UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

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MEETING

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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

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

8:36 a.m.

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

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

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

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

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

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

Copies of all meeting materials and

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

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

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

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

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

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

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

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

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

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

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

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

So thank you very much for coming.

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

So thank you very much.

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

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

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

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

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

Les?

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

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

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

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

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

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

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

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

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

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

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

Center for Construction Research and Training.

MEMBER CASSANO: Victoria Cassano. I'm also an occupational medicine physician, retired military, radiation health and safety officer, and also worked with the VA on -- as the head of the Environmental and Occupational Exposure Service.

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

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

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

CHAIR MARKOWITZ: And also Mark Griffon?

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

CHAIR MARKOWITZ: Did anybody hear

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

MEMBER GRIFFON: Mark Griffon. Can you hear me?

CHAIR MARKOWITZ: Yes.

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

CHAIR MARKOWITZ: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

PARTICIPANT: Not dot gov?

CHAIR MARKOWITZ: Dot gov. Good. Good point. Okay. Thank you.

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

(No audible response.)

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

MS. LEITON: Rachel.

(Laughter.)

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

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

So, Ms. Leiton? Thank you.

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

you can get on with your business.

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

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

stakeholders moving forward.

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

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

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

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

But just a couple of other things.

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

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

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

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

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

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

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

The same thing with causation

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

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

Just a few current statistics.

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

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

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

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

additional events we're going to do.

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

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

It's also going to be republished

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

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

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

subscribe to it and get updates as that happens.

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

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

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

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

CHAIR MARKOWITZ: Questions?

MEMBER SOKAS: I have a question. This is Rosemary Sokas.

MS. LEITON: Yes?

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

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

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

generic issues are discussed.

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

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

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

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

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

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

MS. LEITON: Absolutely.

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

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

CHAIR MARKOWITZ: Sure.

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

CHAIR MARKOWITZ: Okay.

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

CHAIR MARKOWITZ: Okay. Thank you.

Any other questions? Yes, Dr. Redlich?

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

CHAIR MARKOWITZ: Correct.

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

CHAIR MARKOWITZ: Correct.

MEMBER REDLICH: Okay. Thank you.

CHAIR MARKOWITZ: Which is a draft. It's a draft.

MEMBER REDLICH: Yes.

MS. LEITON: It's a draft.

CHAIR MARKOWITZ: Right.

MS. LEITON: It says draft.

CHAIR MARKOWITZ: Right.

MS. LEITON: Just keep that in mind.

MEMBER REDLICH: Okay. Thank you.

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

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

CHAIR MARKOWITZ: We will.

(Laughter.)

CHAIR MARKOWITZ: Dr. Welch?

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

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

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

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

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

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

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

going to talk about that draft one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

collecting task information.

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

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

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

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

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

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

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

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

John, anything you add on that?

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

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

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

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

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

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

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

right?

MEMBER WELCH: Absolutely.

CHAIR MARKOWITZ: Okay.

MEMBER WELCH: Thanks for that.

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

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

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

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

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

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

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

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

category was statistically and consistently predictive of COPD.

CHAIR MARKOWITZ: Right. Dr. Dement?

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

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

CHAIR MARKOWITZ: So I have

another --

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

CHAIR MARKOWITZ: Right.

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

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

CHAIR MARKOWITZ: Yes, Ms. Vlieger?

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

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

discounted when it's reviewed later on.

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

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

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

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

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

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

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

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

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

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

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

MEMBER BODEN: Okay.

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

MEMBER BODEN: So the reason I raise

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

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

Would you want to add?

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

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

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

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

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

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: Sorry, no.

CHAIR MARKOWITZ: Dr. Dement?

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: Rachel, I did a quick

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

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

MEMBER VLIEGER: All right. Thank you.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

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

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

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

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

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

Dr. Welch?

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

MEMBER SOKAS: So --

MEMBER WELCH: I heard Rosie?

MEMBER SOKAS: Right, it's Rosie. Yes, thank you. I just want -- two quick comments. One is I think if you focus on the OHQ, then removing smoking is an intriguing way of implementing the kind of educational piece for the physicians.

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

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

You have a puzzled look on your face.

CHAIR MARKOWITZ: Well, so this --

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

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

CHAIR MARKOWITZ: Yes.

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

Does anybody want to put it off until tomorrow?

CHAIR MARKOWITZ: Dr. Dement?

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

we not?

CHAIR MARKOWITZ: Yes.

MEMBER DEMENT: Okay.

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

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

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

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

CHAIR MARKOWITZ: Sure.

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

frequency and whether it was direct or bystander.

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

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

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

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

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

there's some --

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

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

MEMBER SOKAS: Right.

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

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

MEMBER BODEN: So moved.

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

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

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

they're slightly different.

MEMBER WELCH: The one that's published.

MS. LEITON: Okay. Thank you.

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

MEMBER SOKAS: Nope. I like it.

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

(Laughter.)

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

(Show of hands.)

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

MEMBER SOKAS: Yes.

MEMBER GRIFFON: Yes.

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

MEMBER WELCH: So it's -- following on

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

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

PARTICIPANT: So moved.

CHAIR MARKOWITZ: And a second?

PARTICIPANT: Second.

CHAIR MARKOWITZ: It's open for discussion.

(No response.)

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

(Show of hands.)

CHAIR MARKOWITZ: And Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Okay. So it's unanimous.

Next?

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

CHAIR MARKOWITZ: Okay. Motion to approve?

PARTICIPANT: So moved.

CHAIR MARKOWITZ: And a second?

PARTICIPANT: Second.

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

(Pause.)

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

(Show of hands.)

CHAIR MARKOWITZ: And Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Okay. This is

accepted.

Is there another part?

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

CHAIR MARKOWITZ: Okay. So, Dr. Boden?

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

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

MEMBER BODEN: Okay.

CHAIR MARKOWITZ: But the question here is --

MEMBER WELCH: Yes, I was wondering whether --

CHAIR MARKOWITZ: Okay.

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

CHAIR MARKOWITZ: Right.

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

CHAIR MARKOWITZ: Right.

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

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

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

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

(No response.)

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

(Show of hands.)

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Mr. Griffon?

MEMBER GRIFFON: Yes.

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

(Show of hands.)

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

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

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

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

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

tasks.

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

PARTICIPANT: So moved.

CHAIR MARKOWITZ: Okay. And a second?

PARTICIPANT: Second.

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

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

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

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

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

MEMBER FRIEDMAN-JIMENEZ: Okay.

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

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

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

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

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

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

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

But so the occupational -- let's say

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

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

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

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

MEMBER WELCH: Okay.

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

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

CHAIR MARKOWITZ: Dr. Dement?

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

First of all, the way we ask these

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

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

CHAIR MARKOWITZ: Dr. Boden?

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

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

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

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

CHAIR MARKOWITZ: You had it Kevin,

but --

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

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

CHAIR MARKOWITZ: Dr. --

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

MEMBER WELCH: Okay.

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

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

CHAIR MARKOWITZ: Dr. Silver?

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

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

So are there other comments on this?

(No response.)

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

PARTICIPANT: So moved.

CHAIR MARKOWITZ: Is there a second?

PARTICIPANT: Second.

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

(No response.)

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

(Show of hands.)

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

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Okay. Thank you. Are there -- Dr. Welch, are there any other recommendations on the OHQ, or are we done?

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

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

MEMBER WELCH: Yes, we need to formulate that.

CHAIR MARKOWITZ: Okay.

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

CHAIR MARKOWITZ: Right. Okay.

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

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

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

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

Dr. Welch?

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: No, we should just continue.

MEMBER WELCH: Oh, okay.

CHAIR MARKOWITZ: Yes.

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

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

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

Now that is -- doesn't include all the

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

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

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

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

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

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

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

The -- our Committee spent some time

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

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

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

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

CHAIR MARKOWITZ: Oh, okay.

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

(Pause.)

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

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

years, that would also be sufficient.

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

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

MEMBER WELCH: No, I don't.

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

BTMed.

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

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

(Laughter.)

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

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

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

recommendation is, but --

(Simultaneous speaking.)

CHAIR MARKOWITZ: There you go. So just --

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

CHAIR MARKOWITZ: Right.

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

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

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

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

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

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

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

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

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

MEMBER CASSANO: Okay.

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

procedure the Occupational History Questionnaire is considered a --

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

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

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

So, Dr. Friedman-Jimenez?

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

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

Dr. Friedman-Jimenez?

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

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

MEMBER FRIEDMAN-JIMENEZ: Okay. I

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

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

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

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

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

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

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

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

Dr. Boden?

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

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

CHAIR MARKOWITZ: Yes. Mr. Turner?

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

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

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

CHAIR MARKOWITZ: Dr. Cassano?

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

each individual presumption. Just my thoughts.

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

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

(Simultaneous speaking.)

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

MEMBER WELCH: Oh, sorry.

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

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

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

CHAIR MARKOWITZ: Dr. Boden?

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

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

maintenance and construction job titles. Just to be clear.

MEMBER BODEN: Yes, understood.

CHAIR MARKOWITZ: Okay.

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

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

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

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

MEMBER WELCH: The list is really occupational categories.

CHAIR MARKOWITZ: Right.

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

(No response.)

CHAIR MARKOWITZ: Dr. Silver?

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

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

Okay. So --

MEMBER WELCH: Okay. So --

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

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

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

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

And time since last exposure, one

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

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

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

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

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

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

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

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

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

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

(No response.)

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

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

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

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

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

sites within the complex.

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

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

MEMBER WELCH: Okay.

CHAIR MARKOWITZ: -- and then --

MEMBER WELCH: That sound good.

CHAIR MARKOWITZ: Yes.

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

CHAIR MARKOWITZ: Right. Okay. So --

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

CHAIR MARKOWITZ: Right.

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

people want to talk to them.

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

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

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

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

I'll read the recommendation and I'll

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And so those are the elements of the rationale.

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

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

(No audible response.)

CHAIR MARKOWITZ: Mr. Griffon?

(No audible response.)

CHAIR MARKOWITZ: Yes, Dr. Silver?

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

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

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

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

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

You had a follow-up comment and then --

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

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

MEMBER SILVER: Well, DOL's Energy

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

CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Dement?

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

CHAIR MARKOWITZ: Okay.

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

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

(No audible response.)

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

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

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Dr. Redlich?

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

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

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

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

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

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

Dr. Cassano?

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

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

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

CHAIR MARKOWITZ: Ms. Vlieger?

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

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

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

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

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

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

MEMBER REDLICH: Yes.

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

MEMBER REDLICH: Yes.

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

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

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

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

(Off-microphone comment.)

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

(Laughter.)

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

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

Motion to accept?

PARTICIPANT: So moved.

CHAIR MARKOWITZ: Second? Any further discussion?

(No response.)

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

(Show of hands.)

CHAIR MARKOWITZ: All those opposed? And any abstentions?

One abstention. So --

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

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

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

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Yes. And, Mr. Griffon? Mark?

(No response.)

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

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

CHAIR MARKOWITZ: Okay.

MEMBER GRIFFON: You didn't hear me.

CHAIR MARKOWITZ: There are -- thank you, Mark. Fifteen Board members present. Fourteen voted in favor and there's on abstention.

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

MEMBER WELCH: Yes.

CHAIR MARKOWITZ: Okay. We'll move on

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

Dr. Cassano?

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

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

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

Wanted to reiterate a little bit about

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

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

happened.

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

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

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

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

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

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

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

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

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

Not all exposures that could cause a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How do they use the Former Worker

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

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

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

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

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

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

Faye, you were lucky.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER CASSANO: Les? Dr. Boden?

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

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

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

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

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

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

them feel compromised as far as their position.

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

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

Dr. Markowitz?

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

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

MEMBER CASSANO: I think you had another --

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

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

CHAIR MARKOWITZ: Right.

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

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

MEMBER VLIEGER: Yes.

CHAIR MARKOWITZ: -- for the level of

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

MEMBER CASSANO: We can add those.

CHAIR MARKOWITZ: Yes.

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

CHAIR MARKOWITZ: Sure, sure.

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

Dr. Dement?

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

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

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

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

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

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

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

provide examples of language for that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

they need to ask for further.

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

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

MS. LEITON: Right.

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

the process.

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

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

(Laughter.)

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

(Laughter.)

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

(Laughter.)

(Simultaneous speaking.)

MS. LEITON: I'm sorry.

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

MS. LEITON: Thank you very much.

MEMBER VLIEGER: However --

(Laughter.)

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

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

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

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

MEMBER CASSANO: Dr. Silver?

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

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

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

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

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

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

PARTICIPANT: You have a comment on the phone.

MEMBER CASSANO: Oh, somebody had -- Rosie?

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

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

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

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

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

isn't totally subjective at some point.

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

MEMBER CASSANO: Yes.

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

MEMBER CASSANO: Yes.

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

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

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

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

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

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Shouldn't that be acceptable?

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

CHAIR MARKOWITZ: Sure.

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

CHAIR MARKOWITZ: Right. Okay. Dr.

Boden?

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

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

MEMBER BODEN: Yes, I know you do.

(Laughter.)

CHAIR MARKOWITZ: So many of them are appropriate.

MEMBER BODEN: Medical and other, yes.

CHAIR MARKOWITZ: Many of them are appropriate.

MEMBER BODEN: Yes.

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

Yes, Ms. Leiton?

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

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

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

MS. LEITON: Problem solved.

(Laughter.)

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

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

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

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

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

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

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

MEMBER SOKAS: Okay. In response to

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

CHAIR MARKOWITZ: No.

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

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

MEMBER CASSANO: Okay.

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

Okay.

CHAIR MARKOWITZ: So Dr. Sokas?

MEMBER SOKAS: Yes, all set.

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

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

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

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

And just to review, the -- the purpose

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

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

I did want to comment that the

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

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

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

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

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

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

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

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

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

Yes. I did follow up- on the

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

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

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

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

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

MEMBER SOKAS: Okay.

MEMBER GRIFFON: -- on this. Yes.

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

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

MEMBER SOKAS: Okay.

CHAIR MARKOWITZ: -- opinion.

MEMBER SOKAS: That sounds good.

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

(Simultaneous speaking.)

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

MEMBER SOKAS: Pardon?

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

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

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

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

Okay. So within a week or so.

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

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

CHAIR MARKOWITZ: Burdensome, burdensome.

MEMBER VLIEGER: More than burdensome.

CHAIR MARKOWITZ: Very burdensome.

MEMBER VLIEGER: Yes.

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

MEMBER SOKAS: Okay.

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

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

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

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

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

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

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

PARTICIPANT: Sure.

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Other comments?

(No audible response.)

CHAIR MARKOWITZ: Thank you, Ms. Leiton.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER SOKAS: Yes, thanks, thanks, Mark.

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

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

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

The -- the contractor clearly seems to

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

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

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

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

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

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

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

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

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

DR. FRIEDMAN-JIMENEZ: Thanks, Rosie.

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

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

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

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

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

MEMBER SOKAS: Thanks, George.

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

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

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

CHAIR MARKOWITZ: So this --

MEMBER SOKAS: I can't hear.

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

MEMBER SOKAS: Well, I am sure. Okay.

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

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

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

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

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

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

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

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

CHAIR MARKOWITZ: Sure.

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

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

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

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

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

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

And so I think there -- again, this

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

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

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

So I think we would like to see a contract separate from the one that is hiring the CMC, that needs to be independent of that particular contract. And we would like to see somebody who's -- the reason I show in the Association of Occupational Environmental Clinics is because they actually have a criteria for membership that includes a public health perspective and a worker-centered perspective.

I'm sure there are other organizations that, or academic groups, or whoever who could do this. But to find someone who clearly understands what the criteria for causation or exacerbation should be and reviews the entire charts along with the CMC letters. And then based on that, we could come up with guidance for briefing package materials that emphasize the appropriate things for the CMC.

So, we have at least two

recommendations we'd like to move forward on. I think organizing the claimant records and making them available, the entire record available to the IH and the CMC is the first one.

CHAIR MARKOWITZ: Okay. So, Dr. Sokas, there's some comment. People would like to make comments. Is this a good time?

MEMBER SOKAS: Oh, sure.

CHAIR MARKOWITZ: Okay. Dr. Welch.

MEMBER WELCH: I just want to say I totally agree with your recommendation to have a separate review of the content of the CMCs by worker-centered occupational physicians. And I think it will be, it will be really, really useful. And in my review of claims over the years, I have struggled with a way to figure out how to, if it was up to me, how to improve the -- how to get consistency among the CMCs.

And I think understanding the cause, contribute, and aggravate, and also requesting the CMCs review the entire file would probably go a very long way toward getting more consistency.

CHAIR MARKOWITZ: Dr. Boden.

MEMBER BODEN: So, first of all, I think your committee's done a great job. These are excellent recommendations.

Having gone through some of the claim files, I know the issues personally. And let me just say a couple of things. One is that I think it is technologically totally feasible to have these be searchable files. It could be done on computers without anybody around, just letting the computers run overnight if necessary, or however long, to make these files have optical character recognition.

And it really does help. Because I did that myself on some of these really large files, and it made a huge difference in my being able to go through them.

The second thing that I would suggest is rather than have the entire record available to the CMC, so I had one file that was over 1700 pages long, and it contained two copies of a 702-page medical record. So it was -- and there were

other duplications as well. But just taking out one of those copies would have almost made it half as long.

And so, the one other suggestion that I would make is if we're going to make the entire file available, it should be the entire file with a minimum of duplication, particularly of these very, very long medical histories.

CHAIR MARKOWITZ: So, I have a comment. I think the Board is charged to look at the quality, objectivity, consistency of the work of the industrial hygienists and the consulting physicians. So I think the Board should conduct a study of a sizeable sample of IH and CMC reports and basically design the evaluation. We would need resources or assistance in actually going through a bunch of these and conducting the study. But I, frankly, think it's something we should do or play a large role in ourselves in order to fulfill the mission of looking at the quality, objectivity, and consistency.

MEMBER SOKAS: So I'm just going to

push back a little bit by reminding you of how you started out your recommendation, which was that most of us have full-time jobs. And suggest that in order to have -- I mean, so we, I can right now tell you what I think; right? But how many records have I reviewed? Maybe, you know, five, ten. I can't remember now. But it kind of -- maybe 12 -- but, but if you want to do it in a meaningful way where every third one gets done, or every fifth one, or every tenth one, then I think you need to hire somebody to do it.

CHAIR MARKOWITZ: Ms. Leiton, did you want to make a comment?

MS. LEITON: Yes, just a couple of points that you may not be aware of.

In terms of what our claims examiners see, we have a database that is divided. I mean we index them by the type of document it is, whether it's an IH report, whether it's a medical report, whether it's a decision, whether it's a development letter, all those things are indexed as the information is either coming in or

leaving. And that's there and available for the claims examiners in the process. So, it is organized for them.

And I understand you guys didn't get that. And it makes it a lot more difficult. But I did want you to know that that is the way that they can see the records.

When we refer documents to a CMC, we do try to provide them with whatever relevant medical is there. We don't just send them a SOAF and that's it. The reason we look for relevant information is because of the 4,000 records that have -- you may have medical that is in completely different condition, that was just a medical note, lots of those. So we try to send them the information that's about the condition we're asking about or, if it's impairment, what's relevant to impairment, those sorts of things.

I know you have a recommendation in for already, for providing them access. And that's something that's, you know, under consideration. But I just wanted to make clear

that we do try to give them what's relevant, along with the question that we're asking them.

MEMBER SOKAS: So, Ms. Leiton, just to comment on that particular piece. It's really hard for the CE to determine, unless they're sort of focusing down ahead of time on one or two diagnoses. But it may be the person who's doing the pre-op clearance for the gall bladder surgery who figures out that the person's got asthma; right? I mean so, so it's hard to exclude whole parts of -- I mean I, I really think that if you've got the CMC looking through, you know, their job is really to sift through everything.

MS. LEITON: I, I mean I can understand that. We've gotten most of the physicians and either CMCs and external physicians have asked that we not provide them with information that doesn't really relate to what we're asking them. But, you know, we, again, that's something you guys have already asked, and we will be looking at it.

CHAIR MARKOWITZ: Dr. Boden.

MEMBER BODEN: So this raises something I hadn't thought about before which is we've looked at the case files that you provided us. We've had some idea in our heads about what you provide the CMCs. It might be worth -- and I ask this particularly of the physicians here on the board -- whether it might be worth looking at what the CMCs see. That was too many Cs, but you get the idea.

MEMBER SOKAS: Yes.

MEMBER BODEN: Because I don't think we really know what they see. And if we're going to -- if we may -- I understand the perspective of somebody who's a contract physician who wants to look at as little as he can, and particularly doesn't want to look at 2700 pages of whatever. But so I guess I'm asking people on the Board whether they think it would be worth our while to see for some of these cases what is provided to their CMCs.

CHAIR MARKOWITZ: Dr. Welch.

DR. SOKAS: I think that --

DR. WELCH: No, go ahead. Go ahead.

CHAIR MARKOWITZ: Go ahead, Dr. Sokas.

MEMBER SOKAS: Oh. I think that's a great idea. I think we tried to do that and wound up getting a set of other responses that really weren't that. So I, for some reason I thought we had done that. And then I think we wound up not. But I think it's a great suggestion.

The other, the other piece I would really be interested in -- and again I realize there's this whole question about confidentiality of contracts and, you know, and that sort of thing -- but it strikes me that if the CMC is being paid by the hour then I don't really understand their complete reluctance to go through, you know, this step. I mean it just, it's striking to me that they're reluctant to really pay attention.

CHAIR MARKOWITZ: Dr. Welch and then Ms. Pope.

DR. WELCH: What the CMC sees is

somewhat related to the question of what the -- how the claims examiner structures the statement of accepted facts. And when that question is very narrow, then the CMC doesn't need very much because they're answering one -- they're not answering anything about the diagnosis.

You know, it's sort of like if we broaden that, which I think is one of the things that Dr. Cassano's committee is looking at, it will be more necessary to include more medical records if the question is broader. As it is now, a lot of times the question is fairly narrow.

So, you might want to comment on that, too.

MEMBER CASSANO: Yes. I think part of it -- we can ask again, you know, what was, you know, we can ask it as a general question and again on specific cases. Well, to get this response from the industrial hygienist or to get this response for the CMC, what did the claims examiner actually send to them? And we might be

able to get a little bit of an idea from that.

But considering that, I mean, sometimes the question is for when is meningioma considered a cancer? And they didn't, I don't think any information went to the CMC. And the fact of the matter is it was a Stage 2 meningioma which is, has some dysplastic characteristics to it and can actually metastasize. But the answer came back, no, it's not.

But this particular CMC said, however, there is an association between a -- I'm now forgetting what the exposure was -- and meningioma. And, therefore, they then went back to the industrial hygienist. But they didn't, nobody asked the CMC is there any relationship between meningioma and anything that this guy was exposed to?

Luckily, this one particular CMC did volunteer that. So, in that case the person was lucky to a certain extent because the case was still denied because the levels were considered too low because they didn't look at aggravation

or contribution, they only looked at straight causation.

So, I'm not quite sure how to -- it's something we're going to have to think about is how to say, well, if you don't want the whole record, you have to get at least this. And just looking at the stuff that's pertinent to the diagnosis, not only based on what Dr. Welch or Dr. Sokas said, but a lot of times there's other information in other workups that are pertinent to the development of the diagnosis. So someone that doesn't have the medical expertise to parse that really can't pick out what's relevant.

And but I don't know how to say it's all or just a little bit. I don't.

CHAIR MARKOWITZ: Ms. Pope.

MEMBER POPE: I agree with that. I think it's a sore point with a program that's supposed to be claimant-friendly, and in so many ways it's not. I agree with the fact that we need to make sure that there is enough information that file that the CMC is available

to be able to see, but not so much that it's so daunting that they, you know, can't possibly get through the whole file and make a decision about what's going on with the claimant.

But I really believe that it all goes back to that CE that is earmarking these particular documents that's going to the CMC where they're not really equipped to do that, to be able to identify what goes to the CMC. It keeps going back to that.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: Before there were PDF files, there were big, fat hard-copy files that each of us has probably had transmitted to us in our work lives. Before there were Post-It Notes, there were paperclips to flag key items of concern. Because people wanted our opinion and trusted what we knew, they gave us the entire file to pursue our curiosity and ply our discipline.

I don't claim to have medical expertise, but a lot of us have public health

training. And to infer causality, temporality is the sine qua non. And it's not always the temporal relationship between the exposure and the disease, though, that's necessary. Sometimes it's the temporal relationship between acute symptoms that were noted early on, preceding the development of a chronic disease.

Isn't a classic teaching example a skin rash? A lot of time goes by and lung disease develops. So the CE may be so focused on the lung disease and the relevant exposures, and not appreciate the significance of the much earlier skin rash. But a doctor who's trained in occupational medicine would need that information.

CHAIR MARKOWITZ: Ms. Vlieger.

MEMBER VLIEGER: In discussions at final adjudication bench hearings with the hearings examiners, when I ask pointedly, can you tell me exactly what was sent to the CMC, and the response has been, no. We have to go off of the SOAF that's provided to the CMC.

And so even within the department, on a number of occasions they can't explain to me how the CMC would have got -- what information they got to reach their decision. So it is a hole in the program somehow.

And I don't think a bibliography is going to cut it because that's really labor-intensive to do. So, this is going to be kind of a hard answer. We don't want to overburden the CMCs till they become so mind-numb with a case that they aren't going to make a rational decision. But on the other hand, many times they aren't receiving the nuances of how we got from A to B.

CHAIR MARKOWITZ: Dr. Welch.

Dr. Cassano.

MEMBER CASSANO: Just one more comment. You can't really audit the quality of the content of the CMC's report unless you know what the content is of what they're working on. You can't blame the CMC for an incomplete or incorrect report if they don't have the

information necessary to make the appropriate decision in the case.

And I would think that from a contract perspective that the department -- that the department would want to make sure that the quality assurance process takes that into account. Because you may be wrongly saying, well the CMC didn't render the correct opinion in this case, when actually, based on what they were given, they did.

MEMBER SOKAS: Well, I'm going to push back on that just a tiny bit, Dr. Cassano, just because there was one who, a CMC evaluation who went to great pains to explain why he did not in particular believe that COPD was the result of workplace exposures. And he cherry-picked some weird references in order to do that.

So, so you -- which I admit, that's kind of an extreme example. But there are a number of other examples where it was also clear that, with the information they had, they simply did not get the nature of the standard of

causation or exacerbation.

So, there are clear examples of poor quality in terms of content and decision-making within some of these files. Although I agree that, you know, the other piece where maybe they don't dig hard enough is, you can't really assess that unless they had access to the full records.

CHAIR MARKOWITZ: So, I want to move back to the recommendation we made at the last meeting. And because we've been discussing this topic for 15 or 20 minutes now, and the question is, and we addressed some of these in this recommendation; the question is whether we want to modify this in some sense.

Our recommendation Number 8 was we recommend that the entire case file should be made available to both the industrial hygienist and the contract medical consultants when a referral is made to either, and not be restricted to the information that the claims examiner believes is relevant. The claims examiner should map the file to indicate where relevant

information is to be.

So, my question is, are we in some sense refining, adding, changing this recommendation?

MEMBER SOKAS: So, I guess the question, so it's mapping -- rather than, I mean for the claims examiner maps it and the record itself is organized into sections. And I think that would do it.

CHAIR MARKOWITZ: I'm sorry. Could someone just repeat what she said. I couldn't understand everything she said.

DR. WELCH: Rosie, were you just saying that, understanding what Ms. Leiton told us, that the file is mapped into sections, and that one recommendation?

MEMBER SOKAS: That is, as long as that's how it's provided to the CMC and the IH, yes.

DR. WELCH: Well, if that's available that way to the claims examiner. But I don't think it's available -- Yes, okay. So part of

the recommendation that we already made was to give them access to it in that format, yes.

CHAIR MARKOWITZ: Right.

MEMBER SOKAS: Okay. And that's then searchable as well; right?

CHAIR MARKOWITZ: Well, we don't, we haven't established that. Ms. Leiton, do you know offhand, the material that's sent to the CMC and the IH, is it searchable?

MS. LEITON: Well, there's two different things. What's sent to them now is not, obviously. But we give them certain, we give them the medical or industrial hygienist records.

What the recommendation, my interpretation of your original recommendation was that the CMC and the IHs would have access to the entire case file, which to us would mean access to what the CEs have access to, which is already indexed. It's indexed by the type of reports, usually incoming or outgoing. It is not in PDF. So we cannot search it by word

necessarily, but we do -- it is indexed to as much detail as possible.

It is indexed and then there's a descriptor line that you can go through and you can sort it however you want, but it's not PDF. Right now that's not the way our technology was built.

CHAIR MARKOWITZ: Okay, thank you.

MEMBER SOKAS: Okay. I mean I think that's, as long as that's available to them that would be fine.

MEMBER CASSANO: Is it possible for us to see what that looks like when we come out on Friday, do you know?

MS. LEITON: I think that we -- let me get back to you.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: So, Dr. Sokas, I know what we recommended last time, what you have on the slide we're looking and the discussion. Is there any recommendation that should be made here?

MEMBER SOKAS: I think for that, your online access to the entire record, no. We can leave that go. And just, you know, kind of say that we, this just emphasizes that we really, really, really want it.

But the second piece we haven't really decided on yet is whether we want to -- what kind of recommendation we can make for quality of content evaluation. And I would like to have at least some understanding of whether this is going to be us doing it, in which case we just, you know, kind of say right now what we think, or whether you want to do it in a formal way where we're recommending that a subcontract we let in order to do that.

CHAIR MARKOWITZ: Dr. Welch.

DR. WELCH: I think one thing to think about as we discuss that question is once there is a briefing package that's sent out that tries to standardize the review and get people to hone in and use the same standard, you'd want periodic assessment after that. You want some ongoing QI

about the content, which is probably not something the Board can commit to provide.

So I actually think sort of maybe a hybrid of having the Board be in charge of the initial review and putting together the briefing book, but hopefully with some additional resources to hire some other physicians to help with the reviews. If we wanted to review 100 files, for example, or pick a year and review some specified subset of a year of files, to have a couple of other heads and hands would be helpful.

So that would be my recommendation. We should pick a number and then because I'm not so sure that -- unless the number, unless you felt a number of, you know, 40 was fine. I don't have an idea of what number we'd need to do. But I think we could probably use a little extra help.

CHAIR MARKOWITZ: Other comments? Dr. Cassano?

MEMBER CASSANO: Yeah, I think,

hinging on what Dr. Welch just said, that there are four district offices. So if we looked at ten from each office, or something like that, we might be able to get a reasonable idea. And, actually, some of the cases we already have would be useful to actually go through with a fine-tooth comb and look at them, if they have CMC reports or IH reports.

CHAIR MARKOWITZ: But the CMCs and IH consultations, are they done on a regional basis or is that a national contractor, so that the Seattle office could easily use a South Carolina physician?

MS. LEITON: They are done on a national basis. So it could be referred -- any referral goes to the national office, then we refer it to our contractor. And our contractor then provides us with whatever doctor it's going to be that will review the case.

So, I mean it won't matter. I mean we could say by district, if you wanted to look at certain types. But if you wanted to pull random

CMCs, depending on what our contract says about that, I'm not going to make any promises right now, but then we could probably do it that way.

CHAIR MARKOWITZ: Dr. Boden.

MEMBER BODEN: Yeah, I'm just trying to make sure that I know where we are in terms of this discussion. So, we have the online access. We've talked about that and clarified it. Have we clarified recommendations as far as the briefing package as far as other things on the list for discussion?

CHAIR MARKOWITZ: So are you referring to the slide we're looking at now?

MEMBER BODEN: Yes.

CHAIR MARKOWITZ: So the first and the last bullet item we've already discussed.

MEMBER BODEN: Right.

CHAIR MARKOWITZ: The second, third, and fourth are tied together. We're really discussing the second at the moment. And the third and the fourth flow from the second.

MEMBER BODEN: Okay, good.

MEMBER CASSANO: The fourth one is being removed, correct? The fourth bullet on the recommendations is being removed, right?

CHAIR MARKOWITZ: Okay. So the question, I guess, is whether or not we're prepared to actually write the language of a recommendation on this topic, or whether we should do that now, whether we should re-look at it probably tomorrow morning, and the specific language. And I know, Dr. Sokas, you're not available, but one of us here could do that.

MEMBER SOKAS: Yeah, I can send you -- I can, you know, just slap some language together and send it to you tonight, and then you guys can discuss it tomorrow.

CHAIR MARKOWITZ: Let's do that. Let's do that.

MEMBER SOKAS: Okay.

CHAIR MARKOWITZ: Because, to me, the sticking point is the boundary between what the Board does and what the department does, and to what extent we have input into the review, and

just make sure it answers the questions that we have. At the same time recognizing we don't have the resources within the Board to look at a sizeable number of claims.

MEMBER SOKAS: Right.

CHAIR MARKOWITZ: So that would be great, Dr. Sokas.

MEMBER SOKAS: All right then, thanks.

CHAIR MARKOWITZ: Is that the end of your -- do you have anything else in your report?

MEMBER SOKAS: No, that was it.

CHAIR MARKOWITZ: Okay. So we're going to move on to the Presumptions Working Group. If you could bring up the slide, Kevin.

So, the working group was formed, I think, at the last meeting. We've had two calls since that time. And if you could go ahead a few slides. Actually, it'd probably better off if I work the slides. If I could have the remote. Oh, it's here. But if you could leave it up, Kevin, to one of the first one that says "Presumptions." Okay.

So, I want to spend a moment summarizing what Dr. Boden has taught us. And if I get it wrong, Dr. Boden, I expect you'll correct me. But, you know, we began to talk about presumptions this morning, but I think it's worth spending a couple minutes just talking about why, why we think -- and the department thinks, actually -- that use of presumptions would be a good way to go.

The first issue is fairness. And there are a few different elements to this fairness. One of them, the principal one is the fact that there simply wasn't a lot of information about exposure at a DOE complex over many decades. And the absence of exposure should not work against appropriate claims. And this was recognized in the act, in the original act in 2000 when the establishment of Special Exposure Cohorts at the gaseous diffusion plants.

Those plants were not the highest radiation plants in the complex. They had lower, on average, exposure radiation than, say, Hanford

or Rocky Flats or Y-12. And, yet, those three gaseous diffusion plants were grandfathered in as the original Special Exposure Cohorts on the radiation cancer side. And they're the only facilities that were identified in the act.

And it was done because it was an admission -- the scientific basis was an admission that there wasn't enough radiation data from those sites to be able to come to a proper decision. So it was only fair then to treat them by route of a presumption: 250 days prior to 1992 in relation to 22 cancers.

And as most of us know, there are now 110, 115 Special Exposure Cohorts. 127, thank you. Okay, 121. So it's gone from three in the original act to consideration of each of many, many more petitions, and now to 121.

So this presumption route has been adopted. And a central part of it is fairness, given the absence of data.

The other advantage of presumptions is that it lends consistency to the process. And it

may be that a presumption could be consistently wrong or consistently right. But there's something to be said for consistency. And when you use a national portfolio of CMCs and IHs, it's quite likely that there's going to be a fair amount of inconsistency. So presumptions provides that kind -- and consistency, frankly, is factor in fairness.

Third, presumptions should make decision-making a lot more straightforward, and then should be able to turn around claims a lot more quickly. Now, I'm not saying that claims turnaround is a problem at present. It certainly there was a problem early in the program. But it's certainly one of the outcomes that the department looks for in judging its program, which is timeliness.

And then, of course, presumptions make the decision-making simpler and, therefore, more efficient. And so there should be fewer moving pieces in a claim which can be passed on presumptions. And maybe will even lessen the

burden on the industrial hygienist and the CMC through application of presumptions.

Now, one of the difficult issues on presumptions is that, depending on where you set the bar, how much exposure automatically gets an accepted claim, you're going to make an error. And you're going to make an error wherever you set the bar. If you set the bar very high, you're going to exclude people who should be compensated. If you make the bar very low, you risk compensating people who perhaps really don't have causation.

And so in developing our presumptions we try to do it based on as much science as is available. But also are frank that, you know, there's an error, wherever you put it there's an error either way. And we should be frank about that.

And then, finally, we mostly talk about positive presumptions. If a claimant meets certain exposure criteria, certain medical criteria for a disease, then they get

compensated. But this reminds us that there are also negative presumptions. And we hear, actually, there are some elements of negative presumptions. For instance, I'm going to talk about asbestos, and in the current policy there's a presumption about exposure after 1995 that it wasn't essentially important exposure. That's negative presumption.

And there was a negative presumption in the post-1995 memo that was recently rescinded, right, that exposures after '95 are under control.

So there are some -- we don't emphasize them -- but there are entities such as negative presumption.

So, Dr. Boden, what have I forgotten in this brief review?

MEMBER BODEN: You're perfect.

CHAIR MARKOWITZ: Okay. Like a student of Dr. Boden.

Okay, so a reminder. Presumptions were incorporated in the original act. And I

have a summary up here of this. This is a summary. I don't provide every detail in the act, but there are examples of how the act accepted the route of presumptions.

And I mentioned before the Special Exposure Cohorts at the gaseous diffusion plants. If you worked one year prior to '92 where dosimetry monitoring was part of your job or a comparable job, and that was sufficient exposure to be linked at one of 22 cancer sites.

And there was also an exposure on silica for a different outcome for non-malignant lung disease, silicosis. And there, again, an exposure, kind of the exposure criteria was set out, which was years of work near, during or near the tunnels of the mines.

I'm going to talk a fair amount about asbestos and then talk about asthma. And this way of looking at things actually was reflected in Dr. Welch's approach to COPD. And we'll hear it again in relation to hearing loss.

But we try to capture, understand

elements of exposure whereby we can make the judgment: was there sufficient exposure to cause, contribute, or aggravate disease? And, obviously, we look at how long a person did that. We are interested, to the extent we can, in which calendar years. Exposures in the '60s were worse than exposures in the 2000s.

Job title for us is really a proxy for trying to understand how much, how intense the exposure might have been, what the tasks would be, and then the frequency of exposure.

And then, finally, latency. To the extent we need to, we recognize that a typical pattern for a chronic disease caused by occupational factors is that the onset occurs at one period of time, and the disease usually doesn't occur, such as cancer, for 15 years or 20 years or 30 years or 40 years. And that gap in time is called latency.

And Dr. Welch addressed it in the COPD, essentially saying there was no latency in the instance of that illness. But that's not

true for cancer.

So here I'll just summarize. I'm going to use this kind of table later on to discuss asbestos, so I just wanted to introduce it here for cancer and silica. This is from the original act. Duration, job title, or calendar years, if they were specified, and the issue of latency.

So asbestos appears in the procedures manual, it appears in the bulletins, circulars. It's a popular topic, relatively popular topic in the guidance provided by the department. And the new draft on presumptions also addresses -- that's part of -- that's being elaborated by the program also addresses asbestos and really summarizes and somewhat changes these.

To remind you, we're talking about a number of different diseases in relation to asbestos. The ones you've all heard of, such as asbestosis, which refers to scarring of the lung tissue itself caused by asbestos; asbestos-related pleural disease, which is scarring of the

lining of the lung called the pleura, which is a non-malignant disease; and then lung cancer. Mesothelioma, which is a malignancy of the pleura, although it can also occur in the abdomen and a couple of other locations, and which is fairly uniquely related to asbestos.

And then cancer of the larynx and ovary, which have been related in repeated studies of workers and others as having a high association with asbestos exposure and considered causally related.

And then, finally, COPD, which we'll go into in a bit. But, really, in I think looking at asbestos presumptions, frankly, COPD ought to fall within the COPD presumption. It's just much clearer if it does.

I have to spend a couple minutes reviewing what the current procedures and policies are. In order for us -- and I've done this within the working group, and I apologize for repeating some of this, but it's hard to remember this, and we need to understand what it

is that we're trying to simplify.

So the exposure, initial piece from the procedures manual said that when the CE looks at an asbestosis claim, the DEEOIC accepts the asbestos was common in a complex. While asbestos did exist at DOE facilities, the nature of employees' exposure would have been varied based on different factors during the period in which they worked, type of work performed, and the location of employment.

And so, then, and this is in Bulletin No. 13-02, the program looks at asbestos specifically around ovarian cancer. And this came up, I think, just so you understand the history, this came up because ovarian cancer was declared in 2012 by the World Health Organization, specifically the International Agency for Research on Cancer, IARC, to be caused by asbestos exposure. So that was the first kind of consensus -- I think it's safe to say it's the first consensus recognition that ovarian cancer was caused by asbestos. And the department

elaborated this bulletin.

So the exposure presumption here is the 250 days of significant asbestos exposure. So, a year. "Significant" is defined as having a job title in List A. I showed List A before. I'll show it again, but it's a set of mostly building trades-type job titles.

Prior to 1986. And there should be 20 years latency between onset of exposure to asbestos and diagnosis of ovarian cancer. Or if the woman has asbestosis or mesothelioma and then has the terrible luck of also developing ovarian cancer, that the exposure would be accepted because they have this other evidence of significant asbestos exposure. This must, hopefully, be extremely rare.

Then here's -- I don't know if you can read it on the big screen, but here's the list and the reference from CDC, 2014, of the jobs that are accepted as involving significant exposure.

Moving on to asbestosis or the

scarring of the lung tissue itself, the 250 days of exposure is required, 10-year latency. And perhaps this slide got out of order. We've finished the ovarian cancer issue.

Claims that don't meet the exposure presumption criteria will be treated individually by the CE and, when needed, by the industrial hygienist. So this is important because presumptions are good and can help the process, but if people don't meet the presumptions they need to be evaluated individually to make sure that they have their fair evaluation.

And then the instruction to the CE is, for claims with more limited evidence of asbestos exposure, refer to a medical opinion, which is the CMC.

So here's a summary of these two -- of the six asbestos-related diseases, cancer of the ovary, asbestosis. Duration is the same, 250 days, 250 days.

Now, there is a more recent bulletin relating to COPD and asbestos. And as Dr. Welch

noted this morning, you need 20 years of exposure for there to be an accepted exposure and claim. And the job titles, they mostly come off of List A. Although for COPD there is the option of having the IH examine the claim.

And then for calendar years, for ovarian cancer it's 1986 is the cut-off for significant exposure. For COPD it's 1980. And then latency, one is 20 years, asbestosis, 10 years. In COPD it's not elaborated.

So, this is Circular 15, which addresses a number of asbestos-related diseases. That's what ARD stands for. And here is a sequence of instructions around understanding the exposure, which we believe should be simplified, which is that post-1986 work at DOE, assume that the potential exposure to asbestos, that there was potential exposure, but at levels below accepted standards. And accepted standards we think refers to the OSHA standard or the equivalent. So, after '86 there might be exposure, but assume that it's under control.

However, for the 19 occupations on that list I just showed, they have potential for greater exposure between '86 and '95, and so the claims examiner is to accept that they were potentially exposed to asbestos, but likely at low levels.

So, for the claims examiner to accept a level of asbestos exposure above the low level, above the level that's assumed, there must be definitive and compelling evidence to show that exposure after '86 at DOE had consistent unprotected contact with asbestos or asbestos-containing materials.

So what the CE is instructed to look for here is, for exposures after 1986, that somewhere in the record it shows that the worker had consistent unprotected contact with asbestos or asbestos-containing materials. And then the CE is provided with a list of various sources to look for this consistent unprotected contact.

And if the evidence is suggestive that the exposure is above the guidelines, then the CE

contacts industrial hygiene regarding the industrial hygienist's evaluation of the facts.

This circular says, at the end, however, that any findings of exposure, including infrequent, incidental exposure, require review of physicians who opine on the possibility of causation. This is necessary, as even minimal exposure to some toxins may have significant aggravating or contributing relationship to the diagnosed illness.

So the CE, having made some decision about whether there was significant enough exposure to refer to the IH, is instructed that even if there is infrequent incidental exposure which sounds like it's insignificant, that the CMC should be involved.

And I don't know how this policy actually played out in reality, but on paper it appeared potentially a little confusing.

So just to summarize then. Elevated exposure is greater than 250 days of work on List A, prior to '86. That's recognized.

Post-'86, assume asbestos exposure was below the accepted standard, except for List A workers.

And for those List A workers in the following decade, assume they had potential exposure but it was likely low.

And to demonstrate greater-than-low-level exposure post-'86 you need definitive and compelling evidence to show consistent, unprotected contact with asbestos.

So if that condition exists, then refer it to the industrial hygienist. But if you find any exposure, it only requires the physician review.

And so this raises a number of issues. One is it wasn't clear what are we presuming about exposure prior to '86. The List A that was constructed that likely had low exposure, this was not necessarily -- this is not evidence-based, certainly not based on evidence from Department of Energy. We know where it came from, but not specific, certainly, to DOE.

Designation of exposure between '86 and '95 is deemed likely low. It doesn't really facilitate decision-making about a claim.

And then, the CE has to use what is a difficult-to-apply standard of consistent, unprotected contact with asbestos-containing material.

So, so remedies. Some items that we can focus on in order to try to improve the clarity of the asbestos presumptions. One is that is List A big enough? Does it, is it all-encompassing enough in terms of what we know about asbestos exposure?

What do we know about likely post-1986 exposures to asbestos?

Can we settle on any calendar year that's sensible? In our last meeting we voted on a recommendation that DOL rescind the post'95 circular which basically says assume post'95 exposures in general were controlled. And part of the rationale was that we thought that picking a precise date really didn't reflect reality.

And then can we consider a minimum exposure duration and latency that is somehow consistent across the asbestos-related diseases?

So, that's the background. And now I'll get to the point.

I'm not going to give you the recommendations first. I want to give you sort of the rationale for them, which is asbestos-related diseases are common at Department of Energy. And my evidence is that in the Former Worker Program we have examined 73,000 DOE workers since the year 1998. And 12 percent of them have evidence on the chest X-ray of asbestos-related scarring. That's not cancer, because we don't collect, in the Former Worker Program we don't collect information about asbestos-related cancers.

And then if you look at individual sites -- Savannah River, Paducah, Hanford, et cetera -- you can look at the percentage that have, either on the construction site, or what are called the production site. Production, as I

said before, is everybody else on the site. So it's maintenance, administration, engineering, service, et cetera. That up to a quarter or a third of those work forces have asbestos-related scarring.

Now, it varies significantly across the sites. In general, it's higher in construction than in the production side. Some of the production side it's 5 percent, 7 percent. I don't want to mislead by saying a quarter to a third of all, because it is quite variable. But it's remarkable that at some sites it's quite common. And not just in construction, which in a way we might expect, but also on the non-construction side.

And this is evidence across the complex at most or all of the sites that there is asbestos-related disease.

I included a picture here from yesterday's tour. We had a very nice tour, thanks to Greg Lewis, Department of Energy, actually for setting this up. And thank you to

our hosts here at Hanford for showing us the site. We spent seven or eight hours going around the site yesterday, so we had a taste of what goes on at Hanford.

And this picture is a picture I took at B Reactor. Very nicely contained asbestos, with a beautiful label on it. I'm sure it's not a hazard to workers.

In general, Item Number 4 is not just within the DOE complex, but in general decades of research on asbestos has clearly demonstrated that maintenance workers and construction workers suffered asbestos-related diseases. That can be in a refinery. It can be in a chemical plant. It can be in, you know, construction in New York City. They have the same experience because of how much asbestos that was routinely used in different products in a variety of settings.

We also know that relatively modest amounts of asbestos can cause asbestos-related diseases. And it varies somewhat, depending on the disease.

And we also know, in general, the time frames of asbestos use in the United States, including DOE, which is that the use dramatically dropped off in the 1980s. But there was a tremendous amount of asbestos in place, and there still is, after the time when asbestos was stopped being, for the most part, introduced into the workplace.

Asbestos has never been banned in the U.S. Some uses have been banned. But to this day we import small amounts. We import some friction products, some textiles, some roofing material. And, hopefully, someday it will be banned.

So this is the recommendation. And there are I think three or four slides. So let me just read it, so then I have a summary slide.

That all DOE workers who worked as maintenance or construction workers at a DOE site for 250 days or more prior to January 1st, 2005, and who are diagnosed 15 years or more after the initiation of such work with one of five

asbestos-associated conditions, will be presumed to have had sufficient asbestos exposure. But it was at least as likely as not that asbestos exposure was a significant factor in aggravating, contributing to, or causing such asbestos-associated conditions.

And the five conditions are asbestosis, asbestos-related pleural disease, lung cancer, cancer of the ovary, and cancer of the larynx. So that I took mesothelioma out of this because they have a somewhat different set of exposure criteria.

So, 250 days or more prior to 2005, diagnosed 15 years or more after onset of work with asbestos will be presumed to have significant exposure.

And I'm going to get into why we kind of came on these particular numbers.

But for malignant mesothelioma, which is the cancer of the lining of the lung or the abdomen, and is known to be caused by quite modest levels of exposure to asbestos, that here,

for DOE workers that worked at maintenance or construction DOE site for 30 days or more prior to 2005, and who are diagnosed 15 years or more after the onset of such work, and who are diagnosed with malignant mesothelioma that they are presumed to have sufficient exposure to meet the standard, which I won't repeat.

And that all claims for one of the six asbestos-associated conditions named above don't meet these two exposure criteria will be referred to industrial hygienist for exposure assessment and to a consulting medical physician for evaluation of medical documentation and causation. And this is to recognize that workers who did not work in construction or maintenance, many of them had significant asbestos exposure, we may not be able to make a presumption for those categories of workers, but that they should be evaluated carefully if they're claiming an asbestos-related disease, both by the industrial hygienist, who can hopefully clarify the extent of their exposure, and also by the physician, who

can make a judgment about whether the quantity of exposure justifies causation and claim acceptance.

And then, finally, the chronic obstructive pulmonary disease may have a contribution from asbestos exposure. However, claims for this disease should be evaluated as part of a broader set of presumptions for chronic obstructive pulmonary disease. Because there's just so many other exposure agents that cause COPD I couldn't really, I don't think there's a strong rationale for separating it out from the other agents, frankly.

And, so, a summary. This chart summarizes for mesothelioma, which is the second column. Third column is asbestosis and asbestos-related pleural scarring. And then the final column on the right is for lung cancer, cancer of the ovary and larynx.

That the duration for mesothelioma would be shorter, 30 days. The others it would be one year.

All job titles within maintenance and construction would be included.

The calendar years would be prior to 2005, which I will discuss in a moment.

And the latency would be uniform across them, which is 15 years.

You could have an asbestos-related disease at 12 years of latency but it would be uncommon. And it can be accepted through a non-presumption route. It would be evaluated by an industrial hygienist and a physician and a decision would be made. It is a very uncommon -- it would occur very uncommonly.

So let me just close this. I think this is -- yeah. A little monolog here on the issue of calendar years.

So there's a choice to be made. You could, as in the COPD recommendation, not specify calendar years and just say if you worked for 250 days maintenance or construction and you developed asbestosis 15 or more years ago, we're going to compensate you. But the fact is, that

doesn't really recognize the reality, that over time asbestos exposure was reduced. It wasn't reduced on a precise date, but over time it did, it did become lower.

And 1995, the mid-'90s is not a bad date for some demarcation of lowering of exposure. First of all, asbestos use dropped dramatically in the 1980s, not just at DOE but across the country. And then it took a while, then 1994 OSHA revised, made its revision of the asbestos standards and it halved the allowable asbestos. And I think there was a policy document within DOE in the mid-'90s relating not just to asbestos but to the set of exposures.

So, you know, as a Board we didn't feel comfortable with the 1995 cutoff in terms of the previous circular we looked at in the fall because we thought that it wouldn't reflect reality that a given date or given year that exposure would go from important to unimportant. So the approach here is to say, okay, in the mid-'90s, by the mid-'90s there probably was

considerable drop. But let's use a 10-year safety margin.

Let's say that if the policies changed, use dropped in the '80s and into the mid-'90s, that it took an additional 10 years for that to become routine practice in the complex, for that dissemination, for the diffusion of knowledge, and for general adoption by the work force of methods of working that really meant significantly less exposure to asbestos.

So this was sort of a compromise between ignoring calendar years, which seemed somehow not to reflect reality, and setting an arbitrary, unrealistic calendar years demarcation like 1995 in which a pronouncement would suddenly lead to absence of exposure, and allow a 10-year phase-in period where exposure would most likely continue to drop, in part because workers accept -- you know, were educated, accepted, and it was accepted on the shop floor that you wouldn't work with asbestos in an uncontrolled fashion.

So that's the proposal on asbestos.

So, comments? Dr. Welch.

DR. WELCH: Although I did have the chance to comment on this prior to the meeting, I think I've just been thinking about it more. I think like we may need, for the non-malignant asbestos-related disease we may need some medical diagnostic criteria to go with it. Because in a way, when you build in, you know, if you build in a really high exposure as your exposure criteria you're saying if there's non-specific scarring in the lung but somebody was an insulator who had 30 years of exposure before 1980, the chance that's asbestosis is very high.

But as we lower the exposure requirement, then the likelihood that an abnormal finding on a B read is asbestosis is lower. But the current system doesn't require the claimant to come in with a specific medical diagnosis of asbestosis. Generally they come in with findings on a B read or a chest X-ray.

So, we might think about how we could add some diagnostic criteria that would, which

would make the process easier. Because we're saying asbestosis but I think the claims examiners or the department is going to say, well, how do we know what's asbestosis then in the context of, this is new? And that's kind of separating in your mind the exposure requirements and the medical diagnostic requirements for those two particular diseases they tend to, you know, we can't diagnosis asbestosis unless you've had enough asbestos exposure that it's likely that the scarring is due to asbestos.

And 250 days is low for causing asbestosis, if that was the only exposure. We picked that number because it would certainly be contributory with other exposures, but you have to somehow know you've got the right diagnosis.

CHAIR MARKOWITZ: Sure. Dr. Cassano.

MEMBER CASSANO: I agree with Dr. Welch on this because a couple of cases that we looked at, pleural plaques -- and I know you include pleural disease -- but pleural plaques in and of themselves create no disability without

fibrosis or reduction in pulmonary function tests. And yet I see people -- and I wasn't going to say this -- but I see that people are compensated just for the evidence that there are pleural plaques, and compensated handsomely for that. And not -- there's no real disease diagnosis there.

So, I think that's something we may want to look at.

CHAIR MARKOWITZ: Mr. Domina is next. But if you have a specific response to that, Dr. Welch?

DR. WELCH: I do. In that the -- it's my understanding under Part E what you get in terms of compensation is medical and weight and impairment rating. So that it's possible that what you're seeing is someone who has two conditions, they have asbestos-related pleural plaque and they also have COPD. And the claim has been accepted for asbestos-related pleural plaque, and they end up getting an impairment reading related to it.

It's okay with me because they have the underlying disease that's also related to the same exposure. But it's not, you know, under Part B there's cash awards. Under Part E there's no cash award. So the -- you might want more precision but I -- it's unlikely that people with asbestos-related pleural scarring and normal pulmonary function tests are getting a big impairment rating. That would be extremely unlikely.

So, but anyway, that's just my two cents. I haven't looked at those same cases before.

CHAIR MARKOWITZ: If I could just, before I move on to Mr. Domina, just so people are clear. Asbestos-related pleural disease is a disease. It is pathology. The pleura is not normal.

And if it's relatively small in extent, then it's unlikely to affect pulmonary function or provide symptoms. If it's extensive, then it can clearly impact pulmonary function.

I just didn't want people to think that asbestos-related pleural disease is not a disease. It is a disease.

All right, Mr. Domina.

MEMBER DOMINA: My comment has to do with the year 2005. Because I don't know if I can live with that. Because of, you know, the late '90s everything went to performance-based contracts. Yeah, maybe they didn't use asbestos anymore, but they also didn't take care of it based on funding or whatever because you look at what's happened, like, during stimulus or what goes on now when they have an asbestos issue, there's had to have been stop works to take care of it, or a certain contractor was fined into the six figures when they imploded a building that they videoed because of the amount of asbestos they put in the air.

And so just, you know, it's -- I don't know if 2005 is going to work for me. I think it needs to go later just for the fact on how things, business is conducted today. You know,

and it's just like what we talked about a little bit yesterday is that when you have run to failure, how much stuff is already failed because a switch turned something off? It's considered still running.

And I just think that I don't believe 2005 is late enough.

CHAIR MARKOWITZ: So is that an argument against using any calendar year? Or would you simply move it to 2008 or 2010?

MEMBER DOMINA: Yeah, I'd probably go to '12 or '15. I mean, just because of what I've witnessed and some of the things that have transpired. And if it's happening here, it's happening across the complex.

CHAIR MARKOWITZ: Okay. Okay.

Ms. Vlieger.

MEMBER VLIEGER: I would like to agree with Mr. Domina. As the planner at the Hanford Site, even though I wasn't a maintenance craft, I was in the field with the maintenance craft planning my jobs, that we do walk down in

contaminated areas. And the amount of asbestos that's just there, and it's not going away, it's not being replaced with something else because it's too expensive to alleviate it.

And here in our climate we have a high desert clime with temperature exchange and wind, and the asbestos becomes friable. It's not immediately fixed in your breathing zone. There just, there you're told, well, just don't brush up against it. But that's not sufficient.

And so until all of the sites go to the ground, you know, they're leveled and no longer exist, I think because of the age of the buildings we're dealing with we have to consider that the exposures are not going to go away.

And I really have a problem with what is the definition of low level asbestos exposure? Because to my knowledge there is no safe level of asbestos exposure, it just depends on your personal physiology and DNA how you're going to react to it. I'm not a physician, but that's my understanding of it.

So what exactly is low level or insignificant.

CHAIR MARKOWITZ: So, let me ask, so in this recommendation we remove any designation of low level or insignificant.

MEMBER VLIEGER: Until you get to the non-production workers. Until you get to the other workers and then it's established by the IH and CMC whether or not it's a significant factor. And there we go with significant again.

So, couple that with the fact that we know there are no individual monitoring records in the personnel records. So that when you go to a non-production worker, I'm a non-production worker at the site, and if I come up with one of these diseases I have to prove, because I'm outside this window, this presumption that we're making, that I was exposed. It's nowhere in my work records. It's nowhere in my performance appraisal. I was not an asbestos worker, so it's not in that medical record. And I would have to prove by showing some monitoring data.

We have no monitoring data. And that's been corroborated by the Department of Energy. They have it. It's not available to go into personnel records.

And so we are creating a left-out class, if you want to put it that way, of people that are in the field side by side with the craft workers on a daily basis.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I am not sure this is the correct solution, but there is different overlap of asbestosis with the pneumoconiosis or just pulmonary fibrosis in reality and also in the current guidelines. And so because and I think one of the issues for mesothelioma and lung cancer and pleural plaques, I think that recognition of those is relatively straightforward.

I think the asbestosis becomes sort of the most programmatic in, you know, is it ILO reading on a chest X-ray? Is it restriction on your pulmonary function test? Is it a low

diffusing capacity? And having reviewed some of the pneumoconiosis claims, I think even if you decide on a nice template, the implementation of that very quickly gets sort of complicated.

So I don't -- wondering whether one took the asbestosis piece and could have kept it with the pneumoconiosis. I mean, because there is -- I mean, if you wanted to take a presumption approach, you know, pulmonary fibrosis interstitial lung disease is relatively an uncommon disease. And if you've been having a lot of metal dust and particulates, you know, that is an increased risk. And if you -- you could have a presumption for pneumoconiosis that would maybe simplify this whole group of the asbestosis and the pneumoconiosis group.

CHAIR MARKOWITZ: So you, so --

MEMBER REDLICH: You know, I just think that this piece, because, you know, I think even if one settled on this, the actual decision-making about what constituted asbestosis could get sort of complicated and also overlap with the

pneumoconiosis.

CHAIR MARKOWITZ: So you're arguing, as Dr. Welch, for setting out medical criteria for the diagnosis?

MEMBER REDLICH: Yes. Especially I think the mesothelioma and the others are, but I think the asbestosis is the one that.

CHAIR MARKOWITZ: Dr. Boden.

MEMBER BODEN: I'm trying to think through this a bit, and also think about the point that you raised at the very beginning about presumptions we're trying to sort of balance false positives and false negatives. And that's always tricky. That's what the 2005 is trying to do.

It does seem to me that you could consider the diagnosis and the pre- or post-2005 as being sort of balancing things. So that if you go more towards the medical diagnosis, maybe you need the cutoff dates less. And if you go with the cutoff date, maybe you need the diagnosis less.

Which means to me maybe you kind of choose one or the other as a way of sort of balancing these things out. That's, again I'm not claiming expertise on the disease but just trying to think about the balancing that we're trying to do.

And I do think that you're right in pointing out that there are workers that are left out of this. And then the question is sort of that shouldn't mean that they're left out of being compensated for those illnesses. But it might be that it's harder for them to get compensated, and that maybe you need to show somehow that there was uncontrolled asbestos exposure. And I don't know how easy or hard that is. You know much better than I do.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: I tend to agree with the concept of removing the 2005. The way we look at it in shipyard workers and in naval vessels, as they said, these buildings are old. And the way it's looked at is any ship whose keel

was laid before 1978, you have to assume that asbestosis was present and anybody on that ship was basically exposed.

So, 2005 again is arbitrary. You have a person that's working in a building that was built in 1957 or even earlier than that, 1945, they haven't removed that asbestos lagging. If something happens or, you know, there was some kind of incident where they had to get into the pipe, I know for a fact that nobody ever goes there and brings the, you know, takes a little sample first and sends it off to industrial hygienist. They rip the darn lagging out and it's over and done with.

So I think 2005 is too arbitrary. Unless a building is so modern that it, you can prove that it was built without the use of asbestos in the lagging or the walls or whatever.

CHAIR MARKOWITZ: So we're going to take one more comment, then we'll go on break.

Dr. Welch.

DR. WELCH: Well, I think, you know,

if you remember that the presumption is a presumption and that it's going to -- there are some people who should be compensated but you need an individual review to figure out who that is. So even if there was exposure after 2005, it's not -- it shouldn't -- I don't think we can assume it's to everybody in the complex, which is what we're saying. Maintenance and construction before 2005 there's general exposure, and after 2005 it would be particular people but not everybody.

So I think having a date is reasonable as long as we have a process where the people who had injurious exposure after 2005 can have their case reviewed without it being extremely burdensome. So we may have to think about that as part of this and how we word that.

CHAIR MARKOWITZ: Okay. So we're going to -- I'm sorry -- we're going to take a break for 15 minutes. We'll reassemble at, 3:00, roughly 3:20, 3:22.

Thank you.

(Whereupon, the above-entitled matter went off the record at 3:08 p.m. and resumed at 3:26 p.m.)

CHAIR MARKOWITZ: We're going to break a few minutes before 4:30 to prepare for the public comment session.

We have 15 people who have requested time. So, today I ask you to -- we have a 90-minute period to ask for public comment. Giving a little bit of warning about this, to limit your comments to about five or six minutes so that everybody gets the same amount of time. I know it's not much time, but concentrate your thoughts, I guess.

Okay, so let's see, Dr. Welch. Do we have Dr. Sokas on the line?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Okay. Mr. Griffon?

MEMBER GRIFFON: Yes, I'm here.

CHAIR MARKOWITZ: Okay. Thank you. And Dr. Welch, looks like she'll be back in a minute.

Okay, so let's continue the discussion here. Mr. Whitley.

MEMBER WHITLEY: As we've talked about presumptions, talked about what Les was talking about, it's kind of a balance. And I would think that from 2005 to present that the way we handle asbestos, and especially asbestos abatement and that kind of stuff, was with policy and all that now.

The problem I've got is what they said, there is groups like HPs and IHs, the supervisors and other lot of groups, that this is going to not put in the presumption. It doesn't mean that they can't still file as they do today, it just means they've got to prove it a little different.

And for the presumption, the balance the way it is, I can live with the way we've got it.

CHAIR MARKOWITZ: Dr. Redlich.

I mean, I would point out, just to follow up that the current policy on List A, the

list of 19 or so specific job titles and closely related job titles. And this proposal really expands that quite considerably to encompass all maintenance and construction workers. It's not saying that others might not be exposed, it's just saying it's a matter of presumption these very broad groups would be presumed to be exposed.

Dr. Silver.

MEMBER SILVER: Could I ask you to put up the language for the IH and CMC evaluations of people who don't fit? Okay.

I wonder if we could move in the direction of Kirk Domina's concerns by borrowing an idea from the statute itself. Under definitions, member of the Special Exposure Cohort for the original Paducah, Portsmouth, and Oak Ridge includes the phrase "was monitored through the use of dosimetry badges for exposure at the plant of the external parts of the employee's body to radiation, or worked in a job that had exposures comparable to that."

By analogy, Congress didn't trust the results of that monitoring that went on. And the union proved and the Washington Post proved that it was held. So just the fact that people were monitored gets them into the Special Exposure Cohort.

So, by analogy, we have reason not to trust a lot of the asbestos abatement work that has happened post-Cold War. What if instead of letting the industrial hygienist look for individual level monitoring data, we tweaked it in a manner analogous to the SECs and say that the person was on a job where area monitoring took place for asbestos.

Why do you do area monitoring for asbestos? Because there is abatement going on. And it doesn't matter what the results were. And you certainly wouldn't have to show the individual had exposure, but they were present in the building that underwent asbestos abatement. How do we know? There was area monitoring.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: So for workers who are not in an ongoing asbestos surveillance program they would present with chronic lung disease, which basically would be either COPD or some form of pulmonary fibrosis.

So, as you pointed out, the link, you know, COPD would fall under whatever the COPD presumption. So then you have workers who have pulmonary fibrosis or pneumoconiosis. And the question would be is that related to their asbestos? Which, I mean I think what you would want to ask is it just related to their work and all the other exposures, machine work and everything else?

So, I could imagine the scenario where asbestosis is, you know, asbestos is denied because for either, you know, one of these reasons but where they might have a work association.

So I just mention that. I think that that group of diseases is problematic, both in terms of determining what you're going to use as

criteria for having it, and also the association. You know, from -- and I probably know less about all of the different processes, but from the two site visits that we've been on, I have been very impressed with the extent of machining work that went on. And the occupation that is best associated with "idiopathic pulmonary fibrosis" is machinists and machining work. You know, metal, separate from beryllium, just exposure to metals.

So I'd just be concerned about this framework. I think it's where there is a clear, maybe, asbestos exposure but I think that -- and this would partially depend on how the claims are coming in -- but I think realistically it's going to be, if you have chronic lung disease, it's going to be either COPD or fibrosis.

CHAIR MARKOWITZ: I am not sure who's next. Dr. Cassano?

MEMBER CASSANO: No, I'm fine.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: Well, again, I am just

asking questions to try to clarify. So what you've just said, I'm trying to figure out what the implications are of what you said. So are you possibly suggesting that there be a pulmonary fibrosis presumption that is parallel to the COPD presumption, and that asbestosis would fall into that?

Or what are the implications of what you said?

MEMBER REDLICH: You know, I'm not, I'm not sure what's best. All I'm saying is that there currently is a category of pneumoconiosis. And so all I think is that in thinking about that category we should just consider asbestosis also being aware of the pneumoconiosis group. That's all.

CHAIR MARKOWITZ: So, you know, my view on this is that we know more about asbestos-related diseases so we, to be more confident in setting out some presumptions that we have confidence in. Asbestosis is part of a larger number of interstitial scarring diseases that

you're raising. Maybe we should treat them as a class in relation not just to asbestos exposure but to a whole variety of other exposures.

To me that would be a different issue, a different set of presumptions. And this could be nested within that, but we know more about asbestos than those others, and so I would argue we continue with this. And then if we want to look more generally at this interstitial scarring disease we can.

MEMBER REDLICH: I think that's reasonable.

CHAIR MARKOWITZ: Dr. Welch.

DR. WELCH: I just want to get back to what Ken suggested in terms of people worked on a job where there's monitoring. I think my concern about asbestos in place is that people were exposed without it being designated as an abatement job. Where, you know, somebody knocks into a pipe and whatever protective covering is off, and that's not fixed for forever, and there's just ongoing exposure from asbestos in

place. Or there's some emergency response and, you know, asbestos gets torn off. But there's no monitoring done during that activity.

Because generally when there's abatement going on there is control of a exposure. So, I don't think you're -- I don't think adding that would really address the question of how you identify the people who would have this intermittent, potentially, high dose, short term exposure because of running into asbestos in a place that hasn't been identified or controlled properly.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: Point taken. I thought it would be a step in the direction of Kirk Domina's concerns, not getting all the way there.

CHAIR MARKOWITZ: I thought it was creative actually.

Dr. Dement.

MEMBER DEMENT: Yeah, I think in the presumptions we need to acknowledge what the

reality is I think exists. I think we can safely say that asbestos exposures in the construction industry, and in the construction industry on the DOE sides, has decreased over time. Most of the exposures lift from installation to treating materials in place.

However, I think, as currently is discussed, you know, there are situations where even though we can say on average we decreased exposures, there are unusual circumstances. And they may be unusual but they may occur frequently. But I don't know how to incorporate those into a presumption. I think we have to be very clear that this is a presumption, it's not a value that you have to meet. There are other routes to get to it.

Unfortunately, and based on some of the reviews that I've done of the cases, I see the presumption values being used as you must meet these in order to qualify for compensation. So I just think we need to, if this is what we settle on, word it in such a way that we do know

and we acknowledge that there are these situations where even though controls are in place and relatively efficient, there are situations when they are not efficient and workers are exposed.

CHAIR MARKOWITZ: Well, we can certainly add that to the rationale.

I'm sorry. Ms. Pope.

MEMBER POPE: I have been involved in situations where as a bargaining unit safety rep where individuals have been exposed to acute exposure through a safety concern. And there have been many documentations of those events happening, whether they be on a routine basis of where something is supposed to operate in a normal manner, or we're doing a decommissioning of that building, those type situations did occur.

So, being able to track that information in terms of the people being exposed to an extreme amount of exposure at a certain time should be acknowledged as well.

CHAIR MARKOWITZ: Other comments? Dr. Sokas? Mr. Griffon?

MEMBER SOKAS: Nothing to add.

CHAIR MARKOWITZ: Okay, thanks.

So, the issue of setting out medical criteria for presumption is not addressed in this recommendation. And would be the subject, I think, of another recommendation. It requires -- it's not as easy as it would seem on the surface. And it requires some thought, I think.

So it's not going to be ready by tomorrow. So I would support considering modifying or adopting this recommendation as an exposure presumption recommendation. And then coming back soon enough with some medical criteria.

There is a balancing between the certainty on the medical criteria side, as Dr. Boden points out, and the certainty on the presumption side. But there's going to be uncertainty on both sides, and we'll just live with it.

So, it seems that I can leave the language of the recommendation, but it seems like the sticking point from the discussion here, or the point of most disagreement, or perhaps the only point of disagreement really is on the calendar year issue, is whether we should specify calendar year, whether we should use pre-2005 or something more recent, 2010, 2015.

And so what I propose, actually, is we delete -- that we vote on that separately, if it makes sense, that we vote on the rest of the recommendation and then vote on the calendar year. The alternative is to set out two alternatives with, one with -- or several alternatives, one without calendar years or different calendar years.

What's your preference, Dr. Boden?

MEMBER BODEN: I would suggest that's a reasonable idea. But I would reverse the order, try to see what level of agreement there is about the calendar year first. And then if there is substantial agreement -- I don't know if

there is -- then --

CHAIR MARKOWITZ: Okay.

MEMBER BODEN: -- it would be easier to vote on the second one.

CHAIR MARKOWITZ: That's fine.

Yeah, Dr. Welch?

DR. WELCH: I was thinking of another way to address it as well would be to make the calendar year more current but add more to the latency. Which would mean that exposures that are occurring intermittently are considered important but there would have been other exposures. Because the latency is sort of saying there had to have been exposures earlier that were also causative.

See what I mean?

CHAIR MARKOWITZ: Yeah.

MEMBER BODEN: Or is that too complicated? Just tell me forget it.

CHAIR MARKOWITZ: I think it's a little bit complicated, personally.

MEMBER BODEN: Okay. Forget it.

Never mind.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: No, nothing.

CHAIR MARKOWITZ: Okay. Okay. You know, the nut of this is that there's -- that the difference of opinion about the extent of exposure to asbestos, say, between 2000 and 2017. And that something that exposure was probably a lot less prevalent and others emphasize the fact that for certain populations there was continued significant exposure. That seems sort of the spectrum of opinion.

So wondering how to phrase this.

MEMBER CASSANO: Actually I'm thinking if we're talking about exposure that occurred pre-2005, so it wouldn't apply to anything where the last exposure was after 2005.

If you're talking about a latency of 15 years, somebody that was just exposed in 2005, you're not going to be adjudicating this, I think, until 2020. So I think we're kind of safe with going with 2005 for that reason. Think

about it.

CHAIR MARKOWITZ: Yeah, I have thought about it. I didn't think it was the best course of action to build in something that could become obsolescent in a few years, but.

MEMBER CASSANO: No, but what I'm saying is --

CHAIR MARKOWITZ: I understand, yeah. No, I get it. Yeah. Kick the can down the road.

MEMBER CASSANO: Well, no, it's not kicking the can down the road. But I think at 2020 if you're talking about an exposure pre-2005, then if they -- if the injury -- if they developed any of these diseases at all it would be in 2020. So the exposure level at 2005 would be much lower, is what I'm saying, at 2006 or beyond.

We're not looking at a case that develops in 2005, we're looking at the last exposure being 2005.

CHAIR MARKOWITZ: So let's --

DR. WELCH: So, I think we'll vote,

however.

MEMBER CASSANO: Fine.

CHAIR MARKOWITZ: What if we voted this way, what if we took a vote on whether we should put any calendar year reference in or not. And then if the vote is that we put a reference year in, that we select a couple of choices and then vote on that.

Does that sequence make sense?

DR. WELCH: Yeah.

CHAIR MARKOWITZ: Okay. So, then the recommendation is that DOE workers who had or who are presumed to have significant asbestos exposure, to be defined in the subsequent recommendation, prior to 2005, January 2st, 2005, will be presumed to have sufficient exposure to be at least as likely as not to be a significant factor in aggravating, contributing, or causing one of these five asbestos-related conditions.

Is that clear?

MEMBER CASSANO: That's clear.

DR. WELCH: Yeah.

CHAIR MARKOWITZ: Okay. Okay.

So, I need a motion to, motion to --

MEMBER CASSANO: You're proposing it with a vote on whether 2005 is the date?

CHAIR MARKOWITZ: That's right. The only right here is whether we should use -- holding everything else the same, all the other variables which we'll now vote on, we'll vote on after this -- that we use the pre-two thousand -- January 1st, 2005, as the relevant time period.

MEMBER CASSANO: So moved.

PARTICIPANT: Second.

CHAIR MARKOWITZ: Okay. Any discussion?

All those -- Yeah?

MEMBER BODEN: One quick comment. We are clear in the rest of this that, that in no way should be bad news for the people who don't meet that criterion, that they're still allowed to go forward? This is not a negative presumption in any way?

CHAIR MARKOWITZ: No, actually now I

just realized -- I had proposed that -- Hold on one sec. I had proposed that we vote first on whether there should be a calendar year, any calendar year or not; right?

MEMBER CASSANO: That's right.

CHAIR MARKOWITZ: Okay. So I'm going to re -- I'm going to withdraw that and reframe that.

So, the proposal is whether the set of exposure criteria should make reference to any calendar year as representing a important demarcation line in terms of identifying significant exposure to asbestos. So that's the recommendation at hand.

And I'm hoping, since we don't, we're not seeing it up here, that we're actually getting this somewhere. It's being recorded. Fine, we'll find it.

So, comments? Okay, yeah, go ahead.

MEMBER REDLICH: We may want to consider the malignant. Because basically the year is using that as a surrogate for amount or

dose of exposure. So for pleural plaques and asbestosis there is more a dose response than something like mesothelioma.

So I'm just wondering about the rationale of that year, given that you, this is something that would be going on into the future. If someone had, you know, worked around asbestos at a DOE site and that was, you know, their main employment and they got a mesothelioma, I wouldn't care that much about whether it was pre-2005 or post.

CHAIR MARKOWITZ: Okay. So you're suggesting a friendly amendment that we exclude mesothelioma from this recommendation.

Other comments on that?

(No response.)

CHAIR MARKOWITZ: So let's, is there a -- well, I accept that as a proposed friendly amendment. So let's vote on it.

All those in favor of revising the proposal, the proposed recommendation so that any calendar year demarcation applies only to the

five other asbestos-related diseases, excluding, if you look at the pink section, the last two lines, it would exclude -- or include those five conditions but it would exclude mesothelioma.

So all those in favor of that?

DR. WELCH: In favor of having no end date?

MEMBER BODEN: Can I suggest an order?

CHAIR MARKOWITZ: Yeah.

MEMBER BODEN: Because actually there are three things we're voting on.

CHAIR MARKOWITZ: Right.

MEMBER BODEN: One is the current thing. The other is without mesothelioma. And the third is nothing at all.

So I think we should vote on the nothing at all first and then --

DR. WELCH: I just wasn't clear that a yes vote --

MEMBER BODEN: Yeah. That's right.

DR. WELCH: So nothing --

MEMBER BODEN: For everything, right.

And then once we've settled that then we can deal with any other issues.

CHAIR MARKOWITZ: So the proposal, the recommendation is that we consider a set of time-related criteria which will be defined subsequently. But no calendar year reference for five asbestos-related diseases, excluding malignant mesothelioma. Okay, so this is no calendar year reference in the exposure criteria. Okay. Is that okay?

DR. WELCH: Yes.

CHAIR MARKOWITZ: Okay, any discussion of that?

(No response.)

CHAIR MARKOWITZ: Okay. All those in favor of that, raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: One, two, three, there are four present.

Dr. Sokas?

MEMBER SOKAS: No.

CHAIR MARKOWITZ: I'm sorry, what was

that? No. Okay.

And, Mr. Griffon?

MEMBER GRIFFON: No.

CHAIR MARKOWITZ: Okay. So there are four -- how many abstentions are there? One, okay.

So four in favor, one abstention.

How many noes? One, two, three, four, five, six, seven, eight, nine, eleven -- right, right, 11 noes. Eleven noes, 4 yeses and 1 abstention.

Okay, so that means that there's some favorable opinion towards introducing a calendar year.

Okay, so let's repeat this same recommendation, that is to say that DOE workers will be defined as having significant asbestos exposure, details to be provided later, if they had this exposure prior to January 1st, 2005.

Now, do we want to pick another reference calendar year that some people are comfortable with? Because there are a lot of --

DR. WELCH: 2005 and 2010.

CHAIR MARKOWITZ: Right, right. So --

MEMBER SOKAS: So, Steve, we've excluded mesothelioma; right?

CHAIR MARKOWITZ: Right now we're excluding malignant mesothelioma.

MEMBER SOKAS: Okay, great.

CHAIR MARKOWITZ: Yeah. So those who feel more comfortable with the later calendar year, any -- Mr. Domina, you wanted closer to 2015 or something; right?

MEMBER DOMINA: Right. Go big or go home.

(Laughter.)

CHAIR MARKOWITZ: Judging from what we saw yesterday at Hanford, I think that happens a lot at DOE.

MEMBER DOMINA: You know, I'm just stating what I've witnessed, what I've seen. And I know if it happens here, it happens across the complex. And it's a concern with me because I have a lot of younger folks that have causes

because of stuff that has transpired. And I also look at the type of work that's being done here and across the complex. And I also look at the age of the current work force and how much it's changing, and how many new people have hired on, like say since 2010 or '12. And I don't want people to be excluded.

I mean, I, I don't see -- yeah, they're doing some monitoring stuff. Is stuff being done safer? I don't know.

I mean, I also know you can monitor not to find things, too. And we've all seen that. I still think it goes on today. And I mean I just, part of my job is to protect everybody. And I just, my opinion.

CHAIR MARKOWITZ: Sure. But we need a calendar year. We need --

MEMBER DOMINA: Go big or go home.

CHAIR MARKOWITZ: Okay, 2015, is that big enough? So should I set the recommendation or the proposal 2005 versus 2015? Is that reasonable?

PARTICIPANT: You have to pick one for the vote.

CHAIR MARKOWITZ: No, I know, I get that. But I just want to lay out what the choices are.

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Okay, fine.

Then the exposure presumptions for asbestos with DOE workers who otherwise meet exposure criteria, that we will set out imminently, who had this significant exposure to asbestos prior to January 1st, 2005, will be judged to have substantial exposure sufficient to be a significant factor in causing, contributing, or aggravating one of the five asbestos-related conditions, that is excluding malignant mesothelioma.

So the first vote will be on 2005. And then we'll take a vote on 2015.

So any, any motions in acceptance.

PARTICIPANT: Move.

CHAIR MARKOWITZ: Second.

PARTICIPANT: Second.

CHAIR MARKOWITZ: Any further discussion?

(No response.)

CHAIR MARKOWITZ: Okay. So all in favor for 2005, raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: Okay, that's five votes present.

Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: And, Mr. Griffon.

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Okay, so that's seven in favor.

How many opposed?

(Show of hands.)

CHAIR MARKOWITZ: Six opposed.

And how many abstentions?

(Show of hands.)

CHAIR MARKOWITZ: One, two. Two abstentions. So that's 15.

So that's 7 to 6 to 2.

I have to confer with the designated federal official because we've never had a close vote.

(Off-microphone comments.)

CHAIR MARKOWITZ: Okay, so that's fine. So let's continue. We've got a consensus.

Now let's go with 2015. So that it's the same recommendation using January 1st, 2015, as the cutoff date. Second? I mean is there a motion to --

PARTICIPANT: So moved.

CHAIR MARKOWITZ: And a second.

PARTICIPANT: Second.

CHAIR MARKOWITZ: Any discussion?

(No response.)

CHAIR MARKOWITZ: Okay. So all those in favor of using 2015 as the key date in determining the significant asbestos exposure, using the same language as in the previous recommendation, all those in favor of January 1st, 2015, please raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: Seven in favor.

Dr. Sokas?

MEMBER SOKAS: No.

CHAIR MARKOWITZ: And, Mr. Griffon?

MEMBER GRIFFON: No.

CHAIR MARKOWITZ: Thank you.

So all those opposed to using 2015, raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: Five present.

And, Dr. Sokas. Oh, she said no. Okay. And he said no.

So that's 7 to 7. But I'm missing a vote. Oh, one abstention. Okay.

Okay, so I guess we'll try 2010. I'm not sure what else to do.

Sure, Dr. Welch?

DR. WELCH: So, just to try to convince people to come over to my point of view, I've been managing a medical surveillance program for sheet metal workers since 1985. And we have

looked at the change in asbestos-related disease on the chest x-ray over time, and particularly looking at people who started work after 1970, which is earlier than we're talking about in terms of disease.

But the EPA banned the spray-on asbestos-containing materials in 1973, which for sheet metal workers was the predominant exposure for them, that and thermal insulation.

We don't see asbestos-related disease, non-malignant asbestos-related disease in the sheet metal workers anymore. We see no asbestosis. And we see a tiny amount of pleural disease. Which is why I feel comfortable saying, you know, I'm saying we're looking at people whose exposure started after 1970, and that group of people. Here we're up to 2005.

So I think we have a pretty good safety, margin of safety there. And the kind of exposures -- and I might be wrong on this, but the intermittent exposures that are happening from asbestos in place, if those are the only

exposure someone has, they didn't have sustained exposure to demolition, uncontrolled demolition work or application work prior to 1973 or 1978, I don't think it's going to be sufficient to cause asbestosis.

It's definitely sufficient to contribute to cause mesothelioma. And we're not going to put in -- I think we've already had the consensus around the table, we haven't voted on it, there will be no cutoff date for mesothelioma. And that's the disease that occurs with much lower exposures.

So, I feel like the presumption will work better because we're not requiring very much exposure, you know, requiring a year of exposure and saying that that can contribute to asbestosis. And that's a low threshold for asbestosis, even considering that we're including years where exposure was pretty low.

So that's why, that's why I'm comfortable with 2005.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER SOKAS: And this is Rosie.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: I'd like to also echo what Dr. Boden said earlier which is that we're really counting on the fact that this is a presumption and that failure to meet the presumption does not mean you automatically get booted out. We simply go into the full evaluation.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I agree with what Laura said, that the likelihood of a new case of asbestosis or pleural plaques at this point is relatively low. But I do see, as a pulmonologist, I get referred a huge number of patients with interstitial lung disease related, you know, with the question of, you know, work exposure.

So I mean I think we should finish up this discussion and pick a year. But I think in practice and moving forward that the much more common scenario will be that a patient develops

chronic either ILD, interstitial lung disease, or COPD with a question of is their exposures at, you know, one of these sites where asbestos was probably not the major exposure.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: I just have a question. We're concentrating on the pulmonary diseases. Do we know that the same dose response holds for ovarian cancer as well? Or is ovarian cancer closer to mesothelioma in the dose required, the dose, the minimal dose that would cause ovarian cancer?

I don't know that answer. I don't know if there's enough investigation been done on ovarian cancer since its only been 2012 that it was considered by IR. Do we know that for certain?

CHAIR MARKOWITZ: No. But we can take a look at those studies quickly enough.

But mesothelioma really is an exception. And the nature of the studies are such that there's a limited number of studies on

ovarian cancer, and it's not possible that they could have, given those studies, identified a brief exposure to asbestos could cause ovarian cancer. Whereas, we can say that about mesothelioma, we can't say it about lung cancer.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: I mean mesothelioma differs from lung cancer in that respect. You need more exposure to contribute to lung cancer.

Yes, Doctor, I'm sorry.

MEMBER BODEN: So I just wanted to say that I've been abstaining but Dr. Welch has convinced me. Just so you know. At least you convinced one person. Probably the only one.

CHAIR MARKOWITZ: Ms. Vlieger.

MEMBER VLIEGER: I guess the question here is harm in excluding or including extra people. And so what harm does it cause to extend the calendar year for this presumption, rather than it being a matter of principle? But what harm does it cause to potential claimants? Does it really hurt anything to make the year further

out. It just means that there's longer time for people to make the claims or be eligible for the claims.

And I don't deal with anybody that wants to walk into an asbestos exposure or say, oh, well, you know I have asbestos disease and they weren't exposed. So my question is why are we at this point selecting a year.

CHAIR MARKOWITZ: I'll tell you what I think. It's credibility. I think if we're not making recommendations based on what we know about this exposure or other exposures, then it's not just our credibility as a Board but the credibility of the program, frankly, for making decisions based on scientific knowledge is compromised. I think that's the real threat.

MEMBER VLIEGER: So what is the current study, what does it say about asbestos at the DOE worksites?

CHAIR MARKOWITZ: Well, no, what we're doing is applying a broad literature. This entity, this exposure, this agent's been more

studied than probably any other, with the exception maybe of lead. And so we're applying what we know of DOE sites and what we know in general to these questions.

Do we know what the prevalence of asbestos exposure at a DOE complex in 2005 or 2010 was? We don't know that.

MEMBER CASSANO: There's no area monitoring for asbestos for those periods?

CHAIR MARKOWITZ: No, I'm sure there was -- I'm sure there was some monitoring. Abatement requires monitoring --

MEMBER CASSANO: Right.

CHAIR MARKOWITZ: -- so I'm sure there was monitoring. And I don't know the results of that, but it'd be surprising if the monitoring-based -- abatement-based monitoring showed much excursion from low levels because that's when they're paying attention.

Dr. Redlich?

MEMBER REDLICH: Yes. My voting against the 2005 was more just sort of getting

tired of our nitpicking about years because it seems that you have to have the diagnosis to begin with. And so if you did have the diagnosis, you know, whatever year you pick, so I agree that, you know, the likelihood of getting disease with more recent exposure is much lower.

I was just thinking more in terms of minimizing the back and forth over years because I think if you have to have the diagnosis. And so, really, what we're -- you know, if someone has bilateral pleural plaques, again, I think that's pretty pathognomonic for asbestos. And the other diagnosis we have here, we do have lung cancer and then we have asbestosis. And so it also -- I mean, it's -- anyway, I think we can vote again and maybe get consensus now.

CHAIR MARKOWITZ: Yes. So is it fair to retake a vote on 2005? Is that fair?

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Okay, okay. So we're going to revote on a recommendation -- whatever recommendation that is that DOE workers

will be considered to have significant asbestos exposure as a matter of presumption with details regarding aspects of the exposure to be provided imminently in the next recommendation when that exposure occurred according to those criteria prior to January 1st, 2005. And that such exposure will be considered as sufficient to be at least as likely as not a significant factor in contributing, aggravating, or causing any of the five asbestos-related diseases that is excluding malignant mesothelioma.

A motion to accept this?

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Yes? Okay. Second? Okay. So any further discussion? Let's just vote on this. All those in favor, raise your hand. One, two, three, four, five, six, seven, eight. There are eight hands raised. Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: And Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: So that's ten. All

those opposed? One -- and one opposed. And how many abstain?

CHAIR MARKOWITZ: Three people are too tired to vote. Maybe four. Well, anyway, we have ten votes -- ten in favor, so that's a consensus enough, the maximum of five votes. Otherwise, do we need -- two-thirds. Okay, fine. Okay, okay.

So, now, let's move on then to the rest of the exposure presumptions. And actually, I guess we can look at what we're looking at now which is that, here, if a DOE worker has worked as a maintenance or construction worker at a DOE site for 250 days or more prior to January 1st, 2005, diagnosed 15 years or more with one of the five conditions: asbestosis, pleural disease, lung cancer, cancer of the ovary and larynx; that they would be accepted as having substantial exposure for the basis of compensation.

Motion to accept and second? Okay. Any further comment?

MEMBER BODEN: Just a question. So

we're going to need to have a second bullet just specifically for mesothelioma?

CHAIR MARKOWITZ: Yes.

MEMBER BODEN: That doesn't include it?

CHAIR MARKOWITZ: Yes.

MEMBER BODEN: Okay.

CHAIR MARKOWITZ: Yes. Mr. Domina?

MEMBER DOMINA: I just want to make sure it's clear. When you're talking maintenance, you're talking about production workers?

CHAIR MARKOWITZ: No, no. We're talking about the maintenance worker workforce, not the production workforce. Well, maintenance, full-time -- the maintenance personnel employed by the prime contractor on site, that's what --

MEMBER DOMINA: All right.

CHAIR MARKOWITZ: Or Garry, you guys can explain to me better what a maintenance worker is, but not the construction worker who

comes -- builds a new building, major renovation. We're talking about a maintenance worker on site.

MEMBER WHITLEY: Maintenance production.

CHAIR MARKOWITZ: Yes. Okay, maintenance production, fine. Okay. All those in favor, raise your hand. Okay, so -- and that's all the hands here and then Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: And Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: So that's 15 votes in favor. So, now, let's move on to mesothelioma, and if someone could remind me what we're changing for the mesothelioma presumption.

MEMBER CASSANO: We're getting rid of the dates.

CHAIR MARKOWITZ: Getting rid of the date? Okay, okay. So the recommendation then would be all DOE workers who worked as maintenance construction workers at a DOE site for 30 days or more and who are diagnosed 15

years or more after the onset of such work with malignant mesothelioma of any bodily site will be presumed to have sufficient exposure to meet the standard of causation under the Act.

Motion to accept? Second? Any discussion? Okay. All those in favor, raise your hand. And Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: And Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Okay. So that's 15 votes in favor of this. I'm sorry. Could you just raise your request?

MEMBER BODEN: Sure. Can you change this on this slide so we have the exact rating on the slide for the record? Just deleting or more -- or sorry -- prior to January 1st. That's what you need to do.

CHAIR MARKOWITZ: Yes, thanks.

MEMBER BODEN: Okay. That's it.

CHAIR MARKOWITZ: Yes, yes.

MEMBER BODEN: Sorry. Can't use all

those signs.

(Pause.)

CHAIR MARKOWITZ: Yes. Okay. So if -- and when you've done that, Kevin, if you could move to the next slide. Okay.

So we should vote on this separately. Let me just read it. All claims for one of the six asbestos-associated conditions named above that do not meet the exposure criteria described in Items 1 and 2 above will be referred to an industrial hygienist for exposure assessment and to a CMC for evaluation of medical documentation and causation, and the six conditions are itemized.

So motion to accept this? Second? Any further discussion on this? I think -- okay. So all those in favor, raise your hand. One, two, three, four, five. Okay. Twelve votes. Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Okay. And all those opposed? Any abstentions? Okay. So 14 votes in favor and one abstention. Okay.

So the final recommendation in the series regarding asbestos has to do with chronic obstructive pulmonary disease. It may have a contribution from asbestos exposure. However, claims for this disease should be evaluated as part of a broader set of presumptions for chronic obstructive pulmonary disease.

So a discussion about this? Is there a motion to accept and a second?

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Okay. All those in favor of this recommendation, raise your hand. One, two, three, four. And Dr. Sokas?

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Mr. Griffon?

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: Okay. So that's 15 votes in favor.

I think that we should take a break

before our 4:30 to 6 o'clock public comment session. Are there any instructions before? We're going to start precisely at 4:30? We need to start at 4:28? What's -- how does it work?

PARTICIPANT: 4:30.

CHAIR MARKOWITZ: 4:30? Okay. And who will give us exact instructions at 4:30?

PARTICIPANT: You have a slide --

CHAIR MARKOWITZ: Okay, okay. So is there --

MR. FITZGERALD: I just want to -- I just want to remind everybody -- it's not on? There we go. I just want to remind everybody, if you're interested in making a public comment and haven't checked in with Carrie Rhoads yet, please do so. And for those of you on the phone, we'll be giving you instructions on the number to call in. In fact, I have it right now, so I might as well read it to you. It's 1-888-957-9863, and the passcode is 1930221#. Thank you.

CHAIR MARKOWITZ: We will reassemble at 4:28. Just please be prompt so we can begin

at 4:30.

(Whereupon, the above-entitled matter went off the record at 4:15 p.m. and resumed at 4:30 p.m.)

CHAIR MARKOWITZ: So we're going to begin the public comment session that goes till 6 o'clock. We have 18 people who have requested speaking time, so 90 divided by 18 is 5. So we're down, unfortunately, to five minutes for each speaker. And there'll be people who have a lot to say, so the problem really is it encroaches on other people's time. So I'd ask you to hold to five minutes, and I will, unfortunately, have to interrupt you when you're close to five minutes so you know that your time is up.

But let's begin. Terrie Barrie is our first speaker.

MS. BARRIE: Hello, Dr. Markowitz and members of the Board. Thank you for providing this opportunity for the public to make comments and offer insight into their claims problem. My

name is Terrie Barrie, and I'm a founding member of the Alliance of Nuclear Worker Advocacy Groups. I want to commend all of you for the excellent work you have done this past year and the accomplishments you have made in providing guidance to the Department of Labor.

To a degree, I'm concerned about the delay of the recommendations that you made back in October. And to a degree, I do understand the issues, as Ms. Leiton explained. But I think that in the future that there should be some kind of timeline set or deadline set that's something similar to what the Secretary of Health and Human Services has for the Part B SEC petitions. So I'd like to have somebody consider that possibly needs to go to Congress itself. But I think in order to make this program the best, that these excellent recommendations that this Board makes to Department of Labor needs to be acted on as quickly as possible.

I want to thank you for discussing the wage loss earlier today, and I think it would

help understand the issues if I gave you a little bit of background on the problems with wage loss. First of all, I've had many advocates say, I don't even recommend going -- or having my claimants file for wage loss. They'll never get it. This is what I've heard from, like, three or four different people. And Ms. Leiton, you know, explained what the procedure manual is and the polices are, and like you've noticed in other procedure manuals or training manuals, that doesn't actually reflect reality.

Wage loss claims are based on the claims examiners' evaluation of medical records to determine whether a covered condition contributed or caused wage loss. I am personally aware of two separate claims where symptoms of the disease were documented in the medical file that was -- and it was evident before the condition was diagnosed, and both of these claims were denied.

In one case, the claims examiner, at one point, demanded that the claimant provide

evidence, and I quote, of the frequency, duration, and severity of the flare-ups of the chronic condition, and this chronic condition was accepted. It was accepted because there was a documented incident of the worker ingesting radioactive materials. The chronic condition was not diagnosed until 1995, years after the incident, and the consequential disease, which was also symptomatic before the diagnosis and was diagnosed in 1997.

But the claims examiner wanted, like, more evidence. You know, how was this flare-up happening? And the only way the claimant or the worker could've provided that medical evidence was to undergo an invasive medical procedure each time that happened. And the frequency of that was happening, like, once a week, and that's just not medically sound or safe. And this evidence that the claims examiner wanted was in addition to the personal physician's -- three personal physicians' letters that were also in the file and submitted to Department of Labor.

Another huge obstacle for the claimants to overcome for the wage loss program is the requirement that the employee must earn wages before the claim trigger month. So if the person has symptoms of, let's say, pneumonia in January of 2006, but it wasn't diagnosed -- and went out work but wasn't diagnosed until March of 2006, but he didn't work before his diagnosis, he doesn't get paid because the policy is that they must earn wages before the claim trigger month. And this is contrary to the clear language of the law requirement.

I ask the Board to review some wage loss claims -- there's not a lot -- and determine if those claims are decided in consistent manner and identify to DEEOIC if there are any problems in implementing the procedure manual. I believe the claims examiners will greatly benefit from your advice about the nature of chronic condition and whether symptoms prior to a disease or a diagnosis of a disease would allow a wage loss claim to be accepted.

The legislation defines four specific areas which the Board will offer advice to the Secretary of Labor.

CHAIR MARKOWITZ: Ms. Barrie, just sorry to interrupt, but we're approaching five minutes.

MS. BARRIE: Okay. I'm almost done. I urge DEEOIC to consult with the Board while developing any issues -- or prior to issuing vital circulars, bulletins, or any changes in the procedure manual that will fall within the Board's responsibilities, and I thank you very much for your service.

CHAIR MARKOWITZ: Thank you.

Deb Jerison?

MS. JERISON: Thanks again to Dr. Markowitz and the Board Members for letting me speak, and I really want to thank you all for the wonderful job that you're doing. It's really appreciated. My name is Deb Jerison. I'm the director of the Energy Employees Claimant Assistance Project.

Recently, I heard from claimants that claims examiners are sending people to the National Cancer Registry to obtain additional information on their cancers. It appears that rather than one registry, each state has its own, and the type of information available is going to vary from state to state.

It's not an easy search for most people to make. I'm wondering if it might be more useful for the claims examiner to search these sites rather than asking the sick workers to do it. Is this something that the medical evidence subcommittee could look into to see if it's a worthwhile option for claimants needing additional medical evidence?

I think that finding a way of getting input from the lower level claims examiners is very important. The Board needs to hear from the people actually doing the claims as well as the supervisors. I think that the idea of an anonymous survey to gather this information is a very good one. Another option might be to reach

out to former claims examiners to learn from their experiences.

And I think it's a good idea of using a coworker model to provide exposure information for facilities without a Site Exposure Matrix. I also wonder if looking into using some of the existing NIOSH Part B technical basis documents and Site Profiles might be useful. Thank you.

CHAIR MARKOWITZ: Thank you.

Next up is Calin Tebay.

MR. TEBAY: Good afternoon. My name is Calin Tebay. I am currently the MSA employee health advocate at Hanford. I am also the sitewide beryllium health advocate at Hanford. I'm here today to discuss or request that the Board review the current DOL criteria -- diagnosis criteria for chronic beryllium disease and sensitivity. I have submitted a document to Ms. Rhoads. I don't know if that was distributed or not to everybody.

MS. RHOADS: It's up on the website.

MR. TEBAY: Okay. Basically, I wanted

to -- since we have not much time, I have submitted the clinical guideline for diagnosis of beryllium sensitization and chronic beryllium disease that was developed by Department of Labor and Industries in 2015. This document is the most recent, complete, and accurate document that we have that is aligned with the DOE complex.

A couple things you will find in this document that's different from the DOL criteria right now is, one, three borderline test results are an accepted criteria for sensitization. Currently, DOL does not accept that.

Two, this draws a distinct line between sarcoidosis and CBD. I also am a beryllium-affected worker. I was diagnosed with sarcoidosis early in 2005 and, through the process, was eventually diagnosed with chronic beryllium disease. And that was a very heavy path to walk, and I kept getting told that there was this fine line. Well, what I found out in that process, that line is not that fine. They are two very distinct, different diseases, and

they can be differentiated with the right testing.

That said, I'll give some other people some time, but I would hope that the Board would review this document in comparison with the current DOL procedure manual diagnosis criteria. Maybe send that to your medical evidence subcommittee and get some feedback on how we can improve the current diagnosis criteria.

CHAIR MARKOWITZ: Okay. Thank you.

Next up is Steven Peterson, and after Steven Peterson is Don Slaugh.

MR. PETERSON: Dr. Markowitz, members of the Board, thank you for hearing from me today. My name is Steve Peterson. I'm a manager for one of the major contractors here at Hanford. Mine is more an observation. As a person who has gone through the claims process, I'd like to know how or what I could do to get the DOL to work better with other federal agencies.

In my particular case, the DOL seems to be maybe perhaps bureaucratic, and it does not

work outside its own agencies or coordinate well with other agencies. Trying to get DOL to work with, say, the Inspector General was very difficult. So is there an avenue or a way that claimants can -- not necessarily appeal their claims but get DOL to communicate directly with other federal agencies?

For example, I had asked OWCP to work with the Inspector General, and I was -- the answer I was given, well, if the Inspector General sends us a request, we can certainly respond. And when I went to the Inspector General, they say, well, if DOL sends us a request, we can respond. And a lot of letters written in exchange, and I had -- some individuals said, please call this agency and they will then provide you additional documentation. I could not get separate federal agencies to talk to one another, and that seemed to be problematic.

My case worker was very sympathetic and very helpful, but I could not get DOL to make

a phone call. Even when I provided a name and a phone number, I could not get them to communicate with them. Is there anything that claimants can do in that area? I received nice letters saying, I'm sorry, but we don't function that way. That's not our -- I don't want to say, responsibility -- but, that's not something that we do.

CHAIR MARKOWITZ: Just a clarification, we don't actually answer questions or --

MR. PETERSON: Yes. I knew that.

CHAIR MARKOWITZ: -- engage in discussion, just to let you know, but the comment has certainly been clear.

MR. PETERSON: Is there someone that claimants can work with to try to --

CHAIR MARKOWITZ: Well --

MR. PETERSON: -- encourage that communication?

CHAIR MARKOWITZ: -- I would suggest you either speak with Ms. Leiton or speak with

Mr. Nelson, the Ombudsman, and have that discussion.

MR. PETERSON: Very good. Thank you very much.

CHAIR MARKOWITZ: Okay. Thank you.

Next is Don Slaugh, and next up after Don Slaugh is D'Lanie Blaze.

MR. SLAUGH: Thank you, Mr. Chairman and Board Members. I appreciate your time. My name is Don Slaugh, and I've been a union site rep for 12 years. I've been on site for 27, and I've been nuclear -- or HPT senior health physics technician for about -- going on 35 years, and I've been at other DOE sites.

My purpose for this is to bring awareness to when you look at claims and people coming in, it's really difficult. You may have a diagnosis of an injury of beryllium disease or some airways disease type syndrome of very limited data that might support that from a workplace. And I wanted to show three areas of concern that I've been looking at for the last

several years.

And there's -- so there's three, and the first one is our HEPA filtration systems, and some of these are legacy issues that we have. HEPA filtration systems on our tanks, which are underground, are there to maintain safety for the worker and the public, mainly from particulates and radionuclides, nothing for the gas and vapors.

One of our problems we're finding is these filters have been in place for a very, very long time, some greater than 29 years in service life. We just have a current document that shows every filter we have in place right now in service, and they're way overdue for a change.

The issues we're finding out there with the filters is -- and I'll just read this. These are some of the filters. Radio filters are found to be saturated with water upon removal and replacement. Water is consistently found in other DSTs which is single-shell farms. Radio filters have similar problems.

So when we have this wetting in these filters, they're not HEPA filters. And the concern is particulate matter being re-suspended out and being aerosolized out into our workers' space, which we do not look at that type except for the rate of allowable radionuclides. That's the only thing we look at from a metal standpoint, except for beryllium. There are some others, but specifically unknowns, we look at rad.

The next is -- oh, excuse me. One other thing is we do -- in this current document we have, we're trying to maintain our power to ventilation systems at less than 50 -- or 70 percent humidity, but we don't have humidity probes in our exhausters. That's one of the recommendations that DOE has actually put in place from the -- Missouri State University did some testing on our finest filters and found that we should put these humidity filters -- or humidity probes in our filters, and I know Savannah River has done that.

The next point is excavations in our tank farms. We do a lot of excavations in or around outside. As a health physics technician, what we've found over the years is we go out there and we don't have health physics set up for a job to go out and do that because we plan it as a non-rad job. But then we come across it and find that, guess what, we have contamination, and we've actually purchased some equipment because of those problems.

So because of that issue, we actually have our rad planners required to go through what is called QMap. The QMap is designed to identify every pipeline unplanned release site that is on site so that when they go in and excavate, they can be aware of those hazards and take control.

The problem is our industrial hygienists aren't even part of that permit. There's an excavation permit, and all it looks at is environment for particulate matter which is for an offsite exposure for particulate matter, not for worker exposure. So we will look at rad

only in those cases.

I looked here recently at a couple of different excavations we've done on the farms, and they do have gases and vapors. But they're not looking at any of the metal of the contaminated waste that's actually been dumped into the grounds that could be aerosolized or the dermal exposure that could be there because we're wetting down the grounds.

If you look at -- there's some data that I provided. History-wise, I did a comprehensive study to find out exactly how much waste came to the tank farms from 2000 -- or excuse me -- 1954 to 2004. And the total amount, if you look at it, it's kind of staggering. We look at -- the tank farms has approximately 56-57 million gallons in the tanks, about 200 megaliters. And in that summary, it'll actually tell you how much waste was transferred to the tank farms to cribs, ponds, ditches, and it's about 270 billion gallons.

So there's a little bit of disparity

there with how much was dumped in the grounds, and in comparison of the tanks to the high-level waste, which is about 900 million gallons of high-level waste that was dumped in or around the grounds that are in our tank farms that we may actually dig up.

I was going to bring a QMap with me that shows you this map. It identifies -- if you go to the QMap, which is maintained by another contractor, you can actually click on that unplanned release site and it'll tell you what was dropped there, what was put into the ground at that time, and you can get a lot of history.

Unfortunately, our industrial hygienists don't have that in their program. They only have four areas they look at. They look at the pipelines of the tanks, the stuff we may buy, like caustics, and put in the tanks, and then other materials that we might do for maintenance. So that's a real concern that I have, and --

CHAIR MARKOWITZ: If you could wrap it

up.

MR. SLAUGH: Okay. The last thing is our chemical vapors. So we have a lot of folks who have come out and helped us. NIOSH, CTH, the STC, and the TVAT have all recommended that we do a -- look at the mixing of chemicals that could be in our airspace and a toxicological study to be able to look at if there's a synergistic effect to these different chemicals and the other possibility of other changes like ions, ozone, chemical inorganics, organics, acid, bases that are in the vapor phase.

Some of these things that we're not looking at right now that we would like to look at and continue to look at and hope you'd take those into consideration when you're looking at folks' claims that we do have a lot of things that we're still learning about.

CHAIR MARKOWITZ: Okay. Thank you very much.

MR. SLAUGH: Thank you very much.

CHAIR MARKOWITZ: Thank you.

Next is D'Lance Blaze. If I have mispronounced your name, forgive me. D'Lanie? D'Lanie.

MS. BLAZE: Hi, guys. I'm D'Lanie Blaze of CORE Advocacy for Nuclear and Aerospace Workers. CORE assists EEOICPA claimants and workers at the Santa Susana Field Laboratory and its associated sites. Thank you for the opportunity to provide public comment.

Coal gasification has been established to be a Department of Energy process at various Rockwell International sites, including Hanford, Rocky Flats, and Area IV of Santa Susana. The Site Exposure Matrix, or the SEM, provides an incomplete list of toxic substances associated with coal gasification processes at Santa Susana. Only carbon and coal ash are listed.

As early as 1978, NIOSH issued recommendations for safety standards that were based on worker exposures associated with every aspect of the coal gasification process and including the potential for exposure to a number

of chemical compounds that can increase the risk of cancer and other illnesses. More recent studies link the process to skin cancer and hearing loss and raises questions about radionuclide and silica exposure as coal gasification workers frequently present with serious lung conditions and radiogenic cancers.

In addition, it appears some of Department of Energy's coal gasification facilities at Santa Susana were removed from the SEM entirely when it was discovered that they existed in Area I at a location known as the Bowl. Currently, only Area IV of Santa Susana is considered to be a covered facility under EEOICPA.

It is troubling that the discovery of Department of Energy operations, processes, and facilities in Area I, which necessitated the Bowl's removal from the SEM, did not prompt a thorough review of DOE's contractual agreements at Santa Susana. CORE Advocacy has obtained copies of those contracts under the Freedom of

Information Act, FOIA.

The contracts document Department of Energy in Rockwell International's construction, integration, modification, operation, and remediation of DOE coal gasification process development units, or PDUs, located at the Bowl in Area I. Other documentation issued by DOE and its contractors specify that the Bowl was located on DOE auctioned land, had been allocated in its entirety to serve DOE's Energy Technology Engineering Center, known as ETEC, and that the Bowl PDUs were contractually defined to be government-owned property and remained so even after the contract's conclusion.

In 2008, Sanford Cohen and Associates, SC&A, issued their review of the NIOSH Site Profile for Santa Susana. SC&A stated, quote, the Department of Energy had operations and facilities in Area I as well as Area IV of Santa Susana. However, no consideration has been given to potential exposure in Area I of Santa Susana Field Laboratory such as potential exposures for

the coal gasification process, end quote.

The Area I facilities of the Bowl appear to be among more than an additional 50 Department of Energy facilities that were summarily excluded from the Santa Susana Site Profile, the majority of which were located in Area IV and considered to be among the primary sources of site radioactivity.

The result has been a dramatically downplayed perception of DOE operations and worker exposures of the site which has hampered EEOICPA eligibility, the dose reconstruction process, claims under Part E, and the accuracy and completeness of the SEM. Currently, DOE coal gasification workers of Area I at the Bowl are just summarily disqualified from EEOICPA.

I realize that it is not within the Board's charter to classify a DOE facility under the Act, but in an interesting paradox, the SEM's accuracy and completeness is considered to be among the Board's top priorities. And the SEM cannot be accurate or complete when Department of

Energy facilities are left out of EEOICPA or when DOE operations, processes, hazardous materials, and all corresponding data are not acknowledged.

I respectfully request the opportunity to submit information on coal gasification and worker exposures at Santa Susana which apply to both Area I and Area IV workers. This information may assist the Board in ensuring that the SEM is accurate and complete.

Currently, Department of Labor and Energy are reviewing CORE Advocacy's report on DOE operations at the Bowl in Area I, and I'd like to submit a copy of that report to you as well. In addition, I believe coal gasification workers squarely meet the VGDF exposure criteria outlined in our meeting earlier today, and I request their consideration as the Board focuses on OHQ recommendations.

Thank you for the opportunity to provide public comment on behalf of Santa Susana employees and EEOICPA claimants.

CHAIR MARKOWITZ: Thank you very much.

MS. BLAZE: Thanks.

CHAIR MARKOWITZ: Next is Elnora Bing and then after Ms. Bing is Stephanie Carroll.

MS. BING: Hello. My name is Elnora S. Bing. I would like to thank the Board, and I would like to thank Ms. Stephanie Carroll for giving me this opportunity to come before the Board and let you know what I did at the Savannah River Site and also my claim.

I worked at the site for 33 and a half years. I was employed in 1972, and I had to leave because of illness in 2005. I was diagnosed with sarcoidosis, and I had previously worked as a lab technician for approximately seven to ten years handling liquid waste -- and that was '72 -- Pu, Eu, neptunium, you name it, cesium. I also, after that, left that lab, and I went to a metallurgical laboratory, and we handled different metals.

I have been affected by the sarcoidosis I have over my lungs. And they say it's sarcoidosis, but all of that I have been

around, I'm not sure about that. I filed a claim for CBD Part B sarcoidosis, 2010. I received an acceptance letter. When I received the acceptance letter, I called a DOE rep because I needed to know for the instructions -- DOL, excuse me.

I wanted further instructions, and the DOL rep told me I'd be receiving a health card in the mail. And then I felt kind of comfortable with him, and I began to tell him some of the things that I encountered at the site and what I had worked with, the conditions, statistics of the deaths and illnesses that were in my building. People right next to me have died.

And he listened, but there was a change in his tone. And he told me that -- he said, well, maybe you will be eligible for another part. Why don't you withdraw your Part B? And I felt kind of comfortable at this point because I was talking to him. He should be knowing what he was telling me was true. He was trying to help me, I thought.

And so -- but I did notice something when I began to tell him about all the sicknesses and all the things that were going on, but he encouraged me. He said, withdraw it because there's compensation under another part. And, of course, I know I deserved it, so I withdrew my acceptance letter.

February 2nd was when I received my acceptance letter. February 8th was when I withdrew it and sent it in according to his instructions because he told me that there would be monetary value. And I knew it should be, but I didn't know how to go about it.

The little bit I know, when I sent it under Part E, refiled again, I came back flatly denied. I was crushed. I couldn't believe it. I didn't understand what was going on. I tried to call the DOE rep. Time after time, they told me that he was out of his office, he could no longer help me, and he was very callous. He didn't really want to talk to me anymore.

And when I filed -- and I want to read

you my comment because I have been struggling for the last seven years to get my voice heard, and I'm finally getting it heard -- I was flatly denied for sarcoidosis, CBD under Part B about where for what I had just received an acceptance letter for. I filed a hearing for COPD and was denied over and over.

I finally realized I was tricked into giving up my claim worth $150,000. I have since refiled with the help of my advocate, Mrs. Stephanie Carroll. My claim was under -- is under reconsideration now. She ordered a copy of my file, which I never was told I could do in the whole seven years I have spent fighting on my own. They never told me they had medical record evidence on file from Savannah River Plant. They just kept insisting that I provide the evidence, and I did over and over.

My advocate has, at this point, some evidence they had the whole time, which is chest x-rays, the report showing profusion three or two from a company doctor, pulmonary chest diagnosed

the restrictions as severe diffusing lung capacity defect, PFT results as low as FVC and FEV1 at 50 percent predicted -- excuse me -- 57 percent predicted and boxes showing blood in my lungs.

I was told to get a beryllium test without regard to the extent of medical evidence on file documenting about the 15 years of prednisone that I had to take because of my condition --

CHAIR MARKOWITZ: Ms. Bing.

MS. BING: -- which would affect the accuracy --

CHAIR MARKOWITZ: Ms. Bing.

MS. BING: -- of the test. And then I was not even told about the test until after my claims were denied. My doctor wrote a report saying that the diagnosis with sarcoidosis was not medically appropriate with a long-term beryllium exposure. They lost the report, and I had to resend it multiple times. It was on file the whole time.

I think they were using the doctors to try to deny my lung disease. Why did they ignore my doctor's report, I cannot understand. Why did they ignore my work conditions that I told them about what I did over and over, I don't understand.

CHAIR MARKOWITZ: Ms. Bing. Ms. Bing.

MS. BING: Why did no one at the Department of Labor help me understand the process to be approved? No one helped me to be -- helped me. They just told me -- that DOL rep told me that. He really shouldn't have told me anything if he knew I was going to be denied, denied, denied. I don't understand that.

CHAIR MARKOWITZ: Mrs. Bing. Mrs. Bing.

MS. BING: These reports should have triggered a response from at least one of three reports done by their doctors that I may have pneumococcus. I know that beryllium or the other metals -- like Eu, Pu, and aluminum -- had to have contributed to my illness because that's

what I did. I ground samples as a metallurgical laboratory technician. For the last seven to eight years, that's what I did.

CHAIR MARKOWITZ: Mrs. Bing.

MS. BING: I cut rich uranium. I cut depleted uranium. I cut beryllium. We cut all of the metals that came from across the site. I had two hearings that let people know what type of work I did as a metallurgical laboratory technician and a lab supervisor. And when I became a lab supervisor, I was in the same environment doing the same work.

CHAIR MARKOWITZ: Mrs. Bing.

MS. BING: I think they ignored my testimony that I was still exposed to the same toxins as a technician.

CHAIR MARKOWITZ: Mrs. Bing.

MS. BING: They wanted me to send them a list of my exposures. How was I supposed to be able to do this?

CHAIR MARKOWITZ: Mrs. Bing, thank you very much for your comments.

Next is Stephanie Carroll.

MS. CARROLL: My name is Stephanie Carroll. Thank you for allowing me to submit public comments today, and I thank you for the excellent work that you're doing. This is the best use of my time ever in this program is to be at these meetings. They're very good.

I am a professional authorized rep specializing in claims for occupational lung disease. In the process of helping workers circumvent the complexities of this program, I've discovered serious problems with the administration of the program.

I know that you are as concerned as I am, that these issues be addressed in a meaningful and efficient manner, and that the EEOICPA achieve the mission that Congress intended. Oftentimes, the program sees the complaints of the ARs as a sign of our frustration in being denied claims, which is understandable. But my complaints are based on the concern that, without an AR, claimants are

being misled and denied claims that are viable under the program requirements.

The bureaucratic culture within the program is overly hostile to claimants. I don't want to paint everyone who works for the EEOICPA with a broad stroke because there are some very dedicated employees trying to do the right thing. I do see a program where CEs are very demoralized, inadequately trained, and not rewarded for going the extra mile to approve claims. First and foremost, they are evaluated by the timeliness in which they complete the adjudication of claims and not by the quality of their work, which may be more difficult to measure.

I have established CBD under the Act for every ruling sensitized worker I've encountered. I've experienced establishing CBD under Part B for all claimants that were tested, treated, or diagnosed with a chronic respiratory disorder prior to 1993. The policy and the PM have inexplicably changed. Now, pre-93 claims

must document, quote, prolonged long-term -- they have to do that twice -- treatment for chronic respiratory disorder prior to 1993, unquote, from the procedure manual to qualify for further adjudication of the claim under pre-1993 established chronic beryllium disease.

The law actually describes chronic beryllium disease as a beryllium illness, and the beryllium illness is established chronic beryllium disease. And you will not see capital letters on the CBD portion of it because it is a statutory illness, and it's not chronic beryllium disease under the modern diagnostic criteria that we experience now. So it's important to pay attention to those capitals. The removal or addition of just two words from the procedure manual or the training material can affect claims adjudication profoundly.

I've reviewed the training slides submitted to the Weighing of Medical Evidence committee -- subcommittee. I was disappointed to learn that the committee will not be reviewing

the weighing of evidence for Part B, CBD, or sarcoidosis. There is a great need for review of the medical evidence as it relates to application of the law. I am pleased that the committee on lung disease will be addressing these issues.

In the training materials that I did review, Slide 20, pre-1993 criteria, there is a list of statutory criteria without access to the underlying slides that were provided. So I would like you to ask for the slides that once you click on each criteria, you kind of get to see details of what they expect to meet each criteria, and that wasn't included in your training that was provided to you from DOL.

A note at the bottom of the slide says that at least one of the documents must show that the claimant received treatment for a chronic respiratory condition prior to 1993, which contradicts the procedure manual and it confuses the situation. So CEs are being trained with the slides in a way that doesn't match the procedure manual, and the procedure manual was changed with

just, I don't know. Just, all of a sudden, they got rid of some words in the criteria to establish pre-93.

This PM policy has been added without any explanation and changes the way the pre-93 cases have been adjudicated for at least 15 years. There are final decisions documenting approval of a pre-93 CBD claim based on the date that a claimant was tested, treated, or diagnosed with a chronic respiratory disorder, not treated long term and prolonged long-term treatment of a chronic respiratory disorder. So that has completely changed. I don't know what's going to happen with pre-93.

The new policy is inconsistent and unfair. It affects the outcome of workers' claims based on when their claims were adjudicated by the program. This policy was established without explanation.

Slide 21, post-93, again, the criteria does not include the underlying slides. Please ask. See that the reference to CBD, all in

capitals, which insinuates that a physician must determine if the abnormalities are consistent with modern-day chronic beryllium disease. The loss specifically describes the illness as established CBD. The PM lists medical findings that the program has long determined to be consistent with established CBD. Like BES, the program specifically lays out the legal definition of covered beryllium illness.

The only reason that a DMC should ever be used for chronic beryllium disease is to determine if the PFTs are showing obstruction, not, is that obstruction consistent with CBD? A physician cannot make that determination because they're making a medical determination. They do it all the time. They say, this person doesn't have CBD. But when they sign the DMC report, it actually reads that they're making their opinion based on their known -- the known qualifications of the program. So they're supposed to be reviewing based on the program requirements, not medical, but they never do that. And they get

paid about $2,000 to do that report.

CHAIR MARKOWITZ: Ms. Carroll, if you could start to wrap it up.

MS. CARROLL: Okay.

CHAIR MARKOWITZ: Thank you.

MS. CARROLL: Okay. CBD under Part E has added requirements for approval demanded by the program but not required by law which is unfair and inconsistent, with prior probative final decisions. The PM demands abnormal BeLPTs for Part E, but the training slides do not include that. I don't know why.

And telephone conference calls, I have a copy of one of the calls that I have submitted that actually discusses -- first of all, there's no PII in there. It discusses the fact that they will use policy call notes for final decisions, recommended decisions, and development. If the CE quotes that in the final decision, they are to turn that telephone conference policy call over to the claimant.

They admit in this policy call that it

is policy, and I would urge you to take a look at my submission of the policy call so that you can push hard to get a copy of those telephone conference calls because that is policy, and it's not fair that authorized reps or any of us can't look at the program and determine if there's consistencies or not. And I think that is the key, get those telephone conference calls.

Thank you very much for listening --

CHAIR MARKOWITZ: Thank you.

MS. CARROLL: -- and I appreciate all your work.

CHAIR MARKOWITZ: Okay. Thank you.

Next is Shirley Kennedy and then after Ms. Kennedy will be Tee Lea Ong. Shirley Kennedy, is she on the phone? No? Oh, okay.

MS. KENNEDY: I'd like to thank all the Board, and this is the first time that I've been here. My questions are, in the SEM, specifically, why do they not list any radionuclides? And the radionuclides that I have concerns with personally are plutonium-238,

plutonium-239, plutonium-240, americium-241.

I was exposed in 2007 of these radionuclides, and I don't know if there was because they only checked for these three. I have COPD, thyroid in my lungs. And the man I replaced doing the borehole job is Mark Anthony, and he died in 2015 of cancer of the esophagus and the stomach. I've had zoledronic acid IV on January 27th because my spine is in the position where my doctor thinks it will collapse just by my weight, so I'm trying to keep my weight off, and I've been denied.

The data that they gave me when they did the diagnosis was wrong. I want each and every person that's had an exposure to be able to get their raw data. I cannot get that raw data, and I want to know why. What words do I have to put in a letter? Who do I have to talk to, to get the 10 CFR 1910.1020? It says that I have that right. Can anyone tell me how I get that raw data?

CHAIR MARKOWITZ: Knowing -- I don't

think anybody on the Board can, but depending on -- you're talking about the radiation data?

MS. KENNEDY: Yes. When -- my bioassays, and I have five of them.

CHAIR MARKOWITZ: You know, I think maybe the Ombudsman's office would be the best. Mr. Nelson or Mr. Levin might be able to help you there, in the second row behind you.

MS. KENNEDY: Okay. And I just encourage everybody to check because my birth date was ten years off. The time that they said I was exposed was two hours prior to the time the job started. Thank you.

CHAIR MARKOWITZ: Thank you very much.

Next is Tee Lea Ong and then after is Jill Allen.

MR. ONG: Hi. My name is Tee Lea Ong with Professional Case Management. Thank you, Chairman Markowitz, and the Board for allowing me to comment.

I have brief, two interrelated comments and, number one, of which is that the

speed by which the recommendation -- really good ones from this Board -- is being implemented by the Department of Labor. And second one that's related to that and it depends on the Board's consideration of what you could do about it is, how much time does the Board still have before its sun sets, and how much work can be done in terms of implementing the recommendations?

So with that said, the two comments. The first one of which is that the speed by which the recommendation has been implemented. From today's comments or conversation, it seems -- and, also, I've been following the publications that the Board has put out. A lot of tremendously good work has been done, so I applaud you for that. And from -- based on today's conversation, I also heard that the Department of Labor has done a good job supporting with the data and so on, so thank you for that.

However, the question is that, from what I could tell, there's only been one of the

recommendations from the Board, a substantive one, that has been implemented since the sitting of the Board, almost exactly a year ago in Washington, D.C. It's about a week off, but nonetheless. And the seating of the Board itself has been delayed substantially, as most of you know.

So on the current course and speed, the question I have is that, what do you think would be some possible alternatives to making sure that all the hard work that's been put in, as well as the hard work that's coming up, is being implemented rigorously at the same pace that the Board has been working? So the comment, slash, question is, is there room to revisit how the implementation of these recommendations are conducted? Meaning that, is one of the recommendations from the Board a change of how these recommendations need to be adopted and reviewed and implemented and, if not, reasons offered as to why not? Or perhaps there's an alternative body that the Board has to report out

to, to make further suggestions of how to implement the recommendations.

Now, onto part two of my comment, which is the time remaining for the Board to continue to work and implement -- or recommend implementation. With what we've seen, if the current pace is one per roughly 12 months or so, my question is, does that imply that we should expect perhaps two to three more to be implemented by the time the Board sunsets? And if so, what is the -- what does the Board intuit as the best way to prioritize the recommendations so that the most impactful and claimant-friendly topics are broached and the recommendation made in order to make sure that the most relevant topics are focused on and implemented?

That's all the comment I have. Thank you.

CHAIR MARKOWITZ: Thank you.

Next is Jill Allen. No? Okay. We'll move on while we're checking the phone.

Jerry Ferson is next. And I should

say -- actually, while he's getting settled in -- that the next will be Bertolla Bugarin.

MR. FERSON: My name is Jerry Ferson. I used to be very active out in the area. I was one of the main safety reps and chairperson for the tank farms. I am the one that built the sampling truck to characterize all the tanks and a number of filtration. I worked at a research lab for a number of years prior to going to the tank farms.

Tank farms though, I got exposed to a lot of mercury. And the -- in 2007, I believe it was, S102 tank, there was a spill. A hose broke and there was a lot of people that were consequently injured as far as mainly to respirate their lungs and different things. One of them who was working with me, he's over here.

But anyway, my B2 microglobulin went up to 1,500. It's not supposed to be over 195. It does damage to the liver and the kidneys and because of the damage there, it also causes a lot of brain damage, nerve damage, whatever. I have

about seven or eight known or documented conditions. I have 89 percent disability. I was in a wheelchair for a number of years. I'm fighting it and because of the good Lord -- I am also a minister, by the way -- I'm retired.

I can't function. Like, my mind, I can't keep it going right. And, anyway, I need help. I'm disabled. My wife is disabled. We take care of my mother-in-law. She is 91. She's disabled. I used to have nursing 24/7 and because of our case worker put in some paperwork that DOL did not like, they dropped all my nursing.

We have been trying to get nursing back. We have tried and tried and tried. And, finally, the gentleman, real nice and politely, told my wife to forget it, quit bothering him, says, when he goes on a breathing tube, you can give me a call then. She said, well, we're not going to call you because he has already stated he will never go on a breathing tube.

There's a lot of people out here that

are workers that I worked with that are trying to get help, and there is no one, really, I'm going to say. You can't say, well, you need to go see this doctor or that doctor, because that's showing favoritism, and I know we need help. We need some guideline of where to go.

I went out and I looked for doctors, one after another. And when I would tell them who the insurance was going to be paid by, DOL, they would drop me, one after another. When I found the doctor, even in the big universities and et cetera, I would ask the question, do you know anything about chemicals, and they would say, no.

And so for people that are starting out, I try to help a lot and try to direct them. But I don't have, I'm going to say, good enough answers to direct them because I don't know good, you could say, doctors or resources they can go to that is trustworthy.

I won't say who he was, but I went to one of them at a university, and I told him, I

said, you can't tell me that I've been exposed to mercury. Oh, yes, I can. He says, if you have this, this, this, this, or this, five things. He says, if you have three of them, I can definitely say you've been chemically exposed. I had four of them, and you know what he said? Yes, but I can't tell where you got it from. I have the physical -- my physical records of the exposures that I had. I had all the paperwork, but I'm going to put it this way. He's in cahoots with DOL.

CHAIR MARKOWITZ: Mr. Ferson, you need to wrap it up, if you would.

MR. FERSON: Okay. But the people -- you can't imagine how many people are out there that are needing help, and we need something or some way of getting help and directing people. Thank you.

CHAIR MARKOWITZ: Thank you. Thank you very much.

Next is Bertolla Bugarin.

MS. BUGARIN: I'll pass. My concerns

were addressed.

CHAIR MARKOWITZ: Okay. Thank you.

Jill Allen, did we identify whether Jill Allen is on the phone? No? Okay. Next is Tom Moore.

MR. MOORE: I've been impressed in hearing what your Board is doing, and I thank you for your work. My name is Tom Moore. I am a former Hanford worker.

The comment -- the primary comment I want to make has to do with consistency. In 2010, I was -- excuse me -- I was diagnosed with prostate cancer. I was advised to go ahead and make a claim on that, so I made the claim. And in 2012, then I got a letter from the final adjudication branch who basically summarized the dose reconstruction report that they had received, and, in it, they found that I was 40.66 percent Probability of Causation. I accepted that. I mean, these are the experts.

So I went on. About four years later, then I was diagnosed with MDS, and I'm not sure

whether I can say that properly but myelodysplastic syndrome is close I can say it. I processed that. I was accepting. I guess that's on the SEC list. Then about a year later, I was diagnosed with COPD. At the same time we made the claim for that, I made -- I was advised to resubmit the prostate cancer because additional cancers supposedly increase the chances of being approved for claims.

When I got the dose reconstruction for the second time, it was interesting to me that every one of the previous dose estimates or the dose findings they found decreased significantly, one by a factor of 32. It was 32 times less than the previous one, and the only explanation was it had been grossly overestimated, and they used more current things.

The interesting thing about it also is that, in both of the documents, they, numerous times, talk about being claimant favorable, and that seems to be something that's mentioned quite often is they try to be claimant favorable. And,

yet, dose reconstruction, I'm not an expert in it, but that's not something brand new. It's not as if in the last few years, this -- in my opinion, that we're all of a sudden doing things we've never done before, so how can we get a factor of 32 less for that?

So I think that this is an example of some inconsistencies. I've been very pleased to hear you folks talking about that.

One other comment I had with respect to almost all of the things you've discussed today had job titles being a significant factor in the presumptions and so forth. I spent four or five years as a machinist to start with and then I went into engineering. I spent the last 19 years as an engineer, retired as an engineering manager. I can tell you that none of these documents that you displayed today included engineers.

Our engineers in the groups that I was a part of were in the field, I would say, almost daily, some of us more than others, exposed to

the same things as other folks. So I fully support your concern that there are people out there that when you look at these documents, they're really not included. And I think that plays a disproportionately strong influence on how claims are adjudicated based on what your job title was. Job titles don't tell you everything you need to know about what your exposures are.

I thank you very much.

CHAIR MARKOWITZ: Thank you.

MR. MOORE: I think you're doing a great job.

CHAIR MARKOWITZ: Thank you.

Next is Richard Bloom and then after Richard Bloom will be Diane Leist.

MR. BLOOM: I made notes, so I want to thank the Board. As an elected official, I serve on a lot of Boards, so I don't want to take much of your time. As -- my comment parallels what was there. I've worked at Hanford since 1980. I took six years off, worked at Rocky Flats for six years tearing down -- tearing out buildings.

I have personally been in 85 percent of every building on the site over the course of my years. I've been an engineer, I've been in environmental, but I can tell you, the planner -- when I walked in, in 1980, the planner of the day was the engineer, the engineering aide, the operator, or the maintenance person who went out there to figure out what was wrong and write down what had to be fixed and investigate it and write up what had to be done. So in your asbestos considerations today, when you say maintenance worker, you're leaving out, really, the ones that got the firsthand look at it and were peeking.

Currently, I am assisting -- I've retired, but I've been talked back a couple of times. I'm assisting with the demolition of PFP, and I'm intimate in the asbestos investigation to prepare it for demolition. What we are finding in that building that was built just before I was born is very unique applications with asbestos that people would never have known.

Asbestos in sheetrock; that sheetrock

had asbestos coating, but the one that looks just like it didn't. I mean, it's really weird stuff that we're finding: the extensive use of asbestos in mastics, mastics in places we never expected to find them.

So I do suggest that if you do get around to defining what maintenance workers are, maintenance workers are a lot broader than people with tools and hammers. They include the RCTs, the RadCon that went out there with them.

Secondly, what you've not included -- and it was alluded to for ships built before X whatever -- people that worked in buildings built prior to 1970 could potentially have had asbestos falling on their desk. I have seen it in person.

We had old labs that were converted to office buildings all over the 300 area and the 200 area. I remember going out and visiting an engineering manager out at 225B -- if I remember the building number correct -- and, oh, we can't go in this area. The asbestos lagging fell off. They'll get to it. That was 1992. So I think a

broader category to include workers, being administrative, you know, clerks.

Also, I am beryllium sensitized, so in my 30 years, I've done no work. I'm a pencil pusher, right? I've been through all these buildings. I've been exposed to all the stuff. But what we've found with beryllium, one of the groups that we -- in the early days, that we found that was high in exposure to beryllium were firefighters because they went out and sprayed the heads to check to make sure they were working. When they sprayed it, what came down, the beryllium. So the firefighters also spent a lot of time in these buildings.

So when you look at these and you hear the concerns of people applying for this and trying to prove they were exposed, when you build these cohorts, be very careful of how you segregate it and how you explain what a maintenance worker is. And then the other thing I would suggest, a cohort for those that were assigned to those buildings. There are records

out there, phone directories which list what buildings everybody was in every year since I was there in 1980. I know they go back to then and they go back further.

So there are records of who was assigned to what buildings over the years, and I appreciate if you would consider them because your job is to help the claims processors and reduce the frustration for those that have to apply for the claims. And I appreciate your time and effort. I understand what you've put yourself and volunteered for because I do that myself.

CHAIR MARKOWITZ: Thank you.

MR. BLOOM: Bye.

CHAIR MARKOWITZ: Next is Donna Hand. I think Ms. Hand is on the phone.

MS. HAND: Hello?

CHAIR MARKOWITZ: Yes. We're here. We can hear you.

MS. HAND: Okay. I know it's getting long and it's getting late. I just want to

remind the Board, thank you very much for some of your recommendations because now the SEM has listed as a reference the NIOSH pocket chemical guide. And so they list the loss of injury entry now that we can use.

However, the SEM says, only diseases covered by Part E are displayed in SEM. Well, doesn't that cover all the diseases? How come the target organs that are defined in the NIOSH pocket chemical guide not also displayed in SEM because they've been all peer reviewed as well as the OSHA? OSHA regulations on chemicals also has been peer reviewed and has set the court criteria before they could even say, okay, you have to have regulations on these.

The other issue is that you're in a prime place to where some of the wording that the Department of Labor uses is implied to be higher than what it is such as significance. They never defined it in their policy procedure manuals. They just underline it and says, it's got to be significant.

However, the regulations did define it and they defined it in 2006 that significant will be any factor. They also defined that the toxic substance only has to have the potential. It doesn't have to definitively do anything. Does it have the potential because of its radiological nature, its chemical nature, or its biological nature?

Level of exposure is never to be addressed nor was it required. That's a moot issue because the thing is, is that OWCP has stated in the regulations, you will consider. It's not mandated, but you must consider the nature, the frequency, and the duration or the nature of a toxic substance or the nature of the job task. Either one, that's what you should consider; the frequency of the exposure to the chemical or toxic substance or the frequency of the job task; the duration of the exposure to the chemical or the duration of the job task.

That's it. That's what then should be considered, and that's what they'll actually --

that's in the regulations. So that's -- a big presumption then is that if you meet those criteria, that should be it.

I'd like to kind of paraphrase something that was done on December of 2009 to a case examiner from their own district medical consultant. And it said, regarding possible exposure, what is significant medically is judged by a number of factors as potential for exposure, administrative controls to minimize it, or any PPE. It is the biological effects of significant exposure and not exposure alone that is significant.

So a puncture wound to the lung do not equate to exposure to toxins or radiation. And if that's the philosophy and the train of thought or the peace of mind that their own DMC were using and are still using, it requires a definitive no. Again, you're applying causation. No. Aggravating and contributing to.

So within these parameters of the actual law, which is binding, that's what the

policy should be also implementing. And if the words aren't defined, then let's define them instead of everybody having subjective opinions such as an upper respiratory infection. It's not a chronic respiratory disorder. But according to the World Health Organization, it would fit that definition.

So, thank you, again, for your time, and I really appreciate all that you guys are doing. Thank you.

CHAIR MARKOWITZ: Thank you, Ms. Hand.

Is Diane Leist -- she was supposed to be available.

MS. LEIST: I'm here.

CHAIR MARKOWITZ: Oh, okay. Sure. You can come on up and then we're going to go to the phone to Ms. Vina Colley.

MS. LEIST: So I didn't have time to really prepare too much because I had more questions, but, in 2015, I was diagnosed with breast cancer. Fortunately, it was something that responded well to treatment.

But I had worked out at Hanford beginning in 1985 when we hired lots of young people as a chemical technologist, or a lab tech, and had worked in a number of the processing facilities. When I wasn't a lab tech, I was also working as an engineering tech additionally, so all around the Hanford site.

And I did go ahead and apply, although my dose reconstruction certainly had me well below dose limits. And in the discussions and subsequent six months' time when we spoke with Department of Labor, it was pointed out the SEM. It was, like, hey, that is a pretty useful database, or at least it's certainly a database with a lot of information.

But there could be more in that database because when I asked to be considered for, oh, you know, perhaps, you know, some chemical exposure during those analyses that we run or the inventories we did or working in the field might have affected that.

And when you looked in the SEM, it's

great. It does have listed your occupations and areas you worked, so you can use that to sort on. But if you just look for breast cancer, it'll show that there are none of those many, many chemicals used at Hanford have not caused breast cancer.

And I look at that and think, I'm not entirely sure. I mean, the information I was sent said, well, you can keep looking and see if something comes up, and your claim will still be there. But I look at some of the things that we worked with routinely. Not exposed to it in any sort of accident because that seems to be one of the things that kept coming up. There were no incidents or no accidents.

But if we worked with chemicals such as -- and I'll just use three examples here because people are familiar with the terms -- toluene, MEK, carbon tet, you know, routinely in doing analysis. Those things -- there certainly is nothing on there that says that they cause breast cancer.

But are there studies out there that did look at these chemicals for -- just specifically in my case or in my interest -- breast cancer? And if those studies are out there, then is there a way -- or it would certainly be more helpful to have that in the SEM so you can say, okay, fair enough?

And I think that is -- just kind of concludes my thought. If there is something out there that disproves it, let us know because even though some of us have great backgrounds -- I'm not a chemist, but I am very familiar with chemicals. I teach DOT transportation and look at hazard class information all the time and MSDS and things like that. But I don't know how to go out there nor do I have the time or the resources to contact every university and see if they've done a study and that sort of thing.

So thank you.

CHAIR MARKOWITZ: Thank you very much.

The next speaker is Vina Colley on the phone. She's not there? Okay.

So I think that our last speaker actually, unless there's someone else who volunteers, is Gary Vander Boegh. I think he might be on the phone.

MR. VANDER BOEGH: Thank you, Dr. Markowitz. I want to thank the Board for all the work that you're doing. I do notice when I have time in between representing claimants -- I had four hearings today, and they were very interesting claims.

We at Paducah are proud. When I was working at Paducah Gaseous Diffusion Plant, I'm an engineer, so I associate with all the issues at Hanford. Actually, Kirk and I have met many a time to discuss the association of the contractors, and I worked for Lockheed Martin. I'm very proud of what Lockheed did, but, again, we really were working under a different contract scenario back in the days that I was Lockheed Martin. And that was probably -- it was Martin Marietta, then Lockheed Martin, and you can kind of follow Paducah issues.

But unbeknownst to me, since I'm a design engineer, I was hired for designing a new 14-million-dollar landfill -- contained landfill that was state of the art. And I was the project manager with Lockheed Martin engineers, my coworkers, and my good friends, Jimmy Massey and Dave Massey, leading this project.

And we got that permitted, used the city leaders in Paducah to help us do that. There was a lot of permitting issues, as you're very well aware, and Dr. Mark, which you and I have talked many other times about the issues of beryllium. And so therefore, when we were operating the plant, all of you probably are aware by now that a false claims was filed in the plant, and we didn't know it.

And so as the investigation transpired and my office was taken over by federal government officials -- and I entered all this into the hearing record today -- we thought that was significant because I think everybody needs to understand I got caught up in the same issues

that the nuclear workers got, and I'm a young man who started in 1992 and never knew what was going on at the Paducah plant other than somebody handed me a project that I had to take over. And as a design engineer, I was more than happy to help them.

That project ended up weighing me two President's awards under President Bill Clinton and then I was able process waste out of the plant. And I noticed that when I developed the waste acceptance criteria, which was very intense and detailed, project managers had to sign off that everything was fine and everything was acceptable -- Kirk will understand this -- everything was done properly. Lo and behold, that's what the false claims was about.

Nobody knew that according to the investigation under the Act that there was falsifications of the waste going on, which meant the new landfill, which was permitted under the State of Kentucky, had just accepted contaminated material that, as an engineer landfill manager,

project manager for Lockheed, I was responsible for the day-to-day activities. A landfill manager title is just strictly a staff title. I'm a staff engineer, class 3, whatever that is. Kirk, I've been long enough that I've forgot.

But the point I'm making is, as waste was generated out of Paducah Gaseous Diffusion Plant that was hazardous, people falsified the classifications of the waste. That's in the news. You can see it. Lockheed Martin got slapped on the wrist.

I still think the world of the Lockheed Martin people: Mr. Van Hook and all those top people at Lockheed. But that was what triggered the investigation that led to the uncovering of bad things that were happening to workers including Chuck Deuschle, Bud Jenkins, John Tillson, and the notorious Ron Fowler who Ron was the nuclear whistleblower.

And we're not trying to take credit. We're just trying to bring everybody across the nation in together and understand that when our

politicians take credit for the sick worker program but then we learn that they're really not wanting the program to be successful. We got to look at the politics involved, and this Board is the best thing that I've seen in a long time because you're asking -- it's almost like, wow, somebody was listening to me.

And so what we did was go out on a limb, and we notified through our channels, and I've got a lot of political connections. And we just started looking at over 400 claims, and we found a pattern; that there was a word -- and Donna Hand has already stolen some of my thunder on the pocket guide. As a nuclear worker, you're licensed -- or you're required to follow 29 CFR 1910.120. Dr. Michael and I have talked many a time, and I understand now he's with OSHA. And so October 28, 2015, I put Dr. Michael on an email, and we had a great conversation.

I then forwarded that to DOE at the top level, and Monica Regalbuto then asked for the resignation of the DOE site manager who, by

the way, people at Rocky Flats would probably remember it, Bill Murphy.

Now, we know that Rachel has got a big cast ahead of her. She's got to bring in all the other agencies, but I was just going through the NIOSH pocket guide that I mentioned to Dr. Michael in October 28, and I put in the hearings today. And, lo and behold, in the SEM has been inserted the very thing that I've been writing emails and arguing, but we didn't know this until two days ago.

And so, if the Board is aware of the requirements of 29 CFR 1910.120, 40-hour training allows you to work in the DOE facility, and I'll yield to Kirk to disagree with me but I know he can't. We don't understand how these workers can come in, give testimony that they've handled hazardous waste and breathe the converter gases and the TCE dumping out, as was discussed today. And then somebody at Lockheed Martin -- who used to be our employer now -- who has bought the company, QTC -- and that's an obvious conflict of

interest -- is then brought in to deny the claims.

Under a CMC, the need for a CMC, which is really not needed because all of the chemicals that we're talking about are in the SEM -- they're in the SEM. And we found shockingly today that one claim was approved for the very same thing the other three have been denied. So there's not consistency.

I hate to be the bearer of bad news here, but I'd like to retire somebody, and I did this to help people who had had their claims inappropriately denied. And I want to say that I've met with Rachel and I've met with John Vance. And, at that time, in 2010, in a meeting in Washington, I thought I knew a lot more than I really know now.

And so Dr. Markowitz, I can just commend the Board for what they're doing, but we got to look at this significant factor issue because if you don't go tackle that issue, well, DOL is -- DOE -- the EEOICPA director is just

strictly going to call Lockheed Martin and say, hey, I need a denial and a significant factor, and just tell them it's not significant.

Well, for goodness sakes, people. We don't -- at Paducah, we don't want Lockheed Martin CMCs being called in. And even we've got 12 cases in the United States Federal Board in the Western District, and Judge Thomas B. Russell and Judge Stivers have even ruled that it doesn't matter what the CMC says.

As long as he makes an opinion -- and Rachel, you'll appreciate this -- the people like Lucero v. DOL in New Mexico, those cases are not overriding what's happening here at Paducah. And I believe we've got a situation where Senator McConnell does not want claimants paid because of the contamination that rivals anybody in the nation.

But we're getting there, and I just want to thank this Board for the work you've done. And I don't have one note in front of me, and I think Donna Hand has probably taken the

pocket guide issue. And I'd like for somebody to tell me, is the pocket guide -- Greg Lewis, I believe -- I don't want to quote Greg, but where does this stand?

We're all trained. Thousands of workers are at the plant right now. Beryllium everywhere. Dust has -- the dust is two inches thick on the 40-acre process building that are 150-foot tall. Don't go in --

CHAIR MARKOWITZ: Mr. Vander Boegh.

MR. VANDER BOEGH: -- the buildings. I try to tell people, don't take tours of nuclear facilities and especially those in the C-720 where two cases today, independent of each other, talked about the converter dust and asbestos.

The heating systems are still there. It was raining down on me in '92. I asked them what it was. They said, oh, don't worry about it. Well, come to find out, that's where they're machining beryllium, and I tell this same story, and all the Paducah workers that I represent want their transcripts provided to this Board.

CHAIR MARKOWITZ: Mr. Vander Boegh.

MR. VANDER BOEGH: Thank you.

CHAIR MARKOWITZ: Thank you very much.

So is there anybody else who wishes to speak in the last few minutes? Okay.

Well, this wraps up the public comment session. Thank you very much for your participation, and we'll resume tomorrow morning at 8 o'clock.

MR. FITZGERALD: All right. This meeting is adjourned. Thank you very much.

(Whereupon, the above-entitled matter went off the record at 5:55 p.m.)

C

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Advisory Board on Toxic Substances and Worker Health

Before: US DOL

Date: 04-19-17

Place: Richland, Washington

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter