistent way and that work tasks are at least mentioned.

I don't see welding mentioned anywhere on the form, just as an example. I don't see degreasing mentioned anywhere on the form. And there are others.

CHAIR MARKOWITZ: So this is Steven. What I'm trying to figure out is you've got this enormous diversity of job titles among claimants that we're all aware of. And it's hard to think about generic list of tasks that could be used in this questionnaire that would cover a lot of different job titles. That's kind of where I get stuck.

MEMBER POPE: This is Duronda. Didn't we at one point as a Board say that we wanted the

IH to interview the claimant to better try to understand the processes that claimants might've been exposed to?

CHAIR MARKOWITZ: Yes, we made that recommendation. That was accepted.

MEMBER POPE: Okay.

CHAIR MARKOWITZ: And we heard this morning that I think that one interview has been completed.

MEMBER POPE: Thank you.

MEMBER DEMENT: Steven, I agree with you. There's not going to be one set of specific tasks that covers everybody. But really based on the claims that I've reviewed on the Board, there are some reasonable ones that are pretty consistent.

And I think somewhere along the way that there needs to be some presentation of these. And I don't know exactly where the place is based on this history form right now. The only place I can see that you can incorporate it is under the discussion introduction part where

it's sort of scripted. Where you give examples, you could give more examples.

Anyway, that's just my thought. I guess it is what it is currently. It'll be piloted, and you'll see sort of what the result is.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I have a comment. Rose and Carrie, you do even more teaching medical students than I do. But when we teach how to take an occupational history, one of the first things we teach is that the job title doesn't tell you everything and you have to ask about what people do.

So could we -- is there a question on how to title work? In other words, could you put in a question, do you have any exposures that you're concerned about that are not typical for your job title?

And that would trigger then an open ended interview by someone would can take -- who has the skills to take a careful occupational

history. Because I find it very difficult to boil this down to an algorithmic approach like a questionnaire that's going to cover all the possibilities.

The questionnaire should just kind of divulge the easy cases. But people do out of title work frequently. I think that's where a lot of some of these exposures are going to be found.

MEMBER GOLDMAN: And this is Rose. This is really difficult. I mean, when we interview somebody for an occupational health visit, yes, you're right, George. Somebody could pay their plumber or whatever. You have no idea what they do. And I usually just start by saying, tell me a typical day. Or what is it that you do? And just have them write a paragraph.

And then based on that paragraph, that leads to additional questions. And your point is well taken because you could follow that initial those are your main job duties. But what else do

you do that might be different from that?

And the problem with that approach is that's usually what we use when it's more recent for somebody. But if they're trying to remember back 10 or 15 or 20 years, it's very difficult. And yet just having a check off, X, Y, and Z, even though it's easy to interview, you're really missing what could be the real exposures.

CHAIR MARKOWITZ: But is there a question that they could ask on this questionnaire that would address those concerns?

MEMBER FRIEDMAN-JIMENEZ: Yeah. You could ask them, do you feel that there are any hazardous exposures that you had at work that are not represented in the questions that you've answered on this questionnaire? If they say, yes, that would be a trigger for an industrial hygienist to ask them a detailed, open-ended history.

MEMBER DEMENT: Well, there actually is a place on the form, and I think Kevin scrolling down. It goes through introduction,

has a place for additional information. If that were scripted appropriately, and it looks like it almost is now, it would provide that. I mean, it's just a discussion.

MEMBER TEBAY: This is Calin Tebay.

CHAIR MARKOWITZ: Calin?

MEMBER TEBAY: This is Calin Tebay. I have a comment. At the Hanford Workforce Engagement Center, we see this every day, right? We have people come in that try. Actually, they're here to find out what their benefit options are and how to prepare to submit claims, including work history.

And what we find out a lot is either they forget, they're unaware of the exposures. They're unaware of a byproduct of welding or an exposure. When they go to the resource center, a lot of times the person doing the interview doesn't understand the exposures or what questions to try and draw out of these people.

My question is is there a specific question that would trigger? And I just heard

this. But there's a specific question that would trigger an IH to have that interview. And is it realistic? Is the DOL going to provide the resources to have that one-on-one interview with these individuals?

What we've been doing is telling people just to write an addendum to all these before they even go in. Because what happens is that they go in and they're put under -- you've got an hour or an hour and a half in there. A lot of times, they don't get communicated via the occupational work history questionnaire everything they've done.

So we try to get to them before that and just say, write an addendum, whether that be a page, a half a page, two pages, of everything you can think of you've done in your career on the site and all the processes you've been involved in, all the tasks, what those were daily, weekly.

But I'm with everybody else. This is, like, the most difficult part of the claim in my

opinion where we see somewhat of a disconnect, right? Because if you don't get this piece right, the claim doesn't go the same. It's not the same all the way through.

And then if you get through the claim and you miss some information, it's really hard to unwind and walk back and start over. Is the Department of Labor going to provide the resources to have an IH reach out to each one of these individuals? And is that IH going to be qualified to try and draw out the information they could or they should for that person's craft or whatever, you know, their employment was, whatever they were during their employment at the site?

So I'm still at a loss on how to put all those pieces together. But this is a very sticky one for here we see every day.

CHAIR MARKOWITZ: This is Steven. Does anybody know? Are these mostly done over the phone, the interviews? Or were they done before COVID?

MEMBER TEBAY: Face to face.

CHAIR MARKOWITZ: Face to face?

MEMBER TEBAY: They're done face to face here, unless you have some kind of disability or you can't make it in. Then they'll do them over the phone. But like a lot of those, if you're just going through the general questionnaire.

And we're saying that at our resource center, we really enjoy our resource center. I think they're pretty good at what they do. But they still, you know, it's hard for somebody that didn't ever work on site or doesn't understand the trade or the craft or what that individual at the site, what those exposures may have been. It's hard for them to even ask the correct questions, right? You know what I mean?

Trying to get the most information out of the claimant that you can get so the claims examiner starts with the information they really need to start putting the pieces of the puzzle together.

MEMBER FRIEDMAN-JIMENEZ: This is part of the art of doing occupational medicine is honing in on what are the important exposures. So I think the key here is to identify the people for whom the occupational health questionnaire does not represent all the important exposures relevant to the health condition that they have.

So what we're looking for is the method for doing that, whether it's a yes/no question or an essay question, having them list the exposures, which in some cases, they may not even know the names of the chemicals. But just have them identify that they, with the questionnaire, didn't capture all of the relevant exposures. And they often have that knowledge themselves.

Now about resources, I think we're obligated to provide resources to take a careful history and identify the relevant exposure for someone that is claiming to have a work-related illness. So I think that's part of what we should be providing.

MEMBER SILVER: I think Calin -- this is Ken Silver. I think Calin Tebay's point about the occupational health questionnaire being pivotal for what happens downstream in the claims process is really important. And if we can flip this on its head, it would be a training program and the workers before they go in to answer the questionnaire.

But short of that, a nice brochure from the Department of Labor that says, your occupational health questionnaire, what to expect. And maybe a lot of the tasks that take up a lot of space could be laid out on there.

Maybe there could be a worksheet analogous to what the IRS provides before they put out the platform that helps you jot down in round numbers and approximations what you think is important so that the person knows that this is a really important encounter.

In that brochure, I would also say something about respirators. Your use or disuse of a respirator will not be held against you. In

fact, if you were issued one, it's a sign that you were probably in a high exposed job. And the resource center people could make sure that the worker and their spouse or their advocate have been over that brochure before coming in to this pivotal encounter.

MEMBER TEBAY: This is Calin Tebay again. I agree with you. We get so many people in this office daily that will come back and say, I didn't turn that information in or I didn't disclose it or I didn't know I should have when I did the interview. Or I got to the interview and I didn't expect to have to answer such specific questions.

I think somewhat of a flyer that was very detailed on what PPE or what processes you were -- I mean, just a reminder to say, you need to jot down these points before you come in. Anything you can think of date-wise, exposure-wise, process-wise, PPE, area, all that stuff so they can be prepared.

Because that's exactly what we do

right now. We tell them, you write down as much as you can remember on this page. And if you have to, you just submit that with the occupational questionnaire. Because if we get it wrong now, going back and trying to start this back over or add these is not the easiest place to be for these folks.

CHAIR MARKOWITZ: This is Steven. Well, actually, they took off PPE from the questionnaire, in part, I think because we pointed out that it's unreliable information and it was a waste of precious time.

But what about proposing that prior to the interview that some sort of worksheet be sent to the claimant with the idea that they would put down whatever they want and bring that to the interview?

MEMBER SILVER: With the triggers that John and you, Steve, were mentioning at the beginning of this conversation.

MEMBER DEMENT: I think it would be helpful and I think you're going to get better

information. That's sort of the reason we've been doing that in BTMed for ever since this program started.

We know that we're missing a lot of information. But we feel that by using some kind of trigger, be it materials, be it tasks, be it work areas that we can at least generate hopefully better information from the workers than we would have otherwise. It's never going to be perfect, but we think it's better.

But that discussion, either with a physician or with an industrial hygienist or the person doing the interview wherever the training might be, that discussion is really key. And their training in terms of being able to understand the exposures and drill down with additional questions where needed is sort of key.

And we suggested that former workers be given priority for those positions to do the interviews. And I think at least our experience at BTMed is that that is -- I think it's helped us in two areas.

One is identification of somebody that's been at the site by the person coming to interview. And also, it leaves some information and knowledge about the work at the site, the actual work that gets done.

MEMBER SILVER: If I were designing the brochure, I would include a sketch of a worker, claimant, age appropriate, dressed appropriate sitting around with a few of his former workmates, like, in a coffee shop putting their heads together before going in to the questionnaire.

MEMBER DEMENT: Actually, you know what? Calin describes that the resource centers is doing a really good job of trying to prepare them before they go in. So if you walk in and you ask these questions sort of out of the blue, it'd be hard for anybody, myself or any worker to actually fill this thing out with great detail without some prior thinking about what's being asked.

CHAIR MARKOWITZ: This is Steven.

Other comments?

So I have a question. If you could scroll this up to one of the exposure classes. I'm still -- I want to ask. Do people think asking the form of the substance and how exposed in the way that the examples are given if that's useful?

MEMBER DEMENT: This is John. I think that information is minimally useful. I think the more important stuff is how were you exposed? Tell me how and what did you do. Most of the time, we're going to know the form of the material. If it's trichloroethylene, we're going to know what it is unless they have skin contact.

MEMBER TEBAY: This is Calin Tebay again. I just wanted to add this quick note here. Apparently, there is a -- and we get this from our resource center which is not too far from us. There's a handout. It's an FAQ. So it's United States Department of Labor frequently asked questions.

It goes through what is the EEOICPA.

It goes through what is covered under Part B. What are the benefits? What's covered under Part E, presumption, benefit amounts, what medical conditions may be compensable, causation, what are the eligible survivors for Part B and Part E, and then what evidence is required for my claim to be accepted.

And under that, it says, your case file must contain evidence of covered employment, a diagnosed medical condition, causation. Causation means a demonstrated relationship between employment exposure and a diagnosed condition. If the employee is deceased, the file must contain evidence establishing that you are an eligible survivor.

So there is an FAQ. Obviously, that doesn't cover what we're talking about here. But they already do currently have an FAQ that's available at this resource center where we may be able to add to the FAQ some additional documentation that would trigger these folks to start preparing for this claim interview before

they get there.

MEMBER DOMINA: Hey, this is Kirk. I don't know why they can't send it out because under Part B, the claimant gets a copy from NIOSH on the CATI interview, the computer-assisted telephone interview, ahead of time, a list of the questions. So I don't know why this can't be done.

CHAIR MARKOWITZ: What's this? What are you referring to, Kirk?

MEMBER DOMINA: On the Part B side, radiation side, the claimant --

CHAIR MARKOWITZ: No, no, no. I get that. When you said you don't understand why this can't be done, what's this?

MEMBER DOMINA: Oh, a copy of the questions they're going to ask them. That's the same thing that NIOSH does. They give them a list a couple weeks ahead of time.

CHAIR MARKOWITZ: That would be kind of the simplest thing. Do you think, though, that this questionnaire would be user-friendly

enough for people to begin to fill out themselves and serve that function as a trigger?

MEMBER DOMINA: Well, I think it needs work. But either, somewhere, you've got to start. And I think Dr. Dement is our expert on the right track for this because my opinion it's kind of like Labor asking us help with on the Part B readers. But yet the IHs, in my opinion, can't possibly know the environment that we've worked at in all these years.

I mean, in all the places that some of these have take place at, you might as well shove them into a box. And you're expected to because that's what we do. And I think that without them physically being there and being in that environment, you can't physically -- very few people, I guess, could put it into words to make them understand what our people have done.

CHAIR MARKOWITZ: So what do people think? Just simply recommending that they send this questionnaire to people prior to the interview so people know what's going to be

asked?

MEMBER TEBAY: This is Calin Tebay again. And I think Dr. Dement is on the right track with this occupational health questionnaire. But I definitely think, like Dr. Silver, that we need at minimum something to trigger these people, the thought process to prepare for this before they get in to go over the health questionnaire or the work history questionnaire.

What happens here at our resource center is I don't think they're a huge fan of sending that questionnaire out beforehand from the simple fact that they like to have that verbal discussion and populate that as they're talking to you rather than having you take that and fill it out yourself and then transferring it from a handwritten form into a digital form so they can submit it.

But at minimum, I think we have to develop something to trigger these people to prepare for the occupational health questionnaire

and that interview process.

MEMBER GOLDMAN: Why -- this is Rose Goldman again. Why can't they get the questionnaire ahead of time but the person would still go through the whole interview process? So the person would've been triggered to try to fill in part of it first. And then the interviewer would just still keep going over everything and help them fill it in and flesh it out more.

MEMBER DEMENT: This is John. That's what happens in the BTMed. They're just given the questions and the task and the materials. And so they have sort of the structure of what to expect when they come in. And they're more prepared. I mean, they can describe better and having some of these triggers. Okay. You were exposed to metals. How were you exposed to metals?

So I think you could probably send the occupational history questionnaire. Maybe with a little more -- a few pages of description of how some of these exposures, for example, solvents

and fumes and vapors, how that might happen in the examples that are given. It might help. I'm sure it would help.

MEMBER FRIEDMAN-JIMENEZ: This is Dr. Friedman-Jimenez. In our occupational medicine clinic, we give a written questionnaire to every patient. I'd say 10 to 20 percent of them can't fill it out at all and needs help to go through the whole thing. And probably 80 percent of them as the doctor goes through it with them, we wind up filling in parts of the questionnaire.

So I'm thinking maybe if you had an online questionnaire, the person could fill it in, whatever percentage of it they felt comfortable with. And then the interviewer would just go through the questionnaire that they've already filled in online and either answer questions or correct what they've done or confirm that that's really what the questionnaire meant.

That way, they will have had time to think about. You won't have to have them double fill out the questionnaire. And you'll confirm

the important parts of it.

MEMBER DEMENT: Let me just read -- this is a paragraph that comes out of the DOL response to specifically the question that we're trying to address.

It says, applying techniques to supply preselected information that employee could attest to absent any collaborating connection or to other evidence obtained during the development may produce unauthentic and unreliable outcomes.

So it's a double edged sword. I mean, so you stimulate the recall. And they phrase it -- I didn't know from reading this, that workers may actually claim exposures that maybe they didn't have. But that's not been our experience over 20 years.

I won't say that's always the case. For the vast majority, we're more concerned with not recalling exposures than we are creating exposures that are not there.

MEMBER FRIEDMAN-JIMENEZ: In our clinic, I find that to be extremely rare. Rose

and Carrie, you have any other perceptions?

MEMBER REDLICH: You mean that workers are going to sort of fudge things or add things that by giving them a form ahead of time? I think that we give them a bit of a form to fill out ahead of time and it's very basic. And then we delve deeper.

But I don't think -- I wouldn't think that would be the issue here. I mean, I could see somebody calling up somebody that they worked with and said, hey, do you remember something about that process we used to do or what's the name of that building?

I mean, I would be less suspicious of them sort of expanding on things that didn't really happen. But maybe I'm naive.

MEMBER FRIEDMAN-JIMENEZ: I mean, you could imagine that someone with sarcoidosis will look up and find out that beryllium exposure produces something similar. And say they worked in a beryllium exposed job.

So I think that's extremely unlikely.

I actually haven't seen that among our patients that I'm aware of. And we do try and confirm the exposures.

MEMBER REDLICH: I mean, in this situation, I think it's even less likely because you can confirm the exposure. Somebody can say they've worked in a beryllium factory as a DOE worker and they haven't had any exposure to that.

So I think it's actually less likely and it could be helpful. I don't see the harm in sending it ahead of time. But I wouldn't use whatever they write there to automatically be digitally inputted. I do agree that one needs to be talking to them additionally about whatever they were thinking about.

MEMBER POPE: I don't see anything wrong with -- I think we're talking about time here. So if you give the individual, the claimant time to think about that process, that job that they did, that exposure that they received, then that enables them to give that information to you. You're just going over what you've already

-- what they've already given you.

And so you just can confirm what they're already saying to you, what they already put on paper. So I think if you allow that claimant time to think about what they've been exposed to, that job that they did. That will enable them to help the claims examiner to examine that information.

MEMBER TEBAY: I agree. This is Calin Tebay again. If we call today -- if I called the resource center from my office for a claimant that's a potential claimant and they've got an opening tomorrow, they schedule that opening for tomorrow morning.

That does not give somebody enough time for them to prepare for that interview, at least to accurate document what they've done. So there's got to be something put in place because we need to give these people this amount of time to trigger them to start documenting their work history, wherever they worked, before they come into this interview.

MEMBER GOLDMAN: This is Rose Goldman again. We noticed too in our clinic that sometimes people do need an urgent visit and we bring them in right away. But in your situation, how much of the time is it that somebody really needs to come in? Is that something that's really thought of or is that a small percentage?

MEMBER TEBAY: Well, here's the thing is you don't necessarily -- I don't believe that you need to fill out the occupational questionnaire -- the work history questionnaire to submit the claim. I don't know if it needs to be complete.

The only time it would be an emergency is if, for instance, you know with the DOL, they only reimburse back to the day you filed a claim. So if I was to come down or be diagnosed with some sort of occupational disease and I wanted to get that claim filed as soon as possible so I could get reimbursed back to that day, right?

Because some people miss that, right? They end up getting a cancer or some kind of

disease going through a bunch of treatment, then coming to file the claim and they miss out on four or five months of reimbursement for medical expenses.

So my point is, is that if I needed to file that claim immediately, I can go file the claim immediately and add the other information as I have time. So if somebody needed to file immediately, the resource center should be able to file a claim to establish the claim date which will get them folks reimbursed back to that day potentially.

And then they could have time to really put their mind together because that's another part of this process. If you have an emergency where you need to file that claim today, the last thing on your mind is putting together your work history in the next 24 to 48 hours so you can fill out the claim. Or a family member can go do it for you. That even makes it tougher. So do you see the hurdle here with that?

(Simultaneous speaking.)

MEMBER MAHS: This is Ron.

MEMBER GOLDMAN: Is it required or is it something optional, I guess?

MEMBER TEBAY: Normally, if we don't have specific information, the resource center says, if you don't have the specific information, you can continue to submit that via the portal. You can go back to the resource center and submit it there. But you don't have to have all the information at the beginning.

So like I said, if there was an emergency where the individual had to file the claim for benefit purposes, then file the claim. But don't require them to fill out the occupational work history questionnaire if they're not prepared, right? Let them have some time to put those thoughts together and get prepared for that so it's accurate.

MEMBER MAHS: What we've done over the years, we save time sheets for workers in construction. Not like they're working in the

same building. There might be two or three different buildings at least. And in ten years, that comes to hundreds and hundreds of different buildings.

So our resource, I don't know how many times over the years of asking for time sheets. We've got time sheets since the '50s. And within the time sheets, it shows where they worked, what they worked on, and what they processed in that building, what kind of toxic chemicals. And they've been listed to get some more information.

MEMBER TEBAY: To be honest, Ron, I wish we had that same database because we don't have that here in our building trade. I was a building trade sheet welder for 20 years.

I worked at Hanford for probably 10 or 11 of those total of that 20 years as a subcontractor. And not one -- I mean, I have my dispatch from the union hall, right? But I don't have anything. It dispatches to the contractor. The contractor doesn't have anything specific that I actually worked on this site or the

processed I did at that point.

MEMBER MAHS: Well, the employers or even DOE, they've got a record where you work through radiation tracking.

MEMBER TEBAY: Yeah, but they -- yeah, on our site, we have those. We have dosimetry records. But as a subcontractor, a lot of times, you're working where you're welding. But you're not required to wear dosimetry. So it doesn't cover all of it is my point. You know what I'm saying? There's still big gaps in the documentation part.

MEMBER POPE: This is Duronda Pope. I'd just echo what Calin and Ron are saying about the gaps and unable to track everything because a lot of times when we were assigned jobs, just that specific job, that job classification, you could be doing outside of that that wasn't documented as you do in that specific job.

But back to the people having time, the claimants have time. I don't know how many times that you get into an interview and you're

trying to recall things and you feel like you're under the gun. And then you miss things. So that makes it even more important to have this form ahead of time so you can have time to think about it.

MEMBER TEBAY: And we can't fault the claims examiner for processing a claim with a recommended denial if they don't have half the information. You know what I'm saying? I mean, they're doing the best they can with the information they got. So I agree with Ron. We have to have as much time as possible in order to prep these people to go in there and fill out this questionnaire as accurately and as full as we can so the claim starts on the right foot.

CHAIR MARKOWITZ: This is Steven. I got dropped for a couple of minutes. So it seems to be general agreement that we recommend the Department send around this questionnaire or perhaps a simplified version of the questionnaire to the claimant prior to the interview. Is that right?

MEMBER TEBAY: Yeah, I agree with that.

MEMBER POPE: Yes.

CHAIR MARKOWITZ: I think the advantage of giving a choice between this questionnaire or a simplified version is that if the Department is set on not giving the exact version of the questionnaire over, a simplified version would still -- user-friendly -- would still serve the same purpose that we're talking about.

MEMBER DEMENT: This is John. I agree with the questionnaire being sent out prior to. I think that's important. I also think if this particular questionnaire is sent out, then for some of these materials, there needs to be, in my opinion, an addendum that goes with it that sort of describes how exposure to some of these things might occur.

CHAIR MARKOWITZ: So let me just interrupt. This is Steven. We have Stephanie Carroll who was a public commenter who had

trouble getting on or something who would like to make a public comment. So if I could just interrupt this discussion for a few minutes and allow her to make her public comment. And we can get back to the discussion which we may need to complete tomorrow morning, if that's all right.

So Kevin, are we set up to allow Stephanie Carroll to make her public comment?

MR. BIRD: Give me one second.

MR. CHANCE: Dr. Markowitz, this is Mike.

CHAIR MARKOWITZ: Yeah.

MR. CHANCE: I'm not sure if anyone from the program is on, but we are tabulating the discussion for questions that we can pass forward on the OHQ, the discussion that you guys --

CHAIR MARKOWITZ: Okay.

MR. CHANCE: -- just had.

CHAIR MARKOWITZ: Okay, good.

MR. CHANCE: So we're trying to keep track of that.

CHAIR MARKOWITZ: Okay. Thank you.

MR. BIRD: Okay. So Stephanie, are you there with us?

MS. CARROLL: I am, thanks. Are you ready? You can all hear me? I am -- my Stephanie Carroll and I'm an authorized rep specializing in lung disease and specifically chronic beryllium disease. And I would like to address the question posed by the DEEOIC staff concerning the DOE.

As you may know, OWCP for years ignored the very suspicious DOE reports done by Johns Hopkins that virtually never found significant disease among the coal miner population.

In 2011, I used a NIOSH certified B reader that was bullied out of the program. He was harassed and questioned in such a manner that it resulted in his withdrawal from ever doing B reads for the Department of Energy workers again. The claims examiners were not accepting a B read without a signature in order to discount the validity of the claimant's B reader.

I met with John Howard of NIOSH and he wrote a letter claiming that at the time his signature was not required on the NIOSH form. By then, the B reader had quit the program. We could never use him again.

This is what claimants are experiencing now. A certified B reader evaluates a digital film without benefit of reading the original radiology report. The CE is requesting a copy of the original radiology report and then disregarding the opinion of the B reader if it does not match the original report.

In other words, if pneumoconiosis or findings consistent with pneumoconiosis are notindicated on the original radiology report, the B reader is put under suspicion.

The problem is not a conflict between two B reads as was stated by Rachel earlier. It's usually a conflict between the original radiology report which was not doing a occupational lung disease review and the B reader's report.

And the conflict contain, yes, the original radiology. The conflict is not advised unless it benefits the claimant. I never see any questions about to B reader looking at the same radiology and coming up with two different findings that come from, say, Rocky Flats. Sometimes they would have two B readers read the same film. There has never been questions when part of it benefits the claimant.

The conflict often results in a threatening letter being sent to claimant's B reader questioning the veracity of his or her report. Of course, this heightened scrutiny appears to only be done in a -- there's a particular B reader, records findings of pneumoconiosis in favor of the claimant. That's what I've seen.

And we've gotten some really threatening letters sent to our current B reader. And I believe it's just a way to get them to quit the program. When an official sends a letter, he's a small business owner usually, from the

Department of Labor questioning a report that he did in such a manner to suggest that you may be submitting fraud or lying about the report.

It's pretty threatening and keeps the claimant from being able to have a source of a non-biased physician to review their radiology. So it's been really awful, and I've noticed it more so lately.

And I think that's because some claimants have -- there's been an uptick of claimants getting their own B readers to look at their chest x-rays. And this is why this has become an issue now, and it wasn't an issue back in the day when Johns Hopkins was doing B reads at 750 bucks a pop and always finding in favor of the companies against the coal miners.

So now that there's some B readers out there supporting workers, I think they would like to get rid of that. So that's where that question came from. It was strange that it was suggested that it was the conflict between two B reads. I haven't seen that. That's not really

the issue. It's claims examiners writing letters saying, we want to see the original radiology that the B reader looked at.

So that's what's going on with the B reads. And then also I looked up glyphosate on the SEM. It does show up, but it reads that there are no diseases that are listed in NLM guides. And that, quote, NLM has not identified any occupational disease where glyphosate is a question.

So if he goes on SEM to see if glyphosate may have had something to do with his cancer, he's going to find that there are no disease relationships there.

So the other thing about SEM you should know is the Department of Labor has a library of all the documents and studies that support everything within the SEM. They used to have it on the SEM that was only seen by claims examiners before it became public. It was with the documents related to each of the, I guess, things that were in the SEM.

So if there was asbestos in SEM, there would be a library document number, a Department of Labor library document number. It wasn't DOE. It was Department of Labor. And that library has all the documents to support SEM.

So it might be helpful for anybody working on the SEM project to know what documentation we already have that supports what chemicals and toxins and illnesses they have in SEM. But they do have that library.

That's all I have to say for today, and thank you all for your work. I appreciate it.

CHAIR MARKOWITZ: Thank you very much. Thank you, Ms. Carroll. So I propose -- it's eight minutes before 5:00, that we try to, if we can, finish this occupational health questionnaire discussion now. If not, we can continue tomorrow morning. But let's try to finish it now. And then we will pick up tomorrow morning at 11:00 a.m. with the other items on our agenda.

We do have time tomorrow. There's a lot of soft spots. So I'm not terribly worried about that. So let's go back to the occupational health questionnaire discussion. Were there other comments that I interrupted the middle of?

Okay. So the general sense from the discussion from the people who spoke is that it would be useable to the process if this questionnaire, the occupational health questionnaire, or a simplified version were sent to the claimants ahead of time with sufficient time for them to fill it out or use it as a memory trigger so that they're better able to participate in the interview.

Were there any -- on the questionnaire itself as we're looking at it, this is the draft, was one change in particular I heard which was under additional information to add some language, add some text in addition to -- I think it's under -- yeah, keep going. It's section -- there it is.

Actually, this digital information is

specifically about incidents. But it could be broadened. And this is Dr. Friedman-Jimenez's idea. Is there any additional information about other exposures or exposures that are sort of unexpected for your job title that you would like to add to the data here? It would be phrased a little better than that.

But were there any other specific changes in this questionnaire we're looking at that people were proposing?

MEMBER DEMENT: This is John Dement. I think in the area specifically under metals, I think welding needs to be added. And so the red text is describing tasks. And under solvents, I think solvent degreasing needs to be added under that red descriptive information.

CHAIR MARKOWITZ: Okay. That's easy enough. Personally, I think you're asking about the form of the toxic substances and how a person is exposed with the inhalation and skin as examples. I personally find that to be mostly a waste of time and a waste of space because that

same information will either come out or be interpretable in the process.

I personally would augment the how do you use this substance with an additional question of what tasks did you perform with this material instead of the form and how exposed in order to get at this information that we've been discussing.

MEMBER REDLICH: This is Carrie. I may have missed it. But in terms of asking about PPE, there's a question at the end. Were there any others?

CHAIR MARKOWITZ: Where are you looking at exactly?

MEMBER REDLICH: I saw it somewhere. I'm just trying to remember where I saw it. Hold on. Oh, under the incidents, what protective equipment were you wearing? Now I must say I find the PPE question frequently more informative of indicating that there was a hazard that you needed to wear PPE for rather than reassurance that there was some kind of full protection. But

I was just wondering if that was addressed anywhere else.

(Simultaneous speaking.)

CHAIR MARKOWITZ: This is Steven. Actually, I do see it in Section 4E in the red ink where it says, information for each job title from Section 4D. Okay. No, no. Go back. Yeah, you see in the second row there. Or actually, both, both examples. They give examples of people who were wearing -- they specify what PPE they were using.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: So what was your thought about this? It's useful? It's not useful?

MEMBER REDLICH: Well, I would probably defer to others, but I was just even looking to just see where it was included. And I see it is. It wasn't just on the events at the end.

CHAIR MARKOWITZ: Well, this is Steven. So correct me if I'm wrong. But I

believe we recommended previously that they remove questions about PPE, mostly because it really didn't provide useable information. And if that is our view, then we should probably apply it to this version of the questionnaire as well. Comments?

MEMBER DEMENT: Steven, this is John again. I think our comment about the PPE on the last questionnaire, it was very voluminous and extensive. I mean, it asked about great detail. I don't object to it being in a description of, I do this work and I used rubber gloves, for example. think that's sort of helpful.

But it's just in an example. You're not going to get it all the time. It's whatever the worker provides. I don't object to it being in this portion of it.

CHAIR MARKOWITZ: Okay. I defer to the industrial hygiene expert. Other comments?

MEMBER TEBAY: Well, what about for those -- I guess my idea is -- this is Calin Tebay -- was not to document the PPE or maybe the

lack of PPE. For instance, I mean, there's been a lot of times where you work out of the field, you don't have the same PPE that's set up, ventilators, exhaust systems, stuff like that you don't have.

So my thought was when you're filling out this occupational questionnaire is I perform this task. Did you wear PPE? No, I didn't have PPE.

For instance, let's go back to welding. It's an easy one. I welded in the field upside down in a confined space or what I would say a confined space. And there's no such thing as an exhaust fan or a localized exhaust in that situation, right? And there was no special PPE for that.

So I guess to kind of go back on what I said is I'm not trying to document that I did wear PPE. Maybe it's a question, were you provided PPE? In that situation, was there PPE available? Or I performed these tasks with no PPE. I mean, and that's not uncommon to not have

the PPE in prior years. So that was kind of my thought process on PPE.

MEMBER POPE: Great point. This is Duronda Pope. That reminds me of laborers that were outside maintaining the grounds, had no PPE.

CHAIR MARKOWITZ: So does that translate into a recommendation that they specifically have asked about PPE? Or in other words, above and beyond it's currently phrased where they give it in the examples? And if so, what would you ask?

MEMBER SILVER: This is Ken Silver. We've been back and forth on this I think in our very first meeting in D.C. Dr. Sokas got everyone's head nodding to what we've heard. A couple of the physicians say today which is that presence of PPE is a marker for a hazardous environment.

But claims examiners were rumored to be interpreting it to mean that the person had low exposures. So rather than reintroducing a trigger about PPE, perhaps it could be captured

in a field that says, anything else to add.

And if the worker has recollections like Calin described, like Duronda described for the grounds keepers, that would be the place for them to volunteer that they had no gear. But I hate to put debate in there for the claims examiners to misinterpret what an affirmative answer to PPE means.

CHAIR MARKOWITZ: So right now in the examples, there is a trigger or a suggestion that the PPE either be addressed or the lack thereof. It's a soft -- as it stands now, it's a soft question or soft trigger. Is that sufficient?

Personally, I think it is because it reminds the claimant to talk about it if they want to. It doesn't give that very specific information that was previously collected that could be misinterpreted in the claims evaluation process.

It gives them the opportunity to say, yeah, I did that and we had nothing. Or we had cotton gloves, or something like that. But it

doesn't sort of force them into a box on that question.

MEMBER FRIEDMAN-JIMENEZ: We could ask several questions. For example, first ask, have you worked in situations where you believe PPE would be necessary? And then the next question, did you have adequate PPE in those situations? So that would be harder to misinterpret as PPE indicating that they weren't exposed.

CHAIR MARKOWITZ: Other comments?

MEMBER DOMINA: This is Kirk. I agree with George because so many times it's not the proper PPE. And that's where I think that things get misinterpreted, especially on a respiratory when it's not the right PPE, right respirator because we just didn't have them. And the same thing --

MEMBER FRIEDMAN-JIMENEZ: The other thing is to boil down three or four thousand work days to did you get PPE or not, just there's no way to do it. So you have to rely on the worker to make a judgment whether PPE was necessary and

then whether they had adequate PPE. Otherwise, you have to ask so many questions about when was the PPE provided and when wasn't it and for which exposures. It's very complicated.

CHAIR MARKOWITZ: So what question -- or maybe we can't resolve this now. It's five after 5:00. But we can resume it tomorrow. If there's specific questions that you would add and where you would add it, that would be helpful.

MEMBER FRIEDMAN-JIMENEZ: I'll draft two questions.

CHAIR MARKOWITZ: Okay. Send them to Kevin, and we can take a look at them tomorrow.

MEMBER FRIEDMAN-JIMENEZ: Okay.

CHAIR MARKOWITZ: Actually, if you wouldn't mind on that, also just playing with the text of that other question at the end where it says additional information. That addresses the concern you raised earlier about unexpected exposures given job title. You know what I mean?

MEMBER FRIEDMAN-JIMENEZ: Okay.

CHAIR MARKOWITZ: Okay, great.

Thanks.

MEMBER FRIEDMAN-JIMENEZ: Just a little more detail in the question, whether all relevant occupational history information wasaddressed, because that may not jog their memory enough. Okay. I'll work on those three questions.

CHAIR MARKOWITZ: Right. And then the additional information section wouldn't be just about incidents. It would be in general.

MEMBER FRIEDMAN-JIMENEZ: Yeah.

CHAIR MARKOWITZ: Thank you. Okay. So I think we should wrap it up and resume tomorrow at 11:00 a.m. We'll close out this discussion. I think we'll probably vote on a recommendation about this as part of that discussion.

We will come back to the issue of assessing CMC and industrial hygienist performance and we'll need a hopefully not very long discussion on site-wide job titles, our response to their response. And then we can deal

with a few miscellaneous issues.

The item for tomorrow morning at 11:30 a.m., revisions in the Procedure Manual and bulletins. That's an open agenda item. If there were any bulletins or Procedure Manual changes that you -- since our last meeting that you wanted to discuss. So I don't have a premeditated discussion about that.

And I don't think there are any new issues that I'm aware of, except we're going to review the public comments and maybe something new will come out of that. We'll see. But I don't expect any problem finishing tomorrow by 2:00. And in fact, we may finish a little bit early.

Can everybody attend tomorrow? Or let me put it this way. Is there anybody who either cannot attend or has to be off at a certain time?

Okay, great. Then Mr. Chance, you want to close the meeting or shall I close it?

MR. CHANCE: Yeah. No, I can do it. Thank you, Doctor. I want to thank everybody for

their participation today. We've had a very, good robust discussion. And we will adjourn for the evening and reconvene at 11:00 tomorrow morning. So everyone have a great evening. Be safe.

(Whereupon, the above-entitled matter went off the record at 5:10 p.m.)