

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

+ + + + +

WEDNESDAY,
APRIL 19, 2017

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The Advisory Board met at 8:30 a.m.
Pacific Time, at the Red Lion Hanford House, 802
George Washington Way, Richland, Washington,
Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

JOHN M. DEMENT
MARK GRIFFON*
KENNETH Z. SILVER
GEORGE FRIEDMAN-JIMENEZ
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair
LAURA S. WELCH
ROSEMARY K SOKAS*
CARRIE A. REDLICH
VICTORIA A. CASSANO

CLAIMANT COMMUNITY:

DURONDA M. POPE

KIRK D. DOMINA

GARRY M. WHITLEY

JAMES H. TURNER

FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

DOUG FITZGERALD

*Participating via telephone

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

2 8:36 a.m.

3 MR. FITZGERALD: Good morning,
4 everyone. My name is Doug Fitzgerald and I'm the
5 -- I'd like to welcome you first to this meeting
6 of the Department of Labor's Advisory Board on
7 Toxic Substances and Worker Health. I'm the
8 Board's designated federal officer, or DFO.

9 A couple of quick housekeeping items.
10 I'd be remiss if I didn't mention that if there's
11 an emergency, there are two exits at either side
12 of the room, and please exit through those exits.
13 And there is a restroom to the right as you go
14 out. And those are kind of the environmental and
15 safety issues I have to inform you of, I guess.

16 But first, on behalf of the Department
17 I wanted to express our appreciation to the Board
18 for their work and diligent efforts preparing for
19 this meeting. And I also want to acknowledge a
20 couple of individuals who helped make this
21 meeting possible. That's Carrie Rhoads, who's
22 with the Board's staff in Washington, as well as

1 Kevin Bird and Melissa Schroeder, our contract
2 officers who were -- who did all of the travel
3 arrangements and the logistics for preparing for
4 this meeting as well.

5 As DFO I serve as the liaison between
6 the Board and the Department. I'm also
7 responsible for ensuring all provisions of the
8 Federal Advisory Committee Act, or the FACA, are
9 met regarding operations of the Board. I work
10 closely with the Board's chair, Dr. Markowitz,
11 and I'm responsible for approving the meeting
12 agenda and for opening and adjourning meetings.
13 I also work with the appropriate agency officials
14 to ensure that all relevant ethics and
15 regulations are satisfied.

16 We have a full agenda for the next
17 day-and-a-half, and you should note that the
18 agenda times are approximate, so as hard as we
19 may try to stay with the agenda, we can't always
20 keep to the exact times. We will try to be
21 mindful of breaks, however.

22 Copies of all meeting materials and

1 public comments are or will be available on the
2 Board's web site under the heading "Meetings."
3 The Board's web site can be found at
4 dol.gov/owcp/energy/regs/compliance/advisoryboard.htm,
5 or you can just Google "Advisory Board on
6 Toxic Substances and Worker Health" and you'll
7 probably get right there.

8 If you haven't already visited the
9 Board's web site, I strongly encourage you to do
10 so. After clicking on today's meeting date,
11 you'll see a page dedicated entirely for this
12 week's meeting. That page contains all materials
13 submitted to us in advance of the meeting, and we
14 will publish any materials that are provided by
15 our presenters throughout the next day-and-a-
16 half. There you can also find today's agenda as
17 well as instructions for participating remotely
18 in both the meeting and the public comment period
19 at the end of the day.

20 If you are participating remotely, I
21 want to point out that the telephone numbers and
22 links for the WebEx sessions are different for

1 each day, so please be mindful of those
2 instructions. If you're joining by WebEx, please
3 note that the session is for viewing only and
4 will not be interactive.

5 The phones will also be muted during
6 the public comment period from 4:30 to 6:00 p.m.
7 today.

8 During Board discussions and prior to
9 the public comment period I would request that
10 people in the room remain as quiet as possible
11 since we're recording the meeting to produce
12 transcripts. We do have a scheduled hour-and-a-
13 half for public comment at the end of the day.
14 The Chair will note that this isn't a question
15 and answer session, but rather an opportunity for
16 the public to provide comments about the topics
17 being considered by the Board.

18 If for any reason the Board members
19 require clarification on an issue that requires
20 participation from the public, the Board may
21 request such information through the Chair or
22 myself.

1 The FACA requires that minutes of this
2 meeting be prepared to include a description of
3 the matters discussed over the next day-and-a-
4 half and any conclusions reached by the Board.
5 As DFO I prepare the minutes and ensure that
6 they're certified by the Board's Chair. The
7 minutes for today's meeting will be available on
8 the web site no later than 90 calendar days from
9 today per FACA regulations, but if they're
10 available sooner, we'll publish them before the
11 90th day.

12 Also, although formal minutes will be
13 prepared because they're required by the FACA,
14 we'll also be publishing verbatim transcripts,
15 which are obviously more detailed. These
16 transcripts will be available on the Board's web
17 site May 20th.

18 And with that, Mr. Chairman, I convene
19 this meeting of the Advisory Board on Toxic
20 Substances and Worker Health. Welcome.

21 CHAIR MARKOWITZ: Thank you. Good
22 morning. Can you hear me in back? Okay.

1 Thanks. So I would like to add a note of welcome
2 to everyone here, my sister and fellow Board
3 members, members of the public who are here, the
4 representatives from the Department of Labor, Dr.
5 Worthington, Dr. Al-Nabulsi from the Department
6 of Energy, Malcolm Nelson, and I think Steven
7 Levin from the Ombudsman Office within the
8 Department of Labor, and other as well, including
9 we have some staff members from Senator Cantwell
10 and Senator Murray's Office.

11 So thank you very much for coming.

12 I want to thank Doug Fitzgerald and
13 Carrie Rhoads for the hard work they've performed
14 on our behalf in keeping the Board properly
15 communicated and logistically supported in order
16 to do our work. In particular Carrie Rhoads
17 works very hard to keep us in touch with each
18 other and to support these meetings.

19 So thank you very much.

20 In previous two face-to-face meetings,
21 which were last April and in October, October in
22 Oak Ridge and last April in Washington, sometimes

1 during the public comment period there were
2 individual DOE workers, former workers who had
3 specific issues relating to their claims, and we
4 found it helpful that there would be members of
5 the Department of Labor here from the EEOICPA
6 Program.

7 Also, I believe there will be someone
8 here from the Washington State Department of
9 Industry and Labor, or Labor and Industry to
10 address questions one-to-one if you -- if members
11 of the public wish on issues of workers'
12 compensation. And of course the Ombudsman Office
13 from DOL is here as well. So that would be an
14 opportunity later in the day, or throughout the
15 day for that matter, if people want to have
16 individual discussions about particular claims.

17 We should go around all do -- the
18 Board will do introductions and then I'll review
19 the agenda briefly.

20 So I'm Steven Markowitz. I'm an
21 occupational medicine physician and
22 epidemiologist from City University of New York.

1 Les?

2 MEMBER BODEN: I'm Les Boden. I'm a
3 professor of public health at the Boston
4 University School of Public Health.

5 MEMBER TURNER: I'm James Turner.
6 I've worked at Rocky Flats for the last 26 years.
7 I was diagnosed in 1990 with chronic beryllium
8 disease.

9 MEMBER VLIEGER: Good morning. I'm
10 Faye Vlieger, a former worker from the Hanford
11 site. I was injured in a chemical exposure there
12 in 2002.

13 MEMBER REDLICH: I'm Carrie Redlich.
14 I'm a professor of medicine at Yale. I'm also an
15 occupational and environmental medicine physician
16 and a pulmonologist and director of the Yale
17 Occupational Environmental Medicine Program.

18 MEMBER SILVER: Ken Silver, associate
19 professor of environmental health in the College
20 of Public Health at East Tennessee State
21 University. Before relocating to Tennessee I
22 worked very closely with Los Alamos workers and

1 families that advocate for passage of this law
2 and following up on implementation.

3 MEMBER FRIEDMAN-JIMENEZ: I'm George
4 Friedman-Jimenez. I'm the director of the
5 Occupational Environmental Medicine Clinic at
6 Bellevue, New York University School of Medicine,
7 and I'm also an epidemiologist.

8 MEMBER DEMENT: I'm John Dement. I'm
9 faculty at Duke University, Industrial Hygiene
10 and Epidemiology.

11 MEMBER DOMINA: I'm Kirk Domina. I'm
12 the employee health advocate for the Hanford
13 Atomic Metal Trades Council here in Richland,
14 Washington. I'm a current worker. I've been on
15 site for 34 years.

16 MEMBER WHITLEY: I'm Garry Whitley.
17 I'm a former worker at the Y-12 Master Security
18 Complex for 42 years.

19 MEMBER WELCH: I'm Laurie Welch. I'm
20 an occupational physician and I'm on the adjunct
21 faculty at George Washington University and work
22 for the Center to Protect Workers' Rights, the

1 Center for Construction Research and Training.

2 MEMBER CASSANO: Victoria Cassano.

3 I'm also an occupational medicine physician,
4 retired military, radiation health and safety
5 officer, and also worked with the VA on -- as the
6 head of the Environmental and Occupational
7 Exposure Service.

8 MEMBER POPE: I'm Duronda Pope. Work
9 with United Steel Workers Emergency Response
10 Team, but also a former worker of Rocky Flats, 25
11 years.

12 CHAIR MARKOWITZ: And we have two
13 Board members on the phone. Rosemary Sokas are
14 you there? Can you introduce yourself?

15 MEMBER SOKAS: Yes, hi. Rosemary
16 Sokas, faculty at Georgetown University and an
17 occupational medicine physician.

18 CHAIR MARKOWITZ: And also Mark
19 Griffon?

20 MEMBER GRIFFON: Yes, hi. Mark
21 Griffon, health physics consultant.

22 CHAIR MARKOWITZ: Did anybody hear

1 that? Mark, could you do that -- say that again?

2 MEMBER GRIFFON: Mark Griffon. Can
3 you hear me?

4 CHAIR MARKOWITZ: Yes.

5 MEMBER GRIFFON: Mark Griffon. I'm a
6 health physics consultant.

7 CHAIR MARKOWITZ: Okay. Thank you.

8 You should have -- members, you should
9 have copies of the agenda which were available at
10 the table outside. I just want to briefly go
11 over it.

12 This meeting is a little bit shorter
13 compared to the meeting -- last two meetings
14 we've had. It's a bit of an experiment. If it
15 ends up we have two little time, then next
16 meeting we'll revert to a somewhat longer
17 meeting. But I believe we should be able to get
18 our work done today and tomorrow morning.

19 First we'll hear from Ms. Leiton,
20 director of the Energy Employees Occupational
21 Illness Program. And then we're going to get
22 throughout the day subcommittee reports. So the

1 Board has four -- the charter gives us four tasks
2 really, and we have these four subcommittees that
3 address each of the tasks. That's the structure
4 of the subcommittees. And in addition, we have a
5 working group to deal on an issue to -- cuts
6 across committees dealing with the use of
7 presumptions in the program. So first we'll hear
8 from the Site Exposure Matrices Subcommittee and
9 then later in the morning from the Weighing
10 Medical Evidence Subcommittee.

11 The times are approximate. I guess
12 how much time each subcommittee report would
13 take, interrupted by breaks and lunch. So we
14 will go beyond the assigned time period if we
15 need to.

16 We're going to hear from -- after
17 lunch from the Industrial Hygiene and CMC
18 Subcommittee. And then later in the afternoon
19 from the Presumptions Working Group.

20 Tomorrow morning we will hear from the
21 Committee on Part B Lung Conditions. And then we
22 have some time mid and later morning to deal with

1 miscellaneous issues. In part that's issues that
2 arise today and early tomorrow morning. So if
3 there are issues that we need to table and deal
4 -- think about overnight and discuss tomorrow
5 morning, we will have time to do that. And then
6 there are some other miscellaneous issues we'll
7 deal with as well tomorrow. And then we close
8 the meeting tomorrow at 11:00 a.m.

9 Now the public comment period is
10 longer. I think it's longer than the previous
11 ones. Previously it was an hour, but we had one
12 on each day. This time because of the time frame
13 of the meeting, we had a longer one on just one
14 day, an hour-and-a-half. So we'll see how that
15 goes.

16 There have been numerous requests to
17 speak at the public comment period. If anyone
18 here decides they want to speak, they should
19 discuss this with Carrie Rhoads so that we can
20 schedule people properly. And for that matter,
21 for people on the phone if you wish to make a
22 public comment -- first of all, you're all

1 welcome to submit written comments, but if you
2 want to make an oral comment today, for people on
3 the phone you should send an email to Carrie
4 through the web site of the Board, which is
5 energyadvisoryboard@dol.com, just to let us know
6 so we can plan out that public comment period.
7 so that email address is
8 energyadvisoryboard@dol.com.

9 PARTICIPANT: Not dot gov?

10 CHAIR MARKOWITZ: Dot gov. Good.

11 Good point. Okay. Thank you.

12 So any comments about the agenda from
13 the Board? Additions?

14 (No audible response.)

15 CHAIR MARKOWITZ: Okay. Good. So
16 let's move on. We'll hear from Laurie Welch, Dr.
17 Welch, for the Site Exposure -- oh, no. I'm
18 sorry. Rachel.

19 MS. LEITON: Rachel.

20 (Laughter.)

21 CHAIR MARKOWITZ: Rachel Leiton is
22 invited to come to the table. And I should say,

1 we have -- in previous meetings we had Department
2 of Energy on the schedule as well. There wasn't
3 -- we -- I discussed it with them. There wasn't
4 a need really for a set time period, but I would
5 invite comments from Dr. Worthington, Dr. Al-
6 Nabulsi during -- throughout today or tomorrow
7 morning if issues arise.

8 So, Ms. Leiton? Thank you.

9 MS. LEITON: Thank you. It's a
10 pleasure to be here. I appreciate the
11 opportunity to speak to the Board, and I also
12 appreciate all the efforts that you guys have
13 made in the past year on various subjects. Mr.
14 Gary Steinberg, who is the deputy director for
15 Office of Workers' Compensation Programs, wanted
16 to be here today. He wanted to attend the tour.
17 I would have attended the tour, but I've been
18 before. I know it's very, very fascinating. I'm
19 glad that you all had the opportunity to do so.
20 But he did want me to read a brief statement from
21 him into the record. And then I've got just a
22 few comments. I'll try to keep it short so that

1 you can get on with your business.

2 First he wanted to convey his
3 appreciation for the hard work the Board has
4 engaged in since its inception. "We have seen a
5 great deal of enthusiasm and focus on the four
6 areas that fall under the Board's purview. While
7 the Department is expected to provide a formal
8 response to the Board's initial eight
9 recommendations after we have confirmed
10 secretary, "I did send an interim response to Dr.
11 Markowitz indicating our agreement with the
12 recommendations on the circular and the reference
13 material for the SEM. Other recommendations were
14 very thoughtful and will be seriously reviewed
15 for potential implementation.

16 "We recognize that the Board meetings
17 serve as a forum for open communication with the
18 public regarding the program. While we did not
19 hold an annual meeting with the advocates in
20 Denver this year, we are working with the Joint
21 Outreach Task Group to consider other forms for
22 communications. We welcome any inputs from our

1 stakeholders moving forward.

2 "I am very pleased with the results of
3 the Board's endeavors over its first year of
4 activities. We look forward to the Board's
5 recommendations on ways to further enhance the
6 SEM, potential presumptions that the program can
7 use in its adjudication process and enhancements
8 to the medical inputs provided to program staff.

9 "I'm also very proud of the
10 improvements that the program team have made over
11 the past several years. We continue to improve
12 the quality and timeliness of our decisions while
13 also enhancing our communications with our
14 claimants, the advocate community and our other
15 stakeholders.

16 "I hope you have a very productive
17 meeting and look forward to hearing positive
18 feedback regarding the activities this week."

19 That's the end of the statement from
20 Mr. Steinberg. I just wanted to make sure I got
21 that into the record.

22 But just a couple of other things.

1 Mr. Steinberg mentioned in his statement that we
2 have delayed our response to the recommendations
3 because we don't have a secretary. We did send
4 an interim response. And in that interim
5 response we mentioned a couple of things. One
6 was that we've already rescinded the one circular
7 along with the memorandum regarding the post-95
8 exposures. That was based on the recommendations
9 of the Board.

10 In addition, we have -- we asked --
11 one question was in regard to the recommendations
12 of the IOM, and that was basically -- that list
13 is very broad and in some ways it's a little bit
14 inherently incoherent -- inconsistent. And so we
15 thought if you can help us narrow that, that list
16 a little bit, I think it would be more helpful
17 for us to say, okay -- because some of them are
18 related to things that really are occupational in
19 nature. So if we can narrow that to things in
20 that list, sites in that list that can maybe
21 really deal with occupation and how we could use
22 that, that would be really helpful.

1 Those were a couple of things I was
2 able to talk to the administration about doing
3 before we send out the formal recommendation --
4 response to the recommendations.

5 I also just wanted to mention that we
6 have -- I've listened to most of the transcripts
7 for the Subcommittee meetings and I'm very
8 excited actually to see what's going to come out
9 of the presumptions and the Occupational History
10 Questionnaire recommendations that you'll have
11 for us.

12 One of the things that we did send
13 after your last meeting on presumptions was just
14 a -- kind of a -- went through all of our policy
15 guidance that's out there and provided a list of
16 our exposure -- lifting up an exposure and
17 causation presumptions with development guidance
18 for certain conditions. And this is something
19 that we pulled together from published -- things
20 we've already published, some things we've been
21 working on. So this hopefully will be something
22 you can take a look at.

1 If you have questions about the
2 references and that sort of thing after you've
3 had a chance to look through this, we will
4 provide that to you. If you want to know where
5 we got these assumptions, we'll probably have to
6 gather that from our science team and medical
7 team to get that to you later, but we thought it
8 might be a good starting point at least just to
9 keep in mind what we've been looking at. But
10 those -- the recommendations that you guys can
11 provide to us will really -- I think will help us
12 in long term.

13 And I listened in on some of the
14 conversations you had about trying to simplify
15 the process so we don't have to run to a doctor
16 every time or don't have to run to an industrial
17 hygienist. I think we want the input of
18 industrial hygienists whenever we can get them,
19 if they're critical, but when we can avoid it, it
20 does move the process along a little bit more
21 smoothly.

22 The same thing with causation

1 presumptions. The big distinction being when you
2 look at the document we've submitted, there's --
3 we've made some exposure presumptions, which are
4 just what can we assume these people were exposed
5 to versus some causation presumptions. This is
6 what they're exposed to and this is a condition
7 that might be related to it. So those are some
8 big distinctions that we're trying to make and I
9 think that you guys are going to really be able
10 to help us with.

11 I just wanted to also say that I'm
12 looking forward to -- the Subcommittee for
13 Weighing Medical Evidence is going to go to the
14 Seattle District Office this Friday, at least
15 some members of it, to meet with our staff.
16 We're going to have senior staff that have been
17 claims examiners before. I think that that
18 conversation, going over cases, will be very
19 helpful. Jolene Smith, who's the DD, the
20 district director for the Seattle office is here
21 today.

22 Just a few current statistics.

1 Nationwide we've spent -- paid over \$13.6 billion
2 in compensation benefits. In Hanford that's
3 about 1.36 billion and in Washington State, for
4 people living in Washington State that's about
5 \$1.1 billion.

6 We have been active with our Joint
7 Outreach Task Force Group. We've had events last
8 quarter in San Bernardino and Simi Valley to just
9 -- again, the point of the Joint Outreach Task
10 Force Group is to get the word out, to make sure
11 we're intaking claims and taking questions as we
12 can. We're going to have another one of those
13 tomorrow here actually in Pasco at the Red Lion
14 there.

15 That one's going to be more of a round
16 table. A lot of times we'll do presentations for
17 the public. This is going to be -- we're going
18 to have tables set up so people can walk around
19 and ask questions, talk about their claims and
20 that sort of thing.

21 For the year we're looking towards
22 doing some mailings and we're still planning what

1 additional events we're going to do.

2 I did send a list of policy updates
3 that have occurred since the last meeting in
4 October. Hopefully you all have seen that, but
5 it's also on our web site, those updates for
6 policy. Basically, there were a couple of new
7 SEC classes, the Santa Susana and Pantex SEC
8 classes. So we created circulars for those. We
9 also had some Procedure Manual updates regarding
10 impairment, home health care, ancillary medical
11 services and the medical bill process.

12 One of the -- our projects that we're
13 currently working on and I expect to be published
14 very soon is a PDF of our Procedure Manual. And
15 it's going to be one Procedure Manual with all
16 the updates in a searchable format so that if you
17 want to search by word -- it's something that
18 we've been trying to do for a long time. But if
19 you want to search by word, if you want to search
20 by subject, it's going to make it a lot easier to
21 do that.

22 It's also going to be republished

1 whenever we make the changes, substantial changes
2 to it so that you don't have to keep looking to
3 find the various versions. It'll all be in
4 there. So I think that's going to be a really
5 big help for our claims examiners, for the
6 public, and I'm looking forward to making that
7 happen.

8 There will be a mechanism also for
9 things that we need to get published really
10 quickly that will get incorporated into it later,
11 but it might be easier to even do that,
12 incorporate it in with this format faster than
13 we've been able to do that in the past.

14 I just also wanted to mention that we
15 have been doing -- we have a subscriber list for
16 email blasts for information about medical
17 benefits and changes that we may have. We've got
18 a lot of subscribers, I think over 400. We're
19 going to be doing something very similar soon for
20 policy, for any updates to policy, trying to make
21 sure that when we make changes to policy, it's
22 out there. It's in an email blast. People can

1 subscribe to it and get updates as that happens.

2 We also started doing quarterly
3 teleconference call with medical providers,
4 meaning not all doctors themselves can attend
5 these sorts of teleconferences about the program
6 just to ask questions, but sometimes they could
7 send their staff or they could come themselves.
8 And what we do is we try to get questions that
9 we've heard from the medical community and
10 provide answers at these quarter -- quarterly
11 teleconference calls. So it's another thing
12 we've been trying to do to just make sure that we
13 are being as responsive as we can be.

14 So I really -- I think that covers
15 most of what I wanted to talk about, but I just
16 again do want to say thank you all for your hard
17 work. And I know it's a pretty time-consuming
18 board and there's a lot of very, very complicated
19 issues to talk about. And we have been -- we try
20 to be as responsive as we can to your data
21 requests and that sort of thing and will continue
22 to do so. And if you need anything additional,

1 of course go through Carrie and we'll provide you
2 with whatever we can, whenever we can.

3 Also I'm here this -- today and
4 tomorrow. If you need to call on me, just please
5 feel free to do so. Do you have any questions
6 from me before I --

7 CHAIR MARKOWITZ: Questions?

8 MEMBER SOKAS: I have a question.

9 This is Rosemary Sokas.

10 MS. LEITON: Yes?

11 MEMBER SOKAS: I just wanted to know
12 whether -- the one recommendation from last time
13 that was having those periodic telephone calls
14 where people troubleshoot, if that might be
15 something that you can comment on whether that
16 could be made searchable as well.

17 MS. LEITON: I'm not sure what you're
18 referring to when you say "periodic
19 troubleshooting." Are you talking about policy
20 calls?

21 CHAIR MARKOWITZ: Yes, I think it's
22 the teleconference calls where cases and issues,

1 generic issues are discussed.

2 MS. LEITON: Well, what we do with
3 those policy calls is we are -- we take them, if
4 they're relevant to the broad policy of what
5 we're doing rather than a specific, very specific
6 case, then we try to incorporate them into our
7 policy and Procedure Manual. That's what we're
8 doing with this new PDF coming up. We've
9 searched through everything that we've had
10 published and tried to make anything that is
11 relevant to moving forward in general policy
12 public.

13 With regard to making the specific
14 calls from the past open to the public, I'm going
15 to have to wait for the secretary on that because
16 it is a formal recommendation.

17 CHAIR MARKOWITZ: I have a question.
18 You referred earlier in your remarks to a new
19 document on -- sort of summarizing or compiling
20 really presumptions that currently exist, and my
21 read of that document is that it keeps some of
22 the current policies. It seems to appear --

1 appears to drop certain language from the current
2 policies and then it adds some new language. Is
3 that -- did I get that right in my read of the --

4 MS. LEITON: What we tried to capture
5 was already out there, but there have been as
6 we've moved forward with certain cases some
7 thought -- changes because of case-specific
8 information. It's something that we're -- we've
9 got a draft of our toxic substance -- or our
10 toxic exposure chapter that we were -- and
11 thinking of adding these things, too. Any input
12 you have on what we have here would be very
13 helpful to us, because some of it hasn't been
14 formally published yet, but it is, like you said,
15 a little bit of wording changes, a little bit of
16 drop this and add that. That's why it's not a
17 public document yet, because we are in draft
18 stages of it.

19 CHAIR MARKOWITZ: So it's possible
20 that some of the recommendations we would come up
21 with today and tomorrow could impact this
22 document?

1 MS. LEITON: Absolutely.

2 CHAIR MARKOWITZ: Okay. My other
3 question is some of the recommendations that we
4 made in the fall I know have been moved forward
5 to the secretary's office. Let's say that
6 they're approved, there's go ahead on some of
7 them. What happens after that? What's the time
8 frame?

9 MS. LEITON: Well, once we get
10 clearance for a response to you on that document,
11 we'll take action as quickly as we can. Some of
12 them require resources that we're a little bit
13 short on right now, but it will be one of our
14 priorities to ensure that anything that we've
15 said that we will do in the -- based on your
16 recommendations we do as quickly as possible. So
17 I can't give you an exact time frame.

18 CHAIR MARKOWITZ: Sure.

19 MS. LEITON: It really depends on the
20 question and which one you're referring to, but
21 we will --

22 CHAIR MARKOWITZ: Okay.

1 MS. LEITON: -- be -- it will be one
2 of our priorities.

3 CHAIR MARKOWITZ: Okay. Thank you.

4 Any other questions? Yes, Dr.
5 Redlich?

6 MEMBER REDLICH: But, Steve, your
7 question regarding the update, was that the
8 chapter 20700 exposure on causation presumptions?

9 CHAIR MARKOWITZ: Correct.

10 MEMBER REDLICH: That's what you were
11 referring to?

12 CHAIR MARKOWITZ: Correct.

13 MEMBER REDLICH: Okay. Thank you.

14 CHAIR MARKOWITZ: Which is a draft.

15 It's a draft.

16 MEMBER REDLICH: Yes.

17 MS. LEITON: It's a draft.

18 CHAIR MARKOWITZ: Right.

19 MS. LEITON: It says draft.

20 CHAIR MARKOWITZ: Right.

21 MS. LEITON: Just keep that in mind.

22 MEMBER REDLICH: Okay. Thank you.

1 CHAIR MARKOWITZ: Any other questions?
2 Okay. Thank you very much, Ms. Leiton.

3 MS. LEITON: Thank you. Hopefully you
4 have a successful meeting.

5 CHAIR MARKOWITZ: We will.

6 (Laughter.)

7 CHAIR MARKOWITZ: Dr. Welch?

8 MEMBER WELCH: Okay. So I've got two
9 slide presentations.

10 Kevin, can we start with the other
11 one, the occupational history one?

12 So two slide presentations, but there
13 are really four areas that we're going to cover
14 in -- out of the SEM Subcommittee.

15 So the one I wanted to start with
16 first is recommendations for the Occupational
17 History Questionnaire. In your agenda book you
18 have my written recommendations and rationale,
19 and that was sent out beforehand. And I know
20 some of you had a chance to read it, but I'm
21 going to summarize the recommendations here, and
22 then if people have questions about the rationale

1 for any part of it, we can talk about that
2 afterwards, after I run through the
3 recommendations.

4 I would say that my committee, our
5 committee, we spent a good amount of time on this
6 going through all the details, and it was
7 extremely helpful to me to get input. I mean, we
8 have a committee that includes people -- every
9 representation of the kind of subgroups on the
10 Board, and I just want to thank everybody for
11 thoughtfulness and input. And so I think we've
12 got something that is -- we believe is doable for
13 the Department of Labor and as -- would also
14 really improve the process.

15 So the idea is that there's a current
16 Occupational History Questionnaire that DOL uses.
17 There was a draft revised one that we looked at
18 in draft, but we're -- here I'm referring to the
19 one that's currently being used. And we're
20 recommending that these changes be made to the
21 current one, kind of jumping over the draft one
22 that Paragon put together. So I'm not really

1 going to talk about that draft one.

2 So what we want to do is retain the
3 list of hazardous exposures materials that are on
4 the current OHQ, but expand them by adding the
5 list from the BTMed Occupational History
6 Questionnaire, which was also sent out to you
7 guys. We do have it available to put up on the
8 screen, but it's an expanded list of tasks and
9 materials beyond what's on the current
10 Occupational History Questionnaire. It's not
11 every task and every material, but it's an
12 available list that we can use to expand what's
13 there.

14 And our experience is that when you
15 have lists of things it helps people recall the
16 work. If you just sit down with somebody and say
17 what do you do, what did you do, and try to
18 capture it from the beginning, it's not as
19 helpful as things that prompt people's memory.
20 And the building trades has a pretty extensive
21 process of doing that using maps and other ways
22 of helping people recall where they worked. But

1 we -- it's our experience that this list of tasks
2 is very helpful. It's not really sufficient.
3 And so then what we say after people are -- have
4 identified the materials that they worked with
5 that then they would be asked to describe how
6 they were exposed to that in free text, which
7 would be captured on the OHQ. So rather than
8 just checking off I did welding as a task, or I
9 was exposed to solvents, it would capture how
10 that individual was exposed to solvents.

11 And those of us who have done
12 occupational medicine over the years know
13 important it is to know what the task is, because
14 that helps people who know about the work
15 environment understand what kind of exposures
16 someone would have had without having to have
17 industrial hygiene monitoring.

18 Then we would ask the worker to rate
19 the frequency of exposure that he has using the
20 scale that we have on the BTMed questionnaire.
21 It's a five-point scale. And then assess if the
22 worker used the material directly or exposed as a

1 bystander, which also helps with some estimate --
2 quantitative -- qualitative estimate of intensity
3 of exposure.

4 There's a new bulletin that I
5 neglected to send out to everybody, but it's
6 called the "Direct Disease Work Link Process,"
7 which allows the claim examiner to -- if someone
8 has -- they've done a certain task, that task is
9 now associated with disease. Rather than the
10 task having be associated with an exposure that's
11 associated with a disease, there's a link in the
12 SEM that says if you did this task, it can be
13 linked to the disease, which is a really great
14 improvement because the SEM is based on
15 individual exposures, not complex mixtures, for
16 example. And tasks often give you exposures to
17 complex mixtures.

18 So as this process gets developed --
19 right now there aren't a lot of these direct
20 disease link work processes, but as the -- if
21 there's an opportunity for DOL to continue to
22 expand those, it's a way to deal with the

1 question of mixtures, which was presented to us
2 many times and we really haven't had a figure out
3 a way to do it. But I'd recommend that people
4 take a look at that bulletin and take a look at
5 the SEM, just sort of FYI.

6 But the thing about it is I think it
7 really fits with this recommendation because if
8 the -- the current OHQ doesn't ask about task, so
9 there's really no way to use the direct link
10 disease work process, or -- I mean, all those
11 words are in there; I'm not sure I'm getting them
12 in the right order -- without information on
13 task, because that's based on task.

14 So it's -- I think that in some ways
15 we're -- the thought process is coming together
16 both from the Board and the DOL about the
17 importance of task. So that's the first one.
18 Retaining the hazard exposures information,
19 getting information on task and detail on
20 frequency and intensity through this process.

21 So here's what the -- this is part of
22 that directories link work process bulletin. So

1 the middle part that says, "Data supplied by an
2 employee or survivor in an occupational history
3 or other personal statements can be accepted as
4 reliable when sufficient detail or other
5 information is provided that documents the scope
6 and type of work performed," which to me I read
7 that by saying a good detailed occupational
8 history can be accepted as reliable because we're
9 going to have the detail about the task, that
10 people describe in detail what they did.

11 And we all have experience that when
12 someone tells you all that information, it's not
13 something that -- it's not just, oh, I think I
14 was exposed. It's a lot of detail. So I was
15 very happy to see that this new bulletin would be
16 relying on the task information that's coming
17 through the occupational history.

18 So we talked about the idea of making
19 a longer task list which would make administering
20 the occupational history much easier. It's much
21 easier to have a list than to have to collect
22 free text, which we're recommending. But

1 everybody here has at some point in time
2 addressed the question or thought about the
3 question about tasks for production workers.

4 I mean, I can't remember how many job
5 titles there are; 20,000, something like that.
6 So a lot of job titles. And then the job title
7 doesn't very well predict the tasks people did
8 because the job titles for the same -- people
9 doing the same set of tasks have different job
10 titles in different sites.

11 So we fairly quickly decided that it
12 really wasn't feasible to create a list of tasks,
13 which is why we came up with the idea that we
14 start with materials and hazards and then have
15 people describe their tasks rather than trying to
16 make a list. But we do have a list on BTMed that
17 includes the tasks that construction workers do;
18 and many of those tasks are performed by
19 production workers as well, so that if we add
20 that list of tasks -- it's not complete, but it's
21 available, it's been tested, we know how useful
22 it is and it will help with the process of

1 collecting task information.

2 And the second one I'm going to
3 present to you is presumption for COPD. COPD is
4 caused by vapors, gas, dust and fumes. And to
5 have the presumption work and really be able to
6 adjudicate claims for COPD you have to be able to
7 assess this exposure. So we're recommending that
8 we have a question added to the OHQ that
9 specifically asks people have you been exposed to
10 vapors, gases, dust and fumes in your work at
11 DOE.

12 Someone -- this would come after
13 they've done all their task and materials, and so
14 if the worker thinks -- they get asked have you
15 already reported all these exposures and the
16 answer's above, good. Fine. We've captured
17 that. But it's an opportunity to circle back and
18 make sure that the process that was used in the
19 list of the work history actually captures
20 exposures to these range of aerosol exposures and
21 also to be sure that the frequency of exposure is
22 there and wanted people -- wanted to specifically

1 ask about the worker's assessment of their
2 frequency of exposure to all of these categories.

3 We've asked them above about their
4 frequency of exposure to welding, for example, or
5 to solvents or other things, but it would be nice
6 to have someone to say, well, when I think over
7 my career, yes, I had daily exposure to something
8 that falls into that category. And that will be
9 really useful when we look at the COPD
10 presumption.

11 The last bullet is something that
12 we're going to have to get DOL's input on as we
13 move on and figure out what to do with it, but
14 work before and after the DOE Complex is part of
15 the cumulative exposure to vapors, gas, dust and
16 fumes. So we would like to have the OHQ collect
17 information on exposures outside of DOE which
18 allows an assessment of the total exposure that
19 they had, because setting a presumption you
20 really want to know that someone had the amount
21 of exposure that we consider minimum and it
22 doesn't have to all be at the DOL complex.

1 But we do understand that the current
2 policy which was set up to be claimant-friendly
3 was to not include exposures outside the DOE
4 Complex. In this case it makes it harder for the
5 claimant I think, but again I think we need to
6 understand better how collecting occupational
7 history or using that in the adjudication for
8 work outside the DOE Complex -- if that's
9 possible to do. And if not, we can readjust.

10 And then as with many things we would
11 love to have this implemented and tested many
12 times rather than just used, because we're
13 talking about something that's a big change,
14 relative big change, and we'd want to make sure,
15 for example, that the information collected on
16 the OHQ is useful to the industrial hygienist
17 when it gets there. And that feedback would be
18 necessary to test a draft, so -- in addition to
19 getting the task information that's in that
20 bulletin 16-03. We just want to state this
21 explicitly and we're -- the Board is happy to
22 help in refining the OHQ.

1 And I don't know if John Dement wants
2 to address that, but he was in charge of doing
3 this for our BTMed questionnaire which we
4 developed in conjunction with workers, but it was
5 very helpful to have a few rounds in focus groups
6 with workers before we implemented it.

7 John, anything you add on that?

8 MEMBER DEMENT: No, I think you've
9 covered the issue quite well.

10 I think the point with regard to the
11 BTMed, we know that it's -- we try to capture
12 what we feel or have felt based on the workers'
13 input over many years. Are there major tasks
14 that they have done largely in the area of
15 construction and maintenance types of work, but
16 some of it does, as Laura said, spill over into
17 more the production side. But they're tasks that
18 people do.

19 And I guess to sort of defend the task
20 approaches, over many years -- we know it's
21 imperfect, but we do know based on working with
22 it and trying to develop some of these

1 qualitative estimates over exposure that it is
2 predictive of several outcomes that we've looked
3 at over the years, and especially respiratory
4 diseases and COPD.

5 MEMBER WELCH: So that's my last slide
6 on the OHQ, so I'd -- questions from the Board?

7 CHAIR MARKOWITZ: Yes, I have -- by
8 the way, do we need -- when we speak, do you need
9 us to mention our name for recognition later?
10 No? Okay. So a couple of comments and
11 questions.

12 First of all, just to clarify -- so
13 you made a distinction between construction and
14 production, which is a distinction made in the
15 Former Worker Medical Screening Program between
16 construction workers and everybody else who
17 worked on site. So I think when you mention
18 production, actually what that means to some of
19 us is a broad range of workers at the site
20 including production, including service,
21 including administrative workers, engineers and
22 the like. So I think that's what you meant,

1 right?

2 MEMBER WELCH: Absolutely.

3 CHAIR MARKOWITZ: Okay.

4 MEMBER WELCH: Thanks for that.

5 CHAIR MARKOWITZ: So the very simple
6 question about vapors, gas, dust and fumes, which
7 looks almost overly simple, right? It's a single
8 question, but that question has been validated in
9 studies. Is that right? Or can you just give a
10 history of that a little bit, because it seems so
11 easy. It's seems almost too good to be true,
12 that a question that simple could produce valid
13 data. So could you just give a little bit of
14 background on that?

15 MEMBER WELCH: Yes. So going back to
16 the idea that inhaled dust exposures or dust and
17 fume exposures can cause COPD goes back many
18 decades now, and the American Thoracic Society
19 first published something about that in 2003.
20 And usually if you get to a professional society
21 creating a statement, there's plenty of data to
22 support it.

1 At that point it was based on really
2 individual exposures, but there were lots of
3 them. And on the -- and the biology would
4 suggest that if you have particulate matter of --
5 generated say with diesel exhaust that causes
6 COPD, particulate matter generated with another
7 process that's creating residual soot is going to
8 cause COPD. So at that -- when those studies
9 came out, it looked it would be not a handful of
10 substances, but many substances.

11 But there have been, oh, I don't know,
12 maybe 15 community-based studies and
13 occupational-based studies, too, but community-
14 based studies where they've looked at people --
15 population-based studies looking at people across
16 not just one industry, but across like the 10,000
17 people in Denmark. Asked a questionnaire. And
18 the question is, were you exposed to vapors,
19 gases, dust and fumes? And that predicted COPD
20 in these big population studies.

21 And there's not a lot of detail you
22 can get when you're doing that big a study,

1 because it's not necessarily one -- but you can
2 see when you do a big population study across a
3 country that it's not one industry or one
4 exposure, because that -- not everyone would be
5 affected by that. You wouldn't find an effect if
6 it was just a small subgroup within that. So
7 it's -- and one after another after another study
8 has found that occupational exposure to VGDF
9 causes COPD.

10 We also know from much work done by a
11 group out of Harvard that air pollution causes
12 COPD, the particulate exposures in the air
13 pollution, which is most likely a lower exposure
14 than what occupational studies are. So that sort
15 of supports the biology as well.

16 But your specific question -- maybe
17 I'm giving too much information, but your
18 specific question is that there are tons of
19 studies that support silica and welding and
20 diesel exhaust causing COPD. And then lots of
21 population-based studies where people -- at --
22 were you exposed at work to this large broad

1 category was statistically and consistently
2 predictive of COPD.

3 CHAIR MARKOWITZ: Right. Dr. Dement?

4 MEMBER DEMENT: I think that's a great
5 explanation. And I think -- so to add to it,
6 there's a growing body of information scientific
7 studies that support the concept that some of
8 these particles, particulates that have been
9 considered relatively low toxicity with regard to
10 regulations are nonetheless contributory to COPD.
11 Coal mine dust is a fairly good example of a
12 relatively low toxicity dust. It has some silica
13 in it, but many, many studies of coal mine dust
14 exposures have actually quantified the decrements
15 in lung function related to these relatively non-
16 toxic materials compared to silica and asbestos.

17 So there's a growing body of data that
18 really supports the concept that these particles
19 that we've pretty much disregarded with regard to
20 occupational regulations in a major part are
21 contributory to these lung diseases.

22 CHAIR MARKOWITZ: So I have

1 another --

2 MEMBER WELCH: Let me make one other
3 point, too, because it -- that follows from what
4 John said. Many of the occupational agents that
5 go into the vapors, gas, dust and fumes have no
6 regulatory standard set for them in addition to
7 saying that the occupational standard for silica
8 was only just reduced to something that's
9 reasonable this year.

10 CHAIR MARKOWITZ: Right.

11 MEMBER WELCH: So it was -- and some
12 people say it's too high still. But, so, current
13 regulatory guidelines for some of the components
14 of VGDF are not protective against this
15 particular outcome even now, but a great number
16 of the agents that could be included in that
17 rubric have no standard, and they've been
18 considered particulates not otherwise regulated,
19 or even just nuisance dust. Well, sorry, there
20 is a standard, but it's so high that it was --
21 it's not at all protective and it's not ever
22 enforced as a standard. So although I didn't say

1 it in -- we're going to talk about it in the COPD
2 one, current exposures can continue to
3 contribute.

4 CHAIR MARKOWITZ: Yes, Ms. Vlieger?

5 MEMBER VLIEGER: I wanted to point out
6 that there are task information that can be
7 entered on the EE-3 when the claim is made,
8 however, what I see a majority of the time is
9 that's kind of considered self-serving if it's
10 not justified within the employment records that
11 are provided under the document acquisition
12 request. And I'd like to get away from that
13 because I don't know any worker that would comb
14 the web looking for some set of terms that would
15 get them benefits versus telling the truth on
16 their form.

17 So on the Occupational History
18 Questionnaire what I'd like to ensure is that
19 when the claimants do those forms and they sign
20 them, they sign EE-3, the OHQ does not have a
21 signature on it, but the information provided is
22 not considered self-serving all the time and

1 discounted when it's reviewed later on.

2 MEMBER WELCH: So do you -- would you
3 suggest adding a signature to the OHQ?

4 MEMBER VLIENER: I would add an
5 affidavit signature like on the other forms
6 because that way there is some mark to it that
7 they know what's on the form and they approved
8 it.

9 The EE-3 section where you can say
10 what your job tasks and category was in very
11 small. And so even when you fill it out in the
12 PDF form, it gets tiny, tiny print just to be
13 able to put enough information in there. So
14 maybe we need to look at the EE-3 where they're
15 reporting their work as well, because this may
16 change that.

17 CHAIR MARKOWITZ: So if I can move
18 onto another topic, the -- you raise the issue of
19 considering outside of DOE exposures. So this is
20 a -- would be a significant change. And we
21 should discuss this, the rationale behind this a
22 little bit.

1 The issue really is taking seriously
2 the statutory language about contributing and
3 aggravating, because if for instance you set a
4 presumption of a minimum of five years of work in
5 DOE say as a carpenter in order to be eligible
6 for compensation for some disease, and that
7 carpenter worked for three years at DOE and then
8 spent 20 years outside of DOE working as a
9 carpenter, clearly they have long-term exposures
10 as a carpenter. But some of the exposure
11 occurred within DOE, not enough to get to the --
12 to a -- if a presumption is established for five
13 years, not enough to cross that threshold to be
14 considered.

15 And the reality is, is that many
16 workers in the complex worked outside as well,
17 particularly in construction and maintenance, but
18 in other jobs as well. And many of those jobs
19 were along the same line. They're blue collar
20 jobs that involved important exposures.

21 So the challenge is to figure out how
22 to consider sort of the totality of exposure. If

1 -- even if part of it is suffered or experienced
2 at DOE and is below say any presumption
3 threshold. And it's not easy, because then you
4 have to obtain information about outside
5 exposures, outside employment. So that changes
6 the nature of the occupational history.

7 MEMBER BODEN: So this raises another
8 interesting question for me, which is actually we
9 do collect what the DOE -- DOE collects
10 information about people's smoking history, which
11 is also a factor that's contributory to COPD.
12 And it seems to me that that history ought be
13 considered in the same way as other occupational
14 exposures; that is, if combined with the DOE
15 exposure there is a history of smoking exposure.
16 But really it's my -- stating this as a
17 statement, but it's really a question. Do you
18 think that all three of those ought to be
19 considered when thinking about the requirement
20 for compensation for COPD?

21 MEMBER WELCH: You'd need to take
22 smoking into account as causing and contributing

1 most importantly if it was more than additive
2 with the dust exposure, would be my opinion. So
3 if it's more than additive or even
4 multiplicative, then the -- you'd have a
5 different presumption of how much exposure you
6 need if someone was a smoker or not. And then --
7 but I think we should maybe talk about that when
8 we get to the COPD presumption.

9 MEMBER BODEN: Okay.

10 MEMBER WELCH: But you did raise the
11 question. I mean, I don't think a smoking
12 history belongs on an Occupational History
13 Questionnaire, personally, but I didn't really
14 think about that one way or another. I mean,
15 it's something that the -- a medical reviewer
16 would want to know down the road when they're
17 trying to assess COPD and probably wouldn't give
18 an opinion if they didn't have it, but for COPD
19 it's -- for work-related COPD it's pretty much
20 irrelevant whether someone was a smoker or not,
21 in my opinion.

22 MEMBER BODEN: So the reason I raise

1 this is I think generally when somebody's
2 reviewing somebody's history and thinking about
3 work-related COPD and they see smoking, they
4 think, aha, right, the smoking caused the COPD.
5 But given the legal structure that we're talking
6 about with the contributing-aggravating-causing
7 criteria, then actually smoking might put
8 somebody -- smoking combined with the DOE
9 exposure might put somebody over a threshold in
10 the same way that another occupational exposure
11 would put them over the threshold and in that
12 case might actually be beneficial to somebody's
13 case, just logically.

14 MEMBER WELCH: Yes, so when we get to
15 the COPD, that would affect the number of years
16 that -- some number of years of exposure to meet
17 a presumption. I mean, I think we should talk
18 about it then because there are different ways to
19 approach that.

20 Would you want to add?

21 MEMBER CASSANO: Yes, a couple of
22 things. I see this -- I mean, it's not just with

1 outside employment, but in general when I've
2 looked -- when we've looked at all of these cases
3 that we looked at in Part E, synergistic effects
4 of multiple toxicants are never looked at. They
5 look at one and then they look at the other and
6 they say, well, this isn't enough to cause
7 disease and the second one isn't enough to cause
8 disease. No toxicant creates damage at whatever
9 level to the exclusion of any other toxicant.

10 And so we have a choice here I think
11 of looking at it as a proportionality versus
12 saying that, well, this person smoked and
13 therefore they're going to get COPD earlier or
14 it's going to be more severe because they smoked
15 in addition to their occupational exposure. I'm
16 not sure that's quite fair to those who develop
17 occupational COPD without any personal exposure
18 for doing that.

19 But one way of looking at this; and I
20 sort of mostly agree with you and with a little
21 bit of hesitation, is that the wording that I've
22 used is no one can say that if Mr. So-And-So had

1 not smoked, they would not have developed COPD,
2 nor can they say that because Mr. Smith smoked he
3 would have developed COPD even if he was not
4 exposed at work. And when you look at that, it
5 becomes irrelevant in some way to -- as you said,
6 to use smoking history as a negative predictor of
7 occupational cause of any disease.

8 CHAIR MARKOWITZ: Ms. Vlieger?

9 MEMBER VLIEGER: Sorry, no.

10 CHAIR MARKOWITZ: Dr. Dement?

11 MEMBER DEMENT: In reviewing these
12 cases, let's say a worker started work outside of
13 DOE, did primarily the same types of work on the
14 DOE site for a number of years, and maybe worked
15 afterwards. In my view as long as the sort of
16 exposure latency pattern is satisfied, that
17 cumulative exposures -- let's say the person
18 developed asbestosis -- that worker's cumulative
19 lifetime exposure all contributed to the ultimate
20 development of his disease. So you can't exclude
21 the DOE work. You can't exclude the other work
22 either.

1 So the best that we can say
2 scientifically is that cumulative exposure was
3 the cause of this person's disease. Therefore,
4 in my view it satisfies -- the DOE work satisfies
5 the issue of at least contributing to the
6 ultimate disease. So I think we have to consider
7 sort of the time sequence of the exposure. Is it
8 at -- as biological how we would have predicted
9 it to be. So DOE exposures that were in that
10 time envelope I think are -- would satisfy the
11 compensation requirement.

12 MEMBER VLIEGER: I just want to point
13 out that there are a number of bulletins with
14 smoking considered as part of causation, and
15 we're going to have a bit of a fur ball when we
16 get into that because I just did a search and
17 there's more than four.

18 Rachel, would you like to speak on
19 that, please?

20 MS. LEITON: Well one of the things
21 we've actually tried to do is not consider
22 smoking as part of causation because of the

1 aggravation and contribution. We've in fact
2 instructed doctors, when we refer this, to kind
3 of look at the exposure to work over the smoking.
4 Now, there are certain requirements. Like when
5 we go to NIOSH, we have to provide them with the
6 smoking history. It's part of their analysis,
7 but in general that's something that we've
8 actually tried to avoid having doctors look at.
9 We tell our CMCs.

10 Now, and I mean because of the
11 aggravation and the contribution factor it's
12 actually something that we've made a point of
13 over the years to try to say try to not -- we're
14 not really looking at smoking history. So it's a
15 complicated issue. If you want to go over
16 specific documents that you've looked at, after
17 this meeting we're happy to look at those and
18 provide specific examples or explanations for
19 that, but overall smoking has been not something
20 that we try to consider.

21 CHAIR MARKOWITZ: Ms. Vlieger?

22 MEMBER VLIEGER: Rachel, I did a quick

1 review of bulletins. I haven't gone all the way
2 through the Procedure Manual during the
3 discussion or in the -- I don't know anything
4 about policy calls because those aren't
5 published, and I haven't looked at circulars, but
6 I cannot find the exact guidance on the things
7 that we would have purview on, on toxic exposures
8 to talk about not including smoking as a
9 causation. Could you talk about that later?

10 MS. LEITON: A lot of it's been in
11 training. I don't think we specifically said in
12 a document do not look at smoking. I would have
13 to look, but I don't know that we've said it in a
14 procedural document. It's something we address
15 in training when we talk to our claims examiners.
16 When we refer cases to CMCs, some of the
17 questions that we've asked, those -- that has
18 been included.

19 MEMBER VLIEGER: All right. Thank
20 you.

21 CHAIR MARKOWITZ: Dr. Friedman-
22 Jimenez?

1 MEMBER FRIEDMAN-JIMENEZ: I think that
2 in the training of physicians smoking history is
3 ingrained as a major thing that you always have
4 to look at. And this is part of the culture of
5 the way that doctors think about disease,
6 especially lung disease.

7 I think trying to change that culture
8 is harder than trying to change the culture in
9 occupational health that we only think about
10 causation and not contributions and aggravation.
11 And I think our efforts would be better spent
12 trying to reeducate the CMCs and other physicians
13 involved and the claims examiners to rethink
14 their concept in terms of contributions to and
15 aggravation of the disease in addition to just
16 causation, rather than trying to get them to not
17 think about smoking.

18 I agree that smoking mathematically
19 comes out irrelevant even when you're talking
20 about causation for some diseases, but there's
21 really not enough science there when you're
22 talking about contribution and aggravation and we

1 should de-emphasize it in a different way rather
2 than trying to say don't think about it. Rather,
3 let's say the standard here is did the exposure
4 aggravate, contribute to or cause the disease?
5 And really hammer on that, getting them to change
6 that. Then automatically smoking will be much
7 less relevant or completely irrelevant.

8 CHAIR MARKOWITZ: I mean, I would just
9 follow up with this comment: I mean, I think on
10 balance ignoring smoking has been and is a good
11 thing because doctors very readily blame smoking
12 for many diseases, in some cases often true. So
13 to -- but it's done to the exclusion of
14 occupational diseases. So on balance ignoring
15 smoking has been I think a claimant-friendly
16 approach.

17 Dr. Welch?

18 MEMBER WELCH: I was also going to say
19 that if we could now focus the issue on the OHQ
20 we could finish this one and maybe vote on the
21 recommendations on it. We've really moved onto a
22 different topic in terms of --

1 MEMBER SOKAS: So --

2 MEMBER WELCH: I heard Rosie?

3 MEMBER SOKAS: Right, it's Rosie.

4 Yes, thank you. I just want -- two quick
5 comments. One is I think if you focus on the
6 OHQ, then removing smoking is an intriguing way
7 of implementing the kind of educational piece for
8 the physicians.

9 The -- I'm getting some feedback. I
10 don't know if you guys are. But the second
11 comment I just wanted to make; and it's been made
12 a million times in the past -- I just wanted to
13 be clear that the family history's coming out,
14 that has no business being in the OHQ.

15 MEMBER WELCH: Yes, okay. Actually I
16 hadn't looked at the things that should come off
17 the OHQ. So I think we'll consider that and make
18 -- we can make an addendum later today, because
19 we were just thinking of the things we needed to
20 add.

21 You have a puzzled look on your face.

22 CHAIR MARKOWITZ: Well, so this --

1 before we move onto the next recommendation, you
2 want to take a vote on this, or do you think
3 there's -- more time is needed and we vote on it
4 tomorrow morning?

5 MEMBER WELCH: I'd say vote on it now
6 because --

7 CHAIR MARKOWITZ: Yes.

8 MEMBER WELCH: Unless anybody feels
9 they need more time, wants to read more
10 documents, wants to think about it more.

11 Does anybody want to put it off until
12 tomorrow?

13 CHAIR MARKOWITZ: Dr. Dement?

14 MEMBER DEMENT: I just want a point of
15 clarification. One of the most important things,
16 or one of the important things I think that this
17 Committee, the SEM Committee considered was the
18 accessibility of the industrial hygienist to the
19 worker to have this OHQ to go back, and if there
20 are things that were fuzzy, get -- directly ask
21 questions of the worker. And I believe we made
22 this as one of our earlier recommendations, have

1 we not?

2 CHAIR MARKOWITZ: Yes.

3 MEMBER DEMENT: Okay.

4 CHAIR MARKOWITZ: So you want to --
5 Dr. Sokas, was that you?

6 MEMBER SOKAS: I just wanted to say
7 I'd like to vote if possible.

8 CHAIR MARKOWITZ: Okay. So, Dr.
9 Welch, you want to --

10 MEMBER WELCH: So I'd leave it up to
11 you. Shall we -- well, there are like four
12 points. Shall we just vote in each point
13 differently, separately?

14 CHAIR MARKOWITZ: Sure.

15 MEMBER WELCH: Okay. So let me just
16 go back to the beginning. So the first point is
17 what we're talking about is adding free text
18 information on tasks. I think we can actually
19 include this one -- no, sorry. We'll just do
20 this. Collecting information on going from
21 exposure of materials with then collecting
22 information on task with details about the

1 frequency and whether it was direct or bystander.

2 So should we do -- how do we vote,
3 Steven?

4 CHAIR MARKOWITZ: Just are there any
5 comments? Yes, Dr. Dement?

6 MEMBER DEMENT: Just a point of
7 clarification. We should probably have in our
8 recommendation number one being that we retain
9 those tasks and materials that are currently in
10 the OHQ, because we had this proposal that we
11 looked at last time, which I think we pretty much
12 rejected.

13 MEMBER WELCH: Yes, I think that's a
14 good point. So why don't we make that our first
15 point. So it should -- we want to retain the
16 hazards, exposures, materials on the current OHQ.
17 Does everybody agree with that?

18 CHAIR MARKOWITZ: Well, so -- hold on.
19 We need to have discussion. But if you want to
20 change the recommendation, we should -- if we can
21 do this, we should see on the Board what the
22 recommendation is that we're voting on so that

1 there's some --

2 MEMBER SOKAS: And the title for that
3 slide is really the recommendation, right? I
4 mean --

5 MEMBER WELCH: Yes, the idea was that
6 that title would be the recommendation.

7 MEMBER SOKAS: Right.

8 MEMBER WELCH: The written document
9 has it -- it's bolded for each one with the
10 rationale. So we should keep -- well, we can
11 keep it this way.

12 CHAIR MARKOWITZ: Okay. So we need a
13 motion on this.

14 MEMBER BODEN: So moved.

15 CHAIR MARKOWITZ: And a second? Hold
16 on. Second? Okay. So it's open for discussion.

17 Ms. Leiton, did you want to make a
18 comment?

19 MS. LEITON: Yes, I just want to make
20 it clear that we are talking about the draft we
21 sent or the one that's published when you're
22 making these recommendations, because I think

1 they're slightly different.

2 MEMBER WELCH: The one that's
3 published.

4 MS. LEITON: Okay. Thank you.

5 CHAIR MARKOWITZ: Okay. So we have
6 this recommendation. Any comments, discussion?
7 Dr. Sokas?

8 MEMBER SOKAS: Nope. I like it.

9 CHAIR MARKOWITZ: Okay. No, that's
10 okay.

11 (Laughter.)

12 CHAIR MARKOWITZ: Okay. So we can
13 call for a vote. All those in favor of this
14 recommendation we're looking at, raise your hand.

15 (Show of hands.)

16 CHAIR MARKOWITZ: We'll get the phone.
17 Okay. And your votes, Dr. Sokas and Mr. Griffon?

18 MEMBER SOKAS: Yes.

19 MEMBER GRIFFON: Yes.

20 CHAIR MARKOWITZ: Okay. So that's
21 unanimous. Next?

22 MEMBER WELCH: So it's -- following on

1 that we recommend adding the list of tasks that
2 we have in BTMed. On the previous one we added
3 the list of exposures. Here we're adding the
4 list of tasks.

5 CHAIR MARKOWITZ: Okay. Is there a
6 motion to accept this?

7 PARTICIPANT: So moved.

8 CHAIR MARKOWITZ: And a second?

9 PARTICIPANT: Second.

10 CHAIR MARKOWITZ: It's open for
11 discussion.

12 (No response.)

13 CHAIR MARKOWITZ: Okay. No
14 discussion. All those in favor of this
15 recommendation, raise your hand.

16 (Show of hands.)

17 CHAIR MARKOWITZ: And Mr. Griffon?

18 MEMBER GRIFFON: Yes.

19 CHAIR MARKOWITZ: Dr. Sokas?

20 MEMBER SOKAS: Yes.

21 CHAIR MARKOWITZ: Okay. So it's
22 unanimous.

1 Next?

2 MEMBER WELCH: So the Committee
3 recommends adding a specific question regarding
4 VGDF with explanations of how that question would
5 be worded here on the screen and in the
6 recommendations.

7 CHAIR MARKOWITZ: Okay. Motion to
8 approve?

9 PARTICIPANT: So moved.

10 CHAIR MARKOWITZ: And a second?

11 PARTICIPANT: Second.

12 CHAIR MARKOWITZ: Okay. It's open for
13 discussion.

14 (Pause.)

15 CHAIR MARKOWITZ: All those in favor
16 of this recommendation, raise your hand.

17 (Show of hands.)

18 CHAIR MARKOWITZ: And Mr. Griffon?

19 MEMBER GRIFFON: Yes.

20 CHAIR MARKOWITZ: Dr. Sokas?

21 MEMBER SOKAS: Yes.

22 CHAIR MARKOWITZ: Okay. This is

1 accepted.

2 Is there another part?

3 MEMBER WELCH: No, as long as
4 everybody's accepting the points that there's --
5 to implement that -- the validity of that
6 question and includes those four other points.
7 But everybody understands that we voted in favor
8 of it. I guess what I might recommend, that that
9 last point, that I make it its own recommendation
10 about outside occupational history and that we
11 vote on that specifically, which we could do
12 tomorrow or after the break. I can just make a
13 new slide for it. Do people think that's a good
14 idea?

15 CHAIR MARKOWITZ: Okay. So, Dr.
16 Boden?

17 MEMBER BODEN: Just a question. We
18 have a fourth point on here that -- did I miss
19 our voting on that -- about testing it multiple
20 times?

21 CHAIR MARKOWITZ: Right, we'll move on
22 to that.

1 MEMBER BODEN: Okay.

2 CHAIR MARKOWITZ: But the question
3 here is --

4 MEMBER WELCH: Yes, I was wondering
5 whether --

6 CHAIR MARKOWITZ: Okay.

7 MEMBER WELCH: It's really -- it's
8 sort of a emphasis question, the fourth bullet
9 point there about --

10 CHAIR MARKOWITZ: Right.

11 MEMBER WELCH: -- collecting
12 occupational history about VGDF outside of DOE
13 work is a big enough point --

14 CHAIR MARKOWITZ: Right.

15 MEMBER WELCH: -- that it's probably
16 worth voting on it as its own recommendation.
17 And I can break out the document afterwards to
18 provide rationale for that.

19 CHAIR MARKOWITZ: Right. So, okay.
20 So as a matter of procedure we're going to retake
21 this vote because there was not full clarity
22 about what we were voting on.

1 So let's make it clear that we are
2 voiding the previous vote just now and we're
3 going to re-vote on this, and that the
4 recommendation is as it reads on the screen about
5 adding VGDF to the questionnaire with all of the
6 elements included on the questionnaire on --
7 excuse me, on the screen except the final
8 bulleted item which addresses including
9 consideration of outside or prior exposures
10 beyond DOE work. So we're going to exclude
11 bullet item No. 4, or the fourth bullet item, and
12 we're going to re-vote.

13 So is there a motion to approve this?
14 And a second? Okay. Any discussion?

15 (No response.)

16 CHAIR MARKOWITZ: Okay. So all those
17 in favor of this motion, raise your hand.

18 (Show of hands.)

19 CHAIR MARKOWITZ: Dr. Sokas?

20 MEMBER SOKAS: Yes.

21 CHAIR MARKOWITZ: Mr. Griffon?

22 MEMBER GRIFFON: Yes.

1 CHAIR MARKOWITZ: Was there anyone --
2 of the members present was there anybody who
3 voted against or abstained? I didn't see
4 everybody's hand.

5 (Show of hands.)

6 CHAIR MARKOWITZ: Okay. Is that a
7 negative vote or --

8 MEMBER FRIEDMAN-JIMENEZ: It's a
9 negative vote.

10 CHAIR MARKOWITZ: Negative? Okay. So
11 all members of the Board voted in favor with --
12 except for one member who voted negatively.

13 So we will consider the issue of
14 outside exposures separately in a -- not right
15 this moment. So let's move on.

16 MEMBER WELCH: And then the last
17 recommendation is that we recommend that the
18 version of the OHQ developed in response to these
19 recommendations be tested multiple times to
20 determine if the information obtained is
21 sufficient to support the process described in
22 16-03, which is tasks, having information on

1 tasks.

2 CHAIR MARKOWITZ: Is there a motion to
3 approve this recommendation?

4 PARTICIPANT: So moved.

5 CHAIR MARKOWITZ: Okay. And a second?

6 PARTICIPANT: Second.

7 CHAIR MARKOWITZ: So is there any
8 discussion about this recommendation? Dr.
9 Friedman-Jimenez?

10 MEMBER FRIEDMAN-JIMENEZ: Just a
11 question. What kind of validation testing did
12 you have in mind in terms of testing multiple
13 times? What did you have in mind with that? A
14 validation study or just pilot testing a
15 questionnaire?

16 MEMBER WELCH: Yes, pilot testing. So
17 for example, it can be done -- focus groups are
18 useful in the beginning. We didn't recommend
19 that in particular, but that the industrial
20 hygienist probably would be the best person to do
21 this, to take a work history, a narrative work
22 history from the worker and then have them

1 complete the form and see if there are things
2 that the worker mentions that aren't captured by
3 the process, particularly tasks.

4 Also to get an understanding of
5 whether the questionnaire is -- it gets long, so
6 do you start losing information from the worker
7 because of the nature of asking about much more
8 detail than we had before. Those are two things
9 I was thinking about. You really have to have an
10 expert who knows what the answer should be from a
11 detailed history with the worker and then compare
12 that to the form. But there may --

13 MEMBER FRIEDMAN-JIMENEZ: Okay.

14 MEMBER WELCH: -- there are probably
15 many other ways to do it. That's what I had in
16 mind. I think if DOL wants to develop a
17 different way of doing it, that's fine.

18 CHAIR MARKOWITZ: Dr. Cassano?

19 MEMBER CASSANO: I just wanted to
20 raise an issue not directly related to this; and
21 maybe Rachel can answer this, but all of this
22 that we're doing to the OHQ may be rendered moot

1 in the claims process because all of the training
2 documents say that the -- everything in the OHQ
3 has to be corroborated through the DAR process or
4 some other internal documentation.

5 And so most of the time all of the
6 information on the OHQ, or for that matter the
7 formal workers' program stuff that may make into
8 the claims folder, isn't even looked at as far as
9 I can see by the CMC or the industrial hygienist,
10 or even the claims examiner.

11 So maybe what I'm seeing in the
12 training materials and what we've seen in cases
13 is different than what actually is happened,
14 Rachel.

15 MS. LEITON: Okay. The -- part -- one
16 of the reasons we want to modify the OHQ is so
17 that we can get to information that is more
18 specific. When we say "corroborate," we are
19 going to look at DAR records, we are -- or
20 document acquisition requests from Department of
21 Energy as well as employment verification
22 documents in terms of the -- is it plausible

1 because they were here or is there -- we're not
2 -- as you guys indicated earlier when you were
3 talking about this, you said, well, when they're
4 talking about work processes, it's really hard to
5 just come up with something that they're not
6 going to -- we're not trying to say that they're
7 going to make anything up. When we verify, we
8 verify the broader as much as we can.

9 I think that going into more details
10 about work processes that we can then look at
11 with regard to this Bulletin 16-03 will be very
12 helpful and connecting the dots. We look at the
13 totality of the evidence. So -- and we're not
14 going to -- I mean I can't say that we're going
15 to go and say every single one of these we'd
16 better find some documentation at -- in the DOE
17 records to corroborate it. It's really going to
18 depend on what they're saying, how much detail
19 they're giving us.

20 I think that testing the questions,
21 like you suggested, could be very helpful in that
22 process, but we do look at everything in the

1 information that's provided to us. The DAR
2 records are very helpful in many occasions.

3 And as I said, you're talking about a
4 work process that's very specific in carpentry or
5 it's very specific to some other occupation. We
6 have SEM that helps us with that and we do have
7 these work processes. I think that all those
8 things together can help, but we're definitely
9 not going to disregard the questions. That's why
10 I think our purpose is to make this a little bit
11 more helpful, make this something that we can use
12 in the adjudication process more efficiently.

13 CHAIR MARKOWITZ: So I have a question
14 about this, the working of this language. It
15 looks as if the new Occupational History
16 Questionnaire -- let me just say that members of
17 the public are not necessarily acquainted with
18 the abbreviations we use, so that when we refer
19 to things we should very briefly explain them so
20 everybody in the room has a chance of
21 understanding what we're discussing as a board.

22 But so the occupational -- let's say

1 the Occupational History Questionnaire changes
2 that we recommend are accepted but they are
3 tested and found not to be sufficient to support
4 the 16-03 process, which is the new policy,
5 newish policy linking diseases with work tasks,
6 but nonetheless having that additional
7 information on tasks is going to be useful, and
8 having the information on vapors, gas, dust and
9 fumes is going to be useful.

10 So I'm wondering whether we should
11 recommend testing this but not link it to see
12 that it's sufficient to support a specific
13 policy, because I think it's going to be useful
14 above and beyond that policy. By the way, we
15 don't know where that policy's even heading.

16 MEMBER WELCH: Actually, I agree with
17 that. As I read it I thought, oh, this is too
18 specific. So how about since I'm taking another
19 recommendation back into --

20 CHAIR MARKOWITZ: Well, I think -- no,
21 we can amend this.

22 MEMBER WELCH: Okay.

1 CHAIR MARKOWITZ: We can amend it.
2 But while we're thinking about new language I
3 think Dr. Sokas wants to say something.

4 MEMBER SOKAS: Thank you. So I mean
5 the point of the questionnaire review is not so
6 much to validate the questionnaire. It's not to
7 sort of see how accurate it is. It's to make
8 sure that the questions make sense and that
9 they're user-friendly, I think. I mean I think
10 that's the initial interpretation I took away
11 from it. And I think you could still interpret
12 the language that way. So it's less a formal
13 validation and more kind of an iterative approach
14 to creating questions that people can actually
15 understand.

16 CHAIR MARKOWITZ: Dr. Dement?

17 MEMBER DEMENT: Yes, I agree with
18 Rosie. I think we're not looking for a
19 statistical validation of this questionnaire.
20 We're primarily interested in a couple of
21 questions.

22 First of all, the way we ask these

1 tasks is relatively important. Can the worker
2 actually identify with it? So it's sort of face
3 validity. And many times in developing these
4 questionnaires for the BTMed we've tested it by
5 sitting with workers in focus groups and asking
6 them about the task. Do they understand it? Is
7 it worded in a way that they can relate to it?
8 And if not, they tell us why not. So I -- it's
9 sort of face validity of the wording of the
10 question and to collect information.

11 The second is of course respondent
12 burden. I mean, we find in the BTMed after we've
13 been with this individual for a half hour to 45
14 minutes we've pretty much exhausted their ability
15 to really participate in the process. So there's
16 -- we're looking at the ability to collect the
17 information in a way that they understand and we
18 can understand in trying to interpret it.

19 CHAIR MARKOWITZ: Dr. Cassano?

20 MEMBER CASSANO: Just a third point to
21 that though is that the claims examiners feel
22 comfortable with it I think is another testing

1 point and that they feel confident that the
2 information is useful to them. Because again, if
3 the claims examiner discounts it, it really don't
4 matter how much good information is on there. So
5 we may want to modify it.

6 CHAIR MARKOWITZ: Dr. Boden?

7 MEMBER BODEN: Hopefully this is my
8 most trivial comment of the day, but I assume
9 that we're -- we'll have to see and wait, but
10 just a small wording correction on the written
11 version refers to "Bullet 16-03." I think we
12 meant "Bulletin."

13 CHAIR MARKOWITZ: So what we need is
14 some new proposed language. Dr. Welch?

15 And, Kevin, is it possible to change
16 this so we can see the language, so we know what
17 we're voting on? Thank you.

18 MEMBER WELCH: So I'd recommend that
19 we have it just end at the end of the sentence so
20 it says "recommended be tested multiple times."
21 Well, wait. Let me just -- multiple times for --

22 CHAIR MARKOWITZ: You had it Kevin,

1 but --

2 MEMBER WELCH: It's the very last one.
3 It's the last one. Yes.

4 So we take out "to determine if the
5 information obtained is sufficient to support the
6 process."

7 CHAIR MARKOWITZ: Dr. --

8 MEMBER SOKAS: How about instead of
9 "tested multiple times," "to be pretested for
10 ease of use?"

11 MEMBER WELCH: Okay.

12 CHAIR MARKOWITZ: I'm sorry. Could
13 someone repeat --

14 MEMBER WELCH: "Pretested" -- "be" --
15 "We recommend that the version of the OHQ
16 developed in response to these recommendations be
17 pretested for ease of use." And we could say
18 "face validity." I'm not sure. Yes, okay.
19 There seems to be some consensus. So "for ease
20 of use and face validity." And the delete the
21 rest of the sentence.

22 CHAIR MARKOWITZ: Dr. Silver?

1 MEMBER SILVER: Are we at all
2 interested in whether these questions that were
3 developed for the construction trades are
4 transferrable to non-construction or production
5 broadly defined? Would we like DOL to report
6 back to us on that issue?

7 CHAIR MARKOWITZ: Yes, I don't think
8 -- I think we should keep this recommendation
9 broad. I don't think we should get into
10 particulars about what we might learn through the
11 pretesting process. I think we'd probably come
12 up with a number of individual items. But we can
13 -- we could add that for instance to the
14 rationale, but I don't see putting it in a
15 general recommendation.

16 So are there other comments on this?

17 (No response.)

18 CHAIR MARKOWITZ: So this is a
19 friendly amendment. This is a revised
20 recommendation. We're going to -- I can't
21 remember. Have we -- is there a motion to accept
22 this recommendation?

1 PARTICIPANT: So moved.

2 CHAIR MARKOWITZ: Is there a second?

3 PARTICIPANT: Second.

4 CHAIR MARKOWITZ: Okay. So are there
5 any comments, further comments on this?

6 (No response.)

7 CHAIR MARKOWITZ: Okay. So all those
8 in favor, please raise your hand.

9 (Show of hands.)

10 CHAIR MARKOWITZ: All those opposed?
11 Any abstentions? And Dr. Sokas?

12 MEMBER SOKAS: Yes.

13 CHAIR MARKOWITZ: Mr. Griffon?

14 MEMBER GRIFFON: Yes.

15 CHAIR MARKOWITZ: Okay. Thank you.

16 Are there -- Dr. Welch, are there any other
17 recommendations on the OHQ, or are we done?

18 MEMBER WELCH: We're going to make a
19 fifth one, which -- to break out the taking
20 occupational history outside of DOE.

21 CHAIR MARKOWITZ: Right. Okay. Okay.
22 But we still need to formulate that?

1 MEMBER WELCH: Yes, we need to
2 formulate that.

3 CHAIR MARKOWITZ: Okay.

4 MEMBER WELCH: So for this -- for what
5 we have here we can't vote on, we've accepted --

6 CHAIR MARKOWITZ: Right. Okay.

7 MEMBER WELCH: -- what we can vote,
8 and I'll present one more.

9 CHAIR MARKOWITZ: It's 10:00. We're
10 going to take a 15-minute break. We'll be back
11 at 10:15 and resume. Thank you.

12 (Whereupon, the above-entitled matter
13 went off the record at 10:02 a.m. and resumed at
14 10:17 a.m.)

15 CHAIR MARKOWITZ: Okay. We're going
16 to get started. All the Board members are
17 physically here. We're going to move on with the
18 SEM report.

19 Dr. Welch?

20 MEMBER WELCH: Okay. So the next one
21 we're going to -- the next topic the Committee
22 worked on was a presumption for COPD, and it

1 really grew out of working on the Occupational
2 History Questionnaire. So we took this one.
3 It's related, very strongly related to exposure
4 assessment, so we took it on as part of the SEM
5 Subcommittee.

6 So there currently is a COPD
7 presumption which I've summarized here on the
8 slide.

9 CHAIR MARKOWITZ: Sorry. Could you
10 explain what -- just what COPD is?

11 MEMBER WELCH: Oh, yes. Thank you.
12 So COPD stands for chronic obstructive pulmonary
13 disease and it's an umbrella term for a
14 combination of people who might be told they have
15 chronic bronchitis or emphysema. Both of those
16 are part of COPD. And what it is it's the
17 development of disease of the airways, either
18 destruction of the airways or extra phlegm
19 production, both of which interfere with airflow
20 in and out of the lung. It's pretty common.

21 And it used to be that smoking was the
22 major cause of COPD. Worldwide smoking is no

1 longer the major cause and the major cause is
2 this -- these vapors, gases, dust and fumes
3 around the world that we were talking about
4 earlier. And it's pretty common. COPD is pretty
5 common among the former workers that we've
6 examined in the building trades. And I think
7 that's probably true for the other program that I
8 was referring to as production workers.

9 So the current bulletin requires 20
10 years of exposure prior to 1980 in a subset of
11 labor categories. And --

12 PARTICIPANT: Sorry. Before you do
13 that, can we wait a second until Dr. Sokas gets
14 back?

15 MEMBER WELCH: Oh, okay. Yes, yes.
16 We'll wait.

17 CHAIR MARKOWITZ: No, we should just
18 continue.

19 MEMBER WELCH: Oh, okay.

20 CHAIR MARKOWITZ: Yes.

21 MEMBER WELCH: Okay. And if someone
22 doesn't meet the presumption for that 20 years of

1 exposure prior to 1980, the bulletin allows an
2 industrial hygienist, which can be a referral
3 from the claims examiner, to provide a well-
4 rationalized discussion of case-specific evidence
5 that again gives them 20 years of asbestos
6 exposure. So if they're not in the labor
7 category, the industrial hygienist can say they
8 have the same kind of exposure those labor
9 categories would have had.

10 And then they have to have medical
11 evidence from a qualified physician which
12 documents a diagnosis of COPD. The bulletin says
13 documented diagnosis of COPD after evidence of 20
14 years of significant asbestos exposure. It's not
15 clear to me in that -- in the way the bulletin
16 works whether that has to be in the medical
17 records, but since we're going to recommend
18 getting rid of this bulletin in any case, we
19 don't really have to understand that. So pretty
20 much it's saying 20 years of asbestos exposure
21 prior to 1980.

22 Now that is -- doesn't include all the

1 dusts that are included in the VGDF combined
2 matrix, and the cutoff of 1980 is -- might be
3 appropriate if all you want to assess is very --
4 high exposure to asbestos, but certainly
5 exposures to the other causes of COPD, the other
6 dusts, vapors, gases, fumes continued after 1980.
7 So both the focus on asbestos and the 1980
8 criteria are way too narrow to encompass current
9 literature and medical evidence about causes of
10 COPD.

11 So we're recommending that it be
12 replaced with a presumption -- different
13 presumption, that it would be any claimant who
14 has a physician's diagnosis of COPD who worked in
15 a covered facility. So they have to have the
16 employment verification and the diagnosis, which
17 can be accepted the way DOL currently does that.

18 They were either in any of the labor
19 categories in Attachment 1, and we would add to
20 Attachment 1 all construction and maintenance as
21 a general category. So in any of the labor
22 categories in Attachment 1 as amended for at

1 least five years cumulative including non-DOE
2 work, or who reported exposure to VGDF on an OHQ
3 for a period which an aggregate total is at least
4 five years cumulative, including non-DOE work, so
5 that the labor categories construction and
6 maintenance the exposure is presumed and that it
7 doesn't have to be necessarily collected on the
8 Occupational History Questionnaire, although it
9 -- we presume it would be. But if the person is
10 not in one of the labor categories on Attachment
11 1, they can still be accepted under this
12 presumption if they report exposure to VGDF on
13 the OHQ. And we discussed how that is going to
14 be reported when we -- and we voted on that as
15 part of the OHQ.

16 So then if they meet those two
17 essentially exposure assessment -- way of
18 assessing exposure to VGDF, they're presumed to
19 have sufficient exposure to toxic agents to
20 aggravate, contribute to or cause COPD. And then
21 we have a footnote that if they -- if a claimant
22 does not meet those requirements, particularly if

1 they've had fewer than five years of exposure,
2 those claims should be further evaluated on an
3 individual basis with an industrial hygiene
4 referral because five years is a -- it's a
5 reasonable standard for the presumption, but
6 there will certainly be many cases that could
7 develop with fewer than five years. And the
8 industrial hygienist and then a CMC could compare
9 that to the literature database and determine
10 whether they had sufficient exposure to
11 aggravate, contribute to or cause.

12 So the document I gave you, the
13 presumptions, has a lot more detail supporting
14 the rationale for this, but -- and we did -- I
15 did talk a little bit when we were talking about
16 adding that question about VGDF to the
17 occupational history about the literature that
18 supports the fact that this large group of
19 aerosol exposures that include vapors, gas, dust
20 and fumes in an occupational setting cause COPD.
21 So I don't think I have to go through that again.

22 The -- our Committee spent some time

1 discussing this five years cumulative, and I've
2 put some rationale in the document for that.
3 It's based on the study that we did in BTMed
4 looking at COPD among construction workers and
5 looking to see at what level of exposures -- how
6 many years of exposure you start to see an impact
7 of the dust on COPD. And that was in that five-
8 year range.

9 And then looking at the other
10 literature, the population-based studies that I
11 mentioned, to see if those could help us with a
12 number of years of exposures used for a
13 presumption. And generally it seems to support
14 that. There are exposures within the VGDF
15 category that probably have a higher risk in
16 terms of a -- if you try to look at estimating
17 how -- what kind of exposures measured in
18 milligrams per cubic meter in the air, what kind
19 of exposures over a lifetime cause occupational
20 COPD, there's some agents that are -- you need --
21 probably need a smaller dose. Some agents you
22 probably need a larger dose, a cumulative dose.

1 So it again looked like those five years is -- we
2 thought it was pretty reasonable for the
3 presumption. And then if people don't have five
4 years, they'd get an individual assessment.

5 So why don't we open it up for
6 discussion?

7 CHAIR MARKOWITZ: Oh, okay.

8 MEMBER WELCH: Well, let me make sure
9 I don't have another slide.

10 (Pause.)

11 MEMBER WELCH: This is what we already
12 voted on that we're adding a specific question on
13 VGDF.

14 Oh, yes, there was one other thing.
15 So these agents are going to be on the --
16 specifically on the Occupational History
17 Questionnaire. So this is a way of being
18 redundant, but all those agents are known to
19 cause COPD individually as well as part of this
20 VGDF matrix. So we're recommending that these --
21 if these specific agents are reported on the OHQ
22 separately or in combination for a period of five

1 years, that would also be sufficient.

2 And as I said, we think that these are
3 going to be much overlapping, but if people
4 report five years of exposure to cement dust,
5 they should also have reported five years of
6 exposure to VGDF. But we're recommending adding
7 these specific exposures because asking people
8 cumulative exposure to this big matrix may be
9 hard for people to understand. But they will
10 know that they did metal cutting and grinding or
11 exposure to diesel exhaust for those periods of
12 time. So it will -- it should manage to capture
13 by being redundant all the claimants who would
14 have had this -- enough exposure to make this
15 presumption.

16 CHAIR MARKOWITZ: Do you have a slide
17 with Attachment 1 just so people can see what the
18 list of job titles --

19 MEMBER WELCH: No, I don't.

20 CHAIR MARKOWITZ: So, Kevin, I have it
21 on mine, if you would bring up my -- and while
22 he's finding that -- so I'm going to just explain

1 BTMed.

2 Dr. Welch referred to BTMed. This is
3 the Former Worker Medical Screening Program
4 supported by the Department of Energy for the
5 last 20 years in which the CPWR has examined 25
6 or 30,000 construction workers, many of them
7 repeatedly over time, in which they've both
8 assisted individuals in understanding their
9 illnesses, but also published studies about their
10 experience regarding COPD and other diseases in
11 the population.

12 So if you just go down until you see
13 a slide that's impossible to read, it's
14 Attachment 1.

15 (Laughter.)

16 CHAIR MARKOWITZ: It may be possible
17 to read up there, but not on the screen that
18 we're looking at.

19 So while he does that, Dr. Cassano,
20 you --

21 MEMBER CASSANO: Yes, it's hard to do
22 this without seeing what her -- what the

1 recommendation is, but --

2 (Simultaneous speaking.)

3 CHAIR MARKOWITZ: There you go. So
4 just --

5 MEMBER WELCH: And this was --
6 Attachment 1 I think appears in two different
7 places, because the Attachment 1 I was talking
8 about was for the COPD presumption.

9 CHAIR MARKOWITZ: Right.

10 MEMBER WELCH: But I think it's the
11 same. It's the same as the attachment for the
12 significant asbestos exposure, and that makes
13 sense. So then for the COPD presumption we would
14 add another bullet that says all construction and
15 maintenance. And some of those are obviously
16 construction and maintenance tasks. Not all of
17 them are. Thank you for putting that up there.

18 CHAIR MARKOWITZ: Okay. Dr. Cassano?
19 So you can go back to her --

20 MEMBER CASSANO: Yes, I just want to
21 add -- ask if we can add something to the caveat
22 at the bottom.

1 MEMBER WELCH: And I didn't talk about
2 this, but we'll -- can you go back up to the
3 first slide? Oh, no. I can. Oh, let's see if
4 I'm capable of doing this. There it is.

5 MEMBER CASSANO: Yes, so you talk the
6 five -- on the caveat on the bottom if somebody
7 doesn't meet the five-years of exposure, but
8 we're still talking only about construction and
9 maintenance workers. And there are people --
10 even the secretaries or the administrative
11 support, some -- most of the time in these
12 facilities they're sitting in a cage in the
13 middle of the production area or they're in an
14 office that isn't isolated. And so I think we
15 need to add whatever -- those persons that don't
16 fall into the occupational categories, or however
17 you want to word that to -- that says anybody.

18 MEMBER WELCH: I think that's there,
19 because it says -- so after the "or." So they're
20 in any of the labor categories in Attachment 1 or
21 with reported exposure to VGDF on the OHQ for a
22 period of five years. So they don't have to be

1 in one of those labor categories. They have to
2 answer the question positively. So that could be
3 anybody.

4 MEMBER CASSANO: Right. That's true
5 if the OHQ is going to be used as prima facie
6 evidence of exposure.

7 MEMBER WELCH: Yes, well, I mean,
8 these things all -- they relate to each other. I
9 mean, you can't have this presumption without
10 those changes on the OHQ because you wouldn't be
11 assessing the -- you need that question for VGDF.
12 So we're -- I'm assuming that that's true. And
13 then --

14 MEMBER CASSANO: Okay.

15 MEMBER WELCH: -- I don't know, it
16 could be that -- I mean, we should probably
17 discuss whether we -- I don't think it makes
18 sense to make a recommendation that the OHQ
19 should be considered a valid piece of
20 information. And actually in the direct disease
21 work process I did put up that part of the text
22 that says it is. So I think now as part of a

1 procedure the Occupational History Questionnaire
2 is considered a --

3 MEMBER CASSANO: Yes, I mean that may
4 be -- we're going to -- you're going to -- we're
5 going to get to my presentation in a little bit,
6 but I think once we do our meeting in -- with the
7 people out in Seattle and we have -- we've delved
8 down to as low a level as we can as far as
9 determining what really happens when -- where the
10 pedal meets the metal or the leather meets the
11 road or whatever you want to say -- that we will
12 then come up with some of those recommendations.
13 And I think that might be with the changes that I
14 think Rachel wants to make regarding the OHQ,
15 that we may be able to make that recommendation.
16 That is it is used. But I'm not ready to do that
17 yet.

18 CHAIR MARKOWITZ: So just to be clear,
19 this recommendation sets out two exposure routes
20 from the presumption linking it to COPD. One
21 exposure route is five years working at DOE in
22 any construction or maintenance job title. And

1 the other route -- and you can go either route.
2 You don't need both. The other route is five
3 years of exposure to vapors, gas, dust and fumes.
4 And in this formulation of the recommendation it
5 can include employment outside of the Department
6 of Energy.

7 So, Dr. Friedman-Jimenez?

8 MEMBER WELCH: Let me just make one
9 correction. You had said the labor category was
10 at DOE, but it's -- it could be outside of DOE as
11 well.

12 CHAIR MARKOWITZ: Okay. I'm sorry.
13 Yes, okay. Okay.

14 Dr. Friedman-Jimenez?

15 MEMBER FRIEDMAN-JIMENEZ: Just a
16 question. Didn't we just vote to remove the
17 occupational history of jobs outside of the DOE
18 from the OHQ?

19 CHAIR MARKOWITZ: So to clarify, we
20 put off that issue for further discussion. So
21 right now we have no position on that issue.

22 MEMBER FRIEDMAN-JIMENEZ: Okay. I

1 just wanted to point out that this will be hard
2 to do. I agree with including non-DOE work. I
3 think that that's contributing in the same way
4 that cigarette smoking is contributing, or
5 analogously. And it's important to know what
6 non-DOE work is being done that involves similar
7 exposures, but that would be hard to do if we
8 didn't have non-DOE work as part of the OHQ.

9 MEMBER WELCH: So my plan was to take
10 that point that we took off that one slide and
11 present it as a separate recommendation. So
12 we're going to recommend it. I just wanted to be
13 able to put it on a slide by itself so we know
14 it's a recommendation. So, but just -- I guess
15 we'll probably do that tomorrow or after lunch,
16 depending on timing. So before we leave here
17 today that we could vote on that.

18 CHAIR MARKOWITZ: Well, but for the
19 sake of clarity I wonder whether we really should
20 include reference to non-DOE work in this
21 presumption, whether we really want to open the
22 door here for this disease with the fact that we

1 haven't made a recommendation or really discussed
2 the recommendation for -- which is something
3 which would apply to a lot of conditions, not
4 just COPD. Think trichloroethylene and kidney
5 cancer, right? So it would apply to a lot of
6 conditions.

7 And so what I wonder is whether we
8 should consider removing that provision from this
9 recommendation and then revisiting the issue of
10 non-DOE work, because it applies to any number of
11 conditions, and then if need be amending this
12 later on to reflect our more considered thinking
13 about non-DOE work.

14 MEMBER WELCH: That's okay with me.
15 Yes, I -- yes, we could do that.

16 Does anybody object to that, to
17 amending it to at this point take off the
18 parenthetical?

19 CHAIR MARKOWITZ: Well, yes. So let's
20 see. Let's have further discussion about that
21 particular point, I think.

22 Dr. Boden?

1 MEMBER BODEN: I think it would be a
2 little simpler to hold off on approving this
3 until after we discuss the other one and then
4 come back to this rather than amending this and
5 then amending it again. So that would be my
6 suggestion is to keep things simple.

7 MEMBER WELCH: We could -- you know
8 what we could do is we could -- there's one more
9 slide too I have that I didn't show you. We
10 could discuss the -- this whole presentation and
11 kind of everybody's got their mind around it and
12 ask all the questions. And then we could vote on
13 it after vote on the adding non-DOE work.

14 CHAIR MARKOWITZ: Yes. Mr. Turner?

15 MEMBER TURNER: I would like to
16 consider all the workers because like at Rocky
17 Flats there was a couple of secretaries that came
18 down with beryllium disease. And I think that it
19 would be all workers.

20 MEMBER WELCH: Yes, the plan is that
21 all workers could be included. If they weren't
22 in -- on the Attachment 1 list, they would need

1 to report that they had vapor, gas, dust and
2 fumes exposure, which the new Occupational
3 History Questionnaire is going to ask people were
4 you exposed to vapors, gas, dust and fumes and
5 for how long? And so they would hit that -- they
6 could get into this presumption without being in
7 one of those job titles. So the plan is
8 everybody is eligible. There's two different
9 ways you can get exposure documented.

10 CHAIR MARKOWITZ: Dr. Cassano?

11 MEMBER CASSANO: Yes, I think as -- in
12 response to the list, I think on that other
13 discussion of non-DOE work we could add -- we
14 could word that in such a way that it could apply
15 to all of these things, all of the considerations
16 and all of the different medical conditions and
17 exposures, that we write it in such a way that it
18 says that when discussing the relationship
19 between an exposure and an outcome that non-DOE
20 work that includes that exposure or synergistic
21 exposures are considered. And I think that would
22 cover it for everything rather than putting it in

1 each individual presumption. Just my thoughts.

2 MEMBER WELCH: Yes, but I think that
3 what Les was saying I think is that if we're
4 going to vote on particularly the five years,
5 that we're all going to agree on the five years,
6 we need to have already agreed that we're
7 including non-DOE work as part of the assessment
8 of causation, contributing and aggravating before
9 -- because that's -- would -- we're assuming that
10 for this. If it was DOE only, you might do
11 something different with the five years. I'm not
12 sure.

13 So let me go ahead and show you the
14 last slide, which --

15 (Simultaneous speaking.)

16 CHAIR MARKOWITZ: But, Dr. Friedman-
17 Jimenez, you have a point --

18 MEMBER WELCH: Oh, sorry.

19 CHAIR MARKOWITZ: -- a follow-up point
20 here.

21 MEMBER FRIEDMAN-JIMENEZ: A comment on
22 that. Similar to smoking I think we should

1 handle non-DOE work as an additional contributing
2 cause. And again, we should really emphasize the
3 concept of aggravation, contribution to and
4 cause, because that sidesteps all of these issues
5 and it's really the fundamental change in culture
6 that we're recommending.

7 CHAIR MARKOWITZ: Dr. Boden?

8 MEMBER BODEN: I have a question about
9 the list of occupations and tasks. I'm wondering
10 -- so the list looks like a good list. I
11 certainly didn't think of anything I would add to
12 it, but I'm wondering if the list should be
13 considered open-ended and whether for example all
14 the work that's been done by the former worker
15 projects might end up having things in it that
16 would add to this list and that we might even
17 think about a recommendation about using that
18 work. But I'm not really sure, so I'm looking to
19 people who really have been more engaged in that.

20 CHAIR MARKOWITZ: So just to clarify,
21 the recommendation is -- expands this Attachment
22 1, that specific list. It includes all

1 maintenance and construction job titles. Just to
2 be clear.

3 MEMBER BODEN: Yes, understood.

4 CHAIR MARKOWITZ: Okay.

5 MEMBER BODEN: But I was wondering --
6 it's always in a way easier to have something on
7 a list than it is to try to figure it out other
8 ways. And I'm wondering whether work that's
9 already been done in this area could actually
10 provide additional useful information about tasks
11 to be added. I'm really wondering. I don't
12 know. I have no set opinion about that.

13 CHAIR MARKOWITZ: Yes, yes, yes. I --
14 yes, I don't think empirical studies are
15 available to really look at the full spectrum of
16 other workers in the DOE Complex to be able to
17 come to a presumption about that. It becomes
18 very complicated because there are a huge number
19 of job titles across the complex that change over
20 the decades and are changed from site to site.
21 So I don't think we have empirical data that we
22 can rest on.

1 MEMBER BODEN: But I was actually
2 thinking about tasks rather than job titles, but
3 maybe the same answer would apply.

4 CHAIR MARKOWITZ: Well, right. Yes,
5 multiply your job titles by X number of tasks per
6 job and you, get an even higher number, so --

7 MEMBER WELCH: The list is really
8 occupational categories.

9 CHAIR MARKOWITZ: Right.

10 MEMBER WELCH: So that -- and that in
11 a way is easier, although there may -- some of
12 the things on those occupational categories
13 probably don't exist at -- in the DOE Complex,
14 but it does cover a lot of people once we agree
15 that construction and maintenance -- that all
16 construction and maintenance are included, that I
17 think will really streamline it.

18 And actually, I mean, one point I
19 should have made at the beginning, having
20 reviewed -- all of us have reviewed a bunch of
21 COPD cases and they -- the number of times that
22 the case goes back to the claims examiner and

1 maybe goes to the final adjudication branch, and
2 then we've seen ones that are remanded and
3 overturned, it seems these cases take a lot of
4 time and a lot of work on the part of Department
5 of Labor staff to make a determination.

6 So we picked this one to start a
7 presumption with to really make it more timely
8 and more -- I guess more fair in a way because it
9 becomes clear who meets the presumption. And
10 we've had cases of construction workers who work
11 at the same site, been there about the same
12 amount of years in similar tasks, and one has
13 their claim accepted and one doesn't. And they
14 know that. They're -- maybe they play poker
15 together. So it -- there's a lot of sense that
16 this particular disease, it's just people don't
17 really understand what they need to provide.

18 So I think it would be better for the
19 workers, but I also -- in terms of timeliness and
20 efficiency we think it will be better for DOL as
21 well. So -- which is really what presumptions
22 do. They streamline the process. And the

1 presumption is good, it's a fair application of
2 the information.

3 CHAIR MARKOWITZ: Dr. Friedman-
4 Jimenez?

5 (No response.)

6 CHAIR MARKOWITZ: Dr. Silver?

7 MEMBER SILVER: A concrete example of
8 Dr. Welch's point, our Presumption Subcommittee
9 recently looked at -- or Working Group looked at
10 a handful of cases, and one of them was a COPD
11 case. Towards the end of the process someone at
12 DOL compiled the list of the doctors, 24 doctors
13 and 1,700 pages.

14 CHAIR MARKOWITZ: So if you could put
15 your card down, Dr. Silver, that would be great.

16 Okay. So --

17 MEMBER WELCH: Okay. So --

18 CHAIR MARKOWITZ: -- you have more,
19 Dr. Welch?

20 MEMBER WELCH: I have a couple more
21 points. So in terms of -- we discussed the
22 issues about timing and duration, and timing

1 since last exposure. And these exposures to
2 vapors, gases, dust and fumes continue to take
3 place on DOE sites. And as I mentioned earlier,
4 for many of the dusts included in the overall
5 category there's not an occupational standard.
6 So that -- and that's why I said many of them are
7 unregulated. So we believe that it should be
8 presumed that relevant reported exposures at any
9 period of employment are contributory up to the
10 present time. So there's no date cutoff where we
11 assume exposure is changed in some way.

12 And duration of exposure, I did talk
13 about that. We started -- I started thinking
14 about it in terms of this 2015 study that we
15 published looking among construction workers
16 about when we began to see a signal for COPD
17 related to dust exposures and then looked at the
18 other literature to see if there was anything
19 that could change that estimate of five years.
20 And it seemed to be supportive. So that was the
21 duration of exposure.

22 And time since last exposure, one

1 might -- let's say somebody has been retired for
2 10 years and gets a diagnosis of COPD. Well,
3 could work have contributed to that if he's
4 already been away from exposure for a long time?
5 And we concluded definitely they can. And that's
6 the nature of that disease. It's slowly
7 progressive.

8 People often, particularly if they're
9 getting COPD and it's getting worse and they're
10 in their 60s, they think, oh, I'm just getting
11 old, I'm slowing down, just can't walk up the
12 stairs fast enough, don't sleep as well, but
13 don't really think about going to the doctor.
14 And people often get a diagnosis of COPD when
15 they get a flu or they get a bad cold and they
16 really feel bad and they go to their doctor. And
17 that was the precipitating event. It didn't --
18 that flu didn't cause their COPD, but it knocked
19 them over to the point where they felt bad enough
20 to go to the doctor.

21 I think that Dr. Redlich can probably
22 substantiate this, but when I was working in the

1 hospital often people would come in and say I'm
2 healthy and you look at their lung function and
3 they meet the criteria for Social Security
4 Disability and you practically have to put them
5 on a ventilator to get over their pneumonia, but
6 they didn't know they had COPD because it came on
7 so slowly and we mostly like to ignore things
8 that we can ignore instead of running to the
9 doctor.

10 So anyway, so that we said time since
11 last exposure shouldn't be considered in
12 determining whether VGDF exposure were
13 contributory to COPD.

14 And then the last point is exposures
15 outside the complex have to be considered. And
16 we've talked about that and we're going to deal
17 with that by going back and voting on another
18 specific recommendation. I think that was my
19 last slide. Yes, I already talked about that.

20 So that the -- there's really one
21 recommendation here, which is the presumption.
22 So as I said before, I think we decided we'll

1 vote on this after we vote on the -- including
2 outside -- work outside of DOE, and we'll have
3 some discussion about that once I can edit the
4 slide to give a -- have a specific
5 recommendation.

6 So, Mr. Chairman, how do you want to
7 proceed?

8 CHAIR MARKOWITZ: Yes, sure. So any
9 further discussion?

10 (No response.)

11 CHAIR MARKOWITZ: So just to remind
12 the Board -- should have done this earlier -- we
13 vote on recommendations, the language, the
14 specific language of recommendations. We don't
15 vote on the rationale. The rationale is provided
16 later. If there are important elements that
17 should be included in the rationale the Board
18 members should raise that at the meeting because
19 the person who elaborated that recommendation
20 will write up the -- a brief but important
21 rationale in the days subsequent to the meeting
22 and it will accompany the submission of the

1 recommendation to the Department of Labor. So
2 just a reminder, we're not taking a vote right
3 now, but we will on other recommendations. We
4 vote on the language of the recommendation, not
5 on the rationale.

6 So is that it, Dr. Welch? We -- okay.
7 So there's one further recommendation that's come
8 out of your committee which I will review, but --

9 MEMBER WELCH: Yes, actually there's
10 also one that I didn't -- I meant to make a slide
11 on it. Let me explain it to people now and I'll
12 bring back a slide.

13 We were -- a question was raised about
14 how to look at exposure assessment at sites
15 without a SEM. And our recommendation from our
16 committee was that when DOL sends a case where
17 there's no SEM to industrial hygienists or the
18 CMC, they include information on the same labor
19 category from other sites so that they -- it's
20 not related directly to that specific person, but
21 it is useful for anybody evaluating that job to
22 know what that job exposure entails at other

1 sites within the complex.

2 And I'm going to write that up as a
3 recommendation we can vote on, but can we discuss
4 it now?

5 CHAIR MARKOWITZ: Well, why don't we
6 -- no, why don't we discuss it when we see the
7 language --

8 MEMBER WELCH: Okay.

9 CHAIR MARKOWITZ: -- and then --

10 MEMBER WELCH: That sound good.

11 CHAIR MARKOWITZ: Yes.

12 MEMBER WELCH: And then there's one
13 more that --

14 CHAIR MARKOWITZ: Right. Okay.

15 So --

16 MEMBER WELCH: -- you volunteered to
17 write up a recommendation.

18 CHAIR MARKOWITZ: Right.

19 So, Kevin, if you could bring up my --
20 and while Kevin's doing that, I just -- I've been
21 asked to point out or ask a couple of people to
22 -- in the audience to identify themselves in case

1 people want to talk to them.

2 The representatives, the staff from
3 Senator Cantwell and Murray's office, if you
4 could just indicate raising your hand who you
5 are.

6 And also Mr. Nelson and Mr. Levin from
7 the Ombudsman's Office.

8 Is there anybody else I was supposed
9 to point out? Okay. Washington State
10 Department of Labor and Industry. There is a
11 person here from -- and she's -- thank you.

12 So we're moving on to the final
13 recommendation from the SEM Committee for this
14 board meeting under discussion this morning.
15 This is a different kind of recommendation; it's
16 not a presumption, but it relates to the SEM and
17 how the SEM is used and how -- frankly the SEM
18 was created and maintained really as the data
19 source for decision -- for a good part of the
20 decision-making that occurs in the claims
21 process.

22 I'll read the recommendation and I'll

1 work through the rationale. Then I can add some
2 background as we do this.

3 So the Board recommends that the
4 Division of Energy Employees Occupational and
5 Illness Compensation Program enhance the
6 scientific and technical capabilities to support
7 the development of program policies and
8 procedures to enhance decision-making on
9 individual claims and to inform its assessment of
10 the merit of the work of its consulting
11 physicians and industrial hygienists.

12 So the next slide. I don't -- Kevin,
13 I don't have control over this, so if you could
14 do it. Or, Laura, you -- no, you can do it if
15 you want. Whatever. Whatever.

16 So you recall the Institute of
17 Medicine examined the Site Exposure Matrices and
18 wrote a hundred-page report in 2013, made a
19 series of recommendations which were challenging,
20 frankly, to implement. And the Department of
21 Labor implemented some and postponed others
22 pending further activities.

1 Among the recommendations were
2 included: (1) making sure that the site exposure
3 matrices incorporate readily available
4 supplemental data sources into the SEM to provide
5 a more complete picture of known exposure disease
6 links and forming an expert advisory panel to
7 establish explicit causal criteria for use in the
8 program, design and implement a method for
9 reviewing possible exposure disease links, and to
10 identify and peer review any new exposure disease
11 links for use in the SEM.

12 The issue of the one which was --
13 we've -- a subject of a prior recommendation of
14 ours from the fall, which is that the DOL use
15 authoritative sources which are identified in
16 SEM, is something that DOL is implementing and
17 has asked actually further assistance in sorting
18 out those data sources, which we will do.

19 But the Institute of Medicine also set
20 out a whole range of tasks which they ascribe to
21 an advisory panel, but really were not for the
22 most part advisory panel functions. They were

1 really ongoing functions that scientific and
2 technical experts needed to weigh in on the
3 program on a regular ongoing basis over the long
4 term.

5 Next slide. We've also -- Laurie,
6 could you do the next slide or hand that to me?
7 Okay.

8 So this is a -- I wrote this up, but,
9 Ms. Leiton, you have to correct me actually if I
10 don't quite have this language, which is that the
11 program has ended its contract with the National
12 Library of Medicine for continually updating the
13 Haz-Map database, which is -- forms part of the
14 core of the SEM. Is that correct language or do
15 I need to amend that.

16 MS. LEITON: We have ended our
17 contract with them, but we do rely on what --
18 they do continue to update it, so we will review
19 and rely on what they have come up with, with
20 regard to any causation or links between disease
21 and exposures. But, yes, our contract itself has
22 ended.

1 CHAIR MARKOWITZ: Okay. Thank you.
2 So the Board has been asked by the program to
3 provide input into numerous possible exposure
4 disease links, some relating to lymphoma, others
5 relating to prostate cancer, and their
6 relationship to toxins. We haven't done that --
7 gotten to that yet. But clearly it's an
8 important need and frankly it's an ongoing need.

9 While the Board will assist in this
10 request, it's noted that the Board members have
11 full-time positions in addition to serving on the
12 Board and really have no scientific staff support
13 to do those -- that kind of literature search and
14 consensus-type recommendations. And moreover,
15 it's really an ongoing thing. Today it's
16 prostate cancer and given toxin, or it's
17 lymphoma. But this -- these issues repeatedly
18 come up.

19 Next. Oh, it's me. And we've also
20 observed -- in working up the presumptions we've
21 had an opportunity to carefully look at the
22 current policies involving important conditions

1 and exposure disease links including chronic
2 obstructive pulmonary disease, COPD, asbestos-
3 related diseases, asthma, and that frankly the
4 current policies are -- do not really fully
5 reflect state-of-the-art scientific knowledge.

6 And so those are the elements of the
7 rationale.

8 Go back to the recommendation. I
9 would say that the Board has -- I think I speak
10 for the Board that we're certainly willing to and
11 would like to assist the Department of Labor in
12 implementing this -- accepting and implementing
13 this recommendation.

14 So it's open for comments. Dr. Sokas?

15 (No audible response.)

16 CHAIR MARKOWITZ: Mr. Griffon?

17 (No audible response.)

18 CHAIR MARKOWITZ: Yes, Dr. Silver?

19 MEMBER SILVER: We also had a
20 recommendation at our meeting I think a year ago
21 to rearrange the organizational chart for the
22 occupational medicine person assigned to this

1 program to create more interaction between them
2 and their peers in other parts of the DOL. And I
3 believe we passed it. And I see this overlapping
4 with that reform in that somebody has to do the
5 internal assessment of scientific and technical
6 merit and perhaps that occupational physician and
7 their newfound peers in other parts of DOL could
8 be the key player in doing that internal
9 assessment.

10 CHAIR MARKOWITZ: So, Kevin, if you
11 could just bring up the recommendations.

12 Let me just respond to that. There --
13 we did recommend in the fall a kind of
14 reorganization of occupational medicine resources
15 within not just OWCP, but actually Department of
16 Labor, I think it was. That was strictly about
17 occupational medicine. It wasn't about all of
18 the functions that we're laying out here. And
19 this would include industrial hygiene -- this
20 recommendation that we're looking at now includes
21 industrial hygiene and toxicology, so it's much
22 broader than that particular recommendation.

1 I would also say that frankly
2 reorganizing occupational medicine within the
3 OWCP or the Department may be -- end up being a
4 little bit more challenging than this
5 recommendation, which is really centered on the
6 program, either internally developing this
7 expertise, enhanced expertise or contracting for
8 it. But it's within the control of the program
9 and subject to availability of resources.

10 You had a follow-up comment and
11 then --

12 MEMBER SILVER: So who do we have in
13 mind to do this ongoing quality improvement? You
14 don't use that phrase, but it was clear to me a
15 moment ago when I knew there was an occupational
16 physician interacting with their peers in DOL to
17 oversee the work of the consulting physicians,
18 but who do we have in mind to improve the
19 analysis of the industrial hygiene work?

20 CHAIR MARKOWITZ: I don't have
21 anybody. You mean a particular entity?

22 MEMBER SILVER: Well, DOL's Energy

1 Employees Program hasn't done it up to now. I
2 think we need kind of a concrete idea of who's
3 going to be the motive force inside the program
4 to really do this. On the medicine I can see
5 someone, but like where is it going to come from?

6 CHAIR MARKOWITZ: Dr. Cassano?

7 MEMBER CASSANO: I sort of feel like
8 Ken does. This is extremely labor-intensive and
9 I'm not sure how many FTEs it would take to do
10 this. And I think you need a small -- maybe a
11 smaller group of people that can review studies
12 that have been done by things like the IOM or
13 things like the Committee on Toxicology at NRC
14 where DOD and others go to, and not always to do
15 a huge study, but just they bring an issue to the
16 Committee on Toxicology and they say, look, this
17 is what we're thinking of doing. Does this make
18 sense? Give us your recommendations. And so
19 it's not a million dollar project.

20 But I think having been inside
21 agencies, this would be so subject to the
22 vagaries of funding and FTE requirements,

1 etcetera, that I don't think it's feasible to
2 have this internally. Just from my experience.

3 CHAIR MARKOWITZ: Just for
4 clarification, you're arguing for DOL to engage
5 in a contractor? Is that what you're saying?

6 MEMBER CASSANO: Well, not a
7 continuous -- well, yes, they -- there could be
8 like an every-two-year re-look at some specific
9 site or some specific exposure medical condition
10 relationship or a group of them similar to what I
11 -- I sent you that Federal Register. But rather
12 than trying to have people in the agency do that
13 -- because even if you brought a cadre of people
14 in there, some of them -- you're not going to
15 have the breadth of expertise you need to do that
16 internally, I don't think.

17 CHAIR MARKOWITZ: Dr. Dement?

18 MEMBER DEMENT: I think the
19 recommendation itself is rather broad. I don't
20 think we're actually telling the DOL how to
21 accomplish this task.

22 CHAIR MARKOWITZ: Okay.

1 MEMBER DEMENT: And I agree with you,
2 I think it needs a -- and depending on the issue,
3 of course, needs a wide range of expertise. And
4 it may be that it's partially inside or partially
5 contract. So I don't -- I think we're simply
6 making a recommendation that -- have it available
7 to them, this ongoing technical/scientific cadre
8 of individuals who can help them in this whole
9 process operationally as it goes forward.

10 CHAIR MARKOWITZ: Dr. Sokas, are you
11 on the line?

12 (No audible response.)

13 CHAIR MARKOWITZ: Okay. So she wanted
14 to make a comment? Is that -- we don't know.
15 Okay.

16 Mr. Griffon, also, if you wanted to --
17 if you want to chime in, you're welcome to.

18 Oh, Dr. -- Ms. Vlieger, yes?

19 MEMBER VLIEGER: Sorry, not doctor.
20 This would not be dissimilar to what the
21 Radiation Board does with the contractors they
22 hire to do the advice on special exposure cohorts

1 where they actually are assigned a task from the
2 board and then they report back. So I don't know
3 that it would have to be a permanent-type
4 contract or that it could be maybe task-specific,
5 but I think because of the limitations of our
6 meetings and such that it certainly would help
7 move forward some of the questions that come up.

8 MEMBER SOKAS: This is Rosie. I'm off
9 mute now.

10 CHAIR MARKOWITZ: Yes, go ahead, Dr.
11 Sokas.

12 MEMBER SOKAS: Thank you. So I mean,
13 I totally agree that a subcontract -- and in the
14 same way that there's a kind of a parent contract
15 for the CMC, there could be an ongoing contract
16 for -- and I would suggest a group that has an
17 explicit worker-centered approach like AOC, for
18 example, where you could have a toxicologist
19 brought in for a particular task,
20 epidemiologists, physicians, industrial
21 hygienists, but you would specify that -- so I
22 think I heard others say that it doesn't have to

1 be laid out entirely in this recommendation, but
2 that it's generally easier for the agency to do
3 this kind of work.

4 We're going to have the same
5 recommendation for our subcommittee because
6 there's just no way the members of the
7 subcommittee can perform the functions needed.
8 And it's clear that current staffing isn't able
9 to do it. So your recommendation is absolutely
10 on point, but it could be approached through a
11 contract.

12 CHAIR MARKOWITZ: Dr. Redlich?

13 MEMBER REDLICH: No, I was just going
14 to strongly agree with the recommendation and
15 exactly how it's carried out I think could be
16 worked out.

17 I think the other -- an additional
18 reason this is so important is that -- I mean, I
19 have spent 25 years trying to educate practicing
20 pulmonologists about occupational lung diseases,
21 and my clinical practice is almost entirely
22 patients referred by pulmonologists to assess if

1 there is possible work-related disease. And
2 unfortunately treating physicians throughout the
3 United States are really most of them quite
4 clueless about diagnosing work-related medical
5 conditions. My own experience is predominantly
6 with pulmonary COPD and asthma.

7 And so I think that this is just a
8 very important fact that people need to
9 understand so that -- which is why depending on
10 the documentation that a treating physician
11 provides -- why that documentation may not be
12 sufficient. And so that the need to make very
13 clear guidelines and review those and have them
14 based on the latest information -- the physicians
15 doing this out and all across the United States
16 aren't themselves going to be able to do it
17 correctly.

18 CHAIR MARKOWITZ: So I have a question
19 actually about this, which is that this
20 recommendation lays out certain functions of this
21 enhanced capacity. And my question is whether we
22 should -- whether there are additional ones,

1 whether we should limit it to these three,
2 whether we should have an additional clause that
3 says other functions may also be useful to the
4 program. Because I am concerned there may be
5 some other uses of this capacity and we don't
6 want to artificially limit our idea about this to
7 these particular functions.

8 Dr. Cassano?

9 MEMBER CASSANO: Maybe "enhance" isn't
10 the proper word. Maybe it's "broaden" its
11 scientific and technical capabilities. I know
12 this is some of semantic, but that -- "enhance"
13 sort of means you build up what you have rather
14 than broaden it to include outside groups. And
15 that would solve the problem for me.

16 And as far as adding other functions
17 other than development of program policies and
18 procedures, I think it's fine the way it is,
19 because I think that encompasses including
20 information about exposure, information about
21 nexus relationships and stuff like that because
22 it talks about supporting the development of

1 policies. So I think -- I don't think we need to
2 add everything possible that this scientific body
3 could do for them.

4 CHAIR MARKOWITZ: Ms. Vlieger?

5 MEMBER VLIEGER: In your comment about
6 limiting it, are you thinking that maybe we
7 should not limit it to consulting only on
8 physicians and industrial hygienists? I think I
9 would agree with that, that we don't want to only
10 look at that issue because that's not our sole
11 charge. If we're going to have outside -- if
12 we're going to task an outside contractor to help
13 us with something, I would not want to limit that
14 recommendation to only specific areas like
15 physicians and industrial hygienists.

16 CHAIR MARKOWITZ: Well, so I'm just
17 going to respond to Dr. Cassano. I think
18 "enhance" is the right word, not "broaden"
19 because right now the program does have access to
20 toxicology, industrial hygiene, occupational
21 medicine, and with perhaps some element of
22 epidemiology. I'm not sure about that. But

1 "enhance" means really a much deeper bench and
2 perhaps to enhance some of the elements of
3 quality as well. So I prefer the word -- the
4 verb "enhance" rather than simple -- simply
5 address the breadth.

6 So is there any suggested amendment to
7 this before we elaborate? Yes, Dr. Redlich?

8 MEMBER REDLICH: So I just have a
9 question. The final one, inform its assessment
10 of the merit of the work of consulting, because
11 that's one piece of the final decision-making.
12 The other is the internal process. So are you
13 not including that?

14 CHAIR MARKOWITZ: No, this is the
15 question I'm raising --

16 MEMBER REDLICH: Yes.

17 CHAIR MARKOWITZ: -- because this is
18 not a complete listing of --

19 MEMBER REDLICH: Yes.

20 CHAIR MARKOWITZ: -- everything that
21 this enhanced capacity can do. So I didn't want
22 that the language of this be something that will

1 seem as limiting. So we could add "and other
2 functions as are deemed helpful to the program"
3 without providing a complete listing.

4 MEMBER REDLICH: Yes, I think it might
5 be good to add some broader statement, because
6 the bottom line is you want to know if the final
7 end product is medically appropriate. So this
8 piece I may be -- but -- and let's see. I guess
9 the enhanced decision-making on individual claims
10 is quite broad, and that probably encompasses all
11 options.

12 CHAIR MARKOWITZ: So should we leave
13 it as it is? Is that the sense?

14 (Off-microphone comment.)

15 CHAIR MARKOWITZ: Okay. That's good
16 because the person who could actually rewrite
17 this apparently left the room.

18 (Laughter.)

19 CHAIR MARKOWITZ: So, okay. So a
20 motion to -- let me read the recommendation.
21 "The Board recommends that the DEEOICP enhance
22 its scientific and technical capabilities to

1 support the development of program policies and
2 procedures to enhance decision-making on
3 individual claims and to inform its assessment of
4 the merit of the work of its consulting
5 physicians and industrial hygienists."

6 Motion to accept?

7 PARTICIPANT: So moved.

8 CHAIR MARKOWITZ: Second? Any further
9 discussion?

10 (No response.)

11 CHAIR MARKOWITZ: So all those Board
12 members who are present, all those in favor of
13 this recommendation, please raise your hand.

14 (Show of hands.)

15 CHAIR MARKOWITZ: All those opposed?
16 And any abstentions?

17 One abstention. So --

18 PARTICIPANT: I agree with it. Just
19 the language is a problem here for some reason.

20 CHAIR MARKOWITZ: So there are 13
21 Board members present. There are 12 votes in
22 favor and 1 abstention.

1 MEMBER SOKAS: And I want to vote yes,
2 please.

3 CHAIR MARKOWITZ: Dr. Sokas?

4 MEMBER SOKAS: Yes.

5 CHAIR MARKOWITZ: Yes. And, Mr.

6 Griffon? Mark?

7 (No response.)

8 CHAIR MARKOWITZ: Okay. So there are
9 14 Board members voting. Thirteen vote in favor
10 and there's one abstention.

11 MEMBER GRIFFON: Steve, did you hear
12 me? I voted yes.

13 CHAIR MARKOWITZ: Okay.

14 MEMBER GRIFFON: You didn't hear me.

15 CHAIR MARKOWITZ: There are -- thank
16 you, Mark. Fifteen Board members present.

17 Fourteen voted in favor and there's on
18 abstention.

19 So I think that -- Dr. Welch, that
20 completes the Subcommittee report?

21 MEMBER WELCH: Yes.

22 CHAIR MARKOWITZ: Okay. We'll move on

1 to -- thank you -- move onto the next
2 subcommittee, which is the Weighing Medical
3 Evidence Subcommittee.

4 Dr. Cassano?

5 MEMBER CASSANO: Good morning,
6 everybody. Thank you for being here, and away we
7 go.

8 So just to reiterate a little bit, the
9 members of my subcommittee are myself, Dr. Boden;
10 Dr. Markowitz is a honorary member, Ms. Pope, Dr.
11 Silver and Ms. Vlieger.

12 I wanted to review what the task was
13 for our subcommittee. We were asked not to look
14 at specific scientific information or medical
15 information, but basically to make
16 recommendations pertaining to the materials
17 available to the CEs, the logic process used by
18 the CEs and the training materials available on
19 specific toxicants outside of the SEM and make
20 recommendations. That's what we were asked to do
21 of one of the four functions.

22 Wanted to reiterate a little bit about

1 our prior meetings. We had a meeting in July of
2 2016 and then a second meeting in September of
3 2016. And then in the Full Committee meeting
4 based on the review of the information we made a
5 recommendation to the Full Committee that the
6 entire case file should be sent to the entire --
7 to the IH and/or the CMC when a review was
8 requested.

9 And the reason for this was that we
10 found that using only the SOAF, which was
11 basically all that went, that the IH and the CMC
12 had a certain amount of tunnel vision when
13 looking at the totality of the claim and that
14 information that they might have considered in
15 adjudicating the claim if they had seen it was
16 not available.

17 We also asked to review the Part E
18 claims and that we receive the entire case files
19 to review so that we knew what was missing and
20 what was not, because the first set of cases that
21 we reviewed only had the SOAF and a couple of
22 other things. It didn't have the Occupational

1 Health Questionnaire, it didn't have the EE-1.
2 And so we requested that we looked at the entire
3 case file. And I guess my statement at this
4 point is sometimes you need to be careful what
5 you ask for.

6 (Laughter.)

7 MEMBER CASSANO: So, and we asked to
8 review the training materials provided to the CE.
9 Interestingly enough, we were first told, oh,
10 there aren't any outside of the Procedure Manual.
11 And then at some point in time a whole list of
12 online training documents showed up. And so we
13 looked at those I guess in our -- we looked at
14 those at the next meeting.

15 And finally, we believed at that point
16 it was necessary to speak with claims examiners
17 to understand how they used all of the
18 information they were given and the process -- I
19 don't know how that got turned, but the process
20 by which they made decisions.

21 So we had a third subcommittee meeting
22 in December of 2016 and we reviewed all of these

1 training materials. And I'm not going to go
2 through each and every individual one, but there
3 was a very good introduction to the claims
4 process session. There is a whole training
5 document on weighing the medical evidence. We
6 didn't spend much time on the beryllium disease
7 because there -- Carrie -- the whole Beryllium
8 Group was working on that separately. And the
9 development for causation and exposure and
10 development for exposure, both the Participant
11 Guide and for the CEs.

12 And then we reviewed 14 Part E cases
13 based upon the use of a template that I
14 developed; I think I showed it at the last
15 meeting, where we went through to see if the
16 proper information was actually available. I'm
17 not going to put that up on the screen.

18 So this is the result of what we came
19 up with between the 12th of December and the
20 current state of affairs.

21 In general we believe that the
22 training documents were actually very good. They

1 were very detailed, they explained what needed to
2 be done based on the information that they --
3 that were -- that they were given, or if
4 information was not available. There are -- were
5 several problems.

6 We did note in reviewing the claims
7 folders versus the training documents that there
8 were some gaps between what the documents
9 required and what actually this -- the -- was
10 happening at the claims office didn't always
11 follow.

12 Training documents specifically state
13 to use the OHQ, the SEM, the CMC and the IH
14 toxicology review to determine exposure and
15 causation, and it explicitly stated that the SEM
16 is never to be used as a sole reason for denial.
17 So, but that's not necessarily what we saw. And
18 it also says that the Oak Ridge Institute for
19 Science and Education, the OHQ, the Medical
20 Monitoring Program and the Former Worker Programs
21 are all considered acceptable sources of medical
22 evidence, but again didn't seem that that always

1 happened.

2 One thing that was problematic in the
3 development for causation was no CMC review is
4 necessary if no known exposure to a toxic
5 substance or no plausible scientific association
6 between a toxin and a disease. And we're not
7 quite sure how a CE can parse that. So that was
8 one -- that was another issue that we had with
9 the training documents.

10 It does state that you're supposed to
11 look at labor processes. Buildings and areas
12 should be used when a person's labor category is
13 not listed in the SEM. So some of the things
14 that we just heard about as far as lists and some
15 of the presumptions, they're actually supposed to
16 look at all of that.

17 And an interesting comment about the
18 Former Worker Program was that before EEOICPA was
19 established you could use the Former Worker
20 Program documentation as prima facie evidence,
21 but after 2000 it had to be corroborated. And
22 again, I think when we talk about the

1 Occupational History Questionnaire and the FWP
2 programs, I think that's going to get fixed. And
3 the OHQ evidence must also be corroborated by
4 other evidence.

5 And we noted that only the SOAF goes
6 to the IH and the CMC, and we had already
7 recommended that the entire case file go. I
8 think -- I don't think that recommendation is
9 going to be implemented because I think it's
10 considered too onerous and I -- and now that we
11 know -- I know a little bit and all of us know a
12 little bit more about the process, I think we can
13 more specifically recommend what should go both
14 to the IH and/or to the CMC. The industrial
15 hygienist really has no interest in 1,000 pages
16 of medical laboratory work and things like that.
17 They -- that's not their purview and it's
18 confusing I think to send all that.

19 And as we said before, the SOAF
20 precludes the consultant from making their own
21 findings of fact, and technically according to
22 the law, the industrial -- or their regulations,

1 the industrial hygienist and the CMC are not
2 supposed to do their own fact finding. And that
3 again is problematic because we -- again, if they
4 don't have all of the information from which to
5 render a reasonable opinion based on all of the
6 evidence, then they're doing a claimant, and the
7 Department, quite frankly, a disservice.

8 And I'm not putting all this out there
9 to be judgmental, but this is our committee
10 telling it as we see it.

11 Review of case files. This was
12 actually quite interesting. There -- not all of
13 the conditions are listed on the EE-1, and that
14 -- for those people who don't know what the EE-1
15 is, that's the actual claim, the initial claim
16 filing -- were adjudicated even though medical
17 evidence was provided verifying the diagnosis. I
18 mean, there were some that had three or four
19 diagnoses, but only one was developed. I mean,
20 it didn't even get to the point of looking at the
21 SEM. So that was an issue.

22 Not all exposures that could cause a

1 particular medical condition were evaluated by
2 the CE. Again, information -- it doesn't seem
3 like anybody ever utilized -- from what we saw
4 anybody utilized information in the OHQ. They
5 would look at the OHQ. They would ask for the
6 DAR. If it wasn't in any of the documents that
7 they got, it was just sort of dropped. And then
8 there were several instances where the claim was
9 -- the claim was denied by the CE only using the
10 SEM without asking either the industrial
11 hygienist or the CMC for -- to render an opinion.

12 What we saw actually was quite the
13 opposite in that even if the SEM supported a
14 nexus between exposure and disease, they would
15 send it to the industrial hygienist for an
16 opinion when in our look at this they really
17 didn't need to because it was well established in
18 the SEM.

19 And as I think Laura mentioned, this
20 becomes particularly troubling for work sites
21 without a SEM. If they don't find it in the SEM,
22 that's the end of it. And I'm not sure how that

1 gets through the final adjudication board, but it
2 didn't in several instances.

3 And some conditions were either
4 accepted or denied despite whether or not a job
5 was listed in criteria for acceptance. And we
6 didn't quite know how that decision was made,
7 even if it didn't go to industrial hygienist.
8 Again, we weren't -- sometimes they were accepted
9 and the person was not on a listed exposure
10 category and sometimes it was denied when people
11 were without additional expertise input.

12 And then again when things went to the
13 CMC, again this sort of tunneling of vision, they
14 were only asked to comment on one or two
15 conditions or answer one or two questions. For
16 instance, is this considered a cancer? And they
17 don't -- didn't ask, gee, even if this wasn't a
18 cancer, is there some relationship between what
19 these people were exposed to and what the medical
20 outcome was?

21 And we already talked about No. 7.
22 And then cases where the -- there was one case

1 where; this was a COPD, the district's office
2 commented on a known exposure outcome
3 relationship. And I think it was nitrogen
4 dioxide, not -- yes, and COPD, yet never asked
5 the CMC to review it and the claim was denied.
6 So that -- and I think the presumptions would
7 have helped with that.

8 A claim where an IH stated there was
9 no evidence for an association between TCE and
10 Parkinson's disease, which is not quite where the
11 literature is at this point. As a matter of
12 fact, another agency has just established a
13 presumption for TCE And Parkinson's disease.

14 They do not consider other exposures
15 and in general do not look at the synergy between
16 exposures at all. And I'm talking about
17 synergistic exposures, multiple exposures in the
18 same workplace and the same person. We're not
19 talking about outside DOE or personal exposures.

20 And then some -- I didn't see this
21 often, but a couple of times we did see a
22 radiation case was not developed because the

1 claimant -- that particular claimant was not part
2 of a Special Exposure Cohort, however, there were
3 other cases where under Part E they were
4 developed.

5 And I think this leads us to a
6 question about consistency. We just looked at
7 two claims. Same exposures, same work
8 categories, two different district offices, two
9 different industrial hygienists, one the claim
10 was accepted, the other the claim was denied.
11 And so, that leads us to some of the questions we
12 are going to ask on Friday.

13 And one of the reasons we don't have
14 any recommendation is because we still don't feel
15 comfortable enough understanding the process to
16 be able to make good recommendations on how to
17 improve it.

18 So there are four of us going to
19 Seattle on Friday. There are -- representatives
20 from the district office will be there. We
21 wanted to speak directly to claims examiners, but
22 there were questions about job security and

1 multiple other non-exempt employee issues that
2 sort of precluded that -- our ability to do that.
3 So we are speaking with multiple people, all of
4 whom I believe have been CEs. They are -- first
5 of all, Christy Lang, who is the regional
6 director will be there. Joleen Smith, who is the
7 director of the Seattle office; Charles Elsen,
8 who is an assistant director; and Sadie Fine, who
9 is a supervisor. And apparently -- at least some
10 of them have done actual claims adjudication.

11 The next question was what kinds of
12 claims were we going to look at? And initially I
13 -- we had requested claims from the Seattle
14 office, and we would like to have seen claims
15 that were in the process of adjudication because
16 we wanted to be able to look at the logic process
17 as they were going through it. That was again
18 determined to be inappropriate because they
19 didn't want the CEs to have any outside influence
20 in making the claims decision, which I can
21 understand. If I'm sitting there as an occ-doc
22 asking questions about a claim that they're

1 adjudicating to go yes, ma'am, yes, ma'am, and --
2 it's not fair to the claims examiner to do that,
3 and we agreed.

4 So how we ended up is there were four
5 cases that were chosen by our subcommittee that
6 we had already reviewed in December that we had
7 questions about. And we are going to -- we have
8 already developed those questions to ask on those
9 that are specific to those cases. There's a
10 lymphoma case, there's a multiple autoimmunity
11 disease case, a meningioma I believe or a -- I
12 can't remember whether it's a meningioma or
13 glioblastoma, and a case of diabetes and another
14 -- couple of other contentions.

15 Then each district office picked two
16 cases that had already been adjudicated that they
17 chose and then sent to us, and we will be
18 discussing those as well. So we have a total of
19 12 cases to discuss on Friday, 8 of which the
20 district offices picked and 4 of which we picked.

21 And my feeling is that they have given
22 us -- we are -- have been told that we are

1 running the meeting, that this is our meeting and
2 they will respond to our questions.

3 But I also think two other things. I
4 think that if there are representatives there
5 that have questions about those cases, they
6 should certainly ask us as well.

7 So the content of the discussion will
8 be general questions about the process. We all
9 know what the training document says, but how are
10 you -- how do you actually use the OHQ? Do you
11 use it?

12 And then again how is the SOAF
13 developed? What is their logic process regarding
14 what I think we should put into the statement of
15 accepted facts? And again, part of that, how
16 does the CE determine what questions to ask the
17 consultant and what they don't think is
18 important? And the whole purpose of getting at
19 this is to find out how we can make this whole
20 process more equitable based on what we've seen
21 on the case files.

22 How do they use the Former Worker

1 Program documents? I've never seen them in any
2 of the case files even when the -- on the OHQ the
3 person says we've been -- I was in the Former
4 Worker Program.

5 And then we saw a lot -- we didn't
6 really know, but when an outside opinion is
7 available but they still send it to the CMC, how
8 do you determine which is more probative and do
9 you even send it -- do you send the other --
10 which you should I think -- send the other
11 doctor's medical opinion to the CMC, because a
12 lot of times if it's a well-developed medical
13 opinion there will be references and there will
14 be a good rationale.

15 And determining which is more
16 probative, I've seen situations where I thought
17 quite frankly the outside consultant's medical
18 opinion was much more probative than the one
19 developed by the CMC, yet it was disregarded
20 because that person was not the treating
21 physician. And I'm like, well, that sort of
22 rules out of having any occupational physician

1 write a -- having their medical opinion accepted
2 because most of the time we're not the treating
3 physician. We are the consultant that determines
4 the nexus. So there are all these sort of
5 inconsistencies that we see that we need to get
6 to the root cause for.

7 And again, this is not judgmental at
8 all. This is just -- this is a big program.
9 There are lots of different people that are doing
10 these files, some with more experience than
11 others, some with more understanding of what the
12 situation is like in these various work sites and
13 how do we make it more equitable?

14 So again, questions on the individual
15 -- those were the general questions. And then
16 after that we'll go into the individual cases.
17 And people are still developing the questions
18 they want to ask because quite frankly we didn't
19 get these files until the early part of last week
20 and most of them are somewhere between -- there
21 was one that was 291 pages.

22 Faye, you were lucky.

1 And then there was one that was 2,700
2 pages. And most of them were somewhere between
3 1,000 and 2,500 pages. Most -- a lot of us
4 didn't actually get through all of them. So
5 we're still working on the questions.

6 But several contentions were raised on
7 the EE-1. With medical evidence why were only
8 one or two developed? Where did you make that
9 decision? Why did you make that decision? And
10 what documentation did you use to do that?
11 Again, we ask it as a general question, but then
12 when we get into the case file we want to ask
13 that question about the OHQ again because if we
14 don't see evidence that it was used, if we're
15 told that it was used, then again there's a
16 disconnect between the ideal and the actual.

17 Again, how does the CE determine which
18 goes -- what goes into the SOAF because we see a
19 whole bunch of information that seems
20 appropriate, but it doesn't get into the SOAF.
21 And why were cases denied only after SEM review?
22 That should never happen according to training

1 documents. And why were only some questions
2 asked of the district medical consultant? Now
3 hopefully after we get through all of that there
4 will be a general discussion on how to make the
5 process better.

6 There were a couple of other
7 recommendations. And I think that's actually the
8 end of the slide presentation. There are a
9 couple of other things, and then I'm going to ask
10 members of my committee to add what they need to
11 add.

12 We think it would be a very good idea
13 to look at some of these cases retrospectively
14 and see how the presumptions would have assisted
15 in the development of this claim. We think that
16 might be a useful process.

17 And then one of the things; I think it
18 was Dr. Silver that raised this, is when you look
19 at some of the IH and the CMC reports, there's
20 this sort of wanton abuse of the word
21 "significant." In one paragraph in a SOAF it
22 said, "The industrial hygienist determined that

1 there was significant exposure to toxic in A, B
2 and C." And the next sentence said, "But the CMC
3 determined that that was not -- the exposure was
4 not significant enough to cause disease." No
5 rationale for either in either the industrial
6 hygienist's report or the CMC's report. And this
7 gets put into the final statement of the case.

8 And significant to most
9 epidemiologists and most occ-docs has a meaning.
10 It has a specific meaning, and it's not a
11 qualitative word. It's a quantitative word for
12 the most part. And so to use it in a
13 diametrically opposed way in the same paragraph
14 seems totally irrational to me. And we need to
15 get to how this gets developed in this way. And
16 that's what we're hoping to do on Friday. I
17 don't know if it will work. And after that we're
18 going to sit and put our heads together and come
19 up with real recommendations. We can't do that
20 we feel until we get to the end of the line here.

21 In some ways this committee is most
22 dependent on the information that we get from the

1 agency and from the sites because without that we
2 cannot move forward. And so we're very grateful
3 quite frankly to the agency that they responded
4 to us in getting us the training materials and
5 getting us the additional cases so we can
6 actually work on this.

7 Finally, there was one issue that was
8 raised to Dr. Markowitz that he assigned to my
9 committee, and I think I -- at some point I can
10 present it. We haven't really discussed it, but
11 I think it's going to need some broader input
12 than my subcommittee, and that is a question
13 about -- people basically have symptoms, they
14 have medical problems for a long period of time,
15 just like you mentioned with COPD, and then they
16 finally get a diagnosis.

17 But the wage loss for the disability
18 is only retroactive to the date of diagnosis.
19 And the question then; I think this is what the
20 person was asking, is how do you compensate for
21 wage loss prior to a definitive diagnosis when
22 you've been having problems with this issue for 5

1 or 10 years? And I'm not sure if that's
2 something that our subcommittee in and of itself
3 can look at. I think there may be policy that we
4 have to look at, but I think there should be
5 input from other people on the whole committee in
6 order to do that. But I wanted to raise it here
7 as an issue that we are going to look at.

8 So I'm finished with my formal report
9 and I -- anybody on the subcommittee want to add,
10 please go ahead. Faye?

11 MEMBER VLIEGER: In reviewing our
12 individual cases one of the ones that I was
13 assigned to review the DAR records came from SRS,
14 Savannah River Site. And it was disconcerting
15 that in the DAR records the IH portion of it made
16 a statement about the fact that because this was
17 a clerk they were not exposed to any toxic
18 substances. And I felt that sending that to the
19 Department of Labor that way without any context
20 really, because they just said the clerk labor
21 category was not exposed to toxic substances,
22 therefore there was nothing to report, was front

1 loading a decision that they had no business
2 making a statement on. And so I just wanted to
3 comment that.

4 Dr. Worthington, if you'd like to talk
5 about that one later on, because it would be PII
6 information.

7 But I felt that the SRS site had no
8 business making that kind of a statement when
9 there was only asked for provide us all pertinent
10 records.

11 MEMBER CASSANO: Les? Dr. Boden?

12 MEMBER BODEN: So one area that's a
13 little different from the things that you just
14 talked about but that is of concern to me; and I
15 haven't really thought about how to frame it for
16 DOL, is in looking over these cases there were a
17 number of them in which it was clear that the
18 person making the claim was not either medically
19 or legally sophisticated and that their claim
20 failed at least in part because they didn't
21 provide the records that were needed for the
22 claim to go forward.

1 And one thing that I think our group
2 wants to -- or at least I want to think about is
3 ways that aside from having somebody who's in an
4 advisory capacity towards that individual person
5 that DOL might help clarify to people what they
6 need to do in order to provide the necessary
7 medical evidence to have their claim go forward.
8 That is done to some extent, but it doesn't seem
9 to be effective in many cases.

10 MEMBER POPE: I also think that it
11 would have been great to have the actual CEs to
12 speak with, because being a bargaining unit
13 employee or worker myself, I know for a fact that
14 talking to the worker, the people that do the
15 work, you actually find out what's going on.
16 Being that we're going to be talking to the
17 supervisors, that's fine, but I believe that the
18 reason why we're getting all these
19 inconsistencies is because the CEs are
20 formulating their own opinions about these cases
21 and in a position that they should not be, in my
22 personal opinion, and formulating their opinions

1 about whether this case should go to the IH or
2 the CMC.

3 I also found that looking over the
4 cases that I was assigned to being that identical
5 -- not really identical, but similar conditions
6 were diagnosed and then one was approved and one
7 was not just leads you to a lot of questions as
8 to why not? It is seen like there was a lot of
9 supporting data that was in this file that should
10 have made that file being approved, but just try
11 to understand all that and not coming from a
12 judgmental place, but coming from a place of
13 trying to understand the reasoning behind that.

14 MEMBER CASSANO: Just let me respond.
15 I think one of the things that we had talked
16 about earlier was a survey that could be sent
17 out. And I don't know if we would have the
18 resources to do this, but the only way we could
19 really do this was to -- would be to have a
20 really good validated survey that went out to
21 CEs, non-identifiable, etcetera, and returned in
22 some way that we would not -- that would not make

1 them feel compromised as far as their position.

2 And I think that's part of the issue
3 that if they -- if somebody feels, well, if I
4 speak out and I say something, whether it's true
5 or not, but it is a perception that if my
6 supervisor doesn't like what I say, somehow I'm
7 going to get retaliated against. And again, that
8 is not to say that would happen, but people feel
9 that. I mean, anybody that's ever had a boss I
10 think feels that, whether you're a physician or
11 an industrial hygienist or a clerk or whatever.

12 And I think the only way to be able to
13 really do that would be with a good validated
14 survey, and we would need somebody to help us
15 develop that. And I don't think we have the
16 resources to do it.

17 Dr. Markowitz?

18 CHAIR MARKOWITZ: Well, the issue of
19 -- just to speak to that point, the issue of
20 resources, first we need to decide whether we --
21 what role such a survey would play, whether we
22 would advocate for it. And then we can request

1 resources. So I don't think the lack of
2 resources should hinder us from moving forward
3 with a good idea.

4 MEMBER CASSANO: I think you had
5 another --

6 CHAIR MARKOWITZ: Yes, I had another
7 point. Actually, the questions in the interview
8 process for Friday, I didn't see the EE-3. Isn't
9 that the occupational history information that
10 the claimant provides as part of the initial
11 application claim?

12 MEMBER VLIEGER: This is Faye. EE-1
13 is the application form.

14 CHAIR MARKOWITZ: Right.

15 MEMBER VLIEGER: It doesn't list any
16 exposures or experience. The EE-3 would list the
17 sites they worked at, the buildings, their labor
18 categories and tasks.

19 CHAIR MARKOWITZ: Okay. So my
20 question was whether you could ask --

21 MEMBER VLIEGER: Yes.

22 CHAIR MARKOWITZ: -- for the level of

1 that. And then secondly, I didn't see that you
2 asked directly about their own experience using
3 the site exposure matrices. So --

4 MEMBER CASSANO: We can add those.

5 CHAIR MARKOWITZ: Yes.

6 MEMBER CASSANO: Okay. I mean, as I
7 said, we have not -- we are still in the process
8 of developing questions.

9 CHAIR MARKOWITZ: Sure, sure.

10 MEMBER CASSANO: We're going to meet
11 again. We met last night. We're going to meet
12 again Thursday night in order to actually get
13 more questions going. Because until you actually
14 look at the files, you don't know. And I guess I
15 wasn't -- when I say EE-1, I think I was
16 including EE-1 and EE-3 as one whole document.
17 So that's just my ignorance in doing that. But
18 we can certainly add that.

19 Dr. Dement?

20 MEMBER DEMENT: I think it cuts across
21 several different aspects of medical evidence and
22 exposure evidence, but one of the issues that

1 based on my review of many of the files is the
2 deceased workers. I mean, they can't speak for
3 themselves. The next of kin typically -- they
4 may know their job classification where they
5 worked, but know very little about actual
6 exposures in work.

7 So a sort of broader context is how
8 can we supplement that information either with --
9 we've talked about sites that don't have an SEM
10 and looking at comparable workers. How can we
11 think about supplementing that with information
12 that we think is reasonably reliable? Even in a
13 lot of cases I reviewed, not here, but coworker
14 affidavits and statements about what they did and
15 what their fellow worker did are often quite
16 valuable.

17 MEMBER WELCH: I just wanted to make
18 a comment on what Les had said about helping the
19 workers get the correct information. And it's
20 something that I don't know whether it's -- your
21 subcommittee could look at it, but I've seen a
22 number of those requests that go out to the

1 worker for more information, and the language
2 could be way simpler and more straightforward.

3 And sometimes it's asking for
4 something that the worker thinks they've already
5 supplied. So the worker sent in all of their
6 exposure information and the letter is asking for
7 exposure information. So it's quite confusing.
8 So it would help to say we've received this,
9 this, this and this, but it's not sufficient for
10 this reason and can you provide what's missing?
11 It's not -- they're -- the claims examiner must
12 have thought through that to ask for more.

13 So if you could also add to your many
14 lists of tasks the language that's being used.
15 Maybe it's standard language. Maybe it's always
16 the same. I don't know whether the claims
17 examiner is -- writes the letters or whether
18 they're using a standard language that's provided
19 by the Department and is there a way we could
20 provide examples? Because it's really -- there
21 are a few things a claims examiner goes back and
22 asks for to move the case forward. We could

1 provide examples of language for that.

2 MEMBER BODEN: Yes, just to respond to
3 that, I think that's a good idea. Sometimes it
4 -- I think it looks to the claims examiner -- and
5 even to me as am I'm reading it like the claims
6 examiner is kind of saying what's missing but
7 there's still some link that's not -- there's
8 some connection that's not made and the person
9 doesn't go ahead and get something which might be
10 not that hard to get. And it would be useful to
11 find out how to make that link better. And I
12 don't -- I really don't know the answer to the
13 question, but it's an important question, I
14 think.

15 MEMBER CASSANO: I think some of the
16 improvements to the Occupational History
17 Questionnaire might help that greatly in
18 prompting them to get the correct information.
19 And maybe that's something that might be an -- we
20 can think about this in the -- an addendum to the
21 Occupational History Questionnaire that says,
22 hey, if you are in this -- these job categories

1 or this is what your potential exposure is, you
2 will need to provide some -- the appropriate
3 documentation. And that may be the easiest way
4 to do it. But that's going to be something we
5 discuss after Friday, I think.

6 MEMBER BODEN: I think it will be --
7 I think that's a -- going to be a process. We're
8 going to have to talk to people and try to figure
9 it out. I don't think we know in advance what a
10 good way of doing that is.

11 MEMBER SOKAS: And one of the
12 questions might be whether those requests for
13 additional information are all pre-populated, if
14 those are all like legally approved templates
15 that have to get used or whether there is an
16 opportunity to shape it a little bit more.

17 PARTICIPANT: Actually, Rachel, you
18 might be able to answer that right now about the
19 request for information.

20 MS. LEITON: Absolutely. One of the
21 things I've always actually stressed is that I
22 don't like templates because of that reason of

1 using something that isn't relevant. We try to
2 train our people on -- look for what's already
3 there, ask for medical evidence, factual
4 evidence. Some of the offices divide it into
5 medical evidence that's need, factual evidence
6 that's needed, and other offices don't.

7 We do have what we're -- we do have a
8 correspondence library that we're kind of
9 building up, but that's really more like
10 acknowledgment letters, things like that. When
11 it comes to crafting a development letter after
12 we've received information, we do try to stress
13 that they be as specific as possible as to what
14 they're looking for, but if they don't get
15 anything that -- or if they don't get any
16 exposure information at all or they don't get any
17 medical, sometimes they will ask for everything
18 that they think that they can ask for.

19 And I think tailoring those letters is
20 always a challenge for claims examiners to know,
21 okay, I don't want to leave out something. Some
22 offices specifically say this is what we've

1 received, this is what we need. Putting those in
2 layperson's terms is oftentimes a challenge as
3 well. But, yes, there is opportunity for making
4 changes to it because we don't have development
5 letter templates as a rule. We might have follow
6 this format, but we don't have here's what you
7 need to put in every letter.

8 MEMBER CASSANO: I'm wondering if
9 sometimes the reason the continued requests go
10 out isn't because the claimant isn't providing
11 the right information, but because the CE doesn't
12 realize they have the information or they don't
13 really have a good understanding of what they
14 need to ask.

15 So I'm wondering if there's any
16 opportunity at that point for the CE to go to the
17 industrial hygienist for instance and say, look,
18 I've got this claim for -- don't even have to ask
19 names. Just a general question. I've got a
20 claim for such and such and -- for this medical
21 condition. I have -- the guy has worked here.
22 The SEM isn't helping me very much. What can you

1 tell me I should ask this guy for in order to
2 help his claim move along?

3 MS. LEITON: There is actually an
4 opportunity for that. The claims examiners can
5 email our lead industrial hygienists or they can
6 talk to them on the phone. And in fact they do
7 ask them those questions. I'm not really clear
8 on this or I've got this evidence. What do you
9 think I can do more with it? We also have
10 medical physicians on staff, the medical
11 directors on the staff. Now we have nurses on
12 staff that we can go to and ask those questions
13 as well, if there are clarifications that are
14 required.

15 I think that the claims examiners in
16 general terms do -- I mean, they're going to
17 review what they've received, but can I say that
18 I've never seen them ask the question again even
19 though they might have something. I can't say
20 that because it happens. But in general they are
21 trained to look at what they already had, make
22 sure they understand as best as they can what

1 they need to ask for further.

2 MEMBER BODEN: Yes, actually the
3 things that I'm talking about are not things that
4 the claims examiners have missed. Let me tell
5 you a little sort of anecdote.

6 I had a friend who was one of the
7 leading workers' compensation claimant's
8 attorneys in Massachusetts and who prided himself
9 on how well he could explain the process and what
10 people needed to do and so on and so forth. And
11 after having done this for quite a few years a
12 graduate student asked him if she could interview
13 some of his claimants. And she reported back to
14 him that when she asked them how well they
15 understood his explanations, most of them said I
16 really didn't understand anything he was saying.

17 MS. LEITON: Right.

18 MEMBER BODEN: So I think the
19 intentions are there, and the letters seem
20 reasonable to me, but it really sometimes takes a
21 certain amount of figuring out to know what
22 actually works for people who aren't experts in

1 the process.

2 MEMBER CASSANO: Thank you. Any other
3 questions or comments?

4 MEMBER VLIEGER: This is Faye. First
5 of all, it's not often that I do this, so,
6 Rachel, pay attention.

7 (Laughter.)

8 MEMBER VLIEGER: The letters have
9 improved significantly since the beginning of the
10 program. I mean, leaps and bounds. So -- did
11 you hear that?

12 (Laughter.)

13 MS. LEITON: I'm sorry. I was
14 actually --

15 (Laughter.)

16 (Simultaneous speaking.)

17 MS. LEITON: I'm sorry.

18 MEMBER VLIEGER: The letters to the
19 claimants since the inception of the program have
20 improved leaps and bounds.

21 MS. LEITON: Thank you very much.

22 MEMBER VLIEGER: However --

1 (Laughter.)

2 MEMBER VLIEGER: Yes, she would like
3 me to stop there, I'm sure. However, it does
4 seem to be a subjective area which is always hard
5 to get people to go along with a program if it's
6 kind of free form, all play.

7 So there are those letters that I see
8 from certain district offices, certain areas of
9 district offices where it is obviously a
10 boilerplate. It is quite obviously boilerplate
11 and at times there have been cut and paste errors
12 from other claimants' information in the file.

13 So this is just a recurring training
14 problem. It's been that way in all government.
15 And we do cut and paste errors all over the
16 place. But I do think that when we're dealing
17 with the workers that if we can be less technical
18 in what we're requesting, specifically saying --
19 if you just write PFT down, they're not going to
20 know. If you write pulmonary function test,
21 which means this, then -- particularly in the
22 lung cases when that's one of the major missing

1 pieces of data, then I think it would help us
2 great.

3 MEMBER CASSANO: Dr. Silver?

4 MEMBER SILVER: I want to thank DOL
5 for providing these most recent claim files in a
6 much better organized fashion that earlier
7 batches. They were sequentially laid out over
8 time, which reminds me that we saw a news item
9 about a new contract between the Officer of
10 Workers' Compensation Programs and a private firm
11 to manage the records of this and other programs.
12 And maybe before we leave tomorrow we could learn
13 a little bit more about that. It would be nice
14 if a table of contents feature was built into all
15 of these claims files, particularly if we're
16 going to recommend that the IHS and CMCs under
17 certain circumstances receive their full file.

18 After my rant about the word
19 "significant" yesterday I slept on it and
20 realized it should be used in the punch line,
21 because that's the statutory standard. And in
22 public health school one of my missions is to

1 make sure our students don't use it wantonly.
2 "Substantial" Is a decent substitute, and quite
3 conveniently within administrative law
4 "substantial" is something less than a
5 preponderance of evidence. So we could consider
6 that.

7 And in one of these claims I did see
8 an example of the answers given by a claimant on
9 the OHQ being used against him on the issue of
10 personal protective equipment. We had a little
11 colloquy at the beginning of our Oak Ridge
12 meeting. Dr. Sokas rightly pointed out that
13 wearing a PPE is a red flag for hazardous
14 exposures, and some of us were worried that it
15 might be used against claimants. A skin cancer
16 case had exactly that going on in these claims.

17 And I'll save comments about training
18 versus education for another day.

19 MEMBER CASSANO: I was reminded by Dr.
20 Markowitz that it is lunch time. We need to take
21 a break. So once again, I want to thank the
22 members of my subcommittee. Yes?

1 PARTICIPANT: You have a comment on
2 the phone.

3 MEMBER CASSANO: Oh, somebody had --
4 Rosie?

5 MEMBER SOKAS: I want to comment, but
6 I'll save it for later. We kind of overlapped
7 quite a bit in some of the discussion areas, and
8 so we had a recommendation about organizing the
9 records and charts.

10 MEMBER CASSANO: Okay. Thanks. I
11 want to again thank the members of the
12 subcommittee. For those of us from the East
13 Coast, we were up until the wee hours of the
14 night out here trying to look through these
15 records, and everybody did a really land office
16 job here on looking at them. Thank you very
17 much.

18 CHAIR MARKOWITZ: So it's 12:00. We
19 can continue this committee discussion at 1:00
20 when we will reconvene. Thank you.

21 (Whereupon, the above-entitled matter
22 went off the record at 12:02 p.m. to resume at

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1:00 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:06 p.m.)

CHAIR MARKOWITZ: Okay. Let's get started now.

So there are two members who are a little late, but I know they are going to be a couple minutes late, but they will be here shortly: Dr. Friedman-Jimenez and Dr. Welch.

So we are going to continue where we left off this morning, with the Medical Evidence Subcommittee. Dr. Cassano?

MEMBER CASSANO: We wanted to continue a little bit of this discussion about how -- and I am totally -- not quite clueless, but totally at a loss for how to approach this -- on how to determine -- if there is a way to determine wage loss over a period of time prior to definitive diagnosis where the wage loss should be considered in those conditions that are slowly progressive or not diagnosed properly for a period of time from when symptoms develop. And I am not quite sure how to do that in any way that

1 isn't totally subjective at some point.

2 CHAIR MARKOWITZ: So yes, so I think
3 the issue, if I understand it, is identifying a
4 date, appropriate date for wage loss.

5 MEMBER CASSANO: Yes.

6 CHAIR MARKOWITZ: Should it coincide
7 with the date of diagnosis for the accepted
8 claim, or should it -- could it be an earlier
9 diagnosis, for instance a diagnosis when --
10 excuse me, a date when the symptoms became
11 prominent or onset of symptoms, or, in the case
12 of wage loss, presumably symptoms that led to
13 loss of employment, right, stopping the work --

14 MEMBER CASSANO: Yes.

15 CHAIR MARKOWITZ: -- which are
16 significant symptoms. And it could well be that
17 significant symptoms leading to a work stoppage
18 could precede a date of diagnosis, and therefore
19 should the claim for wage loss derive --
20 originate in the date of symptoms leading to work
21 stoppage, or should it date from the date of
22 diagnosis? I think that is the question.

1 MEMBER CASSANO: Yes. I mean, I
2 understand the question. I am just not sure if
3 there is a good way to approach it other -- now,
4 if somebody has gone to doctors with the same
5 complaint for six -- five or six or seven years
6 and finally gets diagnosed, but they weren't --
7 let's say it's a chronic condition and they were
8 being looked at as, you know, recurrent acute
9 exacerbations of something, and then finally
10 somebody says oh no, you've got COPD, you know,
11 you're not getting upper respiratory infections
12 and that is why you're disabled, so there may be
13 a way to look back to the time that the symptoms
14 became -- were first presented clinic -- to
15 someone clinically.

16 Otherwise, you're left -- you know, if
17 you say symptoms were bad enough to lose
18 employment, I would presume that by that point,
19 they had gone to a doctor already. I don't know.

20 CHAIR MARKOWITZ: Well, what are the
21 options? I mean, if the treating physician, the
22 evaluating physician states -- obviously there is

1 a date of diagnosis in the record -- but states
2 or writes that in fact, this person was diagnosed
3 with this disease on such and such a date, but
4 his symptoms -- the onset of significant symptoms
5 was a different date, was an earlier date. It
6 was providing the date, and that these symptoms
7 at that point were sufficient to contribute to
8 his inability to work at that time, so that the
9 physician writes that.

10 MEMBER CASSANO: Yes.

11 CHAIR MARKOWITZ: Shouldn't that be
12 acceptable?

13 MEMBER CASSANO: Well, that -- I think
14 that should be. I don't know what the rules are,
15 but that should be acceptable, but that is
16 incumbent upon the employee or the claimant
17 knowing to ask his --

18 CHAIR MARKOWITZ: Sure.

19 MEMBER CASSANO: -- physician to put
20 that in the record, and so -- and a lot of them
21 don't, so I don't think --

22 CHAIR MARKOWITZ: Right. Okay. Dr.

1 Boden?

2 MEMBER BODEN: So a couple of thoughts
3 about that. So the issue of the knowing to put
4 it in the record could be addressed by the claims
5 examiner in their contact with the claimant,
6 number one. And number two, probably the
7 examining physician would not only have to say
8 that they believe that the onset of symptoms was
9 not extant, but they would have to provide some
10 sort of evidence in the medical record that that
11 was the case, right, I assume, because otherwise,
12 it would be unsupported by -- you know, whatever
13 the wording is in usual -- you can't just make an
14 assertion as a physician. You have to have some
15 reason for the assertion, right?

16 CHAIR MARKOWITZ: True, but we make
17 assertions all the time.

18 MEMBER BODEN: Yes, I know you do.

19 (Laughter.)

20 CHAIR MARKOWITZ: So many of them are
21 appropriate.

22 MEMBER BODEN: Medical and other, yes.

1 CHAIR MARKOWITZ: Many of them are
2 appropriate.

3 MEMBER BODEN: Yes.

4 CHAIR MARKOWITZ: You know, it is
5 based on the medical history. This is what the
6 patient reports. Yes, if there were previous
7 visits in which the person had that symptom, and
8 it was in the medical record, that would add
9 another layer, but if the physician by way of
10 medical history identifies that in fact this
11 person had symptoms that date back 18 months ago,
12 that was when some -- and in fact, they no longer
13 worked at that point due to those symptoms,
14 writes it in the medical record, I don't see why
15 that would need to be corroborated by further
16 prior medical evidence.

17 Yes, Ms. Leiton?

18 MS. LEITON: Just as a point of
19 clarification, what we look for is medical
20 evidence establishing that the individual lost
21 wages as a result of the condition that is
22 covered. It doesn't say it has to be diagnosed

1 at that time. The doctor has to say I believe
2 this person became -- was unable to earn wages or
3 unable to earn a certain amount of wages as a
4 result of their covered condition beginning on
5 this date. It is really -- that is what our
6 procedures say it's tied to, so I just want to
7 make sure that that is clear.

8 CHAIR MARKOWITZ: Okay. Well, that
9 would seem to address the issue, I think. Yes,
10 okay. Okay. Well, that --

11 MS. LEITON: Problem solved.

12 (Laughter.)

13 CHAIR MARKOWITZ: Non-problem solved.
14 Okay, thank you, clarification. Dr. Silver?

15 MEMBER SILVER: We probably shouldn't
16 discuss wage loss again until we review the
17 relevant part of the statute 7385s-2. I am not
18 going to do it here.

19 One thing I have learned from
20 experience is that some DOE contractors had a
21 program they called early medical retirement, so
22 short of people's Social Security age, they left

1 the employment of a DOE contractor with medical
2 conditions that prevented them from continuing to
3 work. So a good write-up for a party claimant
4 would look back at the documentation of the
5 medical retirement and take that into
6 consideration when having diagnosed the
7 occupational illness many years later.

8 CHAIR MARKOWITZ: Any further comments
9 before we move on to the next committee? Go
10 ahead.

11 MEMBER CASSANO: The only other thing
12 I wanted to add was going back to the questions
13 for Friday, if any other members of the Board had
14 thought of questions that you want us to ask on
15 Friday to the -- to the supervisors at the
16 district office, if you can't think off of the
17 top of your head now, you can email them to me.
18 If anybody has any comments now, I would
19 appreciate it.

20 CHAIR MARKOWITZ: Okay. So we are
21 going to move on. Dr. Sokas?

22 MEMBER SOKAS: Okay. In response to

1 Dr. Cassano's question, though, I did want to
2 mention that -- I am getting feedback here. Are
3 you getting feedback when I speak, or no?

4 CHAIR MARKOWITZ: No.

5 MEMBER SOKAS: Okay. Then I am not
6 going to worry about it.

7 And I will -- and I forgot what I was
8 going to say about Dr. Cassano, so I will just
9 get started with us. And Tori, I will call you
10 later, okay?

11 MEMBER CASSANO: Okay.

12 MEMBER SOKAS: Oh, I know what it was.
13 I am sorry. We hadn't made these recommendations
14 that there be some facilitation of the
15 communication between the CEs and the physicians
16 involved, that there were some language problems
17 and challenges, so it might just be interesting
18 to kind of ask about that and to see what they
19 would like to see from the -- the physician who
20 is there who might be able to help, you know,
21 communicate maybe more effectively with some of
22 the either treating physicians or the CMCs.

1 Okay.

2 CHAIR MARKOWITZ: So Dr. Sokas?

3 MEMBER SOKAS: Yes, all set.

4 CHAIR MARKOWITZ: Okay. Let me just,
5 I want to -- I need to make an announcement. I
6 just want to announce again I think to members of
7 the public who are either on the phone or present
8 here that we have a public comment session
9 beginning at 4:30, and that if you would like to
10 speak, you should simply give to on the side your
11 name if you haven't done so. And some people may
12 be unaware they are able to sign up and comment,
13 but you can up until the 4:30 time slot.

14 So okay, Dr. Sokas, you can go now.

15 MEMBER SOKAS: Okay. Great. And I am
16 going to ask someone to forward those slides if
17 -- I don't know if that is Kevin or you or -- .

18 So this is the Subcommittee on
19 Industrial Hygiene and Consultative Medical
20 Reports, and I would like to move on to the
21 second slide, please.

22 And just to review, the -- the purpose

1 of the subcommittee is to really evaluate the
2 work itself of the hygienist and the physician to
3 ensure quality, objectivity, and consistency, and
4 we are mostly focused right now on the quality
5 piece of it, but they are all intertwined, as you
6 can imagine. And I just put up for your
7 appreciation the members of the subcommittee, so
8 you've got everybody there in front of you, and
9 Mr. Griffon on the phone. You can go to the next
10 one, please.

11 All right. And this again is a
12 reminder because many of these will directly
13 impact quality, objectivity, and consistency. So
14 we had previously recommended that a process be
15 established in which the industrial hygienist
16 would be able to directly interview the claimant,
17 so that remains something that we're very
18 interested in. We did -- and I appreciate Ms.
19 Leiton reporting that the -- the concepts that
20 rise to policy level are now being developed in a
21 way that is searchable by people outside DOL.

22 I did want to comment that the

1 teleconference notes that we reviewed included
2 comments that might not necessarily rise to a
3 programmatic level. I mean, there was a
4 discussion back and forth about someone who
5 committed suicide and what that meant for the
6 different aspects of the program, and so there
7 may well be pieces of information within those
8 teleconferences that -- that are the real nuts
9 and bolts of how things are handled that might
10 nevertheless, you know, be useful for others to
11 see if there is a way to de-identify and scrub
12 them, you know, and so it -- it does remain a
13 request that we have had previously.

14 The one that -- that Dr. Cassano and
15 Dr. Silver and others commented on that -- that I
16 want to highlight because we're going to go into
17 it a little bit more is the request that the
18 entire claimant case file would be available to
19 the claimant online, and we were told that there
20 are approaches to having that happen, that that
21 is under development right now to make sure that
22 the -- the technology is functioning adequately,

1 and this we think would also help moving forward
2 with the -- the physician and industrial
3 hygienist evaluations because they -- they
4 clearly need to be able to go through the entire
5 case file on occasion.

6 We -- we repeat the request that was
7 mentioned at the beginning about having an
8 occupational medicine resource at the Department
9 level that would allow for additional depth as
10 well as coverage when the physician hired by the
11 program is not available, and that the -- and
12 that the entire case file -- again, this has been
13 recommended in the past, but that the complete
14 case file be made available.

15 Now, if I could go on to the next one,
16 we can get into some more specifics. So the
17 subcommittee met in December, and one of the
18 things that we couldn't really not comment on
19 were the -- the depth and the -- the multitude of
20 comments that were made by the public during that
21 meeting, and so we did want to thank the
22 Department for having the ombudsman and other

1 personnel available, and we are very grateful
2 that that is happening again today.

3 There was, and I don't know if Mr.
4 Griffon is -- is on the -- I know he is on the
5 phone, but I wanted to turn this next bullet
6 point over to him, that we would like to see a
7 formal tracking and response to the comments that
8 are created or that are brought forward, and --
9 and I would like to ask Mr. Griffon to describe
10 how that -- no, I am sorry. If you could go back
11 one? We are not ready for the IH review. Right.
12 So -- whoops, sorry. Was there one in between?

13 All right. The -- the one that has
14 the date on the top of it, if we could get to
15 that slide? Next -- this one. Okay. So if we
16 could stay with this one for just a minute and
17 ask Mr. Griffon if he wouldn't mind describing a
18 little bit about the approach that the Radiation
19 Board takes?

20 MEMBER GRIFFON: Yes, sure, Rosie.
21 This is Mark Griffon.

22 Yes. I did follow up- on the

1 Radiation Board side. I can't remember exactly
2 when we -- when I was on that board, when we
3 initiated this, but we had had an ongoing sort of
4 question of there were lots of public comments,
5 and it was unclear how -- what action NIOSH had
6 taken in response to those comments and sort of
7 tracking them as time went on, and so eventually
8 -- again, it wasn't right in the beginning, when
9 the Board first started, but eventually NIOSH set
10 up a system, a fairly simple Excel spreadsheet
11 type tracking system to track comments made and
12 what the sort of response, if necessary.

13 Sometimes, it was questions related to
14 individual claims, so then the response might
15 have been that the Agency contacted the
16 individual and discussed their claim, you know?
17 Other times, when there were broader comments,
18 there were other ways that they, you know,
19 addressed the concern. But at least we had a
20 system that we could see what -- you know, what
21 items were sort of pending, what were closed out,
22 and what were individual issues.

1 And I got the NIOSH people to forward
2 I think a couple of months of examples, or a
3 couple meetings of examples, of those
4 spreadsheets to the Department of Labor because I
5 think they did have some privacy issues in them.
6 They were just emails, you know, internal
7 government email, and I don't think they can be
8 shared at this point, but the DOL is considering
9 that to adopt in similar situations. That is my
10 understanding, anyway, is that DOL is considering
11 a similar tracking approach.

12 MEMBER SOKAS: The question for the
13 Board as a whole is whether this needs a formal
14 resolution, or whether we will just kind of
15 follow up in subcommittee to see if that is going
16 forward.

17 MEMBER GRIFFON: Or Rosie, maybe we
18 can just ask Labor right now if they -- you know,
19 if they have gone any further with this, or where
20 they stand --

21 MEMBER SOKAS: Okay.

22 MEMBER GRIFFON: -- on this. Yes.

1 MEMBER SOKAS: So I don't know if Ms.
2 Leiton would want to comment on that now, or -- ?

3 CHAIR MARKOWITZ: The -- the hands or
4 the lack of hands, so let me run this for you. I
5 personally don't think we need a formal
6 recommendation on this issue. I think we would
7 make a request. We know that DOL is moving on
8 it, and we will follow up and make sure it
9 happens in a timely way. That is my own --

10 MEMBER SOKAS: Okay.

11 CHAIR MARKOWITZ: -- opinion.

12 MEMBER SOKAS: That sounds good.

13 The next bullet point is similar, in
14 it was one of the issues that was raised --

15 (Simultaneous speaking.)

16 CHAIR MARKOWITZ: Dr. Sokas? Dr.
17 Sokas? I am sorry, I am sorry.

18 MEMBER SOKAS: Pardon?

19 CHAIR MARKOWITZ: Someone just raised
20 their hand here. Ms. Vlieger?

21 MEMBER VLIEGER: Sorry, Dr. Sokas. I
22 was a little slow.

1 Do we know that there is a process
2 going on for this, and what is the rollout date
3 for it?

4 CHAIR MARKOWITZ: So I am informed
5 that the comments have been entered into a
6 spreadsheet, and I don't have a date, but I don't
7 know, maybe Carrie, do you have any sense of
8 movement on this?

9 Okay. So within a week or so.

10 MEMBER SOKAS: So Ms. Vlieger, I am
11 going to turn the final bullet on this slide over
12 to you. This was about a concern that was raised
13 at the meeting about the 200-mile distance for
14 DOL-directed medical evaluation.

15 MEMBER VLIEGER: It is -- DOL from
16 time to time directs a claimant to go through an
17 evaluation by a doctor of their choosing for the
18 continuation or evaluation of home medical
19 services, and this stipulation of 200 miles,
20 particularly on the aged and ill, is -- I am
21 trying to find a nice word for saying "really not
22 nice."

1 CHAIR MARKOWITZ: Burdensome,
2 burdensome.

3 MEMBER VLIEGER: More than burdensome.

4 CHAIR MARKOWITZ: Very burdensome.

5 MEMBER VLIEGER: Yes.

6 (Laughter.)

7 MEMBER VLIEGER: And so if they can't
8 find a doctor locally to disagree with the doctor
9 that is prescribing the home health, I think that
10 this borders on doctor shopping, which -- which I
11 know you're going to have a comment, Rachel, but
12 I still find it -- I am going to use a word that
13 I like to use -- I find this repugnant. So
14 that's what I have to say on this.

15 MEMBER SOKAS: So I think we did have
16 questions about how often it was put into use and
17 whether it is still necessary, so maybe we will
18 just phrase that as a question to the Department.

19 CHAIR MARKOWITZ: Oh yes, Ms. Leiton?
20 I am sorry.

21 MS. LEITON: Okay. The only reason
22 this provision -- well, the only place you will

1 find this provision about the 200 miles is in the
2 contract that we have with our -- our contract
3 medical consultants. We have had one second
4 opinion since October of 2016. I don't know if
5 that particular one was over 200 miles, but that
6 is the only in-person second opinion that we
7 actually have heard, according to my statistics.

8 You know, the only reason we would go
9 that far -- it is not general practice. We try
10 first to find people who are willing to undertake
11 these examinations through our contractor near
12 the person's home. It is our -- it is what we
13 have asked for first, and we have been working
14 with the contractor to try to get more physicians
15 because we frankly don't have enough physicians
16 to do this, that are willing to do the second
17 opinion evaluations in these particular
18 circumstances with regard to home healthcare.

19 But we are definitely not doctor
20 shopping to find somebody else that will say no.
21 As I have mentioned many, many times, we are in
22 the business to approve claims. When we find it

1 necessary to do an in-person second opinion, we
2 go through our contractor. We try to be as -- we
3 -- we have asked them to be random, but we have
4 asked them to be as close to the person's home as
5 possible. On occasion, it has been not possible,
6 and we haven't been able to find a doctor to do
7 that.

8 And, you know, we are working with the
9 contractor to try, as I said, to get more
10 physicians in more rural areas, but it is not
11 always possible. But again, it is very rare that
12 we -- that we do this.

13 MEMBER SOKAS: So just to clarify for
14 -- for our purposes, it only happened once since
15 October. It is only for second opinions for
16 individuals who are requesting home healthcare.
17 It is not part of the rest of the program.

18 MS. LEITON: For the most part. I
19 mean, we don't -- we have the ability to use
20 second opinions for other issues if it -- if
21 necessary, but that is the majority of any second
22 opinions we'd had in person. We have CMC reviews

1 of case files, that sort of thing, but it is rare
2 that we have others that are -- that it is
3 applicable to other situations.

4 MEMBER SOKAS: Thank you. So I would
5 like to go back to a useful exchange of
6 information. I would like to move on to Mr.
7 Griffon --

8 CHAIR MARKOWITZ: So, I am sorry, Dr.
9 Sokas?

10 (Simultaneous speaking.)

11 CHAIR MARKOWITZ: Dr. Sokas, there is
12 still some discussion here.

13 MEMBER SOKAS: Okay.

14 CHAIR MARKOWITZ: So, okay, so Dr.
15 Cassano?

16 MEMBER CASSANO: This would seem to
17 be, except for some of the most extraordinary
18 cases, a very good place where telemedicine might
19 be able to be utilized, and the local office,
20 local hospital can bring the -- the transmitting
21 equipment over, and then the interview can be
22 done, and, you know, if it's a range of motion

1 issue or if it's a -- whatever the function is
2 that you're looking at, there can be tasks that
3 are given to the person to -- to help evaluate
4 it, but I think that is something that should be
5 looked at in those situations.

6 MS. LEITON: Yes. That will depend on
7 our contractor, probably, and whether they have
8 that, the doctors in there have the ability to do
9 that, but I absolutely agree it could be done
10 that way.

11 CHAIR MARKOWITZ: The other resource,
12 the former worker medical screening programs all
13 use -- pretty much all use local physicians and
14 clinical facilities for the screening exams, and
15 these are clinics under contract to various
16 entities for the medical screening protocol, and
17 they may be receptive. So we could provide you
18 with those -- the names of those clinics.

19 I know the BTMed, which is the
20 construction worker project, uses how many
21 different clinics around the country? 100, and
22 the National Supplemental Program has more than

1 that, so if we could provide those names or those
2 --

3 PARTICIPANT: Sure.

4 CHAIR MARKOWITZ: -- clinics to you,
5 then a contractor might be able to use them.

6 Mr. Vlieger, did you leave yours up or
7 down? I couldn't --

8 MEMBER VLIEGER: I just wanted to
9 comment that while your statistics for the last
10 six months or so may be accurate, I don't think
11 that that has been the application over the past
12 few years in its entirety, and when you're
13 dealing with aged and infirm claimants, any
14 attempt to -- to do it more locally would help
15 them, and I think it would benefit the Department
16 because the additional expense of the travel and
17 all of the other things that go on because they
18 are being sent on government orders basically to
19 go to this claimant would benefit the program
20 overall too.

21 You know, they don't -- the aged, the
22 employed claimants don't always have someone who

1 can take off work and drive them to the
2 designated date and time of the appointment, and
3 so I do. I find this really repugnant, and I
4 hope we don't have to continue it.

5 MEMBER POPE: I had a question about
6 what are the options for that claimant currently?

7 MS. LEITON: Well, they -- they submit
8 any -- if they have to travel, we will pay for
9 it. We have -- in fact, we have paid for, you
10 know -- we have paid for any -- if it's a taxi,
11 if it's whatever they need to take them there, we
12 will pay for it. So that portion of it, since
13 we've asked them to go to this, we will pay for
14 it, if that's what you're asking me.

15 But as I said, we try to avoid it. We
16 really try to avoid it, and I agree that we want
17 to be close to the individual's home if we have
18 to undergo these second opinion evaluations.
19 There have been occasions that that hasn't been
20 possible, and we are trying to reduce that in our
21 contract.

22 CHAIR MARKOWITZ: Other comments?

1 (No audible response.)

2 CHAIR MARKOWITZ: Thank you, Ms.

3 Leiton.

4 MEMBER SOKAS: So if we could go back
5 to the preceding PowerPoint, not this one, but
6 the IH review? And I asked Mr. Griffon if in
7 addition to reading through these -- the next
8 one, the one in between. So this is subcommittee
9 meeting, and then the next PowerPoint after that,
10 this one.

11 And Mark, if you would actually, when
12 you get to the point about the claimant records,
13 describe how it has been handled again at the
14 radiation end.

15 MEMBER GRIFFON: Sure. Yes, this is
16 Mark Griffon again.

17 We -- the subcommittee here, the
18 review of sort of the role of the IH in this
19 process in our subcommittee, and I will go
20 through this sort of quickly because I think a
21 lot of the points the earlier subcommittee, the
22 Medical Evidence Subcommittee, raised a lot of

1 similar points, so I think there is going to be a
2 little bit of overlap with what we found and what
3 that group found, and I am -- and I am really
4 interested in when they do their people probe by
5 visiting the Seattle office. That may be very
6 helpful as well.

7 But the first point is that -- and
8 this is based on a small sample of cases -- but
9 based on these, it seems a little unclear to us
10 what exactly triggered a review, and we -- we
11 didn't go as far as crosswalking the procedures
12 or the training manuals with -- with the cases,
13 but it seemed, again, just on this small sample,
14 that some things that I thought might be useful
15 for an IH review were not included in the IH
16 review, and therefore we sort of had a question
17 of what is the threshold when -- when it goes to
18 an IH review?

19 Also, understanding I think this --
20 this recently changed, I think you have now an IH
21 consulting contractor, but at the time, for a lot
22 of these cases, you had a fairly small number of

1 industrial hygienists available, so there was a
2 resource question too to certainly consider
3 internally.

4 And then when it did go to an IH
5 review, the other point was it -- it seemed as
6 though, again in the small sample, that the
7 questions forwarded or the information forwarded
8 to the IH was truncated. They were asked to
9 opine on certain things rather than the entire
10 claim -- the entire case. So again, how -- how
11 are these determinations made, and are -- are
12 they made in a consistent way I guess is another
13 question.

14 And then this is the point Rosie just
15 asked me to expand on. The organization of the
16 case file in use, as I think was mentioned
17 earlier today, these case files are -- are
18 sometimes thousands of pages, and at least the
19 ones I looked at, they seem to be in no
20 particular order. And I am not sure if that's
21 the way we're receiving these, as one large PDF,
22 or if internally, they have them organized a bit

1 -- a bit better, but I know that -- that on the
2 radiation -- on NIOSH's side of the -- of the
3 program, they have done a pretty good job of
4 organizing these -- the claims files in their
5 database, and I think it allows for a couple
6 things.

7 It allows, number one, they can
8 section off information that is more important to
9 the industrial hygienist versus the physician.
10 You know, you can separate it into different
11 folders. But also, I think on the NIOSH side, it
12 has allowed for a sort of checklist approach to
13 make sure that a claims file is complete, that
14 you have all the pieces in -- in a particular
15 file, and that is useful for the initial claims
16 review, but also if you're going to do a sort of
17 quality assurance program of any sort, or
18 process, I think that would be -- it would be
19 much more efficient if it was organized in some
20 fashion like that.

21 So then, you know, I guess the other
22 thing that I -- that I heard earlier, which we

1 would agree with, is that -- and this is from the
2 Medical Evidence Subcommittee group mentioned
3 that the training documents and the procedures
4 therein didn't necessarily match some of what
5 they observed in the claims files, or the
6 practices that were being carried out by the
7 individual CE. And I guess that would make me
8 again ask the questions about consistency, about
9 fairness, and about, you know, some sort of
10 quality assurance approach needed to make sure
11 we're accounting for this across the board.

12 And I think that's it, Rosie, if that
13 is --

14 MEMBER SOKAS: Yes, thanks, thanks,
15 Mark.

16 So the next piece I want to go through
17 a little bit are the CMC qualifications and the
18 qualities, and I want to remind everyone that we
19 were given a memorandum from February 17th, 2015
20 that was a contractor medical consultant and
21 second opinion audit, an informal audit. But I
22 wanted to remind everybody that that audit really

1 focused on whether the CMCs provided the
2 information the CEs needed, whether from the --
3 the CE perspective, they were able to, you know,
4 kind of get the -- the rationale that they were
5 asking for and the specific questions answered,
6 and I would really characterize that as a process
7 audit, that there was really no content
8 evaluation performed at all. So I want to -- to
9 clarify that.

10 And so when we looked at it, we were
11 looking at it more from the perspective of the
12 quality of the CMC review, and one of the things
13 that struck me was the CMCs -- the people
14 conducting the CMCs, the ones who have been
15 hired, at least on a very small sample, appear to
16 be very well-credentialed. They are the kind of
17 people that you look at the quality of their
18 credentials in terms of board certification,
19 adjunct faculty participation, having actually
20 published peer-reviewed papers and that sort of
21 thing.

22 The -- the contractor clearly seems to

1 have done some work identifying people with --
2 with good credentials, right? I don't want to
3 say that for a large -- for -- I am sorry. I
4 don't want to say that for a -- you know, as a --
5 as a conclusion because we sampled so few cases,
6 but that that -- that that does not seem to be
7 where the problem was.

8 The problem in fact is that, for the
9 most part, they have a very different standard of
10 -- of looking at the outcomes, and they seem to
11 be following sort of standard workers' comp or
12 other -- other guidances that are different than
13 the guidances that are required for this
14 particular standard. And we did try to find out
15 whether they were being paid adequately to go
16 into depth because one of the things they also
17 didn't do was they did not deep dive into any of
18 the medical records. So there was information
19 buried in the medical records, in these thousand
20 pages, that clearly could have been of use that
21 were sometimes overlooked, but it would be, you
22 know, maybe two or three little notations in

1 somebody's -- you know, the workplace clinic
2 where something happened. I mean, so -- so you
3 clearly had to spend some time looking.

4 Now, in the middle of all this, we
5 tried to get a sense of that and were told that
6 it was -- that we couldn't find out what the
7 payments were to these clinicians or whether it
8 was on an hourly or on a per -- you know, per
9 letter basis because that might be a problem for
10 the contractor for their information, but we were
11 -- in the middle of all this, we were kind of
12 told by one of the -- just as a completely
13 separate piece of information, Terrie Barrie sent
14 us information about a medical consultant
15 guidance document that Dr. Schwartz had developed
16 in 2009, and in that document -- which -- which
17 she was referring to us for its guidance on the
18 level of certainty for either causation or
19 exacerbation or contribution, which is what we've
20 been talking about for the last year, so I don't
21 think we need to review that piece now -- but
22 they did in there have an enormous table for how

1 much the CMCs were to be able to bill, and it was
2 huge. I mean, it was like \$75 per 15 minutes, up
3 to eight hours for complicated cases.

4 So I don't know if the contract is
5 differing from that, but it would seem that there
6 is no excuse for not spending more time really
7 looking and finding stuff, but we certainly
8 didn't see evidence that people had worked hard
9 to look and find stuff, and we were again
10 concerned that they were not following this
11 particular program's level of certainty, that
12 they were applying higher standards that are used
13 in other areas.

14 So -- whoops, I am sorry. So back to
15 where we were? I didn't mean to continue. If we
16 could go back to the CMC one? Thank you. That's
17 it.

18 And then just to sort of pile onto
19 what Mark and others have said, that an
20 organizational structure to these records would
21 also be helpful. So the two pieces that seem to
22 be pretty apparent are that the CMC reviews are

1 not really searching to try to find information
2 that would be, you know, hidden in records, and
3 they're also not using the appropriate standards
4 of causation. And I would like to ask Dr.
5 Friedman-Jimenez if he has -- if he would comment
6 on this as well.

7 DR. FRIEDMAN-JIMENEZ: Thanks, Rosie.

8 Yes, I looked at a number of denied
9 cases and was struck by the -- the inconsistency
10 in the -- what seemed to be the standard for
11 causation. And I am not sure what process by
12 which the CMCs are told what the standard is, and
13 I think that it needs to be made clear to them in
14 a formal way that the standard is that the work
15 exposure must have caused or aggravated or
16 contributed to the medical condition that is
17 being considered. I think -- from my small
18 review, it sounds like that was not the case in
19 some of the CMC reviews.

20 Also, in trying to go through some of
21 these records, they are very long, several
22 hundred to 1000 pages, sometimes more. In some

1 cases, they are poorly organized, but what --
2 what I found difficult is that they are not
3 searchable. They are PDF files that are like a
4 bitmapped picture of the record. They are not
5 transformed into searchable files, so if you want
6 to search for the CMC statement, you have to go
7 paging through it dozens or hundreds of pages at
8 a time.

9 I think -- would it be feasible to use
10 an optical character recognition program, scan
11 the records so that they are searchable PDF files
12 rather than non-searchable PDF files? I think
13 that would help a lot, both with CMC access and
14 our access to those records.

15 So yes, I -- I agree with -- with what
16 Rosie is saying, and those are a couple of
17 additional comments.

18 MEMBER SOKAS: Thanks, George.

19 So I think we can go to our final
20 recommendations, and these are really
21 recommendations for discussion with the full
22 Board. The first was to really make a

1 recommendation about the -- the organizing the
2 records into sections and making them searchable.

3 MEMBER CASSANO: I have a couple of
4 questions. Sorry.

5 CHAIR MARKOWITZ: So this --

6 MEMBER SOKAS: I can't hear.

7 CHAIR MARKOWITZ: Yes, no, no, there's
8 some comments on a previous slide that some
9 people want to make.

10 MEMBER SOKAS: Well, I am sure. Okay.

11 MEMBER CASSANO: Okay. Sorry, Rosie,
12 I was listening. And I think I have three
13 comments.

14 First of all on Mark's question about
15 what triggers an IH review, just a quick
16 question. Is that something you want me to add
17 to the list of questions I'm going to ask on
18 Friday? Because that would be, that would be
19 something that we -- and we can easily do that.

20 Number two, regarding the
21 searchability. And I think we had asked in the -
22 - first of all, the CMC doesn't get the record.

1 They get a SOAF and maybe some other
2 documentation and then some pointed questions.
3 So, I think if the standard is not being met it's
4 because they don't have all the information that
5 they need to meet that standard.

6 But the other thing that we ask when
7 we ask that the whole record go to the CMC was
8 that the CE map the case. And that's very easily
9 done. No, you can't search for a particular
10 word, but you can certainly on the bookmark side
11 or on a case map, which is what I'm used to
12 seeing, it says, Dr. So-and-So, you know, pat
13 diagnosis for lung cancer, or whatever. And the
14 page and the record that it's at.

15 And that would suffice, rather than
16 going through the technologically difficult thing
17 of some of these things are handwritten or
18 scribbled or whatever and you're never going to
19 pick up on an OCR reader. But that would be the
20 happy medium for that.

21 And then the only other comment I had
22 was it seems, since there is so much overlap

1 between these, what these two committees -- and
2 we really are sort of dependent on each other --
3 I'm wondering if maybe some point after this,
4 instead of having an individual meeting, her
5 committee and my committee could have, like, a
6 combined subcommittee meeting and sort of discuss
7 the overlap and how to go forward with that.

8 CHAIR MARKOWITZ: Sure.

9 MEMBER SOKAS: Yes, I had the same
10 thoughts, Victoria.

11 So, but getting back to the -- so,
12 organizing the claimant files may be making them
13 entirely approachable. It might not be that
14 easy. But certainly putting them into the
15 different sections or folders should be
16 realistic.

17 I honestly thing that a CMC should
18 wade through the whole darn thing because I don't
19 think it's appropriate that -- I mean, the CE can
20 certainly point out and bookmark, but I, it
21 really is up to the CMC to be looking for that,
22 you know, repeat visit for pneumonia or

1 something, you know, that nobody ever wound up
2 diagnosing as asthma until 15 years later.

3 So those are the kinds of things that
4 I think the CMC really needs to pay attention to,
5 and have the entire record. And we have this
6 kind of -- I apologize, I'm trying to split them
7 rather than lump them -- but I think the goal is
8 to have both the CMC and the IH have the
9 information available to them. And if the record
10 is being created online so that the claimants can
11 have access to it, then that should be relatively
12 straightforward for the CMC and the IH referrals
13 as well.

14 The other point that we wanted to
15 really -- there's several other points, but
16 again, we can sort of lump them -- we really feel
17 that the quality of the CMC letters has to be
18 evaluated for content not just for format and not
19 just for did they, you know, kind of respond
20 using the code words that, you know, need to be
21 used.

22 And so I think there -- again, this

1 gets back a little bit to the recommendation that
2 Steve made that there be some additional
3 resources allocated in terms of, whether it's
4 through personnel or whether it's through
5 consultation, where you have a large enough
6 sample size for past CMC letters as well as
7 ongoing current ones to be able to do a formal
8 quality review for content by people who are
9 willing to put in the time and the effort to see,
10 you know, whether or not -- there's a ton of
11 different examples. I think we've heard some
12 already.

13 We had an example of someone who had
14 worked for -- in the laboratory with all kinds of
15 different solvent exposures for years and years,
16 developed an autoimmune disease. They had been
17 followed in a rheumatology clinic of a medical
18 center for years and years. And nevertheless,
19 the claim for anemia was not even forwarded, I
20 don't think, to the CMC. So it's one of those
21 things where -- or if it was forwarded, they
22 didn't do anything with it. They didn't -- they

1 may have gotten steered in a different direction
2 by the CE and so they didn't bother to look
3 through and find some of this other information.

4 So I think we would like to see a
5 contract separate from the one that is hiring the
6 CMC, that needs to be independent of that
7 particular contract. And we would like to see
8 somebody who's -- the reason I show in the
9 Association of Occupational Environmental Clinics
10 is because they actually have a criteria for
11 membership that includes a public health
12 perspective and a worker-centered perspective.

13 I'm sure there are other organizations
14 that, or academic groups, or whoever who could do
15 this. But to find someone who clearly
16 understands what the criteria for causation or
17 exacerbation should be and reviews the entire
18 charts along with the CMC letters. And then
19 based on that, we could come up with guidance for
20 briefing package materials that emphasize the
21 appropriate things for the CMC.

22 So, we have at least two

1 recommendations we'd like to move forward on. I
2 think organizing the claimant records and making
3 them available, the entire record available to
4 the IH and the CMC is the first one.

5 CHAIR MARKOWITZ: Okay. So, Dr.
6 Sokas, there's some comment. People would like
7 to make comments. Is this a good time?

8 MEMBER SOKAS: Oh, sure.

9 CHAIR MARKOWITZ: Okay. Dr. Welch.

10 MEMBER WELCH: I just want to say I
11 totally agree with your recommendation to have a
12 separate review of the content of the CMCs by
13 worker-centered occupational physicians. And I
14 think it will be, it will be really, really
15 useful. And in my review of claims over the
16 years, I have struggled with a way to figure out
17 how to, if it was up to me, how to improve the --
18 how to get consistency among the CMCs.

19 And I think understanding the cause,
20 contribute, and aggravate, and also requesting
21 the CMCs review the entire file would probably go
22 a very long way toward getting more consistency.

1 CHAIR MARKOWITZ: Dr. Boden.

2 MEMBER BODEN: So, first of all, I
3 think your committee's done a great job. These
4 are excellent recommendations.

5 Having gone through some of the claim
6 files, I know the issues personally. And let me
7 just say a couple of things. One is that I think
8 it is technologically totally feasible to have
9 these be searchable files. It could be done on
10 computers without anybody around, just letting
11 the computers run overnight if necessary, or
12 however long, to make these files have optical
13 character recognition.

14 And it really does help. Because I
15 did that myself on some of these really large
16 files, and it made a huge difference in my being
17 able to go through them.

18 The second thing that I would suggest
19 is rather than have the entire record available
20 to the CMC, so I had one file that was over 1700
21 pages long, and it contained two copies of a 702-
22 page medical record. So it was -- and there were

1 other duplications as well. But just taking out
2 one of those copies would have almost made it
3 half as long.

4 And so, the one other suggestion that I would
5 make is if we're going to make the entire file
6 available, it should be the entire file with a
7 minimum of duplication, particularly of these
8 very, very long medical histories.

9 CHAIR MARKOWITZ: So, I have a
10 comment. I think the Board is charged to look at
11 the quality, objectivity, consistency of the work
12 of the industrial hygienists and the consulting
13 physicians. So I think the Board should conduct
14 a study of a sizeable sample of IH and CMC
15 reports and basically design the evaluation. We
16 would need resources or assistance in actually
17 going through a bunch of these and conducting the
18 study. But I, frankly, think it's something we
19 should do or play a large role in ourselves in
20 order to fulfill the mission of looking at the
21 quality, objectivity, and consistency.

22 MEMBER SOKAS: So I'm just going to

1 push back a little bit by reminding you of how
2 you started out your recommendation, which was
3 that most of us have full-time jobs. And suggest
4 that in order to have -- I mean, so we, I can
5 right now tell you what I think; right? But how
6 many records have I reviewed? Maybe, you know,
7 five, ten. I can't remember now. But it kind of
8 -- maybe 12 -- but, but if you want to do it in a
9 meaningful way where every third one gets done,
10 or every fifth one, or every tenth one, then I
11 think you need to hire somebody to do it.

12 CHAIR MARKOWITZ: Ms. Leiton, did you
13 want to make a comment?

14 MS. LEITON: Yes, just a couple of
15 points that you may not be aware of.

16 In terms of what our claims examiners
17 see, we have a database that is divided. I mean
18 we index them by the type of document it is,
19 whether it's an IH report, whether it's a medical
20 report, whether it's a decision, whether it's a
21 development letter, all those things are indexed
22 as the information is either coming in or

1 leaving. And that's there and available for the
2 claims examiners in the process. So, it is
3 organized for them.

4 And I understand you guys didn't get
5 that. And it makes it a lot more difficult. But
6 I did want you to know that that is the way that
7 they can see the records.

8 When we refer documents to a CMC, we
9 do try to provide them with whatever relevant
10 medical is there. We don't just send them a SOAF
11 and that's it. The reason we look for relevant
12 information is because of the 4,000 records that
13 have -- you may have medical that is in
14 completely different condition, that was just a
15 medical note, lots of those. So we try to send
16 them the information that's about the condition
17 we're asking about or, if it's impairment, what's
18 relevant to impairment, those sorts of things.

19 I know you have a recommendation in
20 for already, for providing them access. And
21 that's something that's, you know, under
22 consideration. But I just wanted to make clear

1 that we do try to give them what's relevant,
2 along with the question that we're asking them.

3 MEMBER SOKAS: So, Ms. Leiton, just to
4 comment on that particular piece. It's really
5 hard for the CE to determine, unless they're sort
6 of focusing down ahead of time on one or two
7 diagnoses. But it may be the person who's doing
8 the pre-op clearance for the gall bladder surgery
9 who figures out that the person's got asthma;
10 right? I mean so, so it's hard to exclude whole
11 parts of -- I mean I, I really think that if
12 you've got the CMC looking through, you know,
13 their job is really to sift through everything.

14 MS. LEITON: I, I mean I can
15 understand that. We've gotten most of the
16 physicians and either CMCs and external
17 physicians have asked that we not provide them
18 with information that doesn't really relate to
19 what we're asking them. But, you know, we,
20 again, that's something you guys have already
21 asked, and we will be looking at it.

22 CHAIR MARKOWITZ: Dr. Boden.

1 MEMBER BODEN: So this raises
2 something I hadn't thought about before which is
3 we've looked at the case files that you provided
4 us. We've had some idea in our heads about what
5 you provide the CMCs. It might be worth -- and I
6 ask this particularly of the physicians here on
7 the board -- whether it might be worth looking at
8 what the CMCs see. That was too many Cs, but you
9 get the idea.

10 MEMBER SOKAS: Yes.

11 MEMBER BODEN: Because I don't think
12 we really know what they see. And if we're going
13 to -- if we may -- I understand the perspective
14 of somebody who's a contract physician who wants
15 to look at as little as he can, and particularly
16 doesn't want to look at 2700 pages of whatever.
17 But so I guess I'm asking people on the Board
18 whether they think it would be worth our while to
19 see for some of these cases what is provided to
20 their CMCs.

21 CHAIR MARKOWITZ: Dr. Welch.

22 DR. SOKAS: I think that --

1 DR. WELCH: No, go ahead. Go ahead.

2 CHAIR MARKOWITZ: Go ahead, Dr. Sokas.

3 MEMBER SOKAS: Oh. I think that's a
4 great idea. I think we tried to do that and
5 wound up getting a set of other responses that
6 really weren't that. So I, for some reason I
7 thought we had done that. And then I think we
8 wound up not. But I think it's a great
9 suggestion.

10 The other, the other piece I would
11 really be interested in -- and again I realize
12 there's this whole question about confidentiality
13 of contracts and, you know, and that sort of
14 thing -- but it strikes me that if the CMC is
15 being paid by the hour then I don't really
16 understand their complete reluctance to go
17 through, you know, this step. I mean it just,
18 it's striking to me that they're reluctant to
19 really pay attention.

20 CHAIR MARKOWITZ: Dr. Welch and then
21 Ms. Pope.

22 DR. WELCH: What the CMC sees is

1 somewhat related to the question of what the --
2 how the claims examiner structures the statement
3 of accepted facts. And when that question is
4 very narrow, then the CMC doesn't need very much
5 because they're answering one -- they're not
6 answering anything about the diagnosis.

7 You know, it's sort of like if we
8 broaden that, which I think is one of the things
9 that Dr. Cassano's committee is looking at, it
10 will be more necessary to include more medical
11 records if the question is broader. As it is
12 now, a lot of times the question is fairly
13 narrow.

14 So, you might want to comment on that,
15 too.

16 MEMBER CASSANO: Yes. I think part of
17 it -- we can ask again, you know, what was, you
18 know, we can ask it as a general question and
19 again on specific cases. Well, to get this
20 response from the industrial hygienist or to get
21 this response for the CMC, what did the claims
22 examiner actually send to them? And we might be

1 able to get a little bit of an idea from that.

2 But considering that, I mean,
3 sometimes the question is for when is meningioma
4 considered a cancer? And they didn't, I don't
5 think any information went to the CMC. And the
6 fact of the matter is it was a Stage 2 meningioma
7 which is, has some dysplastic characteristics to
8 it and can actually metastasize. But the answer
9 came back, no, it's not.

10 But this particular CMC said, however,
11 there is an association between a -- I'm now
12 forgetting what the exposure was -- and
13 meningioma. And, therefore, they then went back
14 to the industrial hygienist. But they didn't,
15 nobody asked the CMC is there any relationship
16 between meningioma and anything that this guy was
17 exposed to?

18 Luckily, this one particular CMC did
19 volunteer that. So, in that case the person was
20 lucky to a certain extent because the case was
21 still denied because the levels were considered
22 too low because they didn't look at aggravation

1 or contribution, they only looked at straight
2 causation.

3 So, I'm not quite sure how to -- it's
4 something we're going to have to think about is
5 how to say, well, if you don't want the whole
6 record, you have to get at least this. And just
7 looking at the stuff that's pertinent to the
8 diagnosis, not only based on what Dr. Welch or
9 Dr. Sokas said, but a lot of times there's other
10 information in other workups that are pertinent
11 to the development of the diagnosis. So someone
12 that doesn't have the medical expertise to parse
13 that really can't pick out what's relevant.

14 And but I don't know how to say it's
15 all or just a little bit. I don't.

16 CHAIR MARKOWITZ: Ms. Pope.

17 MEMBER POPE: I agree with that. I
18 think it's a sore point with a program that's
19 supposed to be claimant-friendly, and in so many
20 ways it's not. I agree with the fact that we
21 need to make sure that there is enough
22 information that file that the CMC is available

1 to be able to see, but not so much that it's so
2 daunting that they, you know, can't possibly get
3 through the whole file and make a decision about
4 what's going on with the claimant.

5 But I really believe that it all goes
6 back to that CE that is earmarking these
7 particular documents that's going to the CMC
8 where they're not really equipped to do that, to
9 be able to identify what goes to the CMC. It
10 keeps going back to that.

11 CHAIR MARKOWITZ: Dr. Silver.

12 MEMBER SILVER: Before there were PDF
13 files, there were big, fat hard-copy files that
14 each of us has probably had transmitted to us in
15 our work lives. Before there were Post-It Notes,
16 there were paperclips to flag key items of
17 concern. Because people wanted our opinion and
18 trusted what we knew, they gave us the entire
19 file to pursue our curiosity and ply our
20 discipline.

21 I don't claim to have medical
22 expertise, but a lot of us have public health

1 training. And to infer causality, temporality is
2 the sine qua non. And it's not always the
3 temporal relationship between the exposure and
4 the disease, though, that's necessary. Sometimes
5 it's the temporal relationship between acute
6 symptoms that were noted early on, preceding the
7 development of a chronic disease.

8 Isn't a classic teaching example a
9 skin rash? A lot of time goes by and lung
10 disease develops. So the CE may be so focused on
11 the lung disease and the relevant exposures, and
12 not appreciate the significance of the much
13 earlier skin rash. But a doctor who's trained in
14 occupational medicine would need that
15 information.

16 CHAIR MARKOWITZ: Ms. Vlieger.

17 MEMBER VLIEGER: In discussions at
18 final adjudication bench hearings with the
19 hearings examiners, when I ask pointedly, can you
20 tell me exactly what was sent to the CMC, and
21 the response has been, no. We have to go off of
22 the SOAF that's provided to the CMC.

1 And so even within the department, on
2 a number of occasions they can't explain to me
3 how the CMC would have got -- what information
4 they got to reach their decision. So it is a
5 hole in the program somehow.

6 And I don't think a bibliography is
7 going to cut it because that's really labor-
8 intensive to do. So, this is going to be kind of
9 a hard answer. We don't want to overburden the
10 CMCs till they become so mind-numb with a case
11 that they aren't going to make a rational
12 decision. But on the other hand, many times they
13 aren't receiving the nuances of how we got from A
14 to B.

15 CHAIR MARKOWITZ: Dr. Welch.

16 Dr. Cassano.

17 MEMBER CASSANO: Just one more
18 comment. You can't really audit the quality of
19 the content of the CMC's report unless you know
20 what the content is of what they're working on.
21 You can't blame the CMC for an incomplete or
22 incorrect report if they don't have the

1 information necessary to make the appropriate
2 decision in the case.

3 And I would think that from a contract
4 perspective that the department -- that the
5 department would want to make sure that the
6 quality assurance process takes that into
7 account. Because you may be wrongly saying, well
8 the CMC didn't render the correct opinion in this
9 case, when actually, based on what they were
10 given, they did.

11 MEMBER SOKAS: Well, I'm going to push
12 back on that just a tiny bit, Dr. Cassano, just
13 because there was one who, a CMC evaluation who
14 went to great pains to explain why he did not in
15 particular believe that COPD was the result of
16 workplace exposures. And he cherry-picked some
17 weird references in order to do that.

18 So, so you -- which I admit, that's
19 kind of an extreme example. But there are a
20 number of other examples where it was also clear
21 that, with the information they had, they simply
22 did not get the nature of the standard of

1 causation or exacerbation.

2 So, there are clear examples of poor
3 quality in terms of content and decision-making
4 within some of these files. Although I agree
5 that, you know, the other piece where maybe they
6 don't dig hard enough is, you can't really assess
7 that unless they had access to the full records.

8 CHAIR MARKOWITZ: So, I want to move
9 back to the recommendation we made at the last
10 meeting. And because we've been discussing this
11 topic for 15 or 20 minutes now, and the question
12 is, and we addressed some of these in this
13 recommendation; the question is whether we want
14 to modify this in some sense.

15 Our recommendation Number 8 was we
16 recommend that the entire case file should be
17 made available to both the industrial hygienist
18 and the contract medical consultants when a
19 referral is made to either, and not be restricted
20 to the information that the claims examiner
21 believes is relevant. The claims examiner should
22 map the file to indicate where relevant

1 information is to be.

2 So, my question is, are we in some
3 sense refining, adding, changing this
4 recommendation?

5 MEMBER SOKAS: So, I guess the
6 question, so it's mapping -- rather than, I mean
7 for the claims examiner maps it and the record
8 itself is organized into sections. And I think
9 that would do it.

10 CHAIR MARKOWITZ: I'm sorry. Could
11 someone just repeat what she said. I couldn't
12 understand everything she said.

13 DR. WELCH: Rosie, were you just
14 saying that, understanding what Ms. Leiton told
15 us, that the file is mapped into sections, and
16 that one recommendation?

17 MEMBER SOKAS: That is, as long as
18 that's how it's provided to the CMC and the IH,
19 yes.

20 DR. WELCH: Well, if that's available
21 that way to the claims examiner. But I don't
22 think it's available -- Yes, okay. So part of

1 the recommendation that we already made was to
2 give them access to it in that format, yes.

3 CHAIR MARKOWITZ: Right.

4 MEMBER SOKAS: Okay. And that's then
5 searchable as well; right?

6 CHAIR MARKOWITZ: Well, we don't, we
7 haven't established that. Ms. Leiton, do you
8 know offhand, the material that's sent to the CMC
9 and the IH, is it searchable?

10 MS. LEITON: Well, there's two
11 different things. What's sent to them now is
12 not, obviously. But we give them certain, we
13 give them the medical or industrial hygienist
14 records.

15 What the recommendation, my
16 interpretation of your original recommendation
17 was that the CMC and the IHS would have access to
18 the entire case file, which to us would mean
19 access to what the CEs have access to, which is
20 already indexed. It's indexed by the type of
21 reports, usually incoming or outgoing. It is not
22 in PDF. So we cannot search it by word

1 necessarily, but we do -- it is indexed to as
2 much detail as possible.

3 It is indexed and then there's a
4 descriptor line that you can go through and you
5 can sort it however you want, but it's not PDF.
6 Right now that's not the way our technology was
7 built.

8 CHAIR MARKOWITZ: Okay, thank you.

9 MEMBER SOKAS: Okay. I mean I think
10 that's, as long as that's available to them that
11 would be fine.

12 MEMBER CASSANO: Is it possible for us
13 to see what that looks like when we come out on
14 Friday, do you know?

15 MS. LEITON: I think that we -- let me
16 get back to you.

17 MEMBER CASSANO: Okay.

18 CHAIR MARKOWITZ: So, Dr. Sokas, I
19 know what we recommended last time, what you have
20 on the slide we're looking and the discussion.
21 Is there any recommendation that should be made
22 here?

1 MEMBER SOKAS: I think for that, your
2 online access to the entire record, no. We can
3 leave that go. And just, you know, kind of say
4 that we, this just emphasizes that we really,
5 really, really want it.

6 But the second piece we haven't really
7 decided on yet is whether we want to -- what kind
8 of recommendation we can make for quality of
9 content evaluation. And I would like to have at
10 least some understanding of whether this is going
11 to be us doing it, in which case we just, you
12 know, kind of say right now what we think, or
13 whether you want to do it in a formal way where
14 we're recommending that a subcontract we let in
15 order to do that.

16 CHAIR MARKOWITZ: Dr. Welch.

17 DR. WELCH: I think one thing to think
18 about as we discuss that question is once there
19 is a briefing package that's sent out that tries
20 to standardize the review and get people to hone
21 in and use the same standard, you'd want periodic
22 assessment after that. You want some ongoing QI

1 about the content, which is probably not
2 something the Board can commit to provide.

3 So I actually think sort of maybe a
4 hybrid of having the Board be in charge of the
5 initial review and putting together the briefing
6 book, but hopefully with some additional
7 resources to hire some other physicians to help
8 with the reviews. If we wanted to review 100
9 files, for example, or pick a year and review
10 some specified subset of a year of files, to have
11 a couple of other heads and hands would be
12 helpful.

13 So that would be my recommendation.
14 We should pick a number and then because I'm not
15 so sure that -- unless the number, unless you
16 felt a number of, you know, 40 was fine. I don't
17 have an idea of what number we'd need to do. But
18 I think we could probably use a little extra
19 help.

20 CHAIR MARKOWITZ: Other comments? Dr.
21 Cassano?

22 MEMBER CASSANO: Yeah, I think,

1 hinging on what Dr. Welch just said, that there
2 are four district offices. So if we looked at
3 ten from each office, or something like that, we
4 might be able to get a reasonable idea. And,
5 actually, some of the cases we already have would
6 be useful to actually go through with a fine-
7 tooth comb and look at them, if they have CMC
8 reports or IH reports.

9 CHAIR MARKOWITZ: But the CMCs and IH
10 consultations, are they done on a regional basis
11 or is that a national contractor, so that the
12 Seattle office could easily use a South Carolina
13 physician?

14 MS. LEITON: They are done on a
15 national basis. So it could be referred -- any
16 referral goes to the national office, then we
17 refer it to our contractor. And our contractor
18 then provides us with whatever doctor it's going
19 to be that will review the case.

20 So, I mean it won't matter. I mean we
21 could say by district, if you wanted to look at
22 certain types. But if you wanted to pull random

1 CMCs, depending on what our contract says about
2 that, I'm not going to make any promises right
3 now, but then we could probably do it that way.

4 CHAIR MARKOWITZ: Dr. Boden.

5 MEMBER BODEN: Yeah, I'm just trying
6 to make sure that I know where we are in terms of
7 this discussion. So, we have the online access.
8 We've talked about that and clarified it. Have
9 we clarified recommendations as far as the
10 briefing package as far as other things on the
11 list for discussion?

12 CHAIR MARKOWITZ: So are you referring
13 to the slide we're looking at now?

14 MEMBER BODEN: Yes.

15 CHAIR MARKOWITZ: So the first and the
16 last bullet item we've already discussed.

17 MEMBER BODEN: Right.

18 CHAIR MARKOWITZ: The second, third,
19 and fourth are tied together. We're really
20 discussing the second at the moment. And the
21 third and the fourth flow from the second.

22 MEMBER BODEN: Okay, good.

1 MEMBER CASSANO: The fourth one is
2 being removed, correct? The fourth bullet on the
3 recommendations is being removed, right?

4 CHAIR MARKOWITZ: Okay. So the
5 question, I guess, is whether or not we're
6 prepared to actually write the language of a
7 recommendation on this topic, or whether we
8 should do that now, whether we should re-look at
9 it probably tomorrow morning, and the specific
10 language. And I know, Dr. Sokas, you're not
11 available, but one of us here could do that.

12 MEMBER SOKAS: Yeah, I can send you --
13 I can, you know, just slap some language together
14 and send it to you tonight, and then you guys can
15 discuss it tomorrow.

16 CHAIR MARKOWITZ: Let's do that.
17 Let's do that.

18 MEMBER SOKAS: Okay.

19 CHAIR MARKOWITZ: Because, to me, the
20 sticking point is the boundary between what the
21 Board does and what the department does, and to
22 what extent we have input into the review, and

1 just make sure it answers the questions that we
2 have. At the same time recognizing we don't have
3 the resources within the Board to look at a
4 sizeable number of claims.

5 MEMBER SOKAS: Right.

6 CHAIR MARKOWITZ: So that would be
7 great, Dr. Sokas.

8 MEMBER SOKAS: All right then, thanks.

9 CHAIR MARKOWITZ: Is that the end of
10 your -- do you have anything else in your report?

11 MEMBER SOKAS: No, that was it.

12 CHAIR MARKOWITZ: Okay. So we're
13 going to move on to the Presumptions Working
14 Group. If you could bring up the slide, Kevin.

15 So, the working group was formed, I
16 think, at the last meeting. We've had two calls
17 since that time. And if you could go ahead a few
18 slides. Actually, it'd probably better off if I
19 work the slides. If I could have the remote.
20 Oh, it's here. But if you could leave it up,
21 Kevin, to one of the first one that says
22 "Presumptions." Okay.

1 So, I want to spend a moment
2 summarizing what Dr. Boden has taught us. And if
3 I get it wrong, Dr. Boden, I expect you'll
4 correct me. But, you know, we began to talk
5 about presumptions this morning, but I think it's
6 worth spending a couple minutes just talking
7 about why, why we think -- and the department
8 thinks, actually -- that use of presumptions
9 would be a good way to go.

10 The first issue is fairness. And
11 there are a few different elements to this
12 fairness. One of them, the principal one is the
13 fact that there simply wasn't a lot of
14 information about exposure at a DOE complex over
15 many decades. And the absence of exposure should
16 not work against appropriate claims. And this
17 was recognized in the act, in the original act in
18 2000 when the establishment of Special Exposure
19 Cohorts at the gaseous diffusion plants.

20 Those plants were not the highest
21 radiation plants in the complex. They had lower,
22 on average, exposure radiation than, say, Hanford

1 or Rocky Flats or Y-12. And, yet, those three
2 gaseous diffusion plants were grandfathered in as
3 the original Special Exposure Cohorts on the
4 radiation cancer side. And they're the only
5 facilities that were identified in the act.

6 And it was done because it was an
7 admission -- the scientific basis was an
8 admission that there wasn't enough radiation data
9 from those sites to be able to come to a proper
10 decision. So it was only fair then to treat them
11 by route of a presumption: 250 days prior to 1992
12 in relation to 22 cancers.

13 And as most of us know, there are now
14 110, 115 Special Exposure Cohorts. 127, thank
15 you. Okay, 121. So it's gone from three in the
16 original act to consideration of each of many,
17 many more petitions, and now to 121.

18 So this presumption route has been
19 adopted. And a central part of it is fairness,
20 given the absence of data.

21 The other advantage of presumptions is
22 that it lends consistency to the process. And it

1 may be that a presumption could be consistently
2 wrong or consistently right. But there's
3 something to be said for consistency. And when
4 you use a national portfolio of CMCs and IHS,
5 it's quite likely that there's going to be a fair
6 amount of inconsistency. So presumptions
7 provides that kind -- and consistency, frankly,
8 is factor in fairness.

9 Third, presumptions should make
10 decision-making a lot more straightforward, and
11 then should be able to turn around claims a lot
12 more quickly. Now, I'm not saying that claims
13 turnaround is a problem at present. It certainly
14 there was a problem early in the program. But
15 it's certainly one of the outcomes that the
16 department looks for in judging its program,
17 which is timeliness.

18 And then, of course, presumptions make
19 the decision-making simpler and, therefore, more
20 efficient. And so there should be fewer moving
21 pieces in a claim which can be passed on
22 presumptions. And maybe will even lessen the

1 burden on the industrial hygienist and the CMC
2 through application of presumptions.

3 Now, one of the difficult issues on
4 presumptions is that, depending on where you set
5 the bar, how much exposure automatically gets an
6 accepted claim, you're going to make an error.
7 And you're going to make an error wherever you
8 set the bar. If you set the bar very high,
9 you're going to exclude people who should be
10 compensated. If you make the bar very low, you
11 risk compensating people who perhaps really don't
12 have causation.

13 And so in developing our presumptions
14 we try to do it based on as much science as is
15 available. But also are frank that, you know,
16 there's an error, wherever you put it there's an
17 error either way. And we should be frank about
18 that.

19 And then, finally, we mostly talk
20 about positive presumptions. If a claimant meets
21 certain exposure criteria, certain medical
22 criteria for a disease, then they get

1 compensated. But this reminds us that there are
2 also negative presumptions. And we hear,
3 actually, there are some elements of negative
4 presumptions. For instance, I'm going to talk
5 about asbestos, and in the current policy there's
6 a presumption about exposure after 1995 that it
7 wasn't essentially important exposure. That's
8 negative presumption.

9 And there was a negative presumption
10 in the post-1995 memo that was recently
11 rescinded, right, that exposures after '95 are
12 under control.

13 So there are some -- we don't
14 emphasize them -- but there are entities such as
15 negative presumption.

16 So, Dr. Boden, what have I forgotten
17 in this brief review?

18 MEMBER BODEN: You're perfect.

19 CHAIR MARKOWITZ: Okay. Like a
20 student of Dr. Boden.

21 Okay, so a reminder. Presumptions
22 were incorporated in the original act. And I

1 have a summary up here of this. This is a
2 summary. I don't provide every detail in the
3 act, but there are examples of how the act
4 accepted the route of presumptions.

5 And I mentioned before the Special
6 Exposure Cohorts at the gaseous diffusion plants.
7 If you worked one year prior to '92 where
8 dosimetry monitoring was part of your job or a
9 comparable job, and that was sufficient exposure
10 to be linked at one of 22 cancer sites.

11 And there was also an exposure on
12 silica for a different outcome for non-malignant
13 lung disease, silicosis. And there, again, an
14 exposure, kind of the exposure criteria was set
15 out, which was years of work near, during or near
16 the tunnels of the mines.

17 I'm going to talk a fair amount about
18 asbestos and then talk about asthma. And this
19 way of looking at things actually was reflected
20 in Dr. Welch's approach to COPD. And we'll hear
21 it again in relation to hearing loss.

22 But we try to capture, understand

1 elements of exposure whereby we can make the
2 judgment: was there sufficient exposure to cause,
3 contribute, or aggravate disease? And,
4 obviously, we look at how long a person did that.
5 We are interested, to the extent we can, in which
6 calendar years. Exposures in the '60s were worse
7 than exposures in the 2000s.

8 Job title for us is really a proxy for
9 trying to understand how much, how intense the
10 exposure might have been, what the tasks would
11 be, and then the frequency of exposure.

12 And then, finally, latency. To the
13 extent we need to, we recognize that a typical
14 pattern for a chronic disease caused by
15 occupational factors is that the onset occurs at
16 one period of time, and the disease usually
17 doesn't occur, such as cancer, for 15 years or 20
18 years or 30 years or 40 years. And that gap in
19 time is called latency.

20 And Dr. Welch addressed it in the
21 COPD, essentially saying there was no latency in
22 the instance of that illness. But that's not

1 true for cancer.

2 So here I'll just summarize. I'm
3 going to use this kind of table later on to
4 discuss asbestos, so I just wanted to introduce
5 it here for cancer and silica. This is from the
6 original act. Duration, job title, or calendar
7 years, if they were specified, and the issue of
8 latency.

9 So asbestos appears in the procedures
10 manual, it appears in the bulletins, circulars.
11 It's a popular topic, relatively popular topic in
12 the guidance provided by the department. And the
13 new draft on presumptions also addresses --
14 that's part of -- that's being elaborated by the
15 program also addresses asbestos and really
16 summarizes and somewhat changes these.

17 To remind you, we're talking about a
18 number of different diseases in relation to
19 asbestos. The ones you've all heard of, such as
20 asbestosis, which refers to scarring of the lung
21 tissue itself caused by asbestos; asbestos-
22 related pleural disease, which is scarring of the

1 lining of the lung called the pleura, which is a
2 non-malignant disease; and then lung cancer.
3 Mesothelioma, which is a malignancy of the
4 pleura, although it can also occur in the abdomen
5 and a couple of other locations, and which is
6 fairly uniquely related to asbestos.

7 And then cancer of the larynx and
8 ovary, which have been related in repeated
9 studies of workers and others as having a high
10 association with asbestos exposure and considered
11 causally related.

12 And then, finally, COPD, which we'll
13 go into in a bit. But, really, in I think
14 looking at asbestos presumptions, frankly, COPD
15 ought to fall within the COPD presumption. It's
16 just much clearer if it does.

17 I have to spend a couple minutes
18 reviewing what the current procedures and
19 policies are. In order for us -- and I've done
20 this within the working group, and I apologize
21 for repeating some of this, but it's hard to
22 remember this, and we need to understand what it

1 is that we're trying to simplify.

2 So the exposure, initial piece from
3 the procedures manual said that when the CE looks
4 at an asbestosis claim, the DEEOIC accepts the
5 asbestos was common in a complex. While asbestos
6 did exist at DOE facilities, the nature of
7 employees' exposure would have been varied based
8 on different factors during the period in which
9 they worked, type of work performed, and the
10 location of employment.

11 And so, then, and this is in Bulletin
12 No. 13-02, the program looks at asbestos
13 specifically around ovarian cancer. And this
14 came up, I think, just so you understand the
15 history, this came up because ovarian cancer was
16 declared in 2012 by the World Health
17 Organization, specifically the International
18 Agency for Research on Cancer, IARC, to be caused
19 by asbestos exposure. So that was the first kind
20 of consensus -- I think it's safe to say it's the
21 first consensus recognition that ovarian cancer
22 was caused by asbestos. And the department

1 elaborated this bulletin.

2 So the exposure presumption here is
3 the 250 days of significant asbestos exposure.
4 So, a year. "Significant" is defined as having a
5 job title in List A. I showed List A before.
6 I'll show it again, but it's a set of mostly
7 building trades-type job titles.

8 Prior to 1986. And there should be 20
9 years latency between onset of exposure to
10 asbestos and diagnosis of ovarian cancer. Or if
11 the woman has asbestosis or mesothelioma and then
12 has the terrible luck of also developing ovarian
13 cancer, that the exposure would be accepted
14 because they have this other evidence of
15 significant asbestos exposure. This must,
16 hopefully, be extremely rare.

17 Then here's -- I don't know if you can
18 read it on the big screen, but here's the list
19 and the reference from CDC, 2014, of the jobs
20 that are accepted as involving significant
21 exposure.

22 Moving on to asbestosis or the

1 scarring of the lung tissue itself, the 250 days
2 of exposure is required, 10-year latency. And
3 perhaps this slide got out of order. We've
4 finished the ovarian cancer issue.

5 Claims that don't meet the exposure
6 presumption criteria will be treated individually
7 by the CE and, when needed, by the industrial
8 hygienist. So this is important because
9 presumptions are good and can help the process,
10 but if people don't meet the presumptions they
11 need to be evaluated individually to make sure
12 that they have their fair evaluation.

13 And then the instruction to the CE is,
14 for claims with more limited evidence of asbestos
15 exposure, refer to a medical opinion, which is
16 the CMC.

17 So here's a summary of these two -- of
18 the six asbestos-related diseases, cancer of the
19 ovary, asbestosis. Duration is the same, 250
20 days, 250 days.

21 Now, there is a more recent bulletin
22 relating to COPD and asbestos. And as Dr. Welch

1 noted this morning, you need 20 years of exposure
2 for there to be an accepted exposure and claim.
3 And the job titles, they mostly come off of List
4 A. Although for COPD there is the option of
5 having the IH examine the claim.

6 And then for calendar years, for
7 ovarian cancer it's 1986 is the cut-off for
8 significant exposure. For COPD it's 1980. And
9 then latency, one is 20 years, asbestosis, 10
10 years. In COPD it's not elaborated.

11 So, this is Circular 15, which
12 addresses a number of asbestos-related diseases.
13 That's what ARD stands for. And here is a
14 sequence of instructions around understanding the
15 exposure, which we believe should be simplified,
16 which is that post-1986 work at DOE, assume that
17 the potential exposure to asbestos, that there
18 was potential exposure, but at levels below
19 accepted standards. And accepted standards we
20 think refers to the OSHA standard or the
21 equivalent. So, after '86 there might be
22 exposure, but assume that it's under control.

1 However, for the 19 occupations on
2 that list I just showed, they have potential for
3 greater exposure between '86 and '95, and so the
4 claims examiner is to accept that they were
5 potentially exposed to asbestos, but likely at
6 low levels.

7 So, for the claims examiner to accept
8 a level of asbestos exposure above the low level,
9 above the level that's assumed, there must be
10 definitive and compelling evidence to show that
11 exposure after '86 at DOE had consistent
12 unprotected contact with asbestos or asbestos-
13 containing materials.

14 So what the CE is instructed to look
15 for here is, for exposures after 1986, that
16 somewhere in the record it shows that the worker
17 had consistent unprotected contact with asbestos
18 or asbestos-containing materials. And then the
19 CE is provided with a list of various sources to
20 look for this consistent unprotected contact.

21 And if the evidence is suggestive that
22 the exposure is above the guidelines, then the CE

1 contacts industrial hygiene regarding the
2 industrial hygienist's evaluation of the facts.

3 This circular says, at the end,
4 however, that any findings of exposure, including
5 infrequent, incidental exposure, require review
6 of physicians who opine on the possibility of
7 causation. This is necessary, as even minimal
8 exposure to some toxins may have significant
9 aggravating or contributing relationship to the
10 diagnosed illness.

11 So the CE, having made some decision
12 about whether there was significant enough
13 exposure to refer to the IH, is instructed that
14 even if there is infrequent incidental exposure
15 which sounds like it's insignificant, that the
16 CMC should be involved.

17 And I don't know how this policy
18 actually played out in reality, but on paper it
19 appeared potentially a little confusing.

20 So just to summarize then. Elevated
21 exposure is greater than 250 days of work on List
22 A, prior to '86. That's recognized.

1 Post-'86, assume asbestos exposure was
2 below the accepted standard, except for List A
3 workers.

4 And for those List A workers in the
5 following decade, assume they had potential
6 exposure but it was likely low.

7 And to demonstrate greater-than-low-
8 level exposure post-'86 you need definitive and
9 compelling evidence to show consistent,
10 unprotected contact with asbestos.

11 So if that condition exists, then
12 refer it to the industrial hygienist. But if you
13 find any exposure, it only requires the physician
14 review.

15 And so this raises a number of issues.
16 One is it wasn't clear what are we presuming
17 about exposure prior to '86. The List A that was
18 constructed that likely had low exposure, this
19 was not necessarily -- this is not evidence-
20 based, certainly not based on evidence from
21 Department of Energy. We know where it came
22 from, but not specific, certainly, to DOE.

1 Designation of exposure between '86
2 and '95 is deemed likely low. It doesn't really
3 facilitate decision-making about a claim.

4 And then, the CE has to use what is a
5 difficult-to-apply standard of consistent,
6 unprotected contact with asbestos-containing
7 material.

8 So, so remedies. Some items that we
9 can focus on in order to try to improve the
10 clarity of the asbestos presumptions. One is
11 that is List A big enough? Does it, is it all-
12 encompassing enough in terms of what we know
13 about asbestos exposure?

14 What do we know about likely post-1986
15 exposures to asbestos?

16 Can we settle on any calendar year
17 that's sensible? In our last meeting we voted on
18 a recommendation that DOL rescind the post '95
19 circular which basically says assume post '95
20 exposures in general were controlled. And part
21 of the rationale was that we thought that picking
22 a precise date really didn't reflect reality.

1 And then can we consider a minimum
2 exposure duration and latency that is somehow
3 consistent across the asbestos-related diseases?

4 So, that's the background. And now
5 I'll get to the point.

6 I'm not going to give you the
7 recommendations first. I want to give you sort
8 of the rationale for them, which is asbestos-
9 related diseases are common at Department of
10 Energy. And my evidence is that in the Former
11 Worker Program we have examined 73,000 DOE
12 workers since the year 1998. And 12 percent of
13 them have evidence on the chest X-ray of
14 asbestos-related scarring. That's not cancer,
15 because we don't collect, in the Former Worker
16 Program we don't collect information about
17 asbestos-related cancers.

18 And then if you look at individual
19 sites -- Savannah River, Paducah, Hanford, et
20 cetera -- you can look at the percentage that
21 have, either on the construction site, or what
22 are called the production site. Production, as I

1 said before, is everybody else on the site. So
2 it's maintenance, administration, engineering,
3 service, et cetera. That up to a quarter or a
4 third of those work forces have asbestos-related
5 scarring.

6 Now, it varies significantly across
7 the sites. In general, it's higher in
8 construction than in the production side. Some
9 of the production side it's 5 percent, 7 percent.
10 I don't want to mislead by saying a quarter to a
11 third of all, because it is quite variable. But
12 it's remarkable that at some sites it's quite
13 common. And not just in construction, which in a
14 way we might expect, but also on the non-
15 construction side.

16 And this is evidence across the
17 complex at most or all of the sites that there is
18 asbestos-related disease.

19 I included a picture here from
20 yesterday's tour. We had a very nice tour,
21 thanks to Greg Lewis, Department of Energy,
22 actually for setting this up. And thank you to

1 our hosts here at Hanford for showing us the
2 site. We spent seven or eight hours going around
3 the site yesterday, so we had a taste of what
4 goes on at Hanford.

5 And this picture is a picture I took
6 at B Reactor. Very nicely contained asbestos,
7 with a beautiful label on it. I'm sure it's not
8 a hazard to workers.

9 In general, Item Number 4 is not just
10 within the DOE complex, but in general decades of
11 research on asbestos has clearly demonstrated
12 that maintenance workers and construction workers
13 suffered asbestos-related diseases. That can be
14 in a refinery. It can be in a chemical plant.
15 It can be in, you know, construction in New York
16 City. They have the same experience because of
17 how much asbestos that was routinely used in
18 different products in a variety of settings.

19 We also know that relatively modest
20 amounts of asbestos can cause asbestos-related
21 diseases. And it varies somewhat, depending on
22 the disease.

1 And we also know, in general, the time
2 frames of asbestos use in the United States,
3 including DOE, which is that the use dramatically
4 dropped off in the 1980s. But there was a
5 tremendous amount of asbestos in place, and there
6 still is, after the time when asbestos was
7 stopped being, for the most part, introduced into
8 the workplace.

9 Asbestos has never been banned in the
10 U.S. Some uses have been banned. But to this
11 day we import small amounts. We import some
12 friction products, some textiles, some roofing
13 material. And, hopefully, someday it will be
14 banned.

15 So this is the recommendation. And
16 there are I think three or four slides. So let
17 me just read it, so then I have a summary slide.

18 That all DOE workers who worked as
19 maintenance or construction workers at a DOE site
20 for 250 days or more prior to January 1st, 2005,
21 and who are diagnosed 15 years or more after the
22 initiation of such work with one of five

1 asbestos-associated conditions, will be presumed
2 to have had sufficient asbestos exposure. But it
3 was at least as likely as not that asbestos
4 exposure was a significant factor in aggravating,
5 contributing to, or causing such asbestos-
6 associated conditions.

7 And the five conditions are
8 asbestosis, asbestos-related pleural disease,
9 lung cancer, cancer of the ovary, and cancer of
10 the larynx. So that I took mesothelioma out of
11 this because they have a somewhat different set
12 of exposure criteria.

13 So, 250 days or more prior to 2005,
14 diagnosed 15 years or more after onset of work
15 with asbestos will be presumed to have
16 significant exposure.

17 And I'm going to get into why we kind
18 of came on these particular numbers.

19 But for malignant mesothelioma, which
20 is the cancer of the lining of the lung or the
21 abdomen, and is known to be caused by quite
22 modest levels of exposure to asbestos, that here,

1 for DOE workers that worked at maintenance or
2 construction DOE site for 30 days or more prior
3 to 2005, and who are diagnosed 15 years or more
4 after the onset of such work, and who are
5 diagnosed with malignant mesothelioma that they
6 are presumed to have sufficient exposure to meet
7 the standard, which I won't repeat.

8 And that all claims for one of the six
9 asbestos-associated conditions named above don't
10 meet these two exposure criteria will be referred
11 to industrial hygienist for exposure assessment
12 and to a consulting medical physician for
13 evaluation of medical documentation and
14 causation. And this is to recognize that workers
15 who did not work in construction or maintenance,
16 many of them had significant asbestos exposure,
17 we may not be able to make a presumption for
18 those categories of workers, but that they should
19 be evaluated carefully if they're claiming an
20 asbestos-related disease, both by the industrial
21 hygienist, who can hopefully clarify the extent
22 of their exposure, and also by the physician, who

1 can make a judgment about whether the quantity of
2 exposure justifies causation and claim
3 acceptance.

4 And then, finally, the chronic
5 obstructive pulmonary disease may have a
6 contribution from asbestos exposure. However,
7 claims for this disease should be evaluated as
8 part of a broader set of presumptions for chronic
9 obstructive pulmonary disease. Because there's
10 just so many other exposure agents that cause
11 COPD I couldn't really, I don't think there's a
12 strong rationale for separating it out from the
13 other agents, frankly.

14 And, so, a summary. This chart
15 summarizes for mesothelioma, which is the second
16 column. Third column is asbestosis and asbestos-
17 related pleural scarring. And then the final
18 column on the right is for lung cancer, cancer of
19 the ovary and larynx.

20 That the duration for mesothelioma
21 would be shorter, 30 days. The others it would
22 be one year.

1 All job titles within maintenance and
2 construction would be included.

3 The calendar years would be prior to
4 2005, which I will discuss in a moment.

5 And the latency would be uniform
6 across them, which is 15 years.

7 You could have an asbestos-related
8 disease at 12 years of latency but it would be
9 uncommon. And it can be accepted through a non-
10 presumption route. It would be evaluated by an
11 industrial hygienist and a physician and a
12 decision would be made. It is a very uncommon --
13 it would occur very uncommonly.

14 So let me just close this. I think
15 this is -- yeah. A little monolog here on the
16 issue of calendar years.

17 So there's a choice to be made. You
18 could, as in the COPD recommendation, not specify
19 calendar years and just say if you worked for 250
20 days maintenance or construction and you
21 developed asbestosis 15 or more years ago, we're
22 going to compensate you. But the fact is, that

1 doesn't really recognize the reality, that over
2 time asbestos exposure was reduced. It wasn't
3 reduced on a precise date, but over time it did,
4 it did become lower.

5 And 1995, the mid-'90s is not a bad
6 date for some demarcation of lowering of
7 exposure. First of all, asbestos use dropped
8 dramatically in the 1980s, not just at DOE but
9 across the country. And then it took a while,
10 then 1994 OSHA revised, made its revision of the
11 asbestos standards and it halved the allowable
12 asbestos. And I think there was a policy
13 document within DOE in the mid-'90s relating not
14 just to asbestos but to the set of exposures.

15 So, you know, as a Board we didn't
16 feel comfortable with the 1995 cutoff in terms of
17 the previous circular we looked at in the fall
18 because we thought that it wouldn't reflect
19 reality that a given date or given year that
20 exposure would go from important to unimportant.
21 So the approach here is to say, okay, in the mid-
22 '90s, by the mid-'90s there probably was

1 considerable drop. But let's use a 10-year
2 safety margin.

3 Let's say that if the policies
4 changed, use dropped in the '80s and into the
5 mid-'90s, that it took an additional 10 years for
6 that to become routine practice in the complex,
7 for that dissemination, for the diffusion of
8 knowledge, and for general adoption by the work
9 force of methods of working that really meant
10 significantly less exposure to asbestos.

11 So this was sort of a compromise
12 between ignoring calendar years, which seemed
13 somehow not to reflect reality, and setting an
14 arbitrary, unrealistic calendar years demarcation
15 like 1995 in which a pronouncement would suddenly
16 lead to absence of exposure, and allow a 10-year
17 phase-in period where exposure would most likely
18 continue to drop, in part because workers accept
19 -- you know, were educated, accepted, and it was
20 accepted on the shop floor that you wouldn't work
21 with asbestos in an uncontrolled fashion.

22 So that's the proposal on asbestos.

1 So, comments? Dr. Welch.

2 DR. WELCH: Although I did have the
3 chance to comment on this prior to the meeting, I
4 think I've just been thinking about it more. I
5 think like we may need, for the non-malignant
6 asbestos-related disease we may need some medical
7 diagnostic criteria to go with it. Because in a
8 way, when you build in, you know, if you build in
9 a really high exposure as your exposure criteria
10 you're saying if there's non-specific scarring in
11 the lung but somebody was an insulator who had 30
12 years of exposure before 1980, the chance that's
13 asbestosis is very high.

14 But as we lower the exposure
15 requirement, then the likelihood that an abnormal
16 finding on a B read is asbestosis is lower. But
17 the current system doesn't require the claimant
18 to come in with a specific medical diagnosis of
19 asbestosis. Generally they come in with findings
20 on a B read or a chest X-ray.

21 So, we might think about how we could
22 add some diagnostic criteria that would, which

1 would make the process easier. Because we're
2 saying asbestosis but I think the claims
3 examiners or the department is going to say,
4 well, how do we know what's asbestosis then in
5 the context of, this is new? And that's kind of
6 separating in your mind the exposure requirements
7 and the medical diagnostic requirements for those
8 two particular diseases they tend to, you know,
9 we can't diagnosis asbestosis unless you've had
10 enough asbestos exposure that it's likely that
11 the scarring is due to asbestos.

12 And 250 days is low for causing
13 asbestosis, if that was the only exposure. We
14 picked that number because it would certainly be
15 contributory with other exposures, but you have
16 to somehow know you've got the right diagnosis.

17 CHAIR MARKOWITZ: Sure. Dr. Cassano.

18 MEMBER CASSANO: I agree with Dr.
19 Welch on this because a couple of cases that we
20 looked at, pleural plaques -- and I know you
21 include pleural disease -- but pleural plaques in
22 and of themselves create no disability without

1 fibrosis or reduction in pulmonary function
2 tests. And yet I see people -- and I wasn't
3 going to say this -- but I see that people are
4 compensated just for the evidence that there are
5 pleural plaques, and compensated handsomely for
6 that. And not -- there's no real disease
7 diagnosis there.

8 So, I think that's something we may
9 want to look at.

10 CHAIR MARKOWITZ: Mr. Domina is next.
11 But if you have a specific response to that, Dr.
12 Welch?

13 DR. WELCH: I do. In that the -- it's
14 my understanding under Part E what you get in
15 terms of compensation is medical and weight and
16 impairment rating. So that it's possible that
17 what you're seeing is someone who has two
18 conditions, they have asbestos-related pleural
19 plaque and they also have COPD. And the claim
20 has been accepted for asbestos-related pleural
21 plaque, and they end up getting an impairment
22 reading related to it.

1 It's okay with me because they have
2 the underlying disease that's also related to the
3 same exposure. But it's not, you know, under
4 Part B there's cash awards. Under Part E there's
5 no cash award. So the -- you might want more
6 precision but I -- it's unlikely that people with
7 asbestos-related pleural scarring and normal
8 pulmonary function tests are getting a big
9 impairment rating. That would be extremely
10 unlikely.

11 So, but anyway, that's just my two
12 cents. I haven't looked at those same cases
13 before.

14 CHAIR MARKOWITZ: If I could just,
15 before I move on to Mr. Domina, just so people
16 are clear. Asbestos-related pleural disease is a
17 disease. It is pathology. The pleura is not
18 normal.

19 And if it's relatively small in
20 extent, then it's unlikely to affect pulmonary
21 function or provide symptoms. If it's extensive,
22 then it can clearly impact pulmonary function.

1 I just didn't want people to think
2 that asbestos-related pleural disease is not a
3 disease. It is a disease.

4 All right, Mr. Domina.

5 MEMBER DOMINA: My comment has to do
6 with the year 2005. Because I don't know if I
7 can live with that. Because of, you know, the
8 late '90s everything went to performance-based
9 contracts. Yeah, maybe they didn't use asbestos
10 anymore, but they also didn't take care of it
11 based on funding or whatever because you look at
12 what's happened, like, during stimulus or what
13 goes on now when they have an asbestos issue,
14 there's had to have been stop works to take care
15 of it, or a certain contractor was fined into the
16 six figures when they imploded a building that
17 they videoed because of the amount of asbestos
18 they put in the air.

19 And so just, you know, it's -- I don't
20 know if 2005 is going to work for me. I think it
21 needs to go later just for the fact on how
22 things, business is conducted today. You know,

1 and it's just like what we talked about a little
2 bit yesterday is that when you have run to
3 failure, how much stuff is already failed because
4 a switch turned something off? It's considered
5 still running.

6 And I just think that I don't believe
7 2005 is late enough.

8 CHAIR MARKOWITZ: So is that an
9 argument against using any calendar year? Or
10 would you simply move it to 2008 or 2010?

11 MEMBER DOMINA: Yeah, I'd probably go
12 to '12 or '15. I mean, just because of what I've
13 witnessed and some of the things that have
14 transpired. And if it's happening here, it's
15 happening across the complex.

16 CHAIR MARKOWITZ: Okay. Okay.
17 Ms. Vlieger.

18 MEMBER VLIEGER: I would like to agree
19 with Mr. Domina. As the planner at the Hanford
20 Site, even though I wasn't a maintenance craft, I
21 was in the field with the maintenance craft
22 planning my jobs, that we do walk down in

1 contaminated areas. And the amount of asbestos
2 that's just there, and it's not going away, it's
3 not being replaced with something else because
4 it's too expensive to alleviate it.

5 And here in our climate we have a high
6 desert climate with temperature exchange and wind,
7 and the asbestos becomes friable. It's not
8 immediately fixed in your breathing zone. There
9 just, there you're told, well, just don't brush
10 up against it. But that's not sufficient.

11 And so until all of the sites go to
12 the ground, you know, they're leveled and no
13 longer exist, I think because of the age of the
14 buildings we're dealing with we have to consider
15 that the exposures are not going to go away.

16 And I really have a problem with what
17 is the definition of low level asbestos exposure?
18 Because to my knowledge there is no safe level of
19 asbestos exposure, it just depends on your
20 personal physiology and DNA how you're going to
21 react to it. I'm not a physician, but that's my
22 understanding of it.

1 So what exactly is low level or
2 insignificant.

3 CHAIR MARKOWITZ: So, let me ask, so
4 in this recommendation we remove any designation
5 of low level or insignificant.

6 MEMBER VLIEGER: Until you get to the
7 non-production workers. Until you get to the
8 other workers and then it's established by the IH
9 and CMC whether or not it's a significant factor.
10 And there we go with significant again.

11 So, couple that with the fact that we
12 know there are no individual monitoring records
13 in the personnel records. So that when you go to
14 a non-production worker, I'm a non-production
15 worker at the site, and if I come up with one of
16 these diseases I have to prove, because I'm
17 outside this window, this presumption that we're
18 making, that I was exposed. It's nowhere in my
19 work records. It's nowhere in my performance
20 appraisal. I was not an asbestos worker, so it's
21 not in that medical record. And I would have to
22 prove by showing some monitoring data.

1 We have no monitoring data. And
2 that's been corroborated by the Department of
3 Energy. They have it. It's not available to go
4 into personnel records.

5 And so we are creating a left-out
6 class, if you want to put it that way, of people
7 that are in the field side by side with the craft
8 workers on a daily basis.

9 CHAIR MARKOWITZ: Dr. Redlich.

10 MEMBER REDLICH: I am not sure this is
11 the correct solution, but there is different
12 overlap of asbestosis with the pneumoconiosis or
13 just pulmonary fibrosis in reality and also in
14 the current guidelines. And so because and I
15 think one of the issues for mesothelioma and lung
16 cancer and pleural plaques, I think that
17 recognition of those is relatively
18 straightforward.

19 I think the asbestosis becomes sort of
20 the most programmatic in, you know, is it ILO
21 reading on a chest X-ray? Is it restriction on
22 your pulmonary function test? Is it a low

1 diffusing capacity? And having reviewed some of
2 the pneumoconiosis claims, I think even if you
3 decide on a nice template, the implementation of
4 that very quickly gets sort of complicated.

5 So I don't -- wondering whether one
6 took the asbestosis piece and could have kept it
7 with the pneumoconiosis. I mean, because there
8 is -- I mean, if you wanted to take a presumption
9 approach, you know, pulmonary fibrosis
10 interstitial lung disease is relatively an
11 uncommon disease. And if you've been having a
12 lot of metal dust and particulates, you know,
13 that is an increased risk. And if you -- you
14 could have a presumption for pneumoconiosis that
15 would maybe simplify this whole group of the
16 asbestosis and the pneumoconiosis group.

17 CHAIR MARKOWITZ: So you, so --

18 MEMBER REDLICH: You know, I just
19 think that this piece, because, you know, I think
20 even if one settled on this, the actual decision-
21 making about what constituted asbestosis could
22 get sort of complicated and also overlap with the

1 pneumoconiosis.

2 CHAIR MARKOWITZ: So you're arguing,
3 as Dr. Welch, for setting out medical criteria
4 for the diagnosis?

5 MEMBER REDLICH: Yes. Especially I
6 think the mesothelioma and the others are, but I
7 think the asbestosis is the one that.

8 CHAIR MARKOWITZ: Dr. Boden.

9 MEMBER BODEN: I'm trying to think
10 through this a bit, and also think about the
11 point that you raised at the very beginning about
12 presumptions we're trying to sort of balance
13 false positives and false negatives. And that's
14 always tricky. That's what the 2005 is trying to
15 do.

16 It does seem to me that you could
17 consider the diagnosis and the pre- or post-2005
18 as being sort of balancing things. So that if
19 you go more towards the medical diagnosis, maybe
20 you need the cutoff dates less. And if you go
21 with the cutoff date, maybe you need the
22 diagnosis less.

1 Which means to me maybe you kind of
2 choose one or the other as a way of sort of
3 balancing these things out. That's, again I'm
4 not claiming expertise on the disease but just
5 trying to think about the balancing that we're
6 trying to do.

7 And I do think that you're right in
8 pointing out that there are workers that are left
9 out of this. And then the question is sort of
10 that shouldn't mean that they're left out of
11 being compensated for those illnesses. But it
12 might be that it's harder for them to get
13 compensated, and that maybe you need to show
14 somehow that there was uncontrolled asbestos
15 exposure. And I don't know how easy or hard that
16 is. You know much better than I do.

17 CHAIR MARKOWITZ: Dr. Cassano.

18 MEMBER CASSANO: I tend to agree with
19 the concept of removing the 2005. The way we
20 look at it in shipyard workers and in naval
21 vessels, as they said, these buildings are old.
22 And the way it's looked at is any ship whose keel

1 was laid before 1978, you have to assume that
2 asbestosis was present and anybody on that ship
3 was basically exposed.

4 So, 2005 again is arbitrary. You have
5 a person that's working in a building that was
6 built in 1957 or even earlier than that, 1945,
7 they haven't removed that asbestos lagging. If
8 something happens or, you know, there was some
9 kind of incident where they had to get into the
10 pipe, I know for a fact that nobody ever goes
11 there and brings the, you know, takes a little
12 sample first and sends it off to industrial
13 hygienist. They rip the darn lagging out and
14 it's over and done with.

15 So I think 2005 is too arbitrary.
16 Unless a building is so modern that it, you can
17 prove that it was built without the use of
18 asbestos in the lagging or the walls or whatever.

19 CHAIR MARKOWITZ: So we're going to
20 take one more comment, then we'll go on break.

21 Dr. Welch.

22 DR. WELCH: Well, I think, you know,

1 if you remember that the presumption is a
2 presumption and that it's going to -- there are
3 some people who should be compensated but you
4 need an individual review to figure out who that
5 is. So even if there was exposure after 2005,
6 it's not -- it shouldn't -- I don't think we can
7 assume it's to everybody in the complex, which is
8 what we're saying. Maintenance and construction
9 before 2005 there's general exposure, and after
10 2005 it would be particular people but not
11 everybody.

12 So I think having a date is reasonable
13 as long as we have a process where the people who
14 had injurious exposure after 2005 can have their
15 case reviewed without it being extremely
16 burdensome. So we may have to think about that
17 as part of this and how we word that.

18 CHAIR MARKOWITZ: Okay. So we're
19 going to -- I'm sorry -- we're going to take a
20 break for 15 minutes. We'll reassemble at, 3:00,
21 roughly 3:20, 3:22.

22 Thank you.

1 (Whereupon, the above-entitled matter
2 went off the record at 3:08 p.m. and resumed at
3 3:26 p.m.)

4 CHAIR MARKOWITZ: We're going to break
5 a few minutes before 4:30 to prepare for the
6 public comment session.

7 We have 15 people who have requested
8 time. So, today I ask you to -- we have a 90-
9 minute period to ask for public comment. Giving
10 a little bit of warning about this, to limit your
11 comments to about five or six minutes so that
12 everybody gets the same amount of time. I know
13 it's not much time, but concentrate your
14 thoughts, I guess.

15 Okay, so let's see, Dr. Welch. Do we
16 have Dr. Sokas on the line?

17 MEMBER SOKAS: Yes.

18 CHAIR MARKOWITZ: Okay. Mr. Griffon?

19 MEMBER GRIFFON: Yes, I'm here.

20 CHAIR MARKOWITZ: Okay. Thank you.

21 And Dr. Welch, looks like she'll be back in a
22 minute.

1 Okay, so let's continue the discussion
2 here. Mr. Whitley.

3 MEMBER WHITLEY: As we've talked about
4 presumptions, talked about what Les was talking
5 about, it's kind of a balance. And I would think
6 that from 2005 to present that the way we handle
7 asbestos, and especially asbestos abatement and
8 that kind of stuff, was with policy and all that
9 now.

10 The problem I've got is what they
11 said, there is groups like HPs and IHs, the
12 supervisors and other lot of groups, that this is
13 going to not put in the presumption. It doesn't
14 mean that they can't still file as they do today,
15 it just means they've got to prove it a little
16 different.

17 And for the presumption, the balance
18 the way it is, I can live with the way we've got
19 it.

20 CHAIR MARKOWITZ: Dr. Redlich.

21 I mean, I would point out, just to
22 follow up that the current policy on List A, the

1 list of 19 or so specific job titles and closely
2 related job titles. And this proposal really
3 expands that quite considerably to encompass all
4 maintenance and construction workers. It's not
5 saying that others might not be exposed, it's
6 just saying it's a matter of presumption these
7 very broad groups would be presumed to be
8 exposed.

9 Dr. Silver.

10 MEMBER SILVER: Could I ask you to put
11 up the language for the IH and CMC evaluations of
12 people who don't fit? Okay.

13 I wonder if we could move in the
14 direction of Kirk Domina's concerns by borrowing
15 an idea from the statute itself. Under
16 definitions, member of the Special Exposure
17 Cohort for the original Paducah, Portsmouth, and
18 Oak Ridge includes the phrase "was monitored
19 through the use of dosimetry badges for exposure
20 at the plant of the external parts of the
21 employee's body to radiation, or worked in a job
22 that had exposures comparable to that."

1 By analogy, Congress didn't trust the
2 results of that monitoring that went on. And the
3 union proved and the Washington Post proved that
4 it was held. So just the fact that people were
5 monitored gets them into the Special Exposure
6 Cohort.

7 So, by analogy, we have reason not to
8 trust a lot of the asbestos abatement work that
9 has happened post-Cold War. What if instead of
10 letting the industrial hygienist look for
11 individual level monitoring data, we tweaked it
12 in a manner analogous to the SECs and say that
13 the person was on a job where area monitoring
14 took place for asbestos.

15 Why do you do area monitoring for
16 asbestos? Because there is abatement going on.
17 And it doesn't matter what the results were. And
18 you certainly wouldn't have to show the
19 individual had exposure, but they were present in
20 the building that underwent asbestos abatement.
21 How do we know? There was area monitoring.

22 CHAIR MARKOWITZ: Dr. Redlich.

1 MEMBER REDLICH: So for workers who
2 are not in an ongoing asbestos surveillance
3 program they would present with chronic lung
4 disease, which basically would be either COPD or
5 some form of pulmonary fibrosis.

6 So, as you pointed out, the link, you
7 know, COPD would fall under whatever the COPD
8 presumption. So then you have workers who have
9 pulmonary fibrosis or pneumoconiosis. And the
10 question would be is that related to their
11 asbestos? Which, I mean I think what you would
12 want to ask is it just related to their work and
13 all the other exposures, machine work and
14 everything else?

15 So, I could imagine the scenario where
16 asbestosis is, you know, asbestos is denied
17 because for either, you know, one of these
18 reasons but where they might have a work
19 association.

20 So I just mention that. I think that
21 that group of diseases is problematic, both in
22 terms of determining what you're going to use as

1 criteria for having it, and also the association.
2 You know, from -- and I probably know less about
3 all of the different processes, but from the two
4 site visits that we've been on, I have been very
5 impressed with the extent of machining work that
6 went on. And the occupation that is best
7 associated with "idiopathic pulmonary fibrosis"
8 is machinists and machining work. You know,
9 metal, separate from beryllium, just exposure to
10 metals.

11 So I'd just be concerned about this
12 framework. I think it's where there is a clear,
13 maybe, asbestos exposure but I think that -- and
14 this would partially depend on how the claims are
15 coming in -- but I think realistically it's going
16 to be, if you have chronic lung disease, it's
17 going to be either COPD or fibrosis.

18 CHAIR MARKOWITZ: I am not sure who's
19 next. Dr. Cassano?

20 MEMBER CASSANO: No, I'm fine.

21 CHAIR MARKOWITZ: Dr. Boden?

22 MEMBER BODEN: Well, again, I am just

1 asking questions to try to clarify. So what
2 you've just said, I'm trying to figure out what
3 the implications are of what you said. So are
4 you possibly suggesting that there be a pulmonary
5 fibrosis presumption that is parallel to the COPD
6 presumption, and that asbestosis would fall into
7 that?

8 Or what are the implications of what
9 you said?

10 MEMBER REDLICH: You know, I'm not,
11 I'm not sure what's best. All I'm saying is that
12 there currently is a category of pneumoconiosis.
13 And so all I think is that in thinking about that
14 category we should just consider asbestosis also
15 being aware of the pneumoconiosis group. That's
16 all.

17 CHAIR MARKOWITZ: So, you know, my
18 view on this is that we know more about asbestos-
19 related diseases so we, to be more confident in
20 setting out some presumptions that we have
21 confidence in. Asbestosis is part of a larger
22 number of interstitial scarring diseases that

1 you're raising. Maybe we should treat them as a
2 class in relation not just to asbestos exposure
3 but to a whole variety of other exposures.

4 To me that would be a different issue,
5 a different set of presumptions. And this could
6 be nested within that, but we know more about
7 asbestos than those others, and so I would argue
8 we continue with this. And then if we want to
9 look more generally at this interstitial scarring
10 disease we can.

11 MEMBER REDLICH: I think that's
12 reasonable.

13 CHAIR MARKOWITZ: Dr. Welch.

14 DR. WELCH: I just want to get back to
15 what Ken suggested in terms of people worked on a
16 job where there's monitoring. I think my concern
17 about asbestos in place is that people were
18 exposed without it being designated as an
19 abatement job. Where, you know, somebody knocks
20 into a pipe and whatever protective covering is
21 off, and that's not fixed for forever, and
22 there's just ongoing exposure from asbestos in

1 place. Or there's some emergency response and,
2 you know, asbestos gets torn off. But there's no
3 monitoring done during that activity.

4 Because generally when there's
5 abatement going on there is control of a
6 exposure. So, I don't think you're -- I don't
7 think adding that would really address the
8 question of how you identify the people who would
9 have this intermittent, potentially, high dose,
10 short term exposure because of running into
11 asbestos in a place that hasn't been identified
12 or controlled properly.

13 CHAIR MARKOWITZ: Dr. Silver.

14 MEMBER SILVER: Point taken. I
15 thought it would be a step in the direction of
16 Kirk Domina's concerns, not getting all the way
17 there.

18 CHAIR MARKOWITZ: I thought it was
19 creative actually.

20 Dr. Dement.

21 MEMBER DEMENT: Yeah, I think in the
22 presumptions we need to acknowledge what the

1 reality is I think exists. I think we can safely
2 say that asbestos exposures in the construction
3 industry, and in the construction industry on the
4 DOE sides, has decreased over time. Most of the
5 exposures lift from installation to treating
6 materials in place.

7 However, I think, as currently is
8 discussed, you know, there are situations where
9 even though we can say on average we decreased
10 exposures, there are unusual circumstances. And
11 they may be unusual but they may occur
12 frequently. But I don't know how to incorporate
13 those into a presumption. I think we have to be
14 very clear that this is a presumption, it's not a
15 value that you have to meet. There are other
16 routes to get to it.

17 Unfortunately, and based on some of
18 the reviews that I've done of the cases, I see
19 the presumption values being used as you must
20 meet these in order to qualify for compensation.
21 So I just think we need to, if this is what we
22 settle on, word it in such a way that we do know

1 and we acknowledge that there are these
2 situations where even though controls are in
3 place and relatively efficient, there are
4 situations when they are not efficient and
5 workers are exposed.

6 CHAIR MARKOWITZ: Well, we can
7 certainly add that to the rationale.

8 I'm sorry. Ms. Pope.

9 MEMBER POPE: I have been involved in
10 situations where as a bargaining unit safety rep
11 where individuals have been exposed to acute
12 exposure through a safety concern. And there
13 have been many documentations of those events
14 happening, whether they be on a routine basis of
15 where something is supposed to operate in a
16 normal manner, or we're doing a decommissioning
17 of that building, those type situations did
18 occur.

19 So, being able to track that
20 information in terms of the people being exposed
21 to an extreme amount of exposure at a certain
22 time should be acknowledged as well.

1 CHAIR MARKOWITZ: Other comments? Dr.
2 Sokas? Mr. Griffon?

3 MEMBER SOKAS: Nothing to add.

4 CHAIR MARKOWITZ: Okay, thanks.

5 So, the issue of setting out medical
6 criteria for presumption is not addressed in this
7 recommendation. And would be the subject, I
8 think, of another recommendation. It requires --
9 it's not as easy as it would seem on the surface.
10 And it requires some thought, I think.

11 So it's not going to be ready by
12 tomorrow. So I would support considering
13 modifying or adopting this recommendation as an
14 exposure presumption recommendation. And then
15 coming back soon enough with some medical
16 criteria.

17 There is a balancing between the
18 certainty on the medical criteria side, as Dr.
19 Boden points out, and the certainty on the
20 presumption side. But there's going to be
21 uncertainty on both sides, and we'll just live
22 with it.

1 So, it seems that I can leave the
2 language of the recommendation, but it seems like
3 the sticking point from the discussion here, or
4 the point of most disagreement, or perhaps the
5 only point of disagreement really is on the
6 calendar year issue, is whether we should specify
7 calendar year, whether we should use pre-2005 or
8 something more recent, 2010, 2015.

9 And so what I propose, actually, is we
10 delete -- that we vote on that separately, if it
11 makes sense, that we vote on the rest of the
12 recommendation and then vote on the calendar
13 year. The alternative is to set out two
14 alternatives with, one with -- or several
15 alternatives, one without calendar years or
16 different calendar years.

17 What's your preference, Dr. Boden?

18 MEMBER BODEN: I would suggest that's
19 a reasonable idea. But I would reverse the
20 order, try to see what level of agreement there
21 is about the calendar year first. And then if
22 there is substantial agreement -- I don't know if

1 there is -- then --

2 CHAIR MARKOWITZ: Okay.

3 MEMBER BODEN: -- it would be easier
4 to vote on the second one.

5 CHAIR MARKOWITZ: That's fine.

6 Yeah, Dr. Welch?

7 DR. WELCH: I was thinking of another
8 way to address it as well would be to make the
9 calendar year more current but add more to the
10 latency. Which would mean that exposures that
11 are occurring intermittently are considered
12 important but there would have been other
13 exposures. Because the latency is sort of saying
14 there had to have been exposures earlier that
15 were also causative.

16 See what I mean?

17 CHAIR MARKOWITZ: Yeah.

18 MEMBER BODEN: Or is that too
19 complicated? Just tell me forget it.

20 CHAIR MARKOWITZ: I think it's a
21 little bit complicated, personally.

22 MEMBER BODEN: Okay. Forget it.

1 Never mind.

2 CHAIR MARKOWITZ: Dr. Redlich.

3 MEMBER REDLICH: No, nothing.

4 CHAIR MARKOWITZ: Okay. Okay. You
5 know, the nut of this is that there's -- that the
6 difference of opinion about the extent of
7 exposure to asbestos, say, between 2000 and 2017.
8 And that something that exposure was probably a
9 lot less prevalent and others emphasize the fact
10 that for certain populations there was continued
11 significant exposure. That seems sort of the
12 spectrum of opinion.

13 So wondering how to phrase this.

14 MEMBER CASSANO: Actually I'm thinking
15 if we're talking about exposure that occurred
16 pre-2005, so it wouldn't apply to anything where
17 the last exposure was after 2005.

18 If you're talking about a latency of
19 15 years, somebody that was just exposed in 2005,
20 you're not going to be adjudicating this, I
21 think, until 2020. So I think we're kind of safe
22 with going with 2005 for that reason. Think

1 about it.

2 CHAIR MARKOWITZ: Yeah, I have thought
3 about it. I didn't think it was the best course
4 of action to build in something that could become
5 obsolescent in a few years, but.

6 MEMBER CASSANO: No, but what I'm
7 saying is --

8 CHAIR MARKOWITZ: I understand, yeah.
9 No, I get it. Yeah. Kick the can down the road.

10 MEMBER CASSANO: Well, no, it's not
11 kicking the can down the road. But I think at
12 2020 if you're talking about an exposure pre-
13 2005, then if they -- if the injury -- if they
14 developed any of these diseases at all it would
15 be in 2020. So the exposure level at 2005 would
16 be much lower, is what I'm saying, at 2006 or
17 beyond.

18 We're not looking at a case that
19 develops in 2005, we're looking at the last
20 exposure being 2005.

21 CHAIR MARKOWITZ: So let's --

22 DR. WELCH: So, I think we'll vote,

1 however.

2 MEMBER CASSANO: Fine.

3 CHAIR MARKOWITZ: What if we voted
4 this way, what if we took a vote on whether we
5 should put any calendar year reference in or not.
6 And then if the vote is that we put a reference
7 year in, that we select a couple of choices and
8 then vote on that.

9 Does that sequence make sense?

10 DR. WELCH: Yeah.

11 CHAIR MARKOWITZ: Okay. So, then the
12 recommendation is that DOE workers who had or who
13 are presumed to have significant asbestos
14 exposure, to be defined in the subsequent
15 recommendation, prior to 2005, January 2st, 2005,
16 will be presumed to have sufficient exposure to
17 be at least as likely as not to be a significant
18 factor in aggravating, contributing, or causing
19 one of these five asbestos-related conditions.

20 Is that clear?

21 MEMBER CASSANO: That's clear.

22 DR. WELCH: Yeah.

1 CHAIR MARKOWITZ: Okay. Okay.

2 So, I need a motion to, motion to --

3 MEMBER CASSANO: You're proposing it
4 with a vote on whether 2005 is the date?

5 CHAIR MARKOWITZ: That's right. The
6 only right here is whether we should use --
7 holding everything else the same, all the other
8 variables which we'll now vote on, we'll vote on
9 after this -- that we use the pre-two thousand --
10 January 1st, 2005, as the relevant time period.

11 MEMBER CASSANO: So moved.

12 PARTICIPANT: Second.

13 CHAIR MARKOWITZ: Okay. Any
14 discussion?

15 All those -- Yeah?

16 MEMBER BODEN: One quick comment. We
17 are clear in the rest of this that, that in no
18 way should be bad news for the people who don't
19 meet that criterion, that they're still allowed
20 to go forward? This is not a negative
21 presumption in any way?

22 CHAIR MARKOWITZ: No, actually now I

1 just realized -- I had proposed that -- Hold on
2 one sec. I had proposed that we vote first on
3 whether there should be a calendar year, any
4 calendar year or not; right?

5 MEMBER CASSANO: That's right.

6 CHAIR MARKOWITZ: Okay. So I'm going
7 to re -- I'm going to withdraw that and reframe
8 that.

9 So, the proposal is whether the set of
10 exposure criteria should make reference to any
11 calendar year as representing a important
12 demarcation line in terms of identifying
13 significant exposure to asbestos. So that's the
14 recommendation at hand.

15 And I'm hoping, since we don't, we're
16 not seeing it up here, that we're actually
17 getting this somewhere. It's being recorded.
18 Fine, we'll find it.

19 So, comments? Okay, yeah, go ahead.

20 MEMBER REDLICH: We may want to
21 consider the malignant. Because basically the
22 year is using that as a surrogate for amount or

1 dose of exposure. So for pleural plaques and
2 asbestosis there is more a dose response than
3 something like mesothelioma.

4 So I'm just wondering about the
5 rationale of that year, given that you, this is
6 something that would be going on into the future.
7 If someone had, you know, worked around asbestos
8 at a DOE site and that was, you know, their main
9 employment and they got a mesothelioma, I
10 wouldn't care that much about whether it was pre-
11 2005 or post.

12 CHAIR MARKOWITZ: Okay. So you're
13 suggesting a friendly amendment that we exclude
14 mesothelioma from this recommendation.

15 Other comments on that?

16 (No response.)

17 CHAIR MARKOWITZ: So let's, is there
18 a -- well, I accept that as a proposed friendly
19 amendment. So let's vote on it.

20 All those in favor of revising the
21 proposal, the proposed recommendation so that any
22 calendar year demarcation applies only to the

1 five other asbestos-related diseases, excluding,
2 if you look at the pink section, the last two
3 lines, it would exclude -- or include those five
4 conditions but it would exclude mesothelioma.

5 So all those in favor of that?

6 DR. WELCH: In favor of having no end
7 date?

8 MEMBER BODEN: Can I suggest an order?

9 CHAIR MARKOWITZ: Yeah.

10 MEMBER BODEN: Because actually there
11 are three things we're voting on.

12 CHAIR MARKOWITZ: Right.

13 MEMBER BODEN: One is the current
14 thing. The other is without mesothelioma. And
15 the third is nothing at all.

16 So I think we should vote on the
17 nothing at all first and then --

18 DR. WELCH: I just wasn't clear that
19 a yes vote --

20 MEMBER BODEN: Yeah. That's right.

21 DR. WELCH: So nothing --

22 MEMBER BODEN: For everything, right.

1 And then once we've settled that then we can deal
2 with any other issues.

3 CHAIR MARKOWITZ: So the proposal, the
4 recommendation is that we consider a set of time-
5 related criteria which will be defined
6 subsequently. But no calendar year reference for
7 five asbestos-related diseases, excluding
8 malignant mesothelioma. Okay, so this is no
9 calendar year reference in the exposure criteria.
10 Okay. Is that okay?

11 DR. WELCH: Yes.

12 CHAIR MARKOWITZ: Okay, any discussion
13 of that?

14 (No response.)

15 CHAIR MARKOWITZ: Okay. All those in
16 favor of that, raise your hand.

17 (Show of hands.)

18 CHAIR MARKOWITZ: One, two, three,
19 there are four present.

20 Dr. Sokas?

21 MEMBER SOKAS: No.

22 CHAIR MARKOWITZ: I'm sorry, what was

1 that? No. Okay.

2 And, Mr. Griffon?

3 MEMBER GRIFFON: No.

4 CHAIR MARKOWITZ: Okay. So there are
5 four -- how many abstentions are there? One,
6 okay.

7 So four in favor, one abstention.

8 How many noes? One, two, three, four,
9 five, six, seven, eight, nine, eleven -- right,
10 right, 11 noes. Eleven noes, 4 yeses and 1
11 abstention.

12 Okay, so that means that there's some
13 favorable opinion towards introducing a calendar
14 year.

15 Okay, so let's repeat this same
16 recommendation, that is to say that DOE workers
17 will be defined as having significant asbestos
18 exposure, details to be provided later, if they
19 had this exposure prior to January 1st, 2005.

20 Now, do we want to pick another
21 reference calendar year that some people are
22 comfortable with? Because there are a lot of --

1 DR. WELCH: 2005 and 2010.

2 CHAIR MARKOWITZ: Right, right. So --

3 MEMBER SOKAS: So, Steve, we've
4 excluded mesothelioma; right?

5 CHAIR MARKOWITZ: Right now we're
6 excluding malignant mesothelioma.

7 MEMBER SOKAS: Okay, great.

8 CHAIR MARKOWITZ: Yeah. So those who
9 feel more comfortable with the later calendar
10 year, any -- Mr. Domina, you wanted closer to
11 2015 or something; right?

12 MEMBER DOMINA: Right. Go big or go
13 home.

14 (Laughter.)

15 CHAIR MARKOWITZ: Judging from what we
16 saw yesterday at Hanford, I think that happens a
17 lot at DOE.

18 MEMBER DOMINA: You know, I'm just
19 stating what I've witnessed, what I've seen. And
20 I know if it happens here, it happens across the
21 complex. And it's a concern with me because I
22 have a lot of younger folks that have causes

1 because of stuff that has transpired. And I also
2 look at the type of work that's being done here
3 and across the complex. And I also look at the
4 age of the current work force and how much it's
5 changing, and how many new people have hired on,
6 like say since 2010 or '12. And I don't want
7 people to be excluded.

8 I mean, I, I don't see -- yeah,
9 they're doing some monitoring stuff. Is stuff
10 being done safer? I don't know.

11 I mean, I also know you can monitor
12 not to find things, too. And we've all seen
13 that. I still think it goes on today. And I
14 mean I just, part of my job is to protect
15 everybody. And I just, my opinion.

16 CHAIR MARKOWITZ: Sure. But we need
17 a calendar year. We need --

18 MEMBER DOMINA: Go big or go home.

19 CHAIR MARKOWITZ: Okay, 2015, is that
20 big enough? So should I set the recommendation
21 or the proposal 2005 versus 2015? Is that
22 reasonable?

1 PARTICIPANT: You have to pick one for
2 the vote.

3 CHAIR MARKOWITZ: No, I know, I get
4 that. But I just want to lay out what the
5 choices are.

6 MEMBER SOKAS: Yes.

7 CHAIR MARKOWITZ: Okay, fine.

8 Then the exposure presumptions for
9 asbestos with DOE workers who otherwise meet
10 exposure criteria, that we will set out
11 imminently, who had this significant exposure to
12 asbestos prior to January 1st, 2005, will be
13 judged to have substantial exposure sufficient to
14 be a significant factor in causing, contributing,
15 or aggravating one of the five asbestos-related
16 conditions, that is excluding malignant
17 mesothelioma.

18 So the first vote will be on 2005.

19 And then we'll take a vote on 2015.

20 So any, any motions in acceptance.

21 PARTICIPANT: Move.

22 CHAIR MARKOWITZ: Second.

1 PARTICIPANT: Second.

2 CHAIR MARKOWITZ: Any further
3 discussion?

4 (No response.)

5 CHAIR MARKOWITZ: Okay. So all in
6 favor for 2005, raise your hand.

7 (Show of hands.)

8 CHAIR MARKOWITZ: Okay, that's five
9 votes present.

10 Dr. Sokas?

11 MEMBER SOKAS: Yes.

12 CHAIR MARKOWITZ: And, Mr. Griffon.

13 MEMBER GRIFFON: Yes.

14 CHAIR MARKOWITZ: Okay, so that's
15 seven in favor.

16 How many opposed?

17 (Show of hands.)

18 CHAIR MARKOWITZ: Six opposed.

19 And how many abstentions?

20 (Show of hands.)

21 CHAIR MARKOWITZ: One, two. Two
22 abstentions. So that's 15.

1 So that's 7 to 6 to 2.

2 I have to confer with the designated
3 federal official because we've never had a close
4 vote.

5 (Off-microphone comments.)

6 CHAIR MARKOWITZ: Okay, so that's
7 fine. So let's continue. We've got a consensus.

8 Now let's go with 2015. So that it's
9 the same recommendation using January 1st, 2015,
10 as the cutoff date. Second? I mean is there a
11 motion to --

12 PARTICIPANT: So moved.

13 CHAIR MARKOWITZ: And a second.

14 PARTICIPANT: Second.

15 CHAIR MARKOWITZ: Any discussion?

16 (No response.)

17 CHAIR MARKOWITZ: Okay. So all those
18 in favor of using 2015 as the key date in
19 determining the significant asbestos exposure,
20 using the same language as in the previous
21 recommendation, all those in favor of January
22 1st, 2015, please raise your hand.

1 (Show of hands.)

2 CHAIR MARKOWITZ: Seven in favor.

3 Dr. Sokas?

4 MEMBER SOKAS: No.

5 CHAIR MARKOWITZ: And, Mr. Griffon?

6 MEMBER GRIFFON: No.

7 CHAIR MARKOWITZ: Thank you.

8 So all those opposed to using 2015,
9 raise your hand.

10 (Show of hands.)

11 CHAIR MARKOWITZ: Five present.

12 And, Dr. Sokas. Oh, she said no.

13 Okay. And he said no.

14 So that's 7 to 7. But I'm missing a
15 vote. Oh, one abstention. Okay.

16 Okay, so I guess we'll try 2010. I'm
17 not sure what else to do.

18 Sure, Dr. Welch?

19 DR. WELCH: So, just to try to
20 convince people to come over to my point of view,
21 I've been managing a medical surveillance program
22 for sheet metal workers since 1985. And we have

1 looked at the change in asbestos-related disease
2 on the chest x-ray over time, and particularly
3 looking at people who started work after 1970,
4 which is earlier than we're talking about in
5 terms of disease.

6 But the EPA banned the spray-on
7 asbestos-containing materials in 1973, which for
8 sheet metal workers was the predominant exposure
9 for them, that and thermal insulation.

10 We don't see asbestos-related disease,
11 non-malignant asbestos-related disease in the
12 sheet metal workers anymore. We see no
13 asbestosis. And we see a tiny amount of pleural
14 disease. Which is why I feel comfortable saying,
15 you know, I'm saying we're looking at people
16 whose exposure started after 1970, and that group
17 of people. Here we're up to 2005.

18 So I think we have a pretty good
19 safety, margin of safety there. And the kind of
20 exposures -- and I might be wrong on this, but
21 the intermittent exposures that are happening
22 from asbestos in place, if those are the only

1 exposure someone has, they didn't have sustained
2 exposure to demolition, uncontrolled demolition
3 work or application work prior to 1973 or 1978, I
4 don't think it's going to be sufficient to cause
5 asbestosis.

6 It's definitely sufficient to
7 contribute to cause mesothelioma. And we're not
8 going to put in -- I think we've already had the
9 consensus around the table, we haven't voted on
10 it, there will be no cutoff date for
11 mesothelioma. And that's the disease that occurs
12 with much lower exposures.

13 So, I feel like the presumption will
14 work better because we're not requiring very much
15 exposure, you know, requiring a year of exposure
16 and saying that that can contribute to
17 asbestosis. And that's a low threshold for
18 asbestosis, even considering that we're including
19 years where exposure was pretty low.

20 So that's why, that's why I'm
21 comfortable with 2005.

22 CHAIR MARKOWITZ: Dr. Redlich.

1 MEMBER SOKAS: And this is Rosie.

2 CHAIR MARKOWITZ: Dr. Sokas?

3 MEMBER SOKAS: I'd like to also echo
4 what Dr. Boden said earlier which is that we're
5 really counting on the fact that this is a
6 presumption and that failure to meet the
7 presumption does not mean you automatically get
8 booted out. We simply go into the full
9 evaluation.

10 CHAIR MARKOWITZ: Dr. Redlich.

11 MEMBER REDLICH: I agree with what
12 Laura said, that the likelihood of a new case of
13 asbestosis or pleural plaques at this point is
14 relatively low. But I do see, as a
15 pulmonologist, I get referred a huge number of
16 patients with interstitial lung disease related,
17 you know, with the question of, you know, work
18 exposure.

19 So I mean I think we should finish up
20 this discussion and pick a year. But I think in
21 practice and moving forward that the much more
22 common scenario will be that a patient develops

1 chronic either ILD, interstitial lung disease, or
2 COPD with a question of is their exposures at,
3 you know, one of these sites where asbestos was
4 probably not the major exposure.

5 CHAIR MARKOWITZ: Dr. Cassano.

6 MEMBER CASSANO: I just have a
7 question. We're concentrating on the pulmonary
8 diseases. Do we know that the same dose response
9 holds for ovarian cancer as well? Or is ovarian
10 cancer closer to mesothelioma in the dose
11 required, the dose, the minimal dose that would
12 cause ovarian cancer?

13 I don't know that answer. I don't
14 know if there's enough investigation been done on
15 ovarian cancer since its only been 2012 that it
16 was considered by IR. Do we know that for
17 certain?

18 CHAIR MARKOWITZ: No. But we can take
19 a look at those studies quickly enough.

20 But mesothelioma really is an
21 exception. And the nature of the studies are
22 such that there's a limited number of studies on

1 ovarian cancer, and it's not possible that they
2 could have, given those studies, identified a
3 brief exposure to asbestos could cause ovarian
4 cancer. Whereas, we can say that about
5 mesothelioma, we can't say it about lung cancer.

6 MEMBER CASSANO: Okay.

7 CHAIR MARKOWITZ: I mean mesothelioma
8 differs from lung cancer in that respect. You
9 need more exposure to contribute to lung cancer.

10 Yes, Doctor, I'm sorry.

11 MEMBER BODEN: So I just wanted to say
12 that I've been abstaining but Dr. Welch has
13 convinced me. Just so you know. At least you
14 convinced one person. Probably the only one.

15 CHAIR MARKOWITZ: Ms. Vlieger.

16 MEMBER VLIEGER: I guess the question
17 here is harm in excluding or including extra
18 people. And so what harm does it cause to extend
19 the calendar year for this presumption, rather
20 than it being a matter of principle? But what
21 harm does it cause to potential claimants? Does
22 it really hurt anything to make the year further

1 out. It just means that there's longer time for
2 people to make the claims or be eligible for the
3 claims.

4 And I don't deal with anybody that
5 wants to walk into an asbestos exposure or say,
6 oh, well, you know I have asbestos disease and
7 they weren't exposed. So my question is why are
8 we at this point selecting a year.

9 CHAIR MARKOWITZ: I'll tell you what
10 I think. It's credibility. I think if we're not
11 making recommendations based on what we know
12 about this exposure or other exposures, then it's
13 not just our credibility as a Board but the
14 credibility of the program, frankly, for making
15 decisions based on scientific knowledge is
16 compromised. I think that's the real threat.

17 MEMBER VLIEGER: So what is the
18 current study, what does it say about asbestos at
19 the DOE worksites?

20 CHAIR MARKOWITZ: Well, no, what we're
21 doing is applying a broad literature. This
22 entity, this exposure, this agent's been more

1 studied than probably any other, with the
2 exception maybe of lead. And so we're applying
3 what we know of DOE sites and what we know in
4 general to these questions.

5 Do we know what the prevalence of
6 asbestos exposure at a DOE complex in 2005 or
7 2010 was? We don't know that.

8 MEMBER CASSANO: There's no area
9 monitoring for asbestos for those periods?

10 CHAIR MARKOWITZ: No, I'm sure there
11 was -- I'm sure there was some monitoring.
12 Abatement requires monitoring --

13 MEMBER CASSANO: Right.

14 CHAIR MARKOWITZ: -- so I'm sure there
15 was monitoring. And I don't know the results of
16 that, but it'd be surprising if the monitoring-
17 based -- abatement-based monitoring showed much
18 excursion from low levels because that's when
19 they're paying attention.

20 Dr. Redlich?

21 MEMBER REDLICH: Yes. My voting
22 against the 2005 was more just sort of getting

1 tired of our nitpicking about years because it
2 seems that you have to have the diagnosis to
3 begin with. And so if you did have the
4 diagnosis, you know, whatever year you pick, so I
5 agree that, you know, the likelihood of getting
6 disease with more recent exposure is much lower.

7 I was just thinking more in terms of
8 minimizing the back and forth over years because
9 I think if you have to have the diagnosis. And
10 so, really, what we're -- you know, if someone
11 has bilateral pleural plaques, again, I think
12 that's pretty pathognomonic for asbestos. And
13 the other diagnosis we have here, we do have lung
14 cancer and then we have asbestosis. And so it
15 also -- I mean, it's -- anyway, I think we can
16 vote again and maybe get consensus now.

17 CHAIR MARKOWITZ: Yes. So is it fair
18 to retake a vote on 2005? Is that fair?

19 MEMBER CASSANO: Yes.

20 CHAIR MARKOWITZ: Okay, okay. So
21 we're going to revote on a recommendation --
22 whatever recommendation that is that DOE workers

1 will be considered to have significant asbestos
2 exposure as a matter of presumption with details
3 regarding aspects of the exposure to be provided
4 imminently in the next recommendation when that
5 exposure occurred according to those criteria
6 prior to January 1st, 2005. And that such
7 exposure will be considered as sufficient to be
8 at least as likely as not a significant factor in
9 contributing, aggravating, or causing any of the
10 five asbestos-related diseases that is excluding
11 malignant mesothelioma.

12 A motion to accept this?

13 MEMBER CASSANO: Yes.

14 CHAIR MARKOWITZ: Yes? Okay. Second?

15 Okay. So any further discussion? Let's just
16 vote on this. All those in favor, raise your
17 hand. One, two, three, four, five, six, seven,
18 eight. There are eight hands raised. Dr. Sokas?

19 MEMBER SOKAS: Yes.

20 CHAIR MARKOWITZ: And Mr. Griffon?

21 MEMBER GRIFFON: Yes.

22 CHAIR MARKOWITZ: So that's ten. All

1 those opposed? One -- and one opposed. And how
2 many abstain?

3 CHAIR MARKOWITZ: Three people are too
4 tired to vote. Maybe four. Well, anyway, we
5 have ten votes -- ten in favor, so that's a
6 consensus enough, the maximum of five votes.
7 Otherwise, do we need -- two-thirds. Okay, fine.
8 Okay, okay.

9 So, now, let's move on then to the
10 rest of the exposure presumptions. And actually,
11 I guess we can look at what we're looking at now
12 which is that, here, if a DOE worker has worked
13 as a maintenance or construction worker at a DOE
14 site for 250 days or more prior to January 1st,
15 2005, diagnosed 15 years or more with one of the
16 five conditions: asbestosis, pleural disease,
17 lung cancer, cancer of the ovary and larynx; that
18 they would be accepted as having substantial
19 exposure for the basis of compensation.

20 Motion to accept and second? Okay.
21 Any further comment?

22 MEMBER BODEN: Just a question. So

1 we're going to need to have a second bullet just
2 specifically for mesothelioma?

3 CHAIR MARKOWITZ: Yes.

4 MEMBER BODEN: That doesn't include
5 it?

6 CHAIR MARKOWITZ: Yes.

7 MEMBER BODEN: Okay.

8 CHAIR MARKOWITZ: Yes. Mr. Domina?

9 MEMBER DOMINA: I just want to make
10 sure it's clear. When you're talking
11 maintenance, you're talking about production
12 workers?

13 CHAIR MARKOWITZ: No, no. We're
14 talking about the maintenance worker workforce,
15 not the production workforce. Well,
16 maintenance, full-time -- the maintenance
17 personnel employed by the prime contractor on
18 site, that's what --

19 MEMBER DOMINA: All right.

20 CHAIR MARKOWITZ: Or Garry, you guys
21 can explain to me better what a maintenance
22 worker is, but not the construction worker who

1 comes -- builds a new building, major renovation.
2 We're talking about a maintenance worker on site.

3 MEMBER WHITLEY: Maintenance
4 production.

5 CHAIR MARKOWITZ: Yes. Okay,
6 maintenance production, fine. Okay. All those
7 in favor, raise your hand. Okay, so -- and
8 that's all the hands here and then Dr. Sokas?

9 MEMBER SOKAS: Yes.

10 CHAIR MARKOWITZ: And Mr. Griffon?

11 MEMBER GRIFFON: Yes.

12 CHAIR MARKOWITZ: So that's 15 votes
13 in favor. So, now, let's move on to
14 mesothelioma, and if someone could remind me what
15 we're changing for the mesothelioma presumption.

16 MEMBER CASSANO: We're getting rid of
17 the dates.

18 CHAIR MARKOWITZ: Getting rid of the
19 date? Okay, okay. So the recommendation then
20 would be all DOE workers who worked as
21 maintenance construction workers at a DOE site
22 for 30 days or more and who are diagnosed 15

1 years or more after the onset of such work with
2 malignant mesothelioma of any bodily site will be
3 presumed to have sufficient exposure to meet the
4 standard of causation under the Act.

5 Motion to accept? Second? Any
6 discussion? Okay. All those in favor, raise
7 your hand. And Dr. Sokas?

8 MEMBER SOKAS: Yes.

9 CHAIR MARKOWITZ: And Mr. Griffon?

10 MEMBER GRIFFON: Yes.

11 CHAIR MARKOWITZ: Okay. So that's 15
12 votes in favor of this. I'm sorry. Could you
13 just raise your request?

14 MEMBER BODEN: Sure. Can you change
15 this on this slide so we have the exact rating on
16 the slide for the record? Just deleting or more
17 -- or sorry -- prior to January 1st. That's what
18 you need to do.

19 CHAIR MARKOWITZ: Yes, thanks.

20 MEMBER BODEN: Okay. That's it.

21 CHAIR MARKOWITZ: Yes, yes.

22 MEMBER BODEN: Sorry. Can't use all

1 those signs.

2 (Pause.)

3 CHAIR MARKOWITZ: Yes. Okay. So if
4 -- and when you've done that, Kevin, if you could
5 move to the next slide. Okay.

6 So we should vote on this separately.
7 Let me just read it. All claims for one of the
8 six asbestos-associated conditions named above
9 that do not meet the exposure criteria described
10 in Items 1 and 2 above will be referred to an
11 industrial hygienist for exposure assessment and
12 to a CMC for evaluation of medical documentation
13 and causation, and the six conditions are
14 itemized.

15 So motion to accept this? Second?
16 Any further discussion on this? I think -- okay.
17 So all those in favor, raise your hand. One,
18 two, three, four, five. Okay. Twelve votes.
19 Dr. Sokas?

20 MEMBER SOKAS: Yes.

21 CHAIR MARKOWITZ: Mr. Griffon?

22 MEMBER GRIFFON: Yes.

1 CHAIR MARKOWITZ: Okay. And all those
2 opposed? Any abstentions? Okay. So 14 votes in
3 favor and one abstention. Okay.

4 So the final recommendation in the
5 series regarding asbestos has to do with chronic
6 obstructive pulmonary disease. It may have a
7 contribution from asbestos exposure. However,
8 claims for this disease should be evaluated as
9 part of a broader set of presumptions for chronic
10 obstructive pulmonary disease.

11 So a discussion about this? Is there
12 a motion to accept and a second?

13 MEMBER CASSANO: Yes.

14 CHAIR MARKOWITZ: Okay. All those in
15 favor of this recommendation, raise your hand.
16 One, two, three, four. And Dr. Sokas?

17 MEMBER SOKAS: Yes.

18 CHAIR MARKOWITZ: Mr. Griffon?

19 MEMBER GRIFFON: Yes.

20 CHAIR MARKOWITZ: Okay. So that's 15
21 votes in favor.

22 I think that we should take a break

1 before our 4:30 to 6 o'clock public comment
2 session. Are there any instructions before?
3 We're going to start precisely at 4:30? We need
4 to start at 4:28? What's -- how does it work?

5 PARTICIPANT: 4:30.

6 CHAIR MARKOWITZ: 4:30? Okay. And
7 who will give us exact instructions at 4:30?

8 PARTICIPANT: You have a slide --

9 CHAIR MARKOWITZ: Okay, okay. So is
10 there --

11 MR. FITZGERALD: I just want to -- I
12 just want to remind everybody -- it's not on?
13 There we go. I just want to remind everybody, if
14 you're interested in making a public comment and
15 haven't checked in with Carrie Rhoads yet, please
16 do so. And for those of you on the phone, we'll
17 be giving you instructions on the number to call
18 in. In fact, I have it right now, so I might as
19 well read it to you. It's 1-888-957-9863, and
20 the passcode is 1930221#. Thank you.

21 CHAIR MARKOWITZ: We will reassemble
22 at 4:28. Just please be prompt so we can begin

1 at 4:30.

2 (Whereupon, the above-entitled matter
3 went off the record at 4:15 p.m. and resumed at
4 4:30 p.m.)

5 CHAIR MARKOWITZ: So we're going to
6 begin the public comment session that goes till 6
7 o'clock. We have 18 people who have requested
8 speaking time, so 90 divided by 18 is 5. So
9 we're down, unfortunately, to five minutes for
10 each speaker. And there'll be people who have a
11 lot to say, so the problem really is it
12 encroaches on other people's time. So I'd ask
13 you to hold to five minutes, and I will,
14 unfortunately, have to interrupt you when you're
15 close to five minutes so you know that your time
16 is up.

17 But let's begin. Terrie Barrie is our
18 first speaker.

19 MS. BARRIE: Hello, Dr. Markowitz and
20 members of the Board. Thank you for providing
21 this opportunity for the public to make comments
22 and offer insight into their claims problem. My

1 name is Terrie Barrie, and I'm a founding member
2 of the Alliance of Nuclear Worker Advocacy
3 Groups. I want to commend all of you for the
4 excellent work you have done this past year and
5 the accomplishments you have made in providing
6 guidance to the Department of Labor.

7 To a degree, I'm concerned about the
8 delay of the recommendations that you made back
9 in October. And to a degree, I do understand the
10 issues, as Ms. Leiton explained. But I think
11 that in the future that there should be some kind
12 of timeline set or deadline set that's something
13 similar to what the Secretary of Health and Human
14 Services has for the Part B SEC petitions. So
15 I'd like to have somebody consider that possibly
16 needs to go to Congress itself. But I think in
17 order to make this program the best, that these
18 excellent recommendations that this Board makes
19 to Department of Labor needs to be acted on as
20 quickly as possible.

21 I want to thank you for discussing the
22 wage loss earlier today, and I think it would

1 help understand the issues if I gave you a little
2 bit of background on the problems with wage loss.
3 First of all, I've had many advocates say, I
4 don't even recommend going -- or having my
5 claimants file for wage loss. They'll never get
6 it. This is what I've heard from, like, three or
7 four different people. And Ms. Leiton, you know,
8 explained what the procedure manual is and the
9 polices are, and like you've noticed in other
10 procedure manuals or training manuals, that
11 doesn't actually reflect reality.

12 Wage loss claims are based on the
13 claims examiners' evaluation of medical records
14 to determine whether a covered condition
15 contributed or caused wage loss. I am personally
16 aware of two separate claims where symptoms of
17 the disease were documented in the medical file
18 that was -- and it was evident before the
19 condition was diagnosed, and both of these claims
20 were denied.

21 In one case, the claims examiner, at
22 one point, demanded that the claimant provide

1 evidence, and I quote, of the frequency,
2 duration, and severity of the flare-ups of the
3 chronic condition, and this chronic condition was
4 accepted. It was accepted because there was a
5 documented incident of the worker ingesting
6 radioactive materials. The chronic condition was
7 not diagnosed until 1995, years after the
8 incident, and the consequential disease, which
9 was also symptomatic before the diagnosis and was
10 diagnosed in 1997.

11 But the claims examiner wanted, like,
12 more evidence. You know, how was this flare-up
13 happening? And the only way the claimant or the
14 worker could've provided that medical evidence
15 was to undergo an invasive medical procedure each
16 time that happened. And the frequency of that
17 was happening, like, once a week, and that's just
18 not medically sound or safe. And this evidence
19 that the claims examiner wanted was in addition
20 to the personal physician's -- three personal
21 physicians' letters that were also in the file
22 and submitted to Department of Labor.

1 Another huge obstacle for the
2 claimants to overcome for the wage loss program
3 is the requirement that the employee must earn
4 wages before the claim trigger month. So if the
5 person has symptoms of, let's say, pneumonia in
6 January of 2006, but it wasn't diagnosed -- and
7 went out work but wasn't diagnosed until March of
8 2006, but he didn't work before his diagnosis, he
9 doesn't get paid because the policy is that they
10 must earn wages before the claim trigger month.
11 And this is contrary to the clear language of the
12 law requirement.

13 I ask the Board to review some wage
14 loss claims -- there's not a lot -- and determine
15 if those claims are decided in consistent manner
16 and identify to DEEOIC if there are any problems
17 in implementing the procedure manual. I believe
18 the claims examiners will greatly benefit from
19 your advice about the nature of chronic condition
20 and whether symptoms prior to a disease or a
21 diagnosis of a disease would allow a wage loss
22 claim to be accepted.

1 The legislation defines four specific
2 areas which the Board will offer advice to the
3 Secretary of Labor.

4 CHAIR MARKOWITZ: Ms. Barrie, just
5 sorry to interrupt, but we're approaching five
6 minutes.

7 MS. BARRIE: Okay. I'm almost done.
8 I urge DEEOIC to consult with the Board while
9 developing any issues -- or prior to issuing
10 vital circulars, bulletins, or any changes in the
11 procedure manual that will fall within the
12 Board's responsibilities, and I thank you very
13 much for your service.

14 CHAIR MARKOWITZ: Thank you.

15 Deb Jerison?

16 MS. JERISON: Thanks again to Dr.
17 Markowitz and the Board Members for letting me
18 speak, and I really want to thank you all for the
19 wonderful job that you're doing. It's really
20 appreciated. My name is Deb Jerison. I'm the
21 director of the Energy Employees Claimant
22 Assistance Project.

1 Recently, I heard from claimants that
2 claims examiners are sending people to the
3 National Cancer Registry to obtain additional
4 information on their cancers. It appears that
5 rather than one registry, each state has its own,
6 and the type of information available is going to
7 vary from state to state.

8 It's not an easy search for most
9 people to make. I'm wondering if it might be
10 more useful for the claims examiner to search
11 these sites rather than asking the sick workers
12 to do it. Is this something that the medical
13 evidence subcommittee could look into to see if
14 it's a worthwhile option for claimants needing
15 additional medical evidence?

16 I think that finding a way of getting
17 input from the lower level claims examiners is
18 very important. The Board needs to hear from the
19 people actually doing the claims as well as the
20 supervisors. I think that the idea of an
21 anonymous survey to gather this information is a
22 very good one. Another option might be to reach

1 out to former claims examiners to learn from
2 their experiences.

3 And I think it's a good idea of using
4 a coworker model to provide exposure information
5 for facilities without a Site Exposure Matrix. I
6 also wonder if looking into using some of the
7 existing NIOSH Part B technical basis documents
8 and Site Profiles might be useful. Thank you.

9 CHAIR MARKOWITZ: Thank you.

10 Next up is Calin Tebay.

11 MR. TEBAY: Good afternoon. My name
12 is Calin Tebay. I am currently the MSA employee
13 health advocate at Hanford. I am also the
14 sitewide beryllium health advocate at Hanford.
15 I'm here today to discuss or request that the
16 Board review the current DOL criteria --
17 diagnosis criteria for chronic beryllium disease
18 and sensitivity. I have submitted a document to
19 Ms. Rhoads. I don't know if that was distributed
20 or not to everybody.

21 MS. RHOADS: It's up on the website.

22 MR. TEBAY: Okay. Basically, I wanted

1 to -- since we have not much time, I have
2 submitted the clinical guideline for diagnosis of
3 beryllium sensitization and chronic beryllium
4 disease that was developed by Department of Labor
5 and Industries in 2015. This document is the
6 most recent, complete, and accurate document that
7 we have that is aligned with the DOE complex.

8 A couple things you will find in this
9 document that's different from the DOL criteria
10 right now is, one, three borderline test results
11 are an accepted criteria for sensitization.
12 Currently, DOL does not accept that.

13 Two, this draws a distinct line
14 between sarcoidosis and CBD. I also am a
15 beryllium-affected worker. I was diagnosed with
16 sarcoidosis early in 2005 and, through the
17 process, was eventually diagnosed with chronic
18 beryllium disease. And that was a very heavy
19 path to walk, and I kept getting told that there
20 was this fine line. Well, what I found out in
21 that process, that line is not that fine. They
22 are two very distinct, different diseases, and

1 they can be differentiated with the right
2 testing.

3 That said, I'll give some other people
4 some time, but I would hope that the Board would
5 review this document in comparison with the
6 current DOL procedure manual diagnosis criteria.
7 Maybe send that to your medical evidence
8 subcommittee and get some feedback on how we can
9 improve the current diagnosis criteria.

10 CHAIR MARKOWITZ: Okay. Thank you.

11 Next up is Steven Peterson, and after
12 Steven Peterson is Don Slaugh.

13 MR. PETERSON: Dr. Markowitz, members
14 of the Board, thank you for hearing from me
15 today. My name is Steve Peterson. I'm a manager
16 for one of the major contractors here at Hanford.
17 Mine is more an observation. As a person who has
18 gone through the claims process, I'd like to know
19 how or what I could do to get the DOL to work
20 better with other federal agencies.

21 In my particular case, the DOL seems
22 to be maybe perhaps bureaucratic, and it does not

1 work outside its own agencies or coordinate well
2 with other agencies. Trying to get DOL to work
3 with, say, the Inspector General was very
4 difficult. So is there an avenue or a way that
5 claimants can -- not necessarily appeal their
6 claims but get DOL to communicate directly with
7 other federal agencies?

8 For example, I had asked OWCP to work
9 with the Inspector General, and I was -- the
10 answer I was given, well, if the Inspector
11 General sends us a request, we can certainly
12 respond. And when I went to the Inspector
13 General, they say, well, if DOL sends us a
14 request, we can respond. And a lot of letters
15 written in exchange, and I had -- some
16 individuals said, please call this agency and
17 they will then provide you additional
18 documentation. I could not get separate federal
19 agencies to talk to one another, and that seemed
20 to be problematic.

21 My case worker was very sympathetic
22 and very helpful, but I could not get DOL to make

1 a phone call. Even when I provided a name and a
2 phone number, I could not get them to communicate
3 with them. Is there anything that claimants can
4 do in that area? I received nice letters saying,
5 I'm sorry, but we don't function that way.
6 That's not our -- I don't want to say,
7 responsibility -- but, that's not something that
8 we do.

9 CHAIR MARKOWITZ: Just a
10 clarification, we don't actually answer questions
11 or --

12 MR. PETERSON: Yes. I knew that.

13 CHAIR MARKOWITZ: -- engage in
14 discussion, just to let you know, but the comment
15 has certainly been clear.

16 MR. PETERSON: Is there someone that
17 claimants can work with to try to --

18 CHAIR MARKOWITZ: Well --

19 MR. PETERSON: -- encourage that
20 communication?

21 CHAIR MARKOWITZ: -- I would suggest
22 you either speak with Ms. Leiton or speak with

1 Mr. Nelson, the Ombudsman, and have that
2 discussion.

3 MR. PETERSON: Very good. Thank you
4 very much.

5 CHAIR MARKOWITZ: Okay. Thank you.

6 Next is Don Slaugh, and next up after
7 Don Slaugh is D'Lanie Blaze.

8 MR. SLAUGH: Thank you, Mr. Chairman
9 and Board Members. I appreciate your time. My
10 name is Don Slaugh, and I've been a union site
11 rep for 12 years. I've been on site for 27, and
12 I've been nuclear -- or HPT senior health physics
13 technician for about -- going on 35 years, and
14 I've been at other DOE sites.

15 My purpose for this is to bring
16 awareness to when you look at claims and people
17 coming in, it's really difficult. You may have a
18 diagnosis of an injury of beryllium disease or
19 some airways disease type syndrome of very
20 limited data that might support that from a
21 workplace. And I wanted to show three areas of
22 concern that I've been looking at for the last

1 several years.

2 And there's -- so there's three, and
3 the first one is our HEPA filtration systems, and
4 some of these are legacy issues that we have.
5 HEPA filtration systems on our tanks, which are
6 underground, are there to maintain safety for the
7 worker and the public, mainly from particulates
8 and radionuclides, nothing for the gas and
9 vapors.

10 One of our problems we're finding is
11 these filters have been in place for a very, very
12 long time, some greater than 29 years in service
13 life. We just have a current document that shows
14 every filter we have in place right now in
15 service, and they're way overdue for a change.

16 The issues we're finding out there
17 with the filters is -- and I'll just read this.
18 These are some of the filters. Radio filters are
19 found to be saturated with water upon removal and
20 replacement. Water is consistently found in
21 other DSTs which is single-shell farms. Radio
22 filters have similar problems.

1 So when we have this wetting in these
2 filters, they're not HEPA filters. And the
3 concern is particulate matter being re-suspended
4 out and being aerosolized out into our workers'
5 space, which we do not look at that type except
6 for the rate of allowable radionuclides. That's
7 the only thing we look at from a metal
8 standpoint, except for beryllium. There are some
9 others, but specifically unknowns, we look at
10 rad.

11 The next is -- oh, excuse me. One
12 other thing is we do -- in this current document
13 we have, we're trying to maintain our power to
14 ventilation systems at less than 50 -- or 70
15 percent humidity, but we don't have humidity
16 probes in our exhausters. That's one of the
17 recommendations that DOE has actually put in
18 place from the -- Missouri State University did
19 some testing on our finest filters and found that
20 we should put these humidity filters -- or
21 humidity probes in our filters, and I know
22 Savannah River has done that.

1 The next point is excavations in our
2 tank farms. We do a lot of excavations in or
3 around outside. As a health physics technician,
4 what we've found over the years is we go out
5 there and we don't have health physics set up for
6 a job to go out and do that because we plan it as
7 a non-rad job. But then we come across it and
8 find that, guess what, we have contamination, and
9 we've actually purchased some equipment because
10 of those problems.

11 So because of that issue, we actually
12 have our rad planners required to go through what
13 is called QMap. The QMap is designed to identify
14 every pipeline unplanned release site that is on
15 site so that when they go in and excavate, they
16 can be aware of those hazards and take control.

17 The problem is our industrial
18 hygienists aren't even part of that permit.
19 There's an excavation permit, and all it looks at
20 is environment for particulate matter which is
21 for an offsite exposure for particulate matter,
22 not for worker exposure. So we will look at rad

1 only in those cases.

2 I looked here recently at a couple of
3 different excavations we've done on the farms,
4 and they do have gases and vapors. But they're
5 not looking at any of the metal of the
6 contaminated waste that's actually been dumped
7 into the grounds that could be aerosolized or the
8 dermal exposure that could be there because we're
9 wetting down the grounds.

10 If you look at -- there's some data
11 that I provided. History-wise, I did a
12 comprehensive study to find out exactly how much
13 waste came to the tank farms from 2000 -- or
14 excuse me -- 1954 to 2004. And the total amount,
15 if you look at it, it's kind of staggering. We
16 look at -- the tank farms has approximately 56-57
17 million gallons in the tanks, about 200
18 megaliters. And in that summary, it'll actually
19 tell you how much waste was transferred to the
20 tank farms to cribs, ponds, ditches, and it's
21 about 270 billion gallons.

22 So there's a little bit of disparity

1 there with how much was dumped in the grounds,
2 and in comparison of the tanks to the high-level
3 waste, which is about 900 million gallons of
4 high-level waste that was dumped in or around the
5 grounds that are in our tank farms that we may
6 actually dig up.

7 I was going to bring a QMap with me
8 that shows you this map. It identifies -- if you
9 go to the QMap, which is maintained by another
10 contractor, you can actually click on that
11 unplanned release site and it'll tell you what
12 was dropped there, what was put into the ground
13 at that time, and you can get a lot of history.

14 Unfortunately, our industrial
15 hygienists don't have that in their program.
16 They only have four areas they look at. They
17 look at the pipelines of the tanks, the stuff we
18 may buy, like caustics, and put in the tanks, and
19 then other materials that we might do for
20 maintenance. So that's a real concern that I
21 have, and --

22 CHAIR MARKOWITZ: If you could wrap it

1 up.

2 MR. SLAUGH: Okay. The last thing is
3 our chemical vapors. So we have a lot of folks
4 who have come out and helped us. NIOSH, CTH, the
5 STC, and the TVAT have all recommended that we do
6 a -- look at the mixing of chemicals that could
7 be in our airspace and a toxicological study to
8 be able to look at if there's a synergistic
9 effect to these different chemicals and the other
10 possibility of other changes like ions, ozone,
11 chemical inorganics, organics, acid, bases that
12 are in the vapor phase.

13 Some of these things that we're not
14 looking at right now that we would like to look
15 at and continue to look at and hope you'd take
16 those into consideration when you're looking at
17 folks' claims that we do have a lot of things
18 that we're still learning about.

19 CHAIR MARKOWITZ: Okay. Thank you
20 very much.

21 MR. SLAUGH: Thank you very much.

22 CHAIR MARKOWITZ: Thank you.

1 Next is D'Lance Blaze. If I have
2 mispronounced your name, forgive me. D'Lanie?
3 D'Lanie.

4 MS. BLAZE: Hi, guys. I'm D'Lanie
5 Blaze of CORE Advocacy for Nuclear and Aerospace
6 Workers. CORE assists EEOICPA claimants and
7 workers at the Santa Susana Field Laboratory and
8 its associated sites. Thank you for the
9 opportunity to provide public comment.

10 Coal gasification has been established
11 to be a Department of Energy process at various
12 Rockwell International sites, including Hanford,
13 Rocky Flats, and Area IV of Santa Susana. The
14 Site Exposure Matrix, or the SEM, provides an
15 incomplete list of toxic substances associated
16 with coal gasification processes at Santa Susana.
17 Only carbon and coal ash are listed.

18 As early as 1978, NIOSH issued
19 recommendations for safety standards that were
20 based on worker exposures associated with every
21 aspect of the coal gasification process and
22 including the potential for exposure to a number

1 of chemical compounds that can increase the risk
2 of cancer and other illnesses. More recent
3 studies link the process to skin cancer and
4 hearing loss and raises questions about
5 radionuclide and silica exposure as coal
6 gasification workers frequently present with
7 serious lung conditions and radiogenic cancers.

8 In addition, it appears some of
9 Department of Energy's coal gasification
10 facilities at Santa Susana were removed from the
11 SEM entirely when it was discovered that they
12 existed in Area I at a location known as the
13 Bowl. Currently, only Area IV of Santa Susana is
14 considered to be a covered facility under
15 EEOICPA.

16 It is troubling that the discovery of
17 Department of Energy operations, processes, and
18 facilities in Area I, which necessitated the
19 Bowl's removal from the SEM, did not prompt a
20 thorough review of DOE's contractual agreements
21 at Santa Susana. CORE Advocacy has obtained
22 copies of those contracts under the Freedom of

1 Information Act, FOIA.

2 The contracts document Department of
3 Energy in Rockwell International's construction,
4 integration, modification, operation, and
5 remediation of DOE coal gasification process
6 development units, or PDUs, located at the Bowl
7 in Area I. Other documentation issued by DOE and
8 its contractors specify that the Bowl was located
9 on DOE auctioned land, had been allocated in its
10 entirety to serve DOE's Energy Technology
11 Engineering Center, known as ETEC, and that the
12 Bowl PDUs were contractually defined to be
13 government-owned property and remained so even
14 after the contract's conclusion.

15 In 2008, Sanford Cohen and Associates,
16 SC&A, issued their review of the NIOSH Site
17 Profile for Santa Susana. SC&A stated, quote,
18 the Department of Energy had operations and
19 facilities in Area I as well as Area IV of Santa
20 Susana. However, no consideration has been given
21 to potential exposure in Area I of Santa Susana
22 Field Laboratory such as potential exposures for

1 the coal gasification process, end quote.

2 The Area I facilities of the Bowl
3 appear to be among more than an additional 50
4 Department of Energy facilities that were
5 summarily excluded from the Santa Susana Site
6 Profile, the majority of which were located in
7 Area IV and considered to be among the primary
8 sources of site radioactivity.

9 The result has been a dramatically
10 downplayed perception of DOE operations and
11 worker exposures of the site which has hampered
12 EEOICPA eligibility, the dose reconstruction
13 process, claims under Part E, and the accuracy
14 and completeness of the SEM. Currently, DOE coal
15 gasification workers of Area I at the Bowl are
16 just summarily disqualified from EEOICPA.

17 I realize that it is not within the
18 Board's charter to classify a DOE facility under
19 the Act, but in an interesting paradox, the SEM's
20 accuracy and completeness is considered to be
21 among the Board's top priorities. And the SEM
22 cannot be accurate or complete when Department of

1 Energy facilities are left out of EEOICPA or when
2 DOE operations, processes, hazardous materials,
3 and all corresponding data are not acknowledged.

4 I respectfully request the opportunity
5 to submit information on coal gasification and
6 worker exposures at Santa Susana which apply to
7 both Area I and Area IV workers. This
8 information may assist the Board in ensuring that
9 the SEM is accurate and complete.

10 Currently, Department of Labor and
11 Energy are reviewing CORE Advocacy's report on
12 DOE operations at the Bowl in Area I, and I'd
13 like to submit a copy of that report to you as
14 well. In addition, I believe coal gasification
15 workers squarely meet the VGDF exposure criteria
16 outlined in our meeting earlier today, and I
17 request their consideration as the Board focuses
18 on OHQ recommendations.

19 Thank you for the opportunity to
20 provide public comment on behalf of Santa Susana
21 employees and EEOICPA claimants.

22 CHAIR MARKOWITZ: Thank you very much.

1 MS. BLAZE: Thanks.

2 CHAIR MARKOWITZ: Next is Elnora Bing
3 and then after Ms. Bing is Stephanie Carroll.

4 MS. BING: Hello. My name is Elnora
5 S. Bing. I would like to thank the Board, and I
6 would like to thank Ms. Stephanie Carroll for
7 giving me this opportunity to come before the
8 Board and let you know what I did at the Savannah
9 River Site and also my claim.

10 I worked at the site for 33 and a half
11 years. I was employed in 1972, and I had to
12 leave because of illness in 2005. I was
13 diagnosed with sarcoidosis, and I had previously
14 worked as a lab technician for approximately
15 seven to ten years handling liquid waste -- and
16 that was '72 -- Pu, Eu, neptunium, you name it,
17 cesium. I also, after that, left that lab, and I
18 went to a metallurgical laboratory, and we
19 handled different metals.

20 I have been affected by the
21 sarcoidosis I have over my lungs. And they say
22 it's sarcoidosis, but all of that I have been

1 around, I'm not sure about that. I filed a claim
2 for CBD Part B sarcoidosis, 2010. I received an
3 acceptance letter. When I received the
4 acceptance letter, I called a DOE rep because I
5 needed to know for the instructions -- DOL,
6 excuse me.

7 I wanted further instructions, and the
8 DOL rep told me I'd be receiving a health card in
9 the mail. And then I felt kind of comfortable
10 with him, and I began to tell him some of the
11 things that I encountered at the site and what I
12 had worked with, the conditions, statistics of
13 the deaths and illnesses that were in my
14 building. People right next to me have died.

15 And he listened, but there was a
16 change in his tone. And he told me that -- he
17 said, well, maybe you will be eligible for
18 another part. Why don't you withdraw your Part
19 B? And I felt kind of comfortable at this point
20 because I was talking to him. He should be
21 knowing what he was telling me was true. He was
22 trying to help me, I thought.

1 And so -- but I did notice something
2 when I began to tell him about all the sicknesses
3 and all the things that were going on, but he
4 encouraged me. He said, withdraw it because
5 there's compensation under another part. And, of
6 course, I know I deserved it, so I withdrew my
7 acceptance letter.

8 February 2nd was when I received my
9 acceptance letter. February 8th was when I
10 withdrew it and sent it in according to his
11 instructions because he told me that there would
12 be monetary value. And I knew it should be, but
13 I didn't know how to go about it.

14 The little bit I know, when I sent it
15 under Part E, refiled again, I came back flatly
16 denied. I was crushed. I couldn't believe it.
17 I didn't understand what was going on. I tried
18 to call the DOE rep. Time after time, they told
19 me that he was out of his office, he could no
20 longer help me, and he was very callous. He
21 didn't really want to talk to me anymore.

22 And when I filed -- and I want to read

1 you my comment because I have been struggling for
2 the last seven years to get my voice heard, and
3 I'm finally getting it heard -- I was flatly
4 denied for sarcoidosis, CBD under Part B about
5 where for what I had just received an acceptance
6 letter for. I filed a hearing for COPD and was
7 denied over and over.

8 I finally realized I was tricked into
9 giving up my claim worth \$150,000. I have since
10 refiled with the help of my advocate, Mrs.
11 Stephanie Carroll. My claim was under -- is
12 under reconsideration now. She ordered a copy of
13 my file, which I never was told I could do in the
14 whole seven years I have spent fighting on my
15 own. They never told me they had medical record
16 evidence on file from Savannah River Plant. They
17 just kept insisting that I provide the evidence,
18 and I did over and over.

19 My advocate has, at this point, some
20 evidence they had the whole time, which is chest
21 x-rays, the report showing profusion three or two
22 from a company doctor, pulmonary chest diagnosed

1 the restrictions as severe diffusing lung
2 capacity defect, PFT results as low as FVC and
3 FEV1 at 50 percent predicted -- excuse me -- 57
4 percent predicted and boxes showing blood in my
5 lungs.

6 I was told to get a beryllium test
7 without regard to the extent of medical evidence
8 on file documenting about the 15 years of
9 prednisone that I had to take because of my
10 condition --

11 CHAIR MARKOWITZ: Ms. Bing.

12 MS. BING: -- which would affect the
13 accuracy --

14 CHAIR MARKOWITZ: Ms. Bing.

15 MS. BING: -- of the test. And then
16 I was not even told about the test until after my
17 claims were denied. My doctor wrote a report
18 saying that the diagnosis with sarcoidosis was
19 not medically appropriate with a long-term
20 beryllium exposure. They lost the report, and I
21 had to resend it multiple times. It was on file
22 the whole time.

1 I think they were using the doctors to
2 try to deny my lung disease. Why did they ignore
3 my doctor's report, I cannot understand. Why did
4 they ignore my work conditions that I told them
5 about what I did over and over, I don't
6 understand.

7 CHAIR MARKOWITZ: Ms. Bing. Ms. Bing.

8 MS. BING: Why did no one at the
9 Department of Labor help me understand the
10 process to be approved? No one helped me to be -
11 - helped me. They just told me -- that DOL rep
12 told me that. He really shouldn't have told me
13 anything if he knew I was going to be denied,
14 denied, denied. I don't understand that.

15 CHAIR MARKOWITZ: Mrs. Bing. Mrs.
16 Bing.

17 MS. BING: These reports should have
18 triggered a response from at least one of three
19 reports done by their doctors that I may have
20 pneumococcus. I know that beryllium or the other
21 metals -- like Eu, Pu, and aluminum -- had to
22 have contributed to my illness because that's

1 what I did. I ground samples as a metallurgical
2 laboratory technician. For the last seven to
3 eight years, that's what I did.

4 CHAIR MARKOWITZ: Mrs. Bing.

5 MS. BING: I cut rich uranium. I cut
6 depleted uranium. I cut beryllium. We cut all
7 of the metals that came from across the site. I
8 had two hearings that let people know what type
9 of work I did as a metallurgical laboratory
10 technician and a lab supervisor. And when I
11 became a lab supervisor, I was in the same
12 environment doing the same work.

13 CHAIR MARKOWITZ: Mrs. Bing.

14 MS. BING: I think they ignored my
15 testimony that I was still exposed to the same
16 toxins as a technician.

17 CHAIR MARKOWITZ: Mrs. Bing.

18 MS. BING: They wanted me to send them
19 a list of my exposures. How was I supposed to be
20 able to do this?

21 CHAIR MARKOWITZ: Mrs. Bing, thank you
22 very much for your comments.

1 Next is Stephanie Carroll.

2 MS. CARROLL: My name is Stephanie
3 Carroll. Thank you for allowing me to submit
4 public comments today, and I thank you for the
5 excellent work that you're doing. This is the
6 best use of my time ever in this program is to be
7 at these meetings. They're very good.

8 I am a professional authorized rep
9 specializing in claims for occupational lung
10 disease. In the process of helping workers
11 circumvent the complexities of this program, I've
12 discovered serious problems with the
13 administration of the program.

14 I know that you are as concerned as I
15 am, that these issues be addressed in a
16 meaningful and efficient manner, and that the
17 EEOICPA achieve the mission that Congress
18 intended. Oftentimes, the program sees the
19 complaints of the ARs as a sign of our
20 frustration in being denied claims, which is
21 understandable. But my complaints are based on
22 the concern that, without an AR, claimants are

1 being misled and denied claims that are viable
2 under the program requirements.

3 The bureaucratic culture within the
4 program is overly hostile to claimants. I don't
5 want to paint everyone who works for the EEOICPA
6 with a broad stroke because there are some very
7 dedicated employees trying to do the right thing.
8 I do see a program where CEs are very
9 demoralized, inadequately trained, and not
10 rewarded for going the extra mile to approve
11 claims. First and foremost, they are evaluated
12 by the timeliness in which they complete the
13 adjudication of claims and not by the quality of
14 their work, which may be more difficult to
15 measure.

16 I have established CBD under the Act
17 for every ruling sensitized worker I've
18 encountered. I've experienced establishing CBD
19 under Part B for all claimants that were tested,
20 treated, or diagnosed with a chronic respiratory
21 disorder prior to 1993. The policy and the PM
22 have inexplicably changed. Now, pre-93 claims

1 must document, quote, prolonged long-term -- they
2 have to do that twice -- treatment for chronic
3 respiratory disorder prior to 1993, unquote, from
4 the procedure manual to qualify for further
5 adjudication of the claim under pre-1993
6 established chronic beryllium disease.

7 The law actually describes chronic
8 beryllium disease as a beryllium illness, and the
9 beryllium illness is established chronic
10 beryllium disease. And you will not see capital
11 letters on the CBD portion of it because it is a
12 statutory illness, and it's not chronic beryllium
13 disease under the modern diagnostic criteria that
14 we experience now. So it's important to pay
15 attention to those capitals. The removal or
16 addition of just two words from the procedure
17 manual or the training material can affect claims
18 adjudication profoundly.

19 I've reviewed the training slides
20 submitted to the Weighing of Medical Evidence
21 committee -- subcommittee. I was disappointed to
22 learn that the committee will not be reviewing

1 the weighing of evidence for Part B, CBD, or
2 sarcoidosis. There is a great need for review of
3 the medical evidence as it relates to application
4 of the law. I am pleased that the committee on
5 lung disease will be addressing these issues.

6 In the training materials that I did
7 review, Slide 20, pre-1993 criteria, there is a
8 list of statutory criteria without access to the
9 underlying slides that were provided. So I would
10 like you to ask for the slides that once you
11 click on each criteria, you kind of get to see
12 details of what they expect to meet each
13 criteria, and that wasn't included in your
14 training that was provided to you from DOL.

15 A note at the bottom of the slide says
16 that at least one of the documents must show that
17 the claimant received treatment for a chronic
18 respiratory condition prior to 1993, which
19 contradicts the procedure manual and it confuses
20 the situation. So CEs are being trained with the
21 slides in a way that doesn't match the procedure
22 manual, and the procedure manual was changed with

1 just, I don't know. Just, all of a sudden, they
2 got rid of some words in the criteria to
3 establish pre-93.

4 This PM policy has been added without
5 any explanation and changes the way the pre-93
6 cases have been adjudicated for at least 15
7 years. There are final decisions documenting
8 approval of a pre-93 CBD claim based on the date
9 that a claimant was tested, treated, or diagnosed
10 with a chronic respiratory disorder, not treated
11 long term and prolonged long-term treatment of a
12 chronic respiratory disorder. So that has
13 completely changed. I don't know what's going to
14 happen with pre-93.

15 The new policy is inconsistent and
16 unfair. It affects the outcome of workers'
17 claims based on when their claims were
18 adjudicated by the program. This policy was
19 established without explanation.

20 Slide 21, post-93, again, the criteria
21 does not include the underlying slides. Please
22 ask. See that the reference to CBD, all in

1 capitals, which insinuates that a physician must
2 determine if the abnormalities are consistent
3 with modern-day chronic beryllium disease. The
4 loss specifically describes the illness as
5 established CBD. The PM lists medical findings
6 that the program has long determined to be
7 consistent with established CBD. Like BES, the
8 program specifically lays out the legal
9 definition of covered beryllium illness.

10 The only reason that a DMC should ever
11 be used for chronic beryllium disease is to
12 determine if the PFTs are showing obstruction,
13 not, is that obstruction consistent with CBD? A
14 physician cannot make that determination because
15 they're making a medical determination. They do
16 it all the time. They say, this person doesn't
17 have CBD. But when they sign the DMC report, it
18 actually reads that they're making their opinion
19 based on their known -- the known qualifications
20 of the program. So they're supposed to be
21 reviewing based on the program requirements, not
22 medical, but they never do that. And they get

1 paid about \$2,000 to do that report.

2 CHAIR MARKOWITZ: Ms. Carroll, if you
3 could start to wrap it up.

4 MS. CARROLL: Okay.

5 CHAIR MARKOWITZ: Thank you.

6 MS. CARROLL: Okay. CBD under Part E
7 has added requirements for approval demanded by
8 the program but not required by law which is
9 unfair and inconsistent, with prior probative
10 final decisions. The PM demands abnormal BeLPTs
11 for Part E, but the training slides do not
12 include that. I don't know why.

13 And telephone conference calls, I
14 have a copy of one of the calls that I have
15 submitted that actually discusses -- first of
16 all, there's no PII in there. It discusses the
17 fact that they will use policy call notes for
18 final decisions, recommended decisions, and
19 development. If the CE quotes that in the final
20 decision, they are to turn that telephone
21 conference policy call over to the claimant.

22 They admit in this policy call that it

1 is policy, and I would urge you to take a look at
2 my submission of the policy call so that you can
3 push hard to get a copy of those telephone
4 conference calls because that is policy, and it's
5 not fair that authorized reps or any of us can't
6 look at the program and determine if there's
7 consistencies or not. And I think that is the
8 key, get those telephone conference calls.

9 Thank you very much for listening --

10 CHAIR MARKOWITZ: Thank you.

11 MS. CARROLL: -- and I appreciate all
12 your work.

13 CHAIR MARKOWITZ: Okay. Thank you.

14 Next is Shirley Kennedy and then after
15 Ms. Kennedy will be Tee Lea Ong. Shirley
16 Kennedy, is she on the phone? No? Oh, okay.

17 MS. KENNEDY: I'd like to thank all
18 the Board, and this is the first time that I've
19 been here. My questions are, in the SEM,
20 specifically, why do they not list any
21 radionuclides? And the radionuclides that I have
22 concerns with personally are plutonium-238,

1 plutonium-239, plutonium-240, americium-241.

2 I was exposed in 2007 of these
3 radionuclides, and I don't know if there was
4 because they only checked for these three. I
5 have COPD, thyroid in my lungs. And the man I
6 replaced doing the borehole job is Mark Anthony,
7 and he died in 2015 of cancer of the esophagus
8 and the stomach. I've had zoledronic acid IV on
9 January 27th because my spine is in the position
10 where my doctor thinks it will collapse just by
11 my weight, so I'm trying to keep my weight off,
12 and I've been denied.

13 The data that they gave me when they
14 did the diagnosis was wrong. I want each and
15 every person that's had an exposure to be able to
16 get their raw data. I cannot get that raw data,
17 and I want to know why. What words do I have to
18 put in a letter? Who do I have to talk to, to
19 get the 10 CFR 1910.1020? It says that I have
20 that right. Can anyone tell me how I get that
21 raw data?

22 CHAIR MARKOWITZ: Knowing -- I don't

1 think anybody on the Board can, but depending on
2 -- you're talking about the radiation data?

3 MS. KENNEDY: Yes. When -- my
4 bioassays, and I have five of them.

5 CHAIR MARKOWITZ: You know, I think
6 maybe the Ombudsman's office would be the best.
7 Mr. Nelson or Mr. Levin might be able to help you
8 there, in the second row behind you.

9 MS. KENNEDY: Okay. And I just
10 encourage everybody to check because my birth
11 date was ten years off. The time that they said
12 I was exposed was two hours prior to the time the
13 job started. Thank you.

14 CHAIR MARKOWITZ: Thank you very much.
15 Next is Tee Lea Ong and then after is
16 Jill Allen.

17 MR. ONG: Hi. My name is Tee Lea Ong
18 with Professional Case Management. Thank you,
19 Chairman Markowitz, and the Board for allowing me
20 to comment.

21 I have brief, two interrelated
22 comments and, number one, of which is that the

1 speed by which the recommendation -- really good
2 ones from this Board -- is being implemented by
3 the Department of Labor. And second one that's
4 related to that and it depends on the Board's
5 consideration of what you could do about it is,
6 how much time does the Board still have before
7 its sun sets, and how much work can be done in
8 terms of implementing the recommendations?

9 So with that said, the two comments.
10 The first one of which is that the speed by which
11 the recommendation has been implemented. From
12 today's comments or conversation, it seems --
13 and, also, I've been following the publications
14 that the Board has put out. A lot of
15 tremendously good work has been done, so I
16 applaud you for that. And from -- based on
17 today's conversation, I also heard that the
18 Department of Labor has done a good job
19 supporting with the data and so on, so thank you
20 for that.

21 However, the question is that, from
22 what I could tell, there's only been one of the

1 recommendations from the Board, a substantive
2 one, that has been implemented since the sitting
3 of the Board, almost exactly a year ago in
4 Washington, D.C. It's about a week off, but
5 nonetheless. And the seating of the Board itself
6 has been delayed substantially, as most of you
7 know.

8 So on the current course and speed,
9 the question I have is that, what do you think
10 would be some possible alternatives to making
11 sure that all the hard work that's been put in,
12 as well as the hard work that's coming up, is
13 being implemented rigorously at the same pace
14 that the Board has been working? So the comment,
15 slash, question is, is there room to revisit how
16 the implementation of these recommendations are
17 conducted? Meaning that, is one of the
18 recommendations from the Board a change of how
19 these recommendations need to be adopted and
20 reviewed and implemented and, if not, reasons
21 offered as to why not? Or perhaps there's an
22 alternative body that the Board has to report out

1 to, to make further suggestions of how to
2 implement the recommendations.

3 Now, onto part two of my comment,
4 which is the time remaining for the Board to
5 continue to work and implement -- or recommend
6 implementation. With what we've seen, if the
7 current pace is one per roughly 12 months or so,
8 my question is, does that imply that we should
9 expect perhaps two to three more to be
10 implemented by the time the Board sunsets? And
11 if so, what is the -- what does the Board intuit
12 as the best way to prioritize the recommendations
13 so that the most impactful and claimant-friendly
14 topics are broached and the recommendation made
15 in order to make sure that the most relevant
16 topics are focused on and implemented?

17 That's all the comment I have. Thank
18 you.

19 CHAIR MARKOWITZ: Thank you.

20 Next is Jill Allen. No? Okay. We'll
21 move on while we're checking the phone.

22 Jerry Ferson is next. And I should

1 say -- actually, while he's getting settled in --
2 that the next will be Bertolla Bugarin.

3 MR. FERSON: My name is Jerry Ferson.
4 I used to be very active out in the area. I was
5 one of the main safety reps and chairperson for
6 the tank farms. I am the one that built the
7 sampling truck to characterize all the tanks and
8 a number of filtration. I worked at a research
9 lab for a number of years prior to going to the
10 tank farms.

11 Tank farms though, I got exposed to a
12 lot of mercury. And the -- in 2007, I believe it
13 was, S102 tank, there was a spill. A hose broke
14 and there was a lot of people that were
15 consequently injured as far as mainly to
16 respirate their lungs and different things. One
17 of them who was working with me, he's over here.

18 But anyway, my B2 microglobulin went
19 up to 1,500. It's not supposed to be over 195.
20 It does damage to the liver and the kidneys and
21 because of the damage there, it also causes a lot
22 of brain damage, nerve damage, whatever. I have

1 about seven or eight known or documented
2 conditions. I have 89 percent disability. I was
3 in a wheelchair for a number of years. I'm
4 fighting it and because of the good Lord -- I am
5 also a minister, by the way -- I'm retired.

6 I can't function. Like, my mind, I
7 can't keep it going right. And, anyway, I need
8 help. I'm disabled. My wife is disabled. We
9 take care of my mother-in-law. She is 91. She's
10 disabled. I used to have nursing 24/7 and
11 because of our case worker put in some paperwork
12 that DOL did not like, they dropped all my
13 nursing.

14 We have been trying to get nursing
15 back. We have tried and tried and tried. And,
16 finally, the gentleman, real nice and politely,
17 told my wife to forget it, quit bothering him,
18 says, when he goes on a breathing tube, you can
19 give me a call then. She said, well, we're not
20 going to call you because he has already stated
21 he will never go on a breathing tube.

22 There's a lot of people out here that

1 are workers that I worked with that are trying to
2 get help, and there is no one, really, I'm going
3 to say. You can't say, well, you need to go see
4 this doctor or that doctor, because that's
5 showing favoritism, and I know we need help. We
6 need some guideline of where to go.

7 I went out and I looked for doctors,
8 one after another. And when I would tell them
9 who the insurance was going to be paid by, DOL,
10 they would drop me, one after another. When I
11 found the doctor, even in the big universities
12 and et cetera, I would ask the question, do you
13 know anything about chemicals, and they would
14 say, no.

15 And so for people that are starting
16 out, I try to help a lot and try to direct them.
17 But I don't have, I'm going to say, good enough
18 answers to direct them because I don't know good,
19 you could say, doctors or resources they can go
20 to that is trustworthy.

21 I won't say who he was, but I went to
22 one of them at a university, and I told him, I

1 said, you can't tell me that I've been exposed to
2 mercury. Oh, yes, I can. He says, if you have
3 this, this, this, this, or this, five things. He
4 says, if you have three of them, I can definitely
5 say you've been chemically exposed. I had four
6 of them, and you know what he said? Yes, but I
7 can't tell where you got it from. I have the
8 physical -- my physical records of the exposures
9 that I had. I had all the paperwork, but I'm
10 going to put it this way. He's in cahoots with
11 DOL.

12 CHAIR MARKOWITZ: Mr. Ferson, you need
13 to wrap it up, if you would.

14 MR. FERSON: Okay. But the people --
15 you can't imagine how many people are out there
16 that are needing help, and we need something or
17 some way of getting help and directing people.
18 Thank you.

19 CHAIR MARKOWITZ: Thank you. Thank
20 you very much.

21 Next is Bertolla Bugarin.

22 MS. BUGARIN: I'll pass. My concerns

1 were addressed.

2 CHAIR MARKOWITZ: Okay. Thank you.

3 Jill Allen, did we identify whether
4 Jill Allen is on the phone? No? Okay. Next is
5 Tom Moore.

6 MR. MOORE: I've been impressed in
7 hearing what your Board is doing, and I thank you
8 for your work. My name is Tom Moore. I am a
9 former Hanford worker.

10 The comment -- the primary comment I
11 want to make has to do with consistency. In
12 2010, I was -- excuse me -- I was diagnosed with
13 prostate cancer. I was advised to go ahead and
14 make a claim on that, so I made the claim. And
15 in 2012, then I got a letter from the final
16 adjudication branch who basically summarized the
17 dose reconstruction report that they had
18 received, and, in it, they found that I was 40.66
19 percent Probability of Causation. I accepted
20 that. I mean, these are the experts.

21 So I went on. About four years later,
22 then I was diagnosed with MDS, and I'm not sure

1 whether I can say that properly but
2 myelodysplastic syndrome is close I can say it.
3 I processed that. I was accepting. I guess
4 that's on the SEC list. Then about a year later,
5 I was diagnosed with COPD. At the same time we
6 made the claim for that, I made -- I was advised
7 to resubmit the prostate cancer because
8 additional cancers supposedly increase the
9 chances of being approved for claims.

10 When I got the dose reconstruction for
11 the second time, it was interesting to me that
12 every one of the previous dose estimates or the
13 dose findings they found decreased significantly,
14 one by a factor of 32. It was 32 times less than
15 the previous one, and the only explanation was it
16 had been grossly overestimated, and they used
17 more current things.

18 The interesting thing about it also is
19 that, in both of the documents, they, numerous
20 times, talk about being claimant favorable, and
21 that seems to be something that's mentioned quite
22 often is they try to be claimant favorable. And,

1 yet, dose reconstruction, I'm not an expert in
2 it, but that's not something brand new. It's not
3 as if in the last few years, this -- in my
4 opinion, that we're all of a sudden doing things
5 we've never done before, so how can we get a
6 factor of 32 less for that?

7 So I think that this is an example of
8 some inconsistencies. I've been very pleased to
9 hear you folks talking about that.

10 One other comment I had with respect
11 to almost all of the things you've discussed
12 today had job titles being a significant factor
13 in the presumptions and so forth. I spent four
14 or five years as a machinist to start with and
15 then I went into engineering. I spent the last
16 19 years as an engineer, retired as an
17 engineering manager. I can tell you that none of
18 these documents that you displayed today included
19 engineers.

20 Our engineers in the groups that I was
21 a part of were in the field, I would say, almost
22 daily, some of us more than others, exposed to

1 the same things as other folks. So I fully
2 support your concern that there are people out
3 there that when you look at these documents,
4 they're really not included. And I think that
5 plays a disproportionately strong influence on
6 how claims are adjudicated based on what your job
7 title was. Job titles don't tell you everything
8 you need to know about what your exposures are.

9 I thank you very much.

10 CHAIR MARKOWITZ: Thank you.

11 MR. MOORE: I think you're doing a
12 great job.

13 CHAIR MARKOWITZ: Thank you.

14 Next is Richard Bloom and then after
15 Richard Bloom will be Diane Leist.

16 MR. BLOOM: I made notes, so I want to
17 thank the Board. As an elected official, I serve
18 on a lot of Boards, so I don't want to take much
19 of your time. As -- my comment parallels what
20 was there. I've worked at Hanford since 1980. I
21 took six years off, worked at Rocky Flats for six
22 years tearing down -- tearing out buildings.

1 I have personally been in 85 percent
2 of every building on the site over the course of
3 my years. I've been an engineer, I've been in
4 environmental, but I can tell you, the planner --
5 when I walked in, in 1980, the planner of the day
6 was the engineer, the engineering aide, the
7 operator, or the maintenance person who went out
8 there to figure out what was wrong and write down
9 what had to be fixed and investigate it and write
10 up what had to be done. So in your asbestos
11 considerations today, when you say maintenance
12 worker, you're leaving out, really, the ones that
13 got the firsthand look at it and were peeking.

14 Currently, I am assisting -- I've
15 retired, but I've been talked back a couple of
16 times. I'm assisting with the demolition of PFP,
17 and I'm intimate in the asbestos investigation to
18 prepare it for demolition. What we are finding
19 in that building that was built just before I was
20 born is very unique applications with asbestos
21 that people would never have known.

22 Asbestos in sheetrock; that sheetrock

1 had asbestos coating, but the one that looks just
2 like it didn't. I mean, it's really weird stuff
3 that we're finding: the extensive use of asbestos
4 in mastics, mastics in places we never expected
5 to find them.

6 So I do suggest that if you do get
7 around to defining what maintenance workers are,
8 maintenance workers are a lot broader than people
9 with tools and hammers. They include the RCTs,
10 the RadCon that went out there with them.

11 Secondly, what you've not included --
12 and it was alluded to for ships built before X
13 whatever -- people that worked in buildings built
14 prior to 1970 could potentially have had asbestos
15 falling on their desk. I have seen it in person.

16 We had old labs that were converted to
17 office buildings all over the 300 area and the
18 200 area. I remember going out and visiting an
19 engineering manager out at 225B -- if I remember
20 the building number correct -- and, oh, we can't
21 go in this area. The asbestos lagging fell off.
22 They'll get to it. That was 1992. So I think a

1 broader category to include workers, being
2 administrative, you know, clerks.

3 Also, I am beryllium sensitized, so in
4 my 30 years, I've done no work. I'm a pencil
5 pusher, right? I've been through all these
6 buildings. I've been exposed to all the stuff.
7 But what we've found with beryllium, one of the
8 groups that we -- in the early days, that we
9 found that was high in exposure to beryllium were
10 firefighters because they went out and sprayed
11 the heads to check to make sure they were
12 working. When they sprayed it, what came down,
13 the beryllium. So the firefighters also spent a
14 lot of time in these buildings.

15 So when you look at these and you hear
16 the concerns of people applying for this and
17 trying to prove they were exposed, when you build
18 these cohorts, be very careful of how you
19 segregate it and how you explain what a
20 maintenance worker is. And then the other thing
21 I would suggest, a cohort for those that were
22 assigned to those buildings. There are records

1 out there, phone directories which list what
2 buildings everybody was in every year since I was
3 there in 1980. I know they go back to then and
4 they go back further.

5 So there are records of who was
6 assigned to what buildings over the years, and I
7 appreciate if you would consider them because
8 your job is to help the claims processors and
9 reduce the frustration for those that have to
10 apply for the claims. And I appreciate your time
11 and effort. I understand what you've put
12 yourself and volunteered for because I do that
13 myself.

14 CHAIR MARKOWITZ: Thank you.

15 MR. BLOOM: Bye.

16 CHAIR MARKOWITZ: Next is Donna Hand.
17 I think Ms. Hand is on the phone.

18 MS. HAND: Hello?

19 CHAIR MARKOWITZ: Yes. We're here.
20 We can hear you.

21 MS. HAND: Okay. I know it's getting
22 long and it's getting late. I just want to

1 remind the Board, thank you very much for some of
2 your recommendations because now the SEM has
3 listed as a reference the NIOSH pocket chemical
4 guide. And so they list the loss of injury entry
5 now that we can use.

6 However, the SEM says, only diseases
7 covered by Part E are displayed in SEM. Well,
8 doesn't that cover all the diseases? How come
9 the target organs that are defined in the NIOSH
10 pocket chemical guide not also displayed in SEM
11 because they've been all peer reviewed as well as
12 the OSHA? OSHA regulations on chemicals also has
13 been peer reviewed and has set the court criteria
14 before they could even say, okay, you have to
15 have regulations on these.

16 The other issue is that you're in a
17 prime place to where some of the wording that the
18 Department of Labor uses is implied to be higher
19 than what it is such as significance. They never
20 defined it in their policy procedure manuals.
21 They just underline it and says, it's got to be
22 significant.

1 However, the regulations did define it
2 and they defined it in 2006 that significant will
3 be any factor. They also defined that the toxic
4 substance only has to have the potential. It
5 doesn't have to definitively do anything. Does
6 it have the potential because of its radiological
7 nature, its chemical nature, or its biological
8 nature?

9 Level of exposure is never to be
10 addressed nor was it required. That's a moot
11 issue because the thing is, is that OWCP has
12 stated in the regulations, you will consider.
13 It's not mandated, but you must consider the
14 nature, the frequency, and the duration or the
15 nature of a toxic substance or the nature of the
16 job task. Either one, that's what you should
17 consider; the frequency of the exposure to the
18 chemical or toxic substance or the frequency of
19 the job task; the duration of the exposure to the
20 chemical or the duration of the job task.

21 That's it. That's what then should be
22 considered, and that's what they'll actually --

1 that's in the regulations. So that's -- a big
2 presumption then is that if you meet those
3 criteria, that should be it.

4 I'd like to kind of paraphrase
5 something that was done on December of 2009 to a
6 case examiner from their own district medical
7 consultant. And it said, regarding possible
8 exposure, what is significant medically is judged
9 by a number of factors as potential for exposure,
10 administrative controls to minimize it, or any
11 PPE. It is the biological effects of significant
12 exposure and not exposure alone that is
13 significant.

14 So a puncture wound to the lung do not
15 equate to exposure to toxins or radiation. And
16 if that's the philosophy and the train of thought
17 or the peace of mind that their own DMC were
18 using and are still using, it requires a
19 definitive no. Again, you're applying causation.
20 No. Aggravating and contributing to.

21 So within these parameters of the
22 actual law, which is binding, that's what the

1 policy should be also implementing. And if the
2 words aren't defined, then let's define them
3 instead of everybody having subjective opinions
4 such as an upper respiratory infection. It's not
5 a chronic respiratory disorder. But according to
6 the World Health Organization, it would fit that
7 definition.

8 So, thank you, again, for your time,
9 and I really appreciate all that you guys are
10 doing. Thank you.

11 CHAIR MARKOWITZ: Thank you, Ms. Hand.

12 Is Diane Leist -- she was supposed to
13 be available.

14 MS. LEIST: I'm here.

15 CHAIR MARKOWITZ: Oh, okay. Sure.

16 You can come on up and then we're going to go to
17 the phone to Ms. Vina Colley.

18 MS. LEIST: So I didn't have time to
19 really prepare too much because I had more
20 questions, but, in 2015, I was diagnosed with
21 breast cancer. Fortunately, it was something
22 that responded well to treatment.

1 But I had worked out at Hanford
2 beginning in 1985 when we hired lots of young
3 people as a chemical technologist, or a lab tech,
4 and had worked in a number of the processing
5 facilities. When I wasn't a lab tech, I was also
6 working as an engineering tech additionally, so
7 all around the Hanford site.

8 And I did go ahead and apply, although
9 my dose reconstruction certainly had me well
10 below dose limits. And in the discussions and
11 subsequent six months' time when we spoke with
12 Department of Labor, it was pointed out the SEM.
13 It was, like, hey, that is a pretty useful
14 database, or at least it's certainly a database
15 with a lot of information.

16 But there could be more in that
17 database because when I asked to be considered
18 for, oh, you know, perhaps, you know, some
19 chemical exposure during those analyses that we
20 run or the inventories we did or working in the
21 field might have affected that.

22 And when you looked in the SEM, it's

1 great. It does have listed your occupations and
2 areas you worked, so you can use that to sort on.
3 But if you just look for breast cancer, it'll
4 show that there are none of those many, many
5 chemicals used at Hanford have not caused breast
6 cancer.

7 And I look at that and think, I'm not
8 entirely sure. I mean, the information I was
9 sent said, well, you can keep looking and see if
10 something comes up, and your claim will still be
11 there. But I look at some of the things that we
12 worked with routinely. Not exposed to it in any
13 sort of accident because that seems to be one of
14 the things that kept coming up. There were no
15 incidents or no accidents.

16 But if we worked with chemicals such
17 as -- and I'll just use three examples here
18 because people are familiar with the terms --
19 toluene, MEK, carbon tet, you know, routinely in
20 doing analysis. Those things -- there certainly
21 is nothing on there that says that they cause
22 breast cancer.

1 But are there studies out there that
2 did look at these chemicals for -- just
3 specifically in my case or in my interest --
4 breast cancer? And if those studies are out
5 there, then is there a way -- or it would
6 certainly be more helpful to have that in the SEM
7 so you can say, okay, fair enough?

8 And I think that is -- just kind of
9 concludes my thought. If there is something out
10 there that disproves it, let us know because even
11 though some of us have great backgrounds -- I'm
12 not a chemist, but I am very familiar with
13 chemicals. I teach DOT transportation and look
14 at hazard class information all the time and MSDS
15 and things like that. But I don't know how to go
16 out there nor do I have the time or the resources
17 to contact every university and see if they've
18 done a study and that sort of thing.

19 So thank you.

20 CHAIR MARKOWITZ: Thank you very much.

21 The next speaker is Vina Colley on the
22 phone. She's not there? Okay.

1 So I think that our last speaker
2 actually, unless there's someone else who
3 volunteers, is Gary Vander Boegh. I think he
4 might be on the phone.

5 MR. VANDER BOEGH: Thank you, Dr.
6 Markowitz. I want to thank the Board for all the
7 work that you're doing. I do notice when I have
8 time in between representing claimants -- I had
9 four hearings today, and they were very
10 interesting claims.

11 We at Paducah are proud. When I was
12 working at Paducah Gaseous Diffusion Plant, I'm
13 an engineer, so I associate with all the issues
14 at Hanford. Actually, Kirk and I have met many a
15 time to discuss the association of the
16 contractors, and I worked for Lockheed Martin.
17 I'm very proud of what Lockheed did, but, again,
18 we really were working under a different contract
19 scenario back in the days that I was Lockheed
20 Martin. And that was probably -- it was Martin
21 Marietta, then Lockheed Martin, and you can kind
22 of follow Paducah issues.

1 But unbeknownst to me, since I'm a
2 design engineer, I was hired for designing a new
3 14-million-dollar landfill -- contained landfill
4 that was state of the art. And I was the project
5 manager with Lockheed Martin engineers, my
6 coworkers, and my good friends, Jimmy Massey and
7 Dave Massey, leading this project.

8 And we got that permitted, used the
9 city leaders in Paducah to help us do that.
10 There was a lot of permitting issues, as you're
11 very well aware, and Dr. Mark, which you and I
12 have talked many other times about the issues of
13 beryllium. And so therefore, when we were
14 operating the plant, all of you probably are
15 aware by now that a false claims was filed in the
16 plant, and we didn't know it.

17 And so as the investigation transpired
18 and my office was taken over by federal
19 government officials -- and I entered all this
20 into the hearing record today -- we thought that
21 was significant because I think everybody needs
22 to understand I got caught up in the same issues

1 that the nuclear workers got, and I'm a young man
2 who started in 1992 and never knew what was going
3 on at the Paducah plant other than somebody
4 handed me a project that I had to take over. And
5 as a design engineer, I was more than happy to
6 help them.

7 That project ended up weighing me two
8 President's awards under President Bill Clinton
9 and then I was able process waste out of the
10 plant. And I noticed that when I developed the
11 waste acceptance criteria, which was very intense
12 and detailed, project managers had to sign off
13 that everything was fine and everything was
14 acceptable -- Kirk will understand this --
15 everything was done properly. Lo and behold,
16 that's what the false claims was about.

17 Nobody knew that according to the
18 investigation under the Act that there was
19 falsifications of the waste going on, which meant
20 the new landfill, which was permitted under the
21 State of Kentucky, had just accepted contaminated
22 material that, as an engineer landfill manager,

1 project manager for Lockheed, I was responsible
2 for the day-to-day activities. A landfill
3 manager title is just strictly a staff title.
4 I'm a staff engineer, class 3, whatever that is.
5 Kirk, I've been long enough that I've forgot.

6 But the point I'm making is, as waste
7 was generated out of Paducah Gaseous Diffusion
8 Plant that was hazardous, people falsified the
9 classifications of the waste. That's in the
10 news. You can see it. Lockheed Martin got
11 slapped on the wrist.

12 I still think the world of the
13 Lockheed Martin people: Mr. Van Hook and all
14 those top people at Lockheed. But that was what
15 triggered the investigation that led to the
16 uncovering of bad things that were happening to
17 workers including Chuck Deuschle, Bud Jenkins,
18 John Tillson, and the notorious Ron Fowler who
19 Ron was the nuclear whistleblower.

20 And we're not trying to take credit.
21 We're just trying to bring everybody across the
22 nation in together and understand that when our

1 politicians take credit for the sick worker
2 program but then we learn that they're really not
3 wanting the program to be successful. We got to
4 look at the politics involved, and this Board is
5 the best thing that I've seen in a long time
6 because you're asking -- it's almost like, wow,
7 somebody was listening to me.

8 And so what we did was go out on a
9 limb, and we notified through our channels, and
10 I've got a lot of political connections. And we
11 just started looking at over 400 claims, and we
12 found a pattern; that there was a word -- and
13 Donna Hand has already stolen some of my thunder
14 on the pocket guide. As a nuclear worker, you're
15 licensed -- or you're required to follow 29 CFR
16 1910.120. Dr. Michael and I have talked many a
17 time, and I understand now he's with OSHA. And
18 so October 28, 2015, I put Dr. Michael on an
19 email, and we had a great conversation.

20 I then forwarded that to DOE at the
21 top level, and Monica Regalbuto then asked for
22 the resignation of the DOE site manager who, by

1 the way, people at Rocky Flats would probably
2 remember it, Bill Murphy.

3 Now, we know that Rachel has got a big
4 cast ahead of her. She's got to bring in all the
5 other agencies, but I was just going through the
6 NIOSH pocket guide that I mentioned to Dr.
7 Michael in October 28, and I put in the hearings
8 today. And, lo and behold, in the SEM has been
9 inserted the very thing that I've been writing
10 emails and arguing, but we didn't know this until
11 two days ago.

12 And so, if the Board is aware of the
13 requirements of 29 CFR 1910.120, 40-hour training
14 allows you to work in the DOE facility, and I'll
15 yield to Kirk to disagree with me but I know he
16 can't. We don't understand how these workers can
17 come in, give testimony that they've handled
18 hazardous waste and breathe the converter gases
19 and the TCE dumping out, as was discussed today.
20 And then somebody at Lockheed Martin -- who used
21 to be our employer now -- who has bought the
22 company, QTC -- and that's an obvious conflict of

1 interest -- is then brought in to deny the
2 claims.

3 Under a CMC, the need for a CMC, which
4 is really not needed because all of the chemicals
5 that we're talking about are in the SEM --
6 they're in the SEM. And we found shockingly
7 today that one claim was approved for the very
8 same thing the other three have been denied. So
9 there's not consistency.

10 I hate to be the bearer of bad news
11 here, but I'd like to retire somebody, and I did
12 this to help people who had had their claims
13 inappropriately denied. And I want to say that
14 I've met with Rachel and I've met with John
15 Vance. And, at that time, in 2010, in a meeting
16 in Washington, I thought I knew a lot more than I
17 really know now.

18 And so Dr. Markowitz, I can just
19 commend the Board for what they're doing, but we
20 got to look at this significant factor issue
21 because if you don't go tackle that issue, well,
22 DOL is -- DOE -- the EEOICPA director is just

1 strictly going to call Lockheed Martin and say,
2 hey, I need a denial and a significant factor,
3 and just tell them it's not significant.

4 Well, for goodness sakes, people. We
5 don't -- at Paducah, we don't want Lockheed
6 Martin CMCs being called in. And even we've got
7 12 cases in the United States Federal Board in
8 the Western District, and Judge Thomas B. Russell
9 and Judge Stivers have even ruled that it doesn't
10 matter what the CMC says.

11 As long as he makes an opinion -- and
12 Rachel, you'll appreciate this -- the people like
13 Lucero v. DOL in New Mexico, those cases are not
14 overriding what's happening here at Paducah. And
15 I believe we've got a situation where Senator
16 McConnell does not want claimants paid because of
17 the contamination that rivals anybody in the
18 nation.

19 But we're getting there, and I just
20 want to thank this Board for the work you've
21 done. And I don't have one note in front of me,
22 and I think Donna Hand has probably taken the

1 pocket guide issue. And I'd like for somebody to
2 tell me, is the pocket guide -- Greg Lewis, I
3 believe -- I don't want to quote Greg, but where
4 does this stand?

5 We're all trained. Thousands of
6 workers are at the plant right now. Beryllium
7 everywhere. Dust has -- the dust is two inches
8 thick on the 40-acre process building that are
9 150-foot tall. Don't go in --

10 CHAIR MARKOWITZ: Mr. Vander Boegh.

11 MR. VANDER BOEGH: -- the buildings.
12 I try to tell people, don't take tours of nuclear
13 facilities and especially those in the C-720
14 where two cases today, independent of each other,
15 talked about the converter dust and asbestos.

16 The heating systems are still there.
17 It was raining down on me in '92. I asked them
18 what it was. They said, oh, don't worry about
19 it. Well, come to find out, that's where they're
20 machining beryllium, and I tell this same story,
21 and all the Paducah workers that I represent want
22 their transcripts provided to this Board.

1 CHAIR MARKOWITZ: Mr. Vander Boegh.

2 MR. VANDER BOEGH: Thank you.

3 CHAIR MARKOWITZ: Thank you very much.

4 So is there anybody else who wishes to
5 speak in the last few minutes? Okay.

6 Well, this wraps up the public comment
7 session. Thank you very much for your
8 participation, and we'll resume tomorrow morning
9 at 8 o'clock.

10 MR. FITZGERALD: All right. This
11 meeting is adjourned. Thank you very much.

12 (Whereupon, the above-entitled matter
13 went off the record at 5:55 p.m.)

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This is to certify that the foregoing transcript

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Substances and Worker Health

Before: US DOL

Date: 04-19-17

Place: Richland, Washington

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Court Reporter

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