U.S. DEPARTMENT OF LABOR

+ + + + +

ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

+ + + + +

MEETING

+ + + + +

THURSDAY
APRIL 22, 2021

+ + + + +

The Board met telephonically at 1:00 p.m. Eastern Standard Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

AARON BOWMAN
MARK CATLIN
KENNETH Z. SILVER
MIKE VAN DYKE

MEDICAL COMMUNITY

GEORGE FRIEDMAN-JIMENEZ
ROSE GOLDMAN
STEVEN MARKOWITZ
MAREK MIKULSKI

CLAIMANT COMMUNITY

JIM KEY
DURONDA M. POPE
CALIN TEBAY
DIANNE WHITTEN

DESIGNATED FEDERAL OFFICIAL

MICHAEL CHANCE

CONTENTS

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

(1:07 p.m.)

MR. CHANCE: Good morning, everyone. My name is Michael Chance, and I'd like to welcome you to today's teleconference 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. Today's date is April 22, 2021. And this is Day One of the two-day conference.

This afternoon, we have a special guest, Christopher Godfrey, who is the Director of OWCP. Chris would like to greet the members of the Board and introduce himself. He will join us at 1:30. That gives us time for me to read through my script and get us underway.

As always, we appreciate the time and diligent work of our Board members in preparing for this meeting and for their forthcoming deliberations. We are scheduled to meet today from 1:00 p.m. to 5:00 p.m. Eastern Time and to reconvene at 1:00 p.m. Eastern Time tomorrow.

This meeting is a virtual conference as we have held since last April due to the COVID pandemic. On the line with me is also Carrie Rhoads from the Department of Labor and Kevin Bird from SIDEM, our logistics coordinator. None of us are in the meeting room together as we usually are to oversee teleconference vehicles. We are also having a moderator to call ourselves due to the current high volume at the conference line. Please be patient with any technical issues or extra time that we might take with the Webex documents. We are trying to run the meeting as efficiently as possible while keeping everyone safe and socially distant.

I'd like to note that there are several medical doctors on the Board and other Board members who deal with emergencies that we would like to extend them, and everyone else, our thanks for allowing them to make the time to have this Board meeting today. And thank you all for everything you've done over the past year, keeping the country safe.

Regarding meeting operations for timing, we have, I believe, one break today. And for Board members, please just put your phone on mute for the break and unmute when we resume. This will make it easier for Kevin with making sure that everyone can participate in the discussion as we resume.

Copies of all meeting materials, any written public comments are or will be available on the Board's website under the heading Meetings and the listing there for this meeting, April 22nd, and tomorrow's on the 23rd, 2021. Documents will also be up on the Webex screen so that everybody can follow along with the discussion. The Board's website can be found at dol.gov/OWCP/energy/regs/compliance/advisoryboard.htm. If you haven't already visited the Board's website, I encourage you to do so. After clicking on today's meeting, you'll see a page dedicated entitled to the day's meeting.

The web page contains publicly available materials submitted to us in advance.

We will publish any materials that are provided to the subcommittee. You should also find today's agenda, as well as instructions for participating remotely. If you're participating remotely and you're having problems, please e-mail us at energyadvisoryboard, all one word, @dol.gov. If you're joining by Webex, please note that the session is for viewing only and will not be interactive.

Please also note that the phones will be muted for non-Advisory Board members until the public comments session today. The call-in information has been posted on the Advisory Board's website so that the public may listen in but not participate in the Board's discussion during the meeting. The public may offer comments during the public comment session, which starts today at 4:15 p.m. Eastern Time. Depending on how many people want to make comments, the Chair will allocate sufficient time for everyone.

We will unmute your phone line when it

is time for you to make a comment. There is no public comment period in tomorrow's session. If you would like to make a comment during the public comment session, please e-mail us, again, at energyadvisoryboard@dol.gov. Let us know, and we will reserve some time for you.

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

As DFO, I see that the minutes are prepared and ensure that they're certified by the Chair. The minutes of today's meeting will be available on the Board's website no later than 90

calendar days from today per FACA regulations. If it's available sooner, we will publish before the 90th day. Also we will be publishing verbatim transcripts which are obviously more detailed in nature. Those transcripts should be available on the Board's website within 30 days.

I would like to remind the Advisory Board members that there are some materials that have been provided to you in your capacity as special government employees and members of the Board, which are not for public disclosure and cannot be shared or discussed publicly, including in this meeting. Please be aware of this as we continue with the meeting today. These materials can be discussed in a general way, which does not include using any personal identifying information such as names, addresses, specific facilities for cases being discussed, or a doctor's name.

Thank you for bearing with me as I had to read all of that into the record. At this point, I will turn over the proceedings to Dr.

Markowitz for his welcome introduction. And then I will come back on with a few extra tidbits of information. And then I believe Kevin or someone, I hope is keeping an eye out for Chris. He's supposed to dial in at 1:30, and maybe just let us know when he's on so we can get him into the meeting. Thank you.

Dr. Markowitz?

CHAIR MARKOWITZ: Sure. Thank you, Mr. Chance. And in our sequence today, particularly the next hour if we need to interrupt what we're doing to hear from Mr. Godfrey, we'll interrupt and then come back to it.

In any case, I'd like to welcome everybody, Board members, the DFO staff, and leadership, the public, whoever else might be attending this meeting to -- I don't know what number meeting it is for the overall Board since 2016, but we've had many meetings. This one, unfortunately, has to be done remotely. I'm hoping by the fall, by our next meeting, that at

a minimum, we will be able to have a hybrid meeting, but we'll see how that goes. One advantage, I guess, of some of this distance is that, in theory, more people can participate from the public.

I will go through the agenda in a moment, but let's do introductions first. I think it's probably easiest if I just call your names, and then you can just introduce yourself. And then I'll call the next person.

So Mr. Key.

MEMBER KEY: Dr. Markowitz, thank you. Jim Key, President of the United Steelworkers Atomic Energy Workers' Council and participant in an advocate of Worker Health Protection Program and of the EEOICPA since its origination.

CHAIR MARKOWITZ: Thank you.

Ms. Pope?

MEMBER POPE: Thank you, Dr. Markowitz. Duronda Pope, Director of Emergency Response Team, United Steelworkers. I am also a former worker of Rocky Flats. I worked out there

25 years.

CHAIR MARKOWITZ: All right. So Mr. Tebay?

MEMBER TEBAY: Calin Tebay, Local 55 and HAMTC sheet metal worker, also on the William Health advocate and the HWEC. That's the Hanford Worker Engagement Center, representative at Hanford, been here about 25 years off and on.

CHAIR MARKOWITZ: Okay. Ms. Whitten.

MEMBER WHITTEN: Good morning. Dianne Whitten. I am with the Hanford Atomic Metal Trades Council. I'm a health advocate, recording secretary, a member of IBEW 984. I'm a grad contact at Hanford currently. And I've been here about 32 years.

CHAIR MARKOWITZ: I think that probably adds up to at least a hundred years of experience beside people we've just heard from.

Next Dr. Bowman?

MEMBER BOWMAN: Yes. I'm Aaron Bowman. I am professor and head of the School of Health Sciences at Purdue University, I am a

toxicologist by training.

CHAIR MARKOWITZ: Mr. Catlin?

MEMBER CATLIN: Thanks, Dr. Markowitz. My name is Mark Catlin. I'm an industrial hygienist, semi-retired and doing some consulting.

CHAIR MARKOWITZ: Thank you. I won't mispronounce your name again.

Dr. Silver?

MEMBER SILVER: Thank you. Ken Silver, associate professor of Environmental Health and College of Public Health at East Tennessee State University. My dissertation work, going back at least 20 years, was on historical emissions and exposures at Los Alamos National Laboratory. I worked very, very closely with the injured workers, sick workers and their families, to help bring the law into existence, and hardly feels like a lot of time has gone by.

CHAIR MARKOWITZ: Okay. Dr. Van Dyke?

MEMBER VAN DYKE: Good afternoon. Mike Van Dyke. I'm associate professor at the

Colorado School of Public Health, industrial hygienist by training and have a long history of repeated DOE sites and doing research there, particularly with beryllium.

CHAIR MARKOWITZ: Nice.

Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Hi. I'm George Friedman-Jimenez, occupational medicine physician, director and attending physician at the Bellevue-NYU Occupational Environmental Medicine Clinic. And I'm also an epidemiologist by training.

CHAIR MARKOWITZ: Dr. Goldman?

MEMBER GOLDMAN: Hi. I'm Dr. Rose Goldman. I, too, am an occupational environmental medicine physician and founder of the Occupational and Environmental Medicine program at Cambridge Health Alliance, also a medical educator and associate professor of environmental health at Harvard School of Public Health and associate professor of medicine at Harvard Medical School.

CHAIR MARKOWITZ: Dr. Mikulski?

MEMBER MIKULSKI: Hi. I'm Marek Mikulski, occupational and environmental health, University of Iowa. I'm an occupational epidemiologist, and I also direct a former Iowa DOE worker medical screening program.

CHAIR MARKOWITZ: Thank you. And I'm Steven Markowitz. I am an occupational medicine physician and epidemiologist. I direct the Barry Commoner Center, City University of New York, and run, for over 20 years, the largest former worker medical screening program in the DOE complex called the Worker Health Protection Program.

So it's 1:20. And usually actually we have the public introduce themselves, but we can't do that in this mode of meeting. But in any event, let me ask you, Mr. Chance, it's 1:20. I can postpone review of the agenda if you want to move ahead with your items. Then I can go back to the agenda after Mr. Godfrey speaks, or I can do the agenda now. What's your preference?

MR. CHANCE: That's fine with me. You

know, in fact, I tried to move around some of the stuff that was later on in the afternoon, the resource part up to this and maybe save us a little bit of time anyway. So if that's okay with you, I can go ahead.

CHAIR MARKOWITZ: Sure. Go ahead.

MR. CHANCE: Okay. And it might not take me ten minutes, so let me start and then we can see where we are.

So the two items that I have before kind of some follow-up issues and some informational issues, particularly for people who are new to the Board, not existing Board members and certainly not you, Dr. Markowitz, is on the whole issue of chartering the Board. And so I just want to make a statement on that so that everybody is clear about what that is and what to expect.

So under the FACA, which is the rules by which we must govern ourselves under, in this environment, we must have a new charter for the Board every two years. The current charter is

expiring in June. We are in the process of getting our new secretary in line to approve it. At this point, we do not anticipate changes, and this should largely be a seamless process for members of the Board so more on that as we finalize the paperwork. But I don't know.

Steven, did you have any comments on that? You've been through that.

CHAIR MARKOWITZ: No. As far as I know, any changes in the charter seemed to not have come, from the point of the Board' perspective, internally from the Department, but from elsewhere. So if the charter doesn't change, then great. If you envision any changes, it would be nice to know when you know.

MR. CHANCE: Right. Understood. So we'll definitely let you know if we see anything, but at this point, we don't anticipate changes. I just wanted to make that little statement because there might be some people who aren't familiar with that. They may hear that come up and wonder what it is. So it's really nothing to

worry about. It's just part and parcel of how we have to do business under the law.

The next thing that I wanted to share with everyone -- and this might be some good news for many and especially, I think, you also Steven, and we've been working on this for a while -- is the issue of resources. And I think it's been maybe about a year since we started talking about a way that we can put together some sort of contract with expertise that will be available to the Board to be able to do some really more in-depth evaluations.

And the way that this will have to begin under the contract requirements that are set out under the federal regulations that govern contracts, we will be issuing something called a Request for Information, and that is an RFI. And I wanted to thank Carrie and others at the Department who did some heavy lifting work putting that together. And, Dr. Markowitz, you and I imagine others on the Board, took a look at the language that was shared with you. We

received your comments and have been working to incorporate those. Know that Carrie is continuing to help me work through that, finalize the document, but I can share that we are very close to being able to get the RFI out onto the street, and we expect it to be released shortly.

And then at that time the way that this will work and the way that we envision it working is that the Request for Information will determine if there are vendors and companies that are out there that are interested in this work in presenting a bid and what's called a Statement of Work. And that will also allow us to ascertain levels of resources that will be required to be able to do this. So I had 20 minutes on the agenda, and I don't think that I have 20 minutes worth of the material, so that's kind of the kernel of what I had to share.

So Dr. Markowitz, do you have questions?

CHAIR MARKOWITZ: So if you could just continue a little bit with the process and the

time frames.

MR. CHANCE: Well, the time frames might be something that I might need Carrie's help with on. I think the RFI goes out -- I don't want to misstate myself, but we might be able to talk about that offline.

And Carrie, unless you're there and you know the specific date, I don't want to say anything wrong.

MS. RHOADS: Yeah. I don't know any specific dates beyond the RFI. So we might need to talk about that.

MR. CHANCE: So, yeah, we don't want to commit to the time frame, but there are time frames that are set up. I just don't know them by heart, but we can certainly share those with you, Steven.

CHAIR MARKOWITZ: Did you say the RFI has been issued already?

MR. CHANCE: No, sir. It is still under review at the Department, but we are pretty hopeful we will be able to get it issued shortly.

CHAIR MARKOWITZ: Okay.

MR. CHANCE: I don't have the time frame, but it should be soon.

CHAIR MARKOWITZ: When you issue it, can you send it to each of the Board members?

MR. CHANCE: I will see how that is done.

CHAIR MARKOWITZ: You know, just the link. I mean, it's going in --

(Simultaneous speaking.)

MR. CHANCE: I understand. Yes. We'll determine how notification can take place.

CHAIR MARKOWITZ: And one of the other background is that I think the Board would be interested in hearing about, was something that you and I discussed with Mr. Pennington, which is one of the complications of our request had to do with -- you know, our request was for help reviewing claims and also help on the scientific and technical side. And the reviewing claims posed a challenge because there was the question of possible need to set up a system of records.

I think that's the official term, but it's something close to that. And that was a big obstacle because that's a protracted process. And there was a second mechanism that sort of allowed us to not quite bypass, but to expedite that kind of work without establishing a new system of records. So I can't remember where we are on that particular issue.

MR. CHANCE: That might be something I need program help with.

John or Rachel, are you aware?

MS. POND: So this is Rachel. You're asking about where we are in the process with regard to the system of records or what that entails? I think the system of records has to do with a database that you guys wanted to create, and that, creating a new database with new information was an issue. So I haven't been involved in the actual procurement process, Mike, I'm not sure how that isn't being incorporated in the RFI of the Statement of Work or any of that.

MR. CHANCE: Right. Carrie, do you

have an answer to that? Or maybe it's something we should talk about offline.

MS. RHOADS: Yeah, maybe we should. I don't know specifically.

CHAIR MARKOWITZ: You know, that's fine. I mean, the issue was since setting up a new system of records is problematic and takes a long time, it was somehow to take advantage of the current system of records that would nonetheless allow us to, you know, perform that function of reviewing claims. And so we can get back to the details of this. I just wanted to know whether we had resolved or made any progress in resolving that question. That seemed to be a possible obstacle.

MS. POND: Yeah. This is Rachel again. I think that what we were going to try to do is instead of treating a whole database, we were going to try to create spreadsheets from the data that we already have, kind of like we have been. But it wouldn't -- we could do it in such a way that it wouldn't be a new system of

records. And that's where we're heading towards. I don't know that it actually has to be part of the RFI. It might just be something that we do once the contract is let, instead of -- but it will speed up the process to not have to worry about that piece of it.

MR. CHANCE: I think you're exactly right, Rachel. That's pretty much outside of the RFI and the contract. That's going to be something that has to be, you know, hammered out once the work is beginning, I think. Well, a little before that, you know, but it's something like that -- so the RFI is not going to be that specific.

CHAIR MARKOWITZ: Okay. Thanks. By the way, I forgot to mention, Ms. Rhoads, if you could, if it's possible to keep a running list of sort of action items from the meeting so we don't have to wait for the summary or the minutes, that would be very helpful.

MS. RHOADS: Yes, indeed, and that's the first one.

CHAIR MARKOWITZ: Thank you. So are there -- other Board members have questions about what Mr. Chance has just discussed?

MEMBER GOLDMAN: This is Rose Goldman. I have a question. This RFI, if I understand, relates to when we've had to review a claims file where different components of the file in different locations and it's hard to pull it together. Would this mean that somebody would put the file together in such a way that medical reports were in one location and IH or other reports in a different location so you didn't have to go sort of trying to look all over to try to find things? Is that what this is about?

MR. CHANCE: No. I mean, I think I'd have to have some help from Rachel on what that is even all about. But, no, I mean, this is a resource contract to get experts together to be able to help you guys do your research work. But with regard to, like, case work, I don't know what that is.

MS. POND: I think what she's saying

is that, you know, part of what I anticipated when I saw what the Board is asking for in terms of resources was some sort of admin assistance help, what's, you know, going through some of the materials, some of the data, some of the reports that, the way that you review them. I think she's talking about is it's sometimes difficult to actually, you know, get through a case file because they're not organized in a certain fashion. I believe the way our case files are normally organized is based on the date of receipt.

And so, you know, that's also hard to say because it really depends on what kind of contract we get because I don't know if there's a mix of admin duties. I think there would be, especially if there's going to be data involved, and then the research side of it. So I would anticipate that. I don't know what the details of it looks like. I don't know what the contract is going to look like, but I would imagine there would be somebody to help with those sorts of

things.

MR. BIRD: Sorry to jump in. This is Kevin. I did want to let you know that Mr. Godfrey is now on the call.

CHAIR MARKOWITZ: So this is Steve Markowitz. So to answer your question, Dr. Goldman, we do envision getting assistance with that, whether that's, you know, by the contract or perhaps within the Department, remains to be seen, but we do plan on reviewing claims that are better organized or better detailed so that will facilitate claim review.

Mr. Chance, you want to continue? You want to go to Mr. Godfrey? What's your preference?

MR. CHANCE: Let's go to Mr. Godfrey. I think that some of the resource -- I think we've noted some of the questions that have come up, and maybe we could do a separate discussion on that once we've got together all the questions that you guys have. Because some of that's going to be related to specific contractual benchmarks

that are in the regulations that I don't want to commit to at this point.

CHAIR MARKOWITZ: Okay. And then we can entertain other questions from the Board members after Mr. Godfrey speaks.

MR. CHANCE: Sure. Sure. Sure.

MR. GODFREY: Okay. Mike, are you ready?

MR. CHANCE: I think so.

MR. GODFREY: Okay. Well, I want to thank Mike for the invitation to be here today. Also thank Rachel for inviting me to participate as well and the encouragement to participate, telling me a little bit about the Board and the things that you've done and accomplished.

So just to start off, I've been at Department of Labor now for quite some time, but specifically in the new position as Director and obviously new since January so I'm still starting to learn, you know, all of the multi-faceted things that happen within OWCP. And working with Rachel has been terrific in terms of learning the

energy program and the many people that are helped through the program. You know, both Mike and Rachel have been terrific administrators and made the job a lot easier as I transition into the position.

Before I was at OWCP, I was already with the Department of Labor as a judge in the FECA program, reviewing the final appeal decisions in FECA cases. Prior to that, I was the workers' compensation commissioner in the state of Iowa, and that was doing both administrative work and appellate legal work. And in that position, I was able to have an advisory board that assisted me primarily with legal matters more so than technical scientific type of work. But it gave me a great understanding that the role that advisory boards can have and the assistance that can be so crucial to be able to run a program.

Also, you know, the work history that I've done has just made it very important to me to work in and protect social insurance programs.

You know, I think it's very special when we can do work that, you know, really helps people that are in bad places, that also works to protect the system so the system is available to all the people that need it.

I just think that the work that happens, especially in the energy program, some of the stories that I've been told by Rachel, of people that have been assisted, these communities that have been helped, it's just so important, you know, the type of work that is being done.

So the main reason I'm here today is just to simply acknowledge the importance of your work. I've reviewed a lot of the materials and the recommendations that have made, and I really appreciate the technical assistance to the program. I can see the proactive nature of your work, and, you know, it's just very impressive. So I look forward to working with you all, learning more about what you do that -- I guess the things I would say is I pledge to be very respectful of your work. I want to be responsive

to your work. I look forward to the recommendations you make, and then working with Mike and Rachel as they make considerations and try to, you know, follow through on the things that you've done.

So I'm hopeful that your work and my administrative work within OWCP can really help us all help the Energy program and, you know, really help us to assist the people that need help and also protect the integrity of the system. So I really don't have a lot more to say other than just that brief introduction and the pledge to, you know, be responsive to the work that you all do and to be respectful and give you, you know, the independence that you need, but also hopefully the follow-up from the programs. And you know, hopefully working together, we can make some really good changes possible.

I don't know if anybody wants to ask any questions or share any information with me. I won't be able to stay on the meeting because of

prior commitments. But if there's any important information or messages that you'd like me to take away, I'd be happy to take a few questions or to listen.

CHAIR MARKOWITZ: This is Steven Markowitz. Thank you for those comments. We really appreciate your understanding of the work that we do, but also obviously the underlying program and how important and meaningful it is to so many people who have worked with DOE in the past.

Any Board members have any comments or questions they want to make at this point?

(No audible response.)

MR. GODFREY: Okay. Well, I can let you get back to your important work. But, again, thank you for the opportunity to speak with you all today, and thank you for the work that you do.

CHAIR MARKOWITZ: Okay. Thanks, Chris.

So this is Dr. Markowitz. Let's return to Mr. Chance. I don't know if there's

additional items he wanted to talk about or do any Board members have any further questions about the RFI or about our request for resources? Any comments or questions?

(No audible response.)

Okay. So, Mr. Chance, were there additional remarks you wanted to make?

MR. CHANCE: No, sir. I think that that's all I wanted to cover. You know, we'll be sharing information with you, Steven, about the RFI process as it moves forward, particularly timing once we know a little bit more. But, like I said, it's been a long time coming, but we are very close to getting this thing done. So I just wanted to share that with everybody. So let me -- hold on a minute. Let me just take one look. I know you're going to go over this.

Okay. So it looks like we're doing pretty good on the agenda. It looks like Rachel is up soon, but if you wanted to go over the agenda items real quick, Steven, we can keep moving.

CHAIR MARKOWITZ: Sure. Okay. Yeah, and we do appreciate the work on getting resources for the Board. We actually made this recommendation a couple years ago now, 2019, and in fact, the previous Board had also made the same request. So we're very happy to see progress here.

In fact, you know, during this meeting, we're going to be covering a lot of ground, and actually with some resources, some of our work probably could have been done more quickly, in a more timely way, working to the advantage of the claimants. Okay.

Let's just briefly review the agenda. If people have questions or they want to add things to the agenda, just chime in, please. Next, we're going to hear from Ms. Pond and Mr. Vance about the program, what's new. We've asked them to review the information items that I had abstracted from the last meeting that required some follow-up information or update or the like.

We'll take a break. We're going to

revisit a couple of recommendations that we made at the last meeting in November, and we have the January 2021 response from the Department. And so we have some comments and may have some questions about that.

And then we're going to move to the issue of the probable human carcinogen and whether there are some that legally should be, that we believe should be added to the SEM and, more importantly, to the decision-making by the program about what is compensable.

Of course, we couldn't avoid COVID forever. So in a few hours, we're going to be discussing, at the request of DOL, some issues related to COVID and I'm hoping that we are able to have a good discussion. It'll continue tomorrow, after our public comments today and that we are able to come up with a recommendation around COVID.

CHAIR MARKOWITZ: We have a public comment period later today. We have two -- so far, as of an hour go, two public commenters who

have signed up. There may be more. But speaking to the public, we welcome those comments. Tomorrow, same time we'll start, continue with the COVID discussion. We'll then move to asbestos. We've made a lot of progress in our interaction with the Department about how asbestos is viewed within the program. And there's just some more back -- a little bit more back-and-forth on asbestos that should be interesting.

We're then going to deal with a request from the Department they made to us in November about application of a way of measuring respiratory impairment, the six-minute walk test. A lot of work has been done on that, so we'll hear about that. And then we're going to discuss, sort of after the break tomorrow, issues of impairment more generally. This is more of an open discussion rather than any plans to get to a particular recommendation on that topic, but we'll see where the discussion goes.

And we have time for new business. I

always like to talk a little bit about Board process, if we can, ways of improving the Board process, communication, decisionmaking and the like. You can see from the agenda tomorrow that we have some extra time.

I don't know, Mr. Bird, whether you can move up the agenda on the screen so that people could be looking at tomorrow.

MR. BIRD: Everyone should have the ability to --

CHAIR MARKOWITZ: Okay. Yes.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Yeah, yeah, sorry about that. Okay. So, yes, as you can see, we have some extra time tomorrow. So if one of our topics runs a little late during today, during tomorrow afternoon, we've got some extra time built in to deal with it, so not to worry about that.

Any comments, questions, or additions on the agenda?

Okay. So fine. Let's then move on to

Ms. Pond and Mr. Vance, and hear from them.

Welcome.

MS. POND: Hello. This is Rachel Pond. I'm the Director of the Energy Compensation Program here at Department of Labor for those of you who don't know in the public. And I am happy to be here, and thank you all for taking the time away from a lot that's going on in the world right now to be here to help us with this program.

I am going to cover some general program updates just to kind of give you guys an idea of what we've been doing the last few months since you last met. And then after that, John will be presenting on the follow-up recommendations that Dr. Markowitz was talking about earlier. I wanted to just first say that, if you have questions for me about any of what I'm going to say, probably best I just get through my part, and then before we go to John's, we can open it up for questions about any of the items that I've talked about in my little spiel.

So first I wanted to talk a little bit about our operational plan goals. What that is, is we have about 30 different timeliness goals related to how quickly we get to a decision, the development steps in between, final decisions, and all of the sorts of steps that means when we -- how long it takes us to refer a case to NIOSH, how long it takes us to, you know, take initial development steps, how long it takes us to refer cases for other types of adjudication, how long it takes us to do industrial hygienist reports and contact medical consultants. It runs the gamut, our operational plan goals.

And so I just wanted to mention that in the last -- this year, this fiscal year, we've been exceeding just about all of them. All of them for -- I just sent that to our Final Adjudication Branch. And so I'm very happy that we've been able to do that. I will talk a little bit about how that funding may be impacted by COVID in a minute.

We've also instituted a new quality

process last year that we've really ramped up more this year. John is going to go into that a bit more since that's the follow-up for something we talked about before. One thing I wanted to mention about that, which he will -- this, actually, we used to have annual accountability reviews, which meant that we would review all the offices once a year and including our Final Adjudication Branch. With this new process of quality review, which is an ongoing immediate review of cases throughout the course of the year, that is going to replace our annual accountability reviews.

The annual accountability reviews were very helpful and very necessary at the beginning of our program, and they've been able to supplement our, you know, timeliness goals over the years.

But with these ongoing reviews and such, we found that the accountability reviews were becoming less and less useful because we were looking at a very small sample of cases over

an entire year. Not small but a representative sample, but it was over the course of a whole year. And this way we're going to be looking exclusively real time. So I just wanted to mention that because I know that accountability reviews were things that were published or that you guys were able to review. We will probably be working out some method of being able to share the information we're gathering from other types of quality reviews.

The other thing that we're doing to supplement the current quality reviews is we have more robust sampling for our claims staff in terms of our supervisors are reviewing more cases every month. They're giving feedback every month on the quality of the work to every claims examiner and Final Adjudication Branch staff in the country. So that process is now being captured very objectively. And it's really going to help us long term with the overall quality of our work.

The next thing I wanted to talk about

a bit is the pandemic and the results of what's been going on in the last year and how that impacted how we do our business and how we process our claims. I'm sure you're aware that -- I believe we talked about last time the bulletins that we published that allowed for telemedicine for routine and other medical appointments. That was something that, you know, we've got a process now so that people don't have to go to a doctor's office in order to be seen under certain circumstances. That has now been extended through September so that we can continue that practice. I know that some have asked if that will be a permanent practice. We are still looking at the options for that. But in the meantime, during this pandemic, we are going to continue that practice.

We've gotten some questions about paying for the COVID vaccine for employees. We have made a decision very recently to go ahead and pay for any COVID vaccine administration for employees that have been accepted into the

program and have conditions that we've accepted. Those will be paid automatically through our bill-processing agent. You know, in terms of that, we decided that, you know, we have a population that's more at risk than a lot of other programs may have, and it's important that we assist in any way we can in helping them get those vaccinations.

With regard to paying for consequential conditions when somebody actually has acquired COVID, that is usually something that would have to be determined to be a consequence of an accepted condition. So, for example, if a person tested positive and they have a pulmonary condition, we have to have a physician's opinion advising us that the COVID was a consequence of the condition that we've accepted. And I know this is a topic that you are going to go into a lot more detail. And the reason that we asked for the Board's assistance on this is that if there are presumptions that we can make within that regard, then we would like

to be able to do that without having to go that extra step of getting a physician's opinion, if and when that's possible.

I mentioned that COVID may be causing some delays, so the delays that we're seeing right now are with obtaining records from the Federal Records Center, obtaining -- because a lot of those records centers are open for a little bit, and then they close again. And so if they're older records, people come back and they want to reopen a claim or they want to add to a claim, and we don't have the old records, we have to wait for those records to come back.

We've also had some delays with Social Security. Social Security assists us with obtaining wage information so that can help us with wage loss, but it also helps us sometimes in obtaining employment verification because, when the Department of Energy doesn't have records, we have to go to Social Security Administration to help the claimant determine, you know, when they worked, where they worked, and tie that into DOE

employment. So those are -- we're seeing some delays there.

And we are waiting for the SSA to come back on certain cases. And then we have some delays with medical appointments, particularly with regards to impairment. So if a physician needs to see a patient for an impairment evaluation and they're unavailable and there's a wait time, and for us to issue a determination, we have to wait for those medical opinions. Sometimes it's in the initial development where they need to see the patients and they haven't -- you know, they don't do telemedicine or, you know, they need to get additional records, that has been time-consuming.

And the final delay has been with the Department of Energy records. Now, some of their records centers are open and able to obtain information for us quickly and easily. Others are not open as much. They don't have as many employees working. And so it's been a challenge to get certain records from certain records

centers. What that ultimately means is that the claimants have to wait for us to adjudicate their claim. The actual way that we count timeliness is once a decision is made, then we can -- or a recommended decision is made, we can go back and look at the time it took for all of these actions.

And so when we start making these decisions, we will see a dip in those timeliness goals. But we are working with all of the agencies to get those records as soon as we can, and hopefully with more vaccinations and such, we will have some of these places opening up a little bit more, but it is a risk that is occurring at this time.

During the pandemic, we have been fortunate at Department of Labor to be able to telework. So 100 percent of our claims staff and final adjudication staff, most of our national office staff are working 100 percent at the current time. One of the ways that we've actually been able to do that is we did start a

project many years ago, back in 2013, to start digitizing our claims files, meaning we had paper from the very beginning, paper case files, stacks of paper and files and file them, and things like that. And the only way you can really review a case was to review the paper. And in 2013, we started slowly, but then as -- you know, in the last couple of years, and then particularly when COVID hit, we realized that we really wanted to be able to ramp that project up and, you know, to digitize as many cases as we possibly could.

We were very successful. Thankfully, we have contractors working around a -- you know, through this pandemic with social distancing to help us digitize these cases. And as of the end of March, we've digitized everything. So now our claims staff can review everything online, all case files, all the materials. So that's been very helpful during this time.

We have also had to close down our resource centers to the public, having one employee in the office per day, and then going

and picking up documents outside the door when somebody needed to submit something, and, you know, so that's been a challenge. They're still working. They're still answering phone calls, and they're still doing occupational history questionnaires virtually, and all of that. I'm hoping that, you know, maybe slowly we can start opening them with social distancing in the near future, just maybe to see claimants on an important basis or something like that, but that's something we're still working on.

The next thing I wanted to talk about is that we -- and I may have mentioned this the last time, but we have a new case assignment process. We started this in our Final Adjudication Branch in 2019. Then in 2020, we started the same process in the district office, which basically means we used to assign cases to our claims staff by jurisdiction. And so any cases where the employee last worked closer to the -- within the Jacksonville region, like Oak Ridge and Paducah, would go to our Jacksonville

office and so and so forth, moving across the country.

What we found was that that process was making it so that the workload distribution wasn't equal. And so you'd have more cases in Seattle and Jacksonville than you would in our Cleveland and Denver offices. So we decided to assign the cases randomly nationwide. And so, you know, I think that's going to allow us greater flexibility in terms of centralizing processes, making sure that we're being consistent across the country. You know, we've got a national administrator for our field offices, Christy Long, who can oversee all of the offices at the same time and has been creating some common physician descriptions, some common practices that they can use, and also it allows for greater flexibility in hiring and such.

During that process, we did extensive training, cross-training, with points of contact related to the Department of Energy facilities, because throughout the years, you know, the

Jacksonville district office, for example, would become more familiar with Paducah, and the Seattle office would become more familiar with Hanford. So we have done some cross-training there, both in the fed and in the district offices. We have resources that they can go to with regard to how to do employment verification.

And then I just wanted to talk about two other things that we've been working on and what we're planning to be working on. We did publish on April 2nd the Version 5.0 of the procedure manual, which just incorporated some of the bulletins that we'd had already and then had things like Authorized Representative Services were validating them in a special way in ECS so that we can have a consistent record of the correct addresses for authorized representatives and things like that.

We also, based on Bulletins 20-08 and 21-01 and based on the information that we received from the Board, we did add it to the procedure manual, the presumptive language with

regard to asthma and Parkinsonism. We added the labor categories for the assessor's presumption of exposure, and we added the language related to non-Hodgkin's lymphoma. We also clarified some language in Chapter 16 regarding obtaining a medical diagnosis. In that chapter, there was a -- we said if you don't know -- if the evidence is not clear on the medical diagnosis, then you would refer the case to a CMC. We made it clear that the first place to ask for clarification would be with a treating physician.

And then we basically had clarification for the coverage for Oak Ridge at K-25. It was the clarification and the dates and what's covered under that SEC. There is a very detailed discussion of what that, is in that procedure manual in the transmittals, 21-01, so I kind of wanted to mention that it's out there.

We are also working on a system that will eventually -- and we're hoping by the end of the fiscal year to begin this process of allowing employee claimants access to their case file

digitally, meaning instead of having to ask for a copy of the case file, the employee claimant and their authorized representative, hopefully at that time as well, will be able to access the case file instead of having to have it copied and sent. And all of that is a pretty big project we're working on with our sister program, the Federal Employees Compensation Program on a system that they've developed to kind of add this feature in.

We're probably going to have to start with employees and then move to survivors due to some Privacy Act concerns. So after the end of this fiscal year, we'll move to working on getting that same access to survivors. But we need to make sure that the privacy of other survivors are protected so that's where we're going first with that project. But I'm very excited, and I think it's going to save a lot of people a lot of time and, you know, help them be able to see their records without having to ask for them specifically.

We also had some SEM updates. In the last six months, there have been just some updates to Los Alamos, Savannah River, Oak Ridge 25 and X-10, Sandia, and Yucca Mountain. You know, one of our mandates is to conduct outreach to let people know about our program. And we used to go around the country, you know, all the time to meet people and to talk to people about the program and provide updates and try to get the word out. That's been a little bit more difficult with the pandemic, but what we have been able to do is have virtual town-hall meetings.

And they've been very successful. We've been able to do one a month, and we've had 200 to 300-plus people attend these outreach meetings. They're by Webex, and basically we've got a different topic every month. We've done medical benefits and survivorship, then the wage loss, impairment and, you know, the federal adjudication process, policy updates and discussion. And so we're continuing to do that.

We've also worked with partner agencies, Department of Energy and NIOSH, on various presentations with regard to their pieces of the program, Department of Justice as well, and RECA. So it's been pretty good because at the end of each session, we have a question and answer period where people -- we can't interact with them directly as well as -- what they'll do is put in a question in a chat, and then we will answer them verbally. So that's not as ideal as being able to see people in person, but it actually has been able to reach more people than a lot of our town-hall meetings did because we went to individual regions. So that's been helpful.

We also have email blasts. We've got a couple of places where people can sign up to be either on an email blast for policy updates or email blast for medical updates. And we have a lot of people that are signed up for that. When we could get information just as things come up, we'll post them, and they can have access to it.

We've also been doing some newspaper ads and announcements where we can to try to reach those that are unaware of the program.

Finally, I just wanted to talk briefly about training. We are in the process -- we got a contractor last year to help us update all of our basic CE training, meaning when we have new claims examiners start, we have a package that they can go through, either with a mentor or with a virtual, you know, supervisor, virtually helping them walk through the training, or on their own. We've got these modules that is updated based on, you know, ongoing changes to policy.

We also supplement those trainings with additional training as issues arise. We have a training specialist right now. He works on various kinds of training. This year we're hoping to do a training with our staff on IH referrals, industrial hygienist referrals, causation and decision writing. That will be done probably in smaller groups and conducted by

staff in our policy branch.

So we're making progress. We continue to evaluate ourselves, evaluate what our needs are, and, you know, adjudicate claims as quickly as we can throughout the pandemic and moving forward. We're still also trying to make progress in, you know, the technology areas and ways in which we can be most successful and also provide the best service we can to our claimants.

That is all I have, and so I'm open to any questions you have about any of that before I turn it over to John.

CHAIR MARKOWITZ: This is Steven Markowitz. Any Board members have comments or questions? I have a couple, but I can let others go first.

MEMBER SILVER: This is Ken Silver. Ms. Pond, thank you very much for that overview. There does seem to be progress on a large number of standing issues, so thank you.

I'm particularly interested in your decision to randomly assign cases to field

offices. Do you know if any of the other OWCP programs that have offices around the country have experience with such a system? I'm thinking of FECA, in particular, which probably is all over the country.

MS. POND: They have 12 district offices, and I believe that they have done some centralization as well. I don't know the details, and I wouldn't want to speak out of turn, but I'm pretty sure that they've done some of that themselves.

And, Mike, could you speak for black lung on whether or not you've done some of that or are planning to?

MR. CHANCE: Yes. Can you hear me?

MS. POND: Yes.

MR. CHANCE: Okay. Hold on. My volume is messed up here. Yeah, so we began doing that readjustment for the very same reason in 2017. We were having backlogs that were building up in certain parts of the country. And in order to make more efficient use of our claims

examiners' time, we started that, you know, so now it's going on about four years, and it's been running very smoothly. We didn't have to do a lot of training, and Rachel says that, you know, that they're addressing that. So I think that as long as people, you know, understand the complexities of the different areas in the country that they have to serve, then it worked out fine for us.

MEMBER SILVER: Yeah. And I urge you to keep an ear to the rail because DOE sites are, you know, really, really complex, and having been involved with claimant families early on and the claimant advocates as the program grew up, I noticed that claimants in some parts of the country -- well, New Mexico is very comfortable with Denver just because of the similar culture, if you will. And over time, the staff builds up a reputation among the families and the claimant advocates for either knowing or not knowing the site. And the claimant advocates often play a role in educating and -- I know this may come as

a shock -- the claims examiners about specific quirks of the DOE site, and over time, they build a rapport, and that leads to efficiencies. So I'd urge you to really monitor this idea of sending claims to field offices that may not have the chops for a specific DOE site.

MS. POND: Yes. I am aware of the issue. And that is why we have, you know, points of contact, people who are more familiar with certain sites, and they have been reaching -- like claims examiners from other parts of the country do reach out to those POCs on a regular basis. You know, I think that, you know, the danger of not doing this centralization is that certain offices would not be able to be maintained because they wouldn't have enough cases. We just have dwindling numbers of cases in certain jurisdictions. And so it really -- the pros to that process outweigh the cons. But I definitely am monitoring that, and I appreciate your comments.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: Other comments or questions?

I have a couple of questions, comments. So with digitization of the files with access by the claimants online, so this is something the Board had expressed an interest in from the beginning because we recommended that in 2016. I think we were pushing on an open door, actually, but did you say that this calendar year you expect that to become a reality? Not for the survivors, per se, but for claimants?

MS. POND: That is the plan. We hope to have that access by the end of the fiscal year. Now, you know, it is an IT project, and we are dependent on some other factors, so don't hold me strictly to that, but that is our plan, and we are on track so far.

CHAIR MARKOWITZ: Okay. Thank you. Another question I have is on the quality assessment. So, you know, some things are easier to measure than others, timeliness, completion, completeness, things like that. You said that a

lot of good work has been done on timeliness and assessment. So we had heard that on some subset of impairment ratings that the claims evaluation or some subset had been prolonged longer than the expected time frames. Is that a problem? Is that an issue, or what's been the evolution on that?

MS. POND: For impairment claims, yes, the claimant has an opportunity to go to the physician of their choice. And so there are certain physicians that claimants want to go to in certain areas. So, for example, we've got one particular physician who has a long backlog of claimants that want to go to that particular physician. So they'll wait, and that means their impairments get delayed until that physician's available or ready to see them. That's one issue.

Another issue, as I said, is COVID has been an issue because doctors aren't seeing as many patients, and they've been slower to make appointments. You know, so we've been trying to

be flexible in terms of we have these deadlines that we have set up, you know, to try to make sure that we are being proactive on the impairments and that we make decisions as soon as we can. But in these cases, if the claimant wants to see a particular physician, well, if they want to go to one of our contract medical consultants, we can send them the records, and they can provide us with an opinion, but the claimant has that option.

So we will wait in some cases, or in some cases, we might say, well, we're going to make a decision at this point, but, you know, provided if you get an appointment, you get more information, you can come back and reopen that issue. So it really depends on the case, but a lot of that has been, at least from what I understand, that claimants want to go to particular physicians, and those physicians are backlogged.

CHAIR MARKOWITZ: So thanks. This is Steve Markowitz. That's understandable. I guess

my question is, once the impairment evaluation reaches the Department in the claims evaluation process, has there been a delay or, you know, a challenge to timeliness on these impairment ratings once the Department has the information?

MS. POND: So we have had some issues with diagnostic evidence supporting the impairment. I think we've come to you, and I think you're going to be talking about the six-minute walk test and looking at how that supports the rating. You know, there have been a very wide range of impairment ratings that may cause us to question, you know, what's the appropriate -- you know, whether they're using the right tables in the guides and things like that. So we've had to do some additional evaluation of that, and we are looking forward to, you know, the Board's discussion on that issue.

CHAIR MARKOWITZ: Okay. Thank you.

Other questions, comments?

So it's Steve Markowitz again. One last question. So for all the quality

assessments, do you ever -- how do you assess whether the claims examiner, when she or he makes their decision, how do you assess? And this may be -- I'd be maybe showing my naivete on this, but how do you assess whether the right decision was made?

MS. POND: Well, that's why we have these quality reviews. Because we've got a whole list of -- you know, there's like it's not a checklist, but we've got an actual database, that in the database, we've got different elements that you need to look for. How they developed the case. You know, did they go to evaluate the Site Exposure Matrices correctly? Did they look at the medical correctly? All of these pieces are all separated out and especially in the supervisory reviews, but also in these quality reviews that are being done by a quality assurance team. And so given that we have these very objective ways to look at a decision, the people that are reviewing it, it's going to be either a supervisor or it's going to be these

quality assurance analysts who are reviewing our procedures and making sure that they're being followed.

So at the end of the day, usually we're going to know this wasn't a correct determination. They made a mistake here in the development, or they didn't get enough information on employment, or, you know, they can easily pinpoint exactly where there might have been a problem. So at the end, if we see that there's an error in the actual decision itself, then we can point that out.

You know, we haven't seen a lot where it's just flat out wrong, but there are things that maybe they could have done differently. And when we see those things, particularly if it's case specific, we can go and say, you know, you need to go back and look at this case and reopen it or take additional development steps.

In other situations, we find trends that maybe they don't understand a certain concept, and we need to do training on it. So

that's kind of how we're utilizing both the sampling that's being conducted on a case-by-case, CE by CE, basis, but also on these quality reviews that are being conducted on an ongoing basis.

CHAIR MARKOWITZ: Okay. Thank you.

MS. POND: And I know John's going to talk a little bit more about that in follow-up to this if I haven't already covered it for him.

CHAIR MARKOWITZ: Okay. Thanks. If there are no other questions or comments, let's move on to Mr. Vance.

MS. POND: Thank you. And also I wanted to just mention that John or I or both of us will be on both days during the times that you're talking about, like, business stuff. Turn it over to John. Thanks.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: All right, well good afternoon, everyone. I'm assuming everyone can hear me I hope.

MR. BIRD: Yes, we can.

MR. VANCE: All right, good. You got me there for a second. Okay. So I think we were covering some discussion of something that we're going to start off with what Dr. Markowitz has asked the program to comment on. So right before or shortly before the Advisory Board meeting, we were sent some questions about some updates that I'm just going to run through. And I believe Carrie Rhoads has distributed this to the Board in writing, so I'm not going to read every response. I'm just going to try to summarize and elaborate as appropriate.

So one of the questions that you've already sort of talked through with Rachel is the fact that we have implemented this new quality assurance program. It is going to be replacing our accountability review process simply because of the amount of ongoing quality assurance that is conducted by the team.

So we do have four individuals that are conducting basically daily reviews of case files for quality assurance. The write-up

explains that they are looking at different components of the decision, but basically they're looking at the quality, accuracy, and sufficiency of development relating to different activities being done by our District Office field operations, by our Final Adjudication Branch, and also by our Medical Benefits Adjudication Branch, which is dedicated to reviewing medical benefit claims made by individuals that have received (audio interference) illness.

So this is an ongoing activity with some, you know, the write-up that we did for it, and I can give you background about the fact that this is a ongoing review. This is very much different from our annual accountability reviews, that this is a static review of very limited number of cases. So the details of how much work is being done by the team is sort of laid out, comments with responses. And I believe that that will be probably put up on the website soon.

But just a quick verbal rundown, for recommended decisions, you know, we are looking

at, just for the period of 2020 -- fiscal year starting in 2020, we reviewed 1,248 cases, 416 decisions, and we have a target -- I'm not going to run through all the details, fast forward May 21, but it is in our write-up in response to that.

I've been involved with that QAC unit. They're very dedicated to looking for, you know, when you're talking about accuracy, what you're talking about is the proper application of program policy, proper interpretation of available evidence, quoting a particular decisional outcome. So it's basically another look at the case file. Keeping in mind that our actual decisional process is also set up for a recommendation to be made and then to be independently evaluated, considered by the Final Adjudication Branch.

So we're looking at both those, the quality and the accuracy of the decision-making at these Medical Benefit Adjudication Branches. So we're very hopeful this process is identifying

issues for our management to help improve the quality of decisional outcomes to identify issues, as Rachel mentioned in trend analysis, where we may need to focus training.

The next question that was posed to us is regarding the proportion of cases that are evaluated by industrial hygienists. The question spoke to how many of our new cases get reviewed by industrial hygienists. We don't really maintain that type of chronological data on, you know, the newness of the case and whether or not that -- whatever definition you want to apply for a new case. We just don't maintain that kind of data.

So when I was developing or coming back and taking a look at this, you know, what I can say is that an IH referral will occur where it is procedurally necessary or it is something that the claims adjudicator has looked at and decided that they need that kind of consultive or consultation with a industrial hygiene expert. So for the period of October 1, 2020 through

March 31, 2021, I was told that we've completed 1,180 contractor IH reviews and 76 internal federal industrial hygiene reviews.

So, as you can see here, audit exposure analysis and characterization of toxins that employees encounter. And of course, that information feeds into our case adjudication process. That information is generally going to be reviewed either by a claimant's own physician or a contractor medical specialist in determining the quality of liability.

There's a question that was posed to the program with regard to the funding or the effort of the program to either develop or create certain claims data. You know, I think that we have talked about this before. I think this is a little separate than the discussion that was introduced at this meeting about the administrative support report. But the program has really taken the position that our mandate under our legislation is case adjudication activities. We don't have, in our view, a

mandate to do activities outside of the case adjudication process. We provided the legislative purpose of the program. And so we really are dedicating more of our appropriated funds to the function of adjudicated cases and anything that falls outside of that activity, which we consider to be -- the researcher and thus the Board has indicated this on behalf of the whole, that a mandate of that.

Something that I did do when I got this request, the Board had asked Dr. Markowitz a question about implementing a new occupational questionnaire committee process. And then at our last meeting, we had reported that we had completed over 600, 12 refused or thereabouts. The Board is interested in some feedback. So I did go out. I did talk to several contacts. I also asked for feedback. And I took the information that I did receive, and I assembled the summary table that's in the written response.

I also provided the Board written comments that I got, unabridged comments from our

field offices, also a research center. But you can get a sense of the feedback, and overall, the reception has been positive. There's definitely a lot more information that is captured that is much more relevant to the work history of the employee. It helps us more carefully adjust and adapt our research into exposures based on data we get from the employee as far as the identification of specific toxins that may be associated with the claimed illness. And so the overall comments that we received were helpful. I think that folks also recognized the fact that we're asking much more detailed information on the claimant versus the sort of checking boxes kind of thing. Fortunately, it better helps provide a little bit more reliable information.

The one thing that we're going to have to take a look at is the fact that we did have multiple comments about the formatting and the text size, that sort of thing. So we're going to go back and try and figure out what we can do to improve the overall readability of the form. I

did share with Carrie this morning -- I'm hoping that she sent that out -- the reference in the procedure manual to that Occupational Health Questionnaire, the sample in the procedure manual that should get circulated.

The fifth question related to the engagement with our medical director with regard to how he is utilized in evaluation of claims and what role he plays. We do have references in the procedure manual about the functions of the medical director. But the written response that we provided basically explains the fact that the medical director, much like any other science expert that we have on staff, is providing expert analysis, expert consultation. He is as an expert. He is a physician, qualified physician, who we seek out his opinion and input on a variety of different adjudication functions. So that can have -- you know, that can touch on virtually any topic that, you know, that involves medicine. So it could be diagnostic, clarifications, questions on anatomy,

credentialing, medical credentialing, impairment, causation, and the medical necessity of services and supplies.

We view the opinion of the medical director much like any other expert that we rely on, that that is the opinion of that individual. And we have to weigh that information in helping us resolve or bring some sort of resolution to an outstanding case. The medical director for our program also does a lot of work in conjunction with the Office of Workers' Compensation in supporting our medical bill pay processing, activities, that has to do with, you know, treatment suites under which we pay medical bills. What is the viable costs to pay for particular types of care? He also is very involved with different kinds of coding issues relating to the implementation and the use of ICD-10 and CPT coding for billing purposes.

And finally, there was a question about bystander exposure, leading to how that's sort of evaluated, and there was a discussion

that somehow we are minimalizing bystander exposure. The response to that is that, you know, we have to evaluate cases based on the information we receive, whether that's contained in the Site Exposure Matrices, whether that's contained in the information that we get from the Department of Energy and all the sites that the employee worked at. And we also utilize the input of experts in the field of industrial hygiene. So if you have an individual who is providing data about the work activities and their contact with particular toxins, we're going to rely on that information and the input of experts to classify and characterize that exposure.

So if you do have individuals that had some sort of incidental exposure, that certainly can be identified and characterized in any kind of analysis that we do. If that is the case, then that information, whether it's incidental exposure or not, to particular toxins, that's going to be up to the physician who's evaluating

that exposure data to determine whether the exposure at the level reported or characterized by the industrial hygienist or determined by the Department of Labor is sufficient to meet that compensability standard under Part D.

So, you know, it's not that we minimalize any type of exposure. It is that we are characterizing the exposures based on the information that is received. And I will just make a comment that this is what is so important about that occupational history questionnaire. More data we have about the particular contact and work that an individual did in conjunction with the particular toxins, the more useful it is for industrial hygienists who evaluate that data in, to find and repair that.

So that is the six questions that we received. I'm sorry if I took more time than I thought I would, but the written responses are available. I have provided to report and you should be receiving the written responses also or feedback that we received from district offices

in regards to occupational history questionnaire feedback.

With that, I'd be happy to answer any other follow-up questions.

CHAIR MARKOWITZ: This is Steven Markowitz. Thank you very much, Mr. Vance. That was great.

Any comments or questions from Board members?

Steve Markowitz, again. I have a question or suggestion really. It's great to see the feedback, especially the positive feedback on the Occupational Health Questionnaire. The Board spent some time assisting the Department in revising the Occupational Health Questionnaire. So it's gratifying to see that it's appreciated in the field. You might -- I don't know, maybe you've done this already, but you might actually ask the industrial hygienists, both federal and the contractors, whether they're finding the new information that they're obtaining when they are looking at these new Occupational Health

Questionnaires that are completed, whether they're finding it more helpful, or whether they have any suggestions about how things might be modified. Because, ultimately, you know, sure, it's the claims examiners using it, but the IH is probably heavily depending on the OHQ for detailed information. So I would suggest you might -- if you haven't, you might ask the IHs how they see them, the new OHQ format.

MR. VANCE: Yeah, I am. Dr. Markowitz, this is John Vance again. I did have a conversation with our industrial hygienist. I was just talking through this very issue, and they said, you know, the Occupational History Questionnaire is always useful in helping them when they're trying to figure out something that they can't understand how the employee would've engaged in a particular toxin or engaged in a process relating to a particular toxin.

So they are using it. They are applying it in their analysis. And I think that they are encouraged by the fact that the work

process data that they get is often much more helpful than the checklist of all different toxins that the claimant used to be able to just sort of check off things and say, well, this is -- here are all the toxins I exposed myself to. Wherein with the new occupational history questionnaire, they're getting more comprehensive and contextual data that helps them shape their opinion. They didn't provide any written responses. They brought me verbally responses.

CHAIR MARKOWITZ: Were those the feds, or are those the contracting IHs?

MR. VANCE: That was the federal staff.

CHAIR MARKOWITZ: I'd be interested to know how, you know, since the feds -- since the contractors are doing most of the -- be interesting how they do it. Something I don't remember, and maybe nobody remembers off the top of their head, is whether the OHQ actually addresses bystander exposure.

And maybe, Ms. Rhoads, at some point

during this meeting, if you could find a copy of the OHQ, we can see whether it does or doesn't. I just don't recall. I don't know whether --

MS. RHOADS: I just sent the link to the OHQ to the Board members' e-mail.

CHAIR MARKOWITZ: Oh, okay. Great, thanks. Okay. I'll take a look at it during break.

I have one final comment or question, but I just want to keep it open to the Board members if they have comments or questions.

Okay. So here's my question. I know we're a little bit overdue for our break. I'm looking at your language and your response for the role of the medical director. I'm trying to figure out how it actually works in practice, because, obviously, the medical director doesn't weigh in on every claim. And yet, you know, when the medical director does get involved, that person expresses an opinion which becomes part of the process. So I guess the question is, how is the medical director drawn into looking at

particular claims? Not in the audit process, I get that. But drawn into assisting claims evaluators or other personnel -- claims examiners, other personnel in looking at individual claims, what are the circumstances under which the medical director is called upon to get involved with individual claims?

MR. VANCE: Dr. Markowitz, it's John Vance. It's going to be dependent on the claims examiner working in conjunction with their management to determine whether or not there's an issue that they feel the medical director may be able to weigh in on that is going to help resolve some sort of outstanding question that the claims examiner has about something that they're evaluating in the case.

So a very relevant example is one where we do see the medical director involved quite frequently is where we're dealing with this very unique procedural reality where we have to look at whether or not a particular types of diagnosed cancer meets the anatomical definition

of a specified cancer under the Special Exposure Cohort definition under Part D. In other words, if you were presenting a pathology report and you want to know if does this qualify as a lymphoma, or does this qualify as a particular type of primary cancer? That's really up to, you know, a medical expert to weigh in on that as far as whether anatomically that probably reported documenting a particular cancer that we could then characterize as a diagnosis for a specified cancer and thereby award an individual coverage under the Special Exposure Cohort. So they'll ask questions relating to that type of situation.

The other types of scenarios that we have seen the medical director ask about are questions where it's a matter of the claims examiner needing some sort of guidance or some sort of input as to whether or not there is something that the medical director can weigh in on to help inform or provide some sort of guidance to the claims examiner, what they should be thinking about as they evaluate a particular

claim. So whether that's, you know, does this diagnosis identified in a pathology report, does this actually report -- what type of cancer are we talking about here? Some of the pathology reports are very hard to interpret.

Also, they will ask the medical director questions about clinical and diagnostic evidence related to their diagnosis, whether there are sufficient documentation to support the diagnosis, or whether there should be additional development that's undertaken. So, I mean, it's really up to the claims examiner who is evaluating the case whether or not something that is really appropriate or not.

MS. POND: John, this is Rachel. Just to clarify, I believe that those recommend- -- any time they go to the medical director, they go through Policy first; is that correct?

MR. VANCE: Yes. When we do get some referrals, we have to make a judgment as to whether or not the medical director is the appropriate source to go to, or whether we would

recommend that just being sent to a contractor medical specialist.

MS. POND: Rachel again. Or back to the treating physician. The medical director also reviews transplants to make sure to approve those, and those usually get approved right away, but that is a conduit for transplants as well.

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay. Thank you. It's Markowitz. So is the opinion of the medical director, is it always put in writing? Is it a written opinion?

MR. VANCE: Yes. It's generally going to be a -- if we're submitting a request to the medical director responder case adjudication issue, then that opinion or that response is going to be uploaded in the case file.

CHAIR MARKOWITZ: Okay. Thanks.

Any other comments or questions?

Okay. Thank you very much. That was great. Thank you, Ms. Pond and also Mr. Vance.

We're going to go on break for ten

minutes, maybe even 13 minutes. We're going to resume at 2:50, according to my clock here.

I think, Mr. Chance, you wanted people to put their phones on mute or whatever. But in any event, please be prompt because we have some really interesting topics coming up.

(Whereupon, the above-entitled matter went off the record at 2:37 p.m. and resumed at 2:54 p.m.)

CHAIR MARKOWITZ: Okay. Welcome back. Steve Markowitz. We're onto the next agenda item. And here we're going to talk about the couple of the recommendations that the Board made in November. And we have the Department's response to our recommendations, so we should discuss that. Next slide.

Now we made a recommendation that we return to the issue of site-wide jobs, and we'd recommended that the Department develop and implement exposure presumptions for those job categories who would likely worked throughout the facility and had potential exposures to all

listed toxic substances at the facility. So just to remind you, we're talking about people like firefighters, security guards, health physics personnel, people who really over time moved around the facility in order to do their work.

So if we can go to the next slide. So I've excerpted the Department's response, and I've, in fact, put some highlights around the most important part. And basically, the Department's response is that it is quoted as inappropriate to assign its broad classification of exposure to specific labor categories in the absence of any underlying documentary support, end of quote. Basically, if I understand it correctly, the position is the data don't exist to support an exposure presumption for those job titles, therefore we can't make those presumptions.

And so let me just kick off discussion of this. It's a little bit of a chicken and egg thing. We know that throughout the decades of operations, Department of Energy, that there's

been variable amount of documentation of the hazards. Certainly in the first few decades, relatively little documentation, and you know, even in the recent decades, selective documentation. I think that Department of -- I think if we had Greg Lewis here, he'd probably, I'm probably quoting him, actually, about this. And it varies from site to site. We looked earlier in the Board process at Hanford versus the Gaseous Diffusion Plants and at Hanford we saw an enormous number of toxic substances associated with some of these site-wide job titles. And we found relatively few with the gaseous diffusion plants. When we did the comparison within, between, or rather among the three gaseous diffusion plants, we found variation in the number of toxic substances for the same job title.

So the underlying problem is that there's limited documentary support. So the question is, what do you do in the absence of that, in the relative absence of that type of

documentation? And to stay with the Department's position here means that you are going to have essentially built-in variation, and sometimes variation that's a little hard to justify. Variation between various sites or between various job titles. And so my own feeling here is that, you know, we could look at firefighters at different sites and how their claims are evaluated and whether there is consistency across those claims. But what we're likely to find is that there's going to be a lot of variation in how firefighters and security guards recorded their exposures, because of what they do and how they deal with it in the light.

So my feeling is that it's more of a problem to tolerate the kind of variation in consideration of these claims than it is to tolerate the lack of documentary support. Knowing that frankly, over the years, the Department just varied and didn't have much documentation they provided for the hazards. Other comments of Board members?

MEMBER KEY: Yes, this is Jim Key. I echo Dr. Markowitz's comments, especially when we are focusing on the origination of the legislation of the Energy Employees Illness Compensation Act, which I was a part of. The SEC was set up at that time for all three gaseous diffusion facilities as a result of no documentation. None could be found. Monitoring had got at the Paducah Gaseous Diffusion Plant in the arena of health physics and industrial hygiene of jobs out on the specific jobs for workers had exposure, did not even begin until the late 1980s. That's the end of my comment.

CHAIR MARKOWITZ: Other comments or --

MEMBER FRIEDMAN-JIMENEZ: This is Dr. Friedman-Jimenez. Another option would be to develop sort of a library of exposures. And as more cases were adjudicated, the information on each exposure, say for a firefighter in one plant versus another plant, would be added to this library, and eventually you would have pretty solid documentation of the level of exposure to

each agent and for firefighters and for maintenance workers and ground-keeping workers. The problem with that is that you then have a changing level of information over time. And then when you may compare to cases that are adjudicated in 2018 and 2024, and they'll have the same exact job, but a very different level of information and would wind up being adjudicated differently, which I don't think is what we want.

So I think Dr. Markowitz's proposal is the best way to address this high variability in the level of documentation. And we know that we're never going to have exact measurements on anyone. But this way, we can put together the best estimates of exposure once and have that be the set level. So I strongly agree with Dr. Markowtiz's proposal.

CHAIR MARKOWITZ: This is Steve Markowitz. So your idea of kind of a living exposure library is fascinating. The SEM is that in part because it does change over time. But your idea of incorporating claimants own

information into ongoing exposure considerations for others is fascinating. It's also, you know, as you say, you know, it just presents all kinds of challenges to a system that deals with compensation. So I agree with you. I don't think it's going to happen, but this is an interesting idea.

MEMBER FRIEDMAN-JIMENEZ: This essentially is a machine-learning approach. It is used a lot now with artificial intelligence. But it has this major downside, which is that you're going to have non-comparable adjudications over time as the level of information grows, which I don't think is acceptable.

MEMBER GOLDMAN: This is Rose Goldman. I have a question on this. I also agree with Dr. Markowitz that we need to address this. I mean, these are common problems that have come up with these kinds of job titles. And what I'm wondering, and I don't quite understand now is with the new questionnaire that we are using, if you have a firefighter, for example, who might be

able to say I went to fires if this person could remember, or at least I was covering our security guard, these buildings during this time period. I'm not sure why we can't go back and say, okay, this person spent hours in this area going through the various locations to be able to say from that building wherever the person remembered they were, that we would give them credit, as a bystander basically, to the exposures in that area.

CHAIR MARKOWITZ: So it's Steve Markowitz. I'm not sure how to proceed here because we have made the case, and the case has been rejected, and I can't really think of a new approach to providing any sort of empirical information. I think if we, probably, if we had a infrastructure within the Board to review claims, you know, conceivably we could look at any number of firefighter claims or security claims and guard claims and see how consistent or inconsistent they are in relation to the exposures across sites or within sites. But

that's a pretty big undertaking. And we don't have that infrastructure at the moment. So I don't see taking that approach. That would provide another level of information, but just don't see it happening. And I don't know whether there's any appeals process for the Board for reconsideration of recommendations. But unless I'm informed otherwise, I think we just have to stayed with this for the moment.

MEMBER GOLDMAN: This is Rose Goldman again. Given that we are looking forward to getting more resources to help with some things, perhaps one could say that in the future when there are more resources available to the Board, one could say, let's select several firefighters or security guards who made claims for certain areas and did fill in the new questionnaire. And to begin to put together something, maybe not as elegant as what Dr. Friedman-Jimenez suggested. But, you know, begin putting together at looking at those cases as individual ones and where they claim they were. And looking at the new

questionnaires and then beginning to put together what their exposures may have been and to revisit those cases sort of as examples. And then we could make, if we got that kind of information, we could then make some suggestions about what could be some default or criteria for security guards or different people or methods for how to approach this once we had those extra resources. That's the end of my comment.

CHAIR MARKOWITZ: Steve Markowitz. So, you know, that postpones this by quite a bit of time. My other concern is that if the firefighter doesn't report these broad exposures because they don't know, and if the SEM doesn't have that breadth, because it doesn't, then we could easily examine claims and still come up with a lack of exposure-disease link that doesn't reflect reality. But we need to move on to the next thing. So are there any final comments on this issue?

MEMBER SILVER: Yes, Ken Silver here. I see a fundamental conceptual distinction

between firefighters and the other job categories. I think Dr. Goldman rightly referred to bystander exposures. A firefighter putting out a fire is hardly a bystander, and the nature of the agents that they're exposed to in a fire is way different from security guards passing through or what safety people do when they're doing their walk-arounds. And I just wonder if in the occupational epi literature, there are a handful of agents, chemicals, where there's well-documented evidence of effects on bystanders that might form the basis for presumptions in these job categories.

So mesothelioma and asbestos, right, pretty much a slam-dunk for bystander exposure. Chronic beryllium disease, as long as we've known about beryllium in America there have been bystander cases. So I wonder if we could further develop the concept of bystander exposure from the empirical evidence that's maybe in the epi literature and deal with firefighters separately.

CHAIR MARKOWITZ: Well, you know what,

we can kick this back for Working Group to try to explorer further approaches. Because I don't think we're going to come up with a revision of the recommendation at the moment, unless someone disagrees. And we can talk about how they integrate bystander exposure into the considerations.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: So let's move on, next slide. Another recommendation we made last November was that the Department develop a independent, third-party-based system of frequently evaluating the objectivity, quality, consistency, of individual claim reports, but actually I think more importantly, the audits of the program, industrial hygienists and physicians. And also that we recommended that the IH reports be audited in the same way that the physicians reports are audited and industrial hygiene review process be audited.

So if we go to the next slide, we have the Department's response to that, which I think

mostly requires some clarification. The Department agreed to implement changes and quality control methods to enhance the independent evaluation of the objectivity, quality, consistency of industrial hygiene, and physician reporting.

Next slide. I just literally took from their response to cases, highlighted the important parts. The Department designed additional methods of objective audit review for the IH evaluations. The Department will develop an audit process separate from the entities engaged in case adjudication to ensure outcomes conform to procedural, qualitative, and consistency standards.

Also, the Department will redesign the contract medical consultants review process to supplement current reviews that are conducted quarterly by the OWCP Medical Director. And they're going to fill an additional position, medical position in the office, that will allow for additional review of these reports from this

additional physician, and a higher degree of objectivity. So I guess my question to Ms. Pond and Mr. Vance is, where are we at with these changes? I realize that it was all of three months ago that this was written; but what's the current status?

MR. VANCE: Dr. Markowitz, this is John Vance. So we talked a lot about the QA process, I mean, that is a big change. That's actually been going on since last year. Again, we're looking at qualitative and policy application accuracy throughout our entire decisional process, whether that's at, you know, the District Office recommended decision stage or the final Adjudication Branch final decision stage. Separately we're looking at the medical adjudication process. So that process, I think, represents a real effort by the program to improve not only the volume of looking at audits for, you know, qualitative inaccuracy standards. And as part of that, they're looking at the sufficiency of the analysis of the decisions

utilizing medical health science in support decisional outcomes. So that's one thing.

We're also looking at, and we are working on, a redesign of our CMC review process. So we're looking at how we used to do the reviews and trying to bring in some more or more objective analysis of that process. So right now we've sort of mapped out some new auditing tools that's developing. We're going to try to look at what we can do to adjust our audit questions and the process that we utilize evaluating those cases. And there's going to have to be some internal discussions about who is going to do that and how can we infuse that objectivity that the Board is recommending. So it's a process in development right now. But I think that the quality assurance, you know, the process is definitely helpful in providing, you know, real-time feedback as they review cases.

MS. POND: And this is Rachel. With regard to the IH referral process and the audits of those, it's presenting more of a challenge for

us, just because we have the audits of the reports within the contract, which is just the QA. And then we have every single report is reviewed by a federal IH. So, you know, so they're reviewing them every single time. So it's done by the contract person and then a federal person. We don't have IHs outside of our program to evaluate IHs. So we talked about having an effective, and I know I talked about this stuff, and we put this in the follow-up, but it's really kind of challenging for us to see our way to look at those reports of the IH without having additional IHs that are part of our program, if you understand what I'm saying. So I don't have an answer, a solid answer for you right now. We're still kind of contemplating how that would work outside of what we're already doing.

CHAIR MARKOWITZ: Okay. Thanks. Any Board members have comments or questions?

MEMBER VAN DYKE: This is Mike Van Dyke. I was just wondering is there a

possibility of being able to contract an IH group that doesn't do these outside evaluations to look at the quality?

MS. POND: Can you hear me now?

CHAIR MARKOWITZ: Yes.

MS. POND: Okay. This is Rachel. So that would mean contracting another contractor to audit the contract. I don't know that that's something that we can actually do. For a variety of contractual reasons, I think that would cause some complications. And again, then we're already another whole group of people to do the same work. And it just becomes expensive and it becomes, I believe there will be some contractual issue in that, but we will continue to evaluate the issue.

CHAIR MARKOWITZ: Other comments or questions? Steve Markowitz. So yeah, the Board actually, when we developed our recommendation, we kind of struggled with this. Because we understand how, you know, challenging these issues are and how to integrate that kind of

quality in decision-making. And the formulation we came up with was an independent third-party of the system. But the question that I really have is, you know, clearly that's kind of the start of this redesign and whether the Board, it's not a question we need an answer to now, but whether the Board can interact with the Department in a more frequent basis or more interactive process where we can kind of assist in this.

This is really a core task of the Board to assess the objectivity, quality, consistency of the work of industrial hygienists and the physician's task number 3, or number 4, of our charter. And we've looked at, you know, the Medical Director's audits and we've looked at claims and we see there are issues. So I guess my question is, is there a way that we can interact a little bit more frequently in providing the Department with the advice that we're supposed to be giving?

MS. POND: So I think that we've talked about this before and part of the problem

was resources on the Board's side. Having, you know, the ability to do those sorts of audits wasn't something that I thought you guys really had the bandwidth to do, because of the fact that you're volunteers and that sort of thing. Now, that being said, I know it's part of your tasks to do those sorts of things. So I would have to, you know, we can maybe talk further about it, you know, how something like that might work.

CHAIR MARKOWITZ: It's Steve Markowitz. I want to make clear, I wasn't volunteering the Board to do the reviews. What I'm saying is what you described in January, and the update seems to reflect this that you're thinking through developing how to improve the system, redesign is the word you used, design. And all I'm saying is next month, and the month after that, and the month after that, instead of waiting six months for us to get another report on what's happening, whether we could, the Board can interact, a subset of the Board can interact with Department more frequently to weigh in on

this issue.

MS. POND: I understand.

CHAIR MARKOWITZ: And I really don't need an answer right away. But it is logical way to proceed.

MR. CHANCE: Steve?

CHAIR MARKOWITZ: Yes?

MR. CHANCE: Steve, it's Mike. Hey, I think we're going to have to -- we'd have to evaluate what kind of implications that has on the whole FACA setup and all that. So I mean once, if you guys can come up with a recommendation, I think that it would have to go like, kind of a more formal route.

CHAIR MARKOWITZ: Yeah, I hear you. Okay. Any final comments? We need to move on, thank you. Any final comments or questions on this?

Okay, so I'm going to turn it over to Dr. Goldman and the Working Group on Probable Human Carcinogens. And I think Kevin, you probably need to switch out the slide shows.

MEMBER GOLDMAN: Thank you very much for this opportunity to present our work. I'm just going to, first of all, start by thanking the people on this Working Group, which is Dr. Aaron Bowman, Duronda Pope, and George Friedman-Jimenez. And also to Dr. Steven Markowitz, who gave us some important guidance on how to approach the next step in the process. I'm just going to, you can go to the next slide, review a couple of things quickly to update some of the people who weren't on the Committee and take us from November to the present.

Which is, our task was to look at the IARC Group 2A, which is called the Probable Human Carcinogens, and to address whether or not they should be added to the SEM, linking them to specific cancers. We can go to the next one, please.

So just as a further update since March 2021, that the Group 1, are the carcinogenic to humans. Group 2A, which is what we're addressing, there was a couple of more

agents added, 89, 2B, 318. And Group 3, was are not classifiable. So what we're really looking at is this Group 2A. Next please.

Again, just as a quick update, that the 2A probable carcinogenic in humans is based upon limited evidence of carcinogenicity in humans and sufficient in experimental animals, or could be inadequate evidence of carcinogenicity in humans and sufficient and experimental animals. And another phase of things being brought in about mechanisms or limited carcinogenicity in humans but belonged, but based on mechanistic considerations to class of agents for which one or more members have been classified. So this is sort of hard to grasp. So I'm going to go into a little bit more detail and also with some illustrations. We can go to the next please.

So just basically what we started with last year, and this is started with the other Chair of this Working Group, Dr. Berenji, was to get a start on this was with 22 agents that had

been updated since 2016. And of those 22 agents, 18 of them were toxic substances. And so the starting point here was with these 18. Could we go to the next, please.

And this was the chart that we showed last year, I mean, last fall, about these 18 and some efforts to look at which ones were even in the SEM at all and which ones were not. So this is a preliminary effort to try to tackle this. And a lot of these agents were actually in the SEM, but not really coordinated with any cancers. Next, please.

So then the next task that we were really looking at for this year, was of these 18 agents, which ones should be included in the SEM and what would be our basis for recommending that? And we did some looking at Group 1 agents. And then I think the approach that we took, with some guidance from Dr. Markowitz, was actually to start looking at which ones actually had some evidence for human cancer, so we would at least know which cancers to be recommending. Could we

go to the next one.

So I just wanted, I think this raises the point of what the approach is here. That we were not going to go and read the primary epidemiological data, which is a vast task. And frankly, that's one that's already been done by IARC. And so I just wanted to show this graphic, which I really say speaks to the work that IARC does. To do this and it's, Kevin, could you just show that graphic please from IARC now.

MR. BIRD: It should be pulling up right now.

MEMBER GOLDMAN: Okay. So I just wanted to show that what happens through IARC is for the agents that they select, they then go through a very detailed systematic review process of screening. They have external committees. They do review most of the literature. And then after reviewing all the literature, they rate how good it is. And they actually then do a synthesis of it and they look at what's the evidence for human cancers and which ones, what

is the evidence for animals and those response and looking at their quality of the studies. And then they also look at mechanistic data synthesis. And here they're looking at the characteristics of the carcinogens, the relevance of the mechanisms and the study quality. And then yes, if we could --

So then what happens when they've gone through this process, they then note the evaluation, which is the evidence of cancer in humans, evidence of cancer in experimental animals, and then the mechanistic evidence. And now if we look at how do you get to be a Group 1? If you have sufficient human evidence, you're right there. Or even if you don't have that, if you have sufficient evidence in animals and very strong mechanistic evidence, you could land in this group.

Now, the important thing here for the Group 2A, is that there are two categories, two ways to get into it, and this is a little easier to see. Which is you could have limited human

evidence with sufficient evidence in cancer or limited human and strong mechanistic and get into Group 2A. But you could also have some agents that are in the Group 2A, where there's really not this limited cancer in humans. So you wouldn't know even which cancers to be able to give them worker compensation for, because we don't even know, we just know that the agents are potential carcinogens and more information could evolve in the future.

So could we go back to the main slide deck, Kevin, please? Right, so just again to show this more clearly, what our working Group was going to do is go through the 18, and see which ones fell into this category where there was some limited evidence in humans. And then see what we would find. Next please.

So that's what we did. We reviewed the 18 toxic substances, and we mostly relied upon IARC because of the kind of review process they have done. And then from relying on IARC, we looked at each of those 18 and said which ones

had, as part of their supporting documentation for being a 2A, limited evidence of cancer in humans. And which ones and which cancers they thought there was limited evidence. And we also mentioned about the other supporting evidence. And I'm going to show you those tables in a minute. But the interesting thing is, out of the 18, there were 11, that had limited evidence of cancer in humans and actually for specific sites.

And then the other thing we've looked at as we went to the human health effects listing in SEM, which included various cancers and looked there to see if any of the 2As were there. And the answer was no. And there was no linkages of these 11, currently to cancers in the SEM. The other thing is IARC had linked some of these agents to breast, prostate, and testicular cancer, but those were not found in the SEM at all.

If we could go further. And well, we put together this chart, which we have sent out and as part of our recommendations, which details

what we found in terms of what the chemical substance is and what are the cancers that have been associated with it with limited evidence, and then what we found in the SEM or not. And go to the next slide, please. Okay. And then this is the continuation of the other 11. Next please.

This is just showing you that for this time what we did was we grouped under each cancer, we're going the other way, which of the 2A carcinogens would be associated with that cancer if we accepted the 2As. And you can see mostly in the lymphoma, non-Hodgkin's is a large category here, large numbers. But for most of them it's adding one or two in the categories. Next.

So what did we come up with for recommendations? The recommendations that we had is we thought that we should add these 11 toxic substances that are found to be probable human carcinogens in Group 2A, that did demonstrate limited human epidemiological evidence. And that

we should add them with linkages for those specific cancers that I just demonstrated in table 1. The other thing that we would recommend is that the SEM should specify that IARC and NTP evaluations are used in addition to the Haz-Map strategy and resource for the purpose of creating these linkages between toxic substances and the human cancer sites. And that for the future, because this is of course new information that is coming out over time, that the future IARC 2A substance-cancer linkages that are identified by IARC and also NTP, it should be incorporated in the SEM. And that this data should be used in addition to the Haz-Map for health effects and linkages and should be updated as we go along in the future.

And I think that's the end of our presentation. So we're open to, I guess questions and discussion. Well, I'll also invite, if any of our other members of the Working Group perhaps, have something you would like to add before we open it up for questions?

MEMBER BOWMAN: Rose, this is Aaron. You did a fantastic job presenting our work, thank you so much. I just want to also acknowledge here, Rose is the leadership of our group, keeping us on task. Thank you so much.

MEMBER GOLDMAN: Thank you.

CHAIR MARKOWITZ: Steve Markowitz. I also thought this was a -- you really nailed this. This is a topic that was raised in 2016 or '17, by the Board because the IOM report in 2013, it pointed out that the SEM was incomplete with reference to taking all of the authoritative information it could from various sources. And I think the Department founded it was just too big a task. And then they asked us for help. And this is, at least for the probable human carcinogens, the end of that fairly long trail. And I think you've done, the Group has done an incredible job of summarizing.

There's also, for maybe the public, members of the public, who don't have this because it was just provided to the Department of

Labor within the past 24 hours. But there's a ten-page summary of the studies, agent by agent for the 11 agents for the various kinds of evidence that are available. That would go along, that would be submitted with this recommendation. And that will be made available online on our website pretty soon. So anyway, I personally, I think that I'm convinced looking at and reading that ten-page summary, knowing actually some of the underlying literature, I'm convinced that you all made the right decision on these 11 agents, that they are most likely human carcinogens, and there's enough data, enough studies pointing to specific sites to allow that to be integrated into the SEM. And I think, you know, when you think about language of the EEOICP Act, that, you know, more likely than not, a significant factor aggravating, contributing or causing, that these probable human carcinogens really make that grade.

MS. POND: Dr. Markowitz, this is Rachel. I just wanted to say this is very, I can

tell a lot of work went into it, and so I think it's going to be very helpful. So thank you very much.

MEMBER GOLDMAN: One thing, this is Rose Goldman again, I just want to say that it was great working with this Group, but as a starting point, we're only talking about 11. So it would seem to me too, that in terms of like taking what it first seemed like, where do we begin with this, but getting it down to at least the starting point of these 11. And saying what we could do with these 11. And also just saying we need to expand the database that they were working with which is IARC and bring it, mostly IARC but also NTP into it. Then seeing what we can do now and implement for 11. I mean, it makes the task, I think, a bit more doable. And then to see how that goes.

CHAIR MARKOWITZ: Steve Markowitz. I think I heard some volunteering effort there, but I'm not going to going to proceeded to that, Dr. Goldman, at the moment. So we have a

recommendation of --

MEMBER GOLDMAN: I volunteer the DOL, Dr. Markowitz, to take this forward to the next steps.

CHAIR MARKOWITZ: Anyway, what we're looking at recommendation on the screen. And so we need to, what I'd like to do is have a formal motion to accept, to second, and then discuss it, and then if possible, vote on it.

MEMBER BOWMAN: This is Aaron Bowman. I put in a formal motion to accept the recommendations.

CHAIR MARKOWITZ: And is there a second?

MEMBER KEY: Jim Key, with a second.

CHAIR MARKOWITZ: Okay. Good, the floor is open to discussion. Steve Markowitz. I would point out while you're thinking about this, that I think this is really a, I can't think of a Workers Comp system frankly, that quite captures this amount of, you know, the universe on cancer. And so I think, you know, it's yet another way in

which the Energy Employees Occupational illness Compensation Program actually would be pioneering, appropriately so but pioneering properly evaluating the relationships between exposure and diseases in the workplace. So are there other comments or questions about this proposal; otherwise we can move to a vote?

MEMBER SILVER: This is Ken Silver. Really nice job. I remember when this discussion started and it was much more sprawling, and you really distilled it down to the crux of the matter. I wonder if, going forward, DOL should keep an eye on some of the alkylating agents for which is not yet evidence of specific cancer sites in humans. If I were claiming advocate for a worker who had exposure to styrene-7,8 oxide or hydrazine or 1,3-Propane sultone, I would advance an argument based on mechanism and animal literature and I would be very impatient if an epidemiological study came out that did identify specific organ sites. I'd be impatient for DOL to incorporate that into the SEM. So how do we

get DOL to keep an eye on the emerging literature for the chemicals that didn't make the cut but are sure suspicious?

MS. POND: I'm not sure if that's a question for DOL. This is Rachel. You know, we're constantly evaluating, SEM is constantly being updated and research is being conducted by a contractor on a regular basis. You know, we can make a note of the specifics that you just mentioned and have our contractor look it over.

MEMBER FRIEDMAN-JIMENEZ: This is Dr. Friedman-Jimenez. I agree with Dr. Silver that this should be a work-in-progress. And I think the path forward is clear. Once we've accepted IARC and to an extent, National Toxicology Program as the valid authorities on cancer risk identification, then I think revisiting, you know, every time a new agent is declared to be Class 1, or Class 2A carcinogen by IARC, then there should be an ongoing mechanism by which the SEM incorporates that information. Just as it incorporates information, new information on

toxicology of other substances that cause other diseases. So I think it's a bigger question of what is the structure of the SEM that we should modify to make it be an ongoing, growing body of information that responds to new science information as it comes out.

I think we have a pretty good bar for making the cut, which is that there's at least limited evidence in humans of carcinogenicity. And so I think it will be clear whether we should include it or not in the same way that we've done with these 11 agents out of the 18. So the question then is, how could the SEM be kept updated? What is the process by which it's updated? Are the industrial hygienists constantly looking at new literature? And so that's a question really for the program. How is the SEM updated, and how often and by what process?

MS. POND: John, do you want to take that, please? This is Rachel.

MR. VANCE: Yeah. So as we've

explained in the past the Site Exposure Matrices is an evolving database. We are, you know, we have folks at work with the Site Exposure Matrices through our contractor, Paragon. We're evaluating new information that's submitted by the public. There's new information that come to light through different scientific organizations. All that information is fed into the continual upgrades to the Site Exposure Matrices. So what Rachel mentioned at the beginning, we're getting constantly new data available about the exposures and toxins at different sites.

The same holds true for different kinds of health effects data. So health effect data is what the group was just discussing with regard to the IARC data. It's what is this that the program and communicate and generalize to its staff that we have the scientific confidence to say, this disease has a viable relationship to this toxin, okay? So it's a matter of lots of different inputs that Paragon and the program receives. So if we're getting input from the

Board, we're getting important from, you know, scientific bodies and other types of information being submitted. All of that stuff has to be evaluated, considered by the program to determine whether or not we're going to add health effects data into the Site Exposure Matrices.

Because at the end of the day, the Site Exposure Matrices is a tool that's helping claims staff evaluate claims and collect and profile individuals about their contact with specific exposures that then are going to be reported to a physician to determine whether or not, you know, causation does exist under the party standard or to apply that data in establishing a standard.

CHAIR MARKOWITZ: Steve Markowitz. Are there --

MEMBER FRIEDMAN-JIMENEZ: Can I just ask a follow-up question to that?

CHAIR MARKOWITZ: Go ahead.

MEMBER FRIEDMAN-JIMENEZ: So what I hear you saying is that largely the program

responds to requests from the public that different agents be added. I'm wondering if there might be an active surveillance mechanism built into the SEM that someone's job would be to keep up with the new publications from IARC and from NTP and other toxicology publications to see whether they're new agents being added. Occasionally there are agents that were thought to be carcinogenic that get delisted. I know that's happened by NTP. So there are some changes that go on, and I think it would be good to have an active process rather than a passive process that only responds to requests from the outside. Is that something that you could entertain or is that something --

MR. VANCE: Yes, there is an active work group that is consequently discussing new information that's becoming available. And that team is comprised of individuals from Paragon, you know, if there is folks that are on that, in that work group from our program or a toxicologist participates in that discussion.

And so that's an evolving conversation about different medical science data that's becoming available that actually does do to a certain extent, what you're talking about. But what I think I'm trying to generally state, maybe not very clearly is, it's really a matter of what's out there. And there's tons of things out there, more information that we're getting, input from the public or the Advisory Board, or that our folks can look at and say, this is something to evaluate and consider, that's going to be helpful, and will inform our Site Exposure Matrices changes and updates.

MEMBER GOLDMAN: This is Rose Goldman again. I think for this, you could just simplify this and just say that in Paragon's review, that they include checking the IARC website. Again, looking at it, just reviewing to make these slides from November to now, there were one or two more 2A carcinogens added and I didn't check to see if there was a toxic substances or something else. So I mean, the task is not

enormous here. They add maybe one Group 1, and maybe two or something every year to this. And I think if you'd put that on their checklist, you know, rather than trying to go and maybe review all of the thousands of articles that are coming out, but use that as a guide. And then go and see the articles that maybe IARC is giving more weight to if they feel the need to do that. But it certainly seems to me that's a totally doable task to put that on their checklist.

CHAIR MARKOWITZ: Steve Markowitz. Just a point of clarification. I think Paragon is probably mostly has expertise in exposure assessment and industrial hygiene. And I understand much of the evolution of the SEM has to do with adding different toxic substances, different places. But are you saying the disease exposure links in the SEM are routinely evaluated for improvement by Paragon, you know, with or without people from the program, the toxicologist --

MR. VANCE: I mean, the

recommendations or any kind of changes that would be permitted to by the Site Exposure, you know, in the Site Exposure Matrices would be evaluated by the program and we determine whether to add them. And I mean, this conversation, you know, originated from that effort where the question was whether or not these probable health effects that were reported by IARC, would this be something that the Board felt in their evaluation, would the Board be confident for the program to utilize those kinds of classifications and expanding guidance in the Site Exposure Matrices?

Because the standard that we've used in the past is basically, you know, there's an established humanistic relationship. And that's where I just don't know that proves that falls into that category. But that's basically it forms the Site Exposure Matrices. And so this group was meeting and talking and this is where that question came up from, in going to the Board and asking could we maybe look at the probables

and see whether or not, you know, the Board would feel comfortable adding new health effect data into the Site Exposure Matrices. So this sort of stems from that work we're doing.

CHAIR MARKOWITZ: Okay. Thank you. That's helpful. So let's go back to the recommendation, which we need to vote on. Any further comments on these recommendations?

MEMBER POPE: This is Duronda Pope. I just wanted to commend Dr. Goldman, Dr. Bowman, and Friedman-Jimenez, the work that they did. I had little to contribute, but this really adds to the help that the SEM needs to identify those carcinogens.

CHAIR MARKOWITZ: Thank you. Any final comments?

MEMBER FRIEDMAN-JIMENEZ: This is Dr. Friedman-Jimenez. I'm thinking maybe the third bullet should be modified to reflect an active process of identifying new changes in the IARC or NTP recommendations, because it just says that new linkages should be incorporated in the SEM,

but it doesn't say how. So maybe annually or semi-annually the IARC and NTP publication should be reviewed by the program to see if there are any changes, listing or delisting of agents that then would be incorporated into the SEM.

CHAIR MARKOWITZ: Steve Markowitz. You know, adding a time-frame that seems reasonable, you know, frequency. I'm not sure we need to tell them the sources because it's kind of self-evident in the way that it's written, right? Identified by IARC or NTP. But if you want to suggest a friendly amendment to the frequency, maybe Dr. Goldman would accept that.

MEMBER GOLDMAN: Sure. I don't know if you want to do it right now, you could pull up the Word document on that third, these recommendations were copied and pasted from the Word document and we could pull that up, thank you, Carrie. And we could, if you'd like, just do some wordsmithing right here. I don't know if I can, oops, wow, I can change it. Future linkages identified should be incorporated in the

SEM. So maybe we should say there should be surveillance or checking of these databases yearly, and that any new substance linkages described, because as George said, it could be delisted, should be incorporated.

I mean maybe the first sentence, I mean, the second sentence in this should become the first sentence, which is to say the data from IARC and NTP should be used in addition to Haz-Map. So we could put that as the first sentence of that. And then to give more specifics, say that at least on a yearly basis going forward, yearly basis, that IARC -- actually we should say because it would also apply to 1, even though we're not doing 1, that future IARC reports concerning Group 1 and 2A, substance-cancer linkages should be incorporated in the SEM.

Actually maybe the way the future rather than, yeah, we could say group. I know we're not speaking to 1, but I think the same process should be to 1, you know, that future IARC Group 1 and 2A cancer linkages should be

incorporated in the SEM. So we wouldn't have to repeat that. So future IARC Group 2A substance-cancer linkages identified by IARC or NTP should be incorporated. I don't know, what do people think about that? It's a little wordy but it captures, I think, the point.

MEMBER BOWMAN: This is Aaron Bowman. I think that's fine. Yearly, I think seems like a reasonable occurrence given the very slow rate at which that happens, which of course occurs because of the very rigorous review process that goes into these assignments by IARC. Just maybe instead of substance-cancer linkages, substance-cancer site linkages that sort of fits better with the first bullet, you know, it specifically cancer sites that we linked in our work on this.

MEMBER GOLDMAN: That's a good point.

MEMBER BOWMAN: Yes, it is substance, dash, cancer site linkages.

MR. BIRD: Sorry, Dr. Bowman, can you just let me know where exactly --

MEMBER BOWMAN: In that very last line

there's a word substance, hyphen, cancer, we want substance, hyphen, cancer site linkages.

MR. BIRD: Great. Thank you.

MEMBER BOWMAN: I do concur that Group 1, here would be applicable, obviously, you know that the evidence is even more outstanding, right. So there's an obvious that doesn't even, the Group 1, are deemed, you know --

MEMBER GOLDMAN: Yeah.

MEMBER BOWMAN: Yeah.

MEMBER GOLDMAN: I would add, I know that we're not doing Group 1. Maybe the future IARC Group 2A and maybe in parenthesis as well as Group 1, close parenthesis, substance human, yes, substance human cancer site linkages because we base this on humans. There's animal data --

MEMBER BOWMAN: Absolutely, yeah, I agree.

MEMBER GOLDMAN: Yes, substance, dash, human cancer site linkages.

MEMBER BOWMAN: Sorry, not there, not there. The other substance.

MEMBER GOLDMAN: Yes, sorry. Yeah.

MEMBER BOWMAN: Yes.

MEMBER GOLDMAN: Yeah, I would say as well as yes, Group 1, substance-human cancer site linkages identified should be incorporated. Yeah, I think that makes sense just to proposing this process if we're putting forth this process recommendation that it would apply to also Group 1.

MEMBER BOWMAN: Just to get back to the point that there are at times the linkage that becomes unlinked, so to speak.

We're talking about the future showing say, linkages and -- I just don't know how to add that wording there in a simple way. But obviously if something is, you know, taken off by IARC for that, we would support their conclusions.

CHAIR MARKOWITZ: This is Steve Markowitz. What we should do is instead of saying incorporated in the SEM, you could say updated in the SEM. And that way, if anything is

delinked that that would represent an update. I don't know if that solves the problem or not.

MEMBER BOWMAN: It solves it for me.

MEMBER FRIEDMAN-JIMENEZ: Yeah, I agree.

MEMBER GOLDMAN: I agree.

CHAIR MARKOWITZ: Well, we should probably vote while everybody agrees. Are there any other comments? Okay. So we're going to take a vote here. I think Ms. Rhoads, I think I turn it over to you.

MS. RHOADS: Yeah, and just to be clear, we're voting on the three bullets all at once that are the screen right now that were just edited.

CHAIR MARKOWITZ: Correct.

MS. RHOADS: Okay. So Dr. Bowman?

MEMBER BOWMAN: Yes.

MS. RHOADS: Mr. Catlin?

MEMBER CATLIN: Yes.

MS. RHOADS: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MS. RHOADS: Dr. Goldman?

MEMBER GOLDMAN: Yes.

MS. RHOADS: Mr. Key?

MEMBER KEY: Yes.

MEMBER POPE: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MS. RHOADS: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MS. RHOADS: Ms. Pope?

MEMBER POPE: Yes.

MS. RHOADS: Dr. Silver?

MEMBER SILVER: Yes.

MS. RHOADS: Mr. Tebay?

MEMBER TEBAY: Yes.

MS. RHOADS: Dr. Van Dyke?

MEMBER VAN DYKE: Yes.

MS. RHOADS: And Ms. Whitten?

MEMBER WHITTEN: Yes.

MS. RHOADS: Okay. That's unanimous.

CHAIR MARKOWITZ: Okay. Thank you very much to the Working Group. We're going to move on. We're running a little bit late, but

that's okay. We do start our public comment session in 18 minutes. So what we're going to start is our COVID. Kevin, if you could go to my slide, slide 16. We're going to go to the COVID query to us by the Board, excuse me, by the Department. Actually, okay go to the next slide. So I tried to summarize what the questions to us are. But the Department, the program seeking input regarding whether it's reasonable under certain circumstances as supported by medical health science to presume that a certain type of accepted work-related illness, such as respiratory disease, will make the effect of a positive diagnosis of COVID-19 worse.

Under such a presumptive scenario, the program would be able to accept that COVID-19, is a compensable, consequential illness without further development. Otherwise, DEEOIC would seek out the opinion of a qualified physician to establish such a relationship as the attached. And then they give us some individual cases. So it's a question of presumption versus having to

evaluate individual case by individual case. And the presumption would be that there are certain health conditions that claimants have and with an accepted claim that if they then develop COVID-19, the fact that the COVID-19 would be accepted as the consequences underlying program-recognized chronic illness.

So let's go to the next slide. I think that, you know, so I'm not sure we need to go through this. But we may, we have it to come back to it if we need to. You know, you have the accepted illness and then you have another, you know, COVID-19 that develops after. And then the question is, what underlying, previously recognized illnesses can COVID-19 be accepted automatically as a consequence of that illness. So next slide. And so what I did here was just for the, it's really a straw proposal, and I don't want to do well on the language right here, but this, you know, if we can conclude this discussion tomorrow, that we could come up with something that looks like this or a variation,

that we recommend that any chronic health condition that's listed by the CDC as being associated with severe COVID-19 disease by the various study types that's directly from the CDC website, be considered to be presumed to lead to COVID-19 disease. That is, the diagnosis of COVID-19 disease is a consequence of those health, chronic health conditions whether it falls or coincides with the onset of those conditions. So again, I don't want to get hung up on the specific language, but, you know, if it's appropriate, that's sort of the ballpark I think where we might consider. Next slide. So --

MEMBER GOLDMAN: Dr. Markowitz, could I just go back to that? This is Rose Goldman. Could we just go back to that?

CHAIR MARKOWITZ: Sure.

MEMBER GOLDMAN: The, not to wordsmith too much, but that is the diagnosis of COVID-19 disease. I mean, I don't know that there's anything that would say you're more likely to get

the diagnosis. I think what's more likely is that having, and what I understood the question was, having one of these other work-related diagnoses led to a worsening of the COVID-19 condition. Because the way it's written now it looks like having one of these conditions makes you more likely to catch it. And I don't know that we could say something like that. But having these conditions, what I've understood, gives you an increased risk for having a worse manifestation of the COVID-19.

MEMBER FRIEDMAN-JIMENEZ: This is Dr. Friedman-Jimenez. Dr. Bowman raised this question in e-mails of there's not a lot of evidence that suggests that underlying conditions increase the risk of infection with SARS-CoV-2. But there is good evidence that some underlying conditions increase the risk of severe COVID-19 disease. So I think, and this is a new disease. So there's going to be evolution of our understanding of COVID over months and years. So right now, as I see it, and I spend a lot of my

day every day doing COVID-19 prevention, as I see it, the evidence supports saying that an underlying condition can contribute to or cause severe COVID-19.

And we don't have to specify whether it's the infection or the severity. It's going to be very difficult to find data. It's hard to study how underlying conditions change the risk of infection with COVID. But it is very clear if there are underlying conditions that do increase the incidence of severe COVID-19 disease. So I think we should just simply replace COVID-19 disease with severe COVID-19 disease. And that will take into account the current evidence as it stands now.

MEMBER BOWMAN: This is, this is Aaron Bowman. I completely agree. Just adding that, we have the word severe up above in that first line, just adding the word severe in front of COVID in that last sentence should cover that.

CHAIR MARKOWITZ: So Kevin, if you could add that, I think you can. Yeah, I think

you could do that directly.

MEMBER GOLDMAN: And it increases --

CHAIR MARKOWITZ: And let's continue the discussion, go ahead.

MEMBER GOLDMAN: I was going to say maybe the, or I guess you could say, the diagnosis of severe COVID disease or the risks of getting it. But if you think diagnosis without having to say increased risk for it, but maybe this is okay. So just as you have it.

CHAIR MARKOWITZ: Yes.

MS. POND: But, Dr. Markowitz, this is Rachel. I just wanted to mention that for our purposes of compensation, the word severe isn't going to matter that much, so you can put it there. But I'm just saying if they've that the diagnosis we'll accept it and we'll accept whatever comes along with it, if it's a consequence of it.

MEMBER GOLDMAN: But what about symptomatic though? I mean, there are people who have asymptomatic conditions. Would you want the

word symptomatic of COVID-19 or not?

MS. POND: Well, at the end of the day, once we put in the ICD-9 code or ICD-10 code for COVID, any treatments or anything that results from that in terms of payment will be paid. So whether they have symptoms or not. If they don't have symptoms, they won't be billing for it. But if they do have symptoms, they will and they'll be paid because we will be able to approve the condition itself.

CHAIR MARKOWITZ: If you could go back to the PowerPoint slide for a moment. If you could go to the next slide. So I just wanted to show people who aren't quite following this issue as closely as others. That this is the CDC update as of three weeks ago on this issue of underlying medical conditions. And if you go to the next slide. And what it does is it provides us with what specific conditions there are and what the evidence is.

MS. POND: Okay. That's very helpful.

CHAIR MARKOWITZ: Yes, so we can

simply, for these purposes, adopt and recommend going forward, quote-unquote, that future medical conditions identified by CDC be incorporated. So these are the set that are supported by -- the CDC did sort of an odd way of categorizing this meta-analysis by doing reviews. Next slide. And then they have the next level. These are additional chronic medical conditions. Many of them are obviously not related to claims under EEOICPA, but these are conditions better supported by various types of analytic epidemiologic studies.

And then finally the next slide. They have a group and it's irrelevant, I think to the program, supported by mixed evidence and includes asthma. So what all this means is that some studies are positive and some studies are negative. And given the definition of, what's supported by mixed evidence means, that gets us into the previous discussion of 2A carcinogens. Next slide. You can go back to the previous slide.

So I have a question. Well, I have a question but let me just open it up to other people first. So I think Ms. Pond may have relieved us of this problem of what do we do about mild COVID disease. Severe disease is generally defined as hospitalization or death. I think that's how the CDC defines it for the purpose of their analysis. But people have mild disease and people have asymptomatic disease. And sometimes that's followed by long-term symptoms. The onset of those symptoms can be delayed. A person may even have asymptomatic disease, laboratory confirmed, or they could have mild disease and then weeks later develop a problem. And that's being, you know, studied as we speak. And some of those people may appear among the claimants and link it to their accepted claim.

And even Dr. Friedman-Jimenez said we don't have right at present good evidence for whether these chronic health conditions are a risk factors for those, that profile of illness,

the mild or the long-haul disease. But I would argue actually, that if we know that the COPD makes the acquisition of the virus, makes it more likely that you develop severe disease, I would think it makes sense the person with COPD, when they acquire the infection, are less likely to have any symptomatic infection and more likely to have mild infection in addition to severe disease. In other words, some people do have severe. Some people will develop mild, perhaps long-haul disease.

Where, if they hadn't had COPD, that it might have been asymptomatic. In other words, so there's a whole continuum of severity of disease. And it's not just at the more severe end that these underlying chronic conditions play a role, but even at the less severe end. And maybe it's a moot scientific point given what Ms. Pond's just said, and I know that we don't have the evidence right now to demonstrate that. But I do think there's a real logic to it.

MEMBER FRIEDMAN-JIMENEZ: So I'll take

that as a friendly amendment and let's maybe remove then severe and replace it was symptomatic. What do people think about that? Because I agree with you, Steven, it's a continuum. And this is a changing landscape as we get more evidence and learn more about COVID and long COVID in particular, which I think is going to be a major player over the next six months or a year and we'll learn more about it. So if we replaced severe COVID with symptomatic COVID, I think people that get asymptomatic COVID, SARS-CoV-2 infection, are not going to be filing compensation claims because they're not having symptoms.

CHAIR MARKOWITZ: Right.

MEMBER FRIEDMAN-JIMENEZ: So I don't think they're going to be claimed here. But symptomatic COVID, I think we could probably support that from the literature at this point.

MEMBER GOLDMAN: Although -- this is Rose, could you go back to the CDC website. Because I think those list of conditions, I mean,

this is a technicality basically and I would just go along with it. But just to say those are conditions that increase a person's risk of severe illness. So that's where that language comes from. So I think what we're saying is that we're going to take these conditions that the CDC listed as increasing a person's risk for severe illness and just adapting it to anybody who has these conditions. Because even if they don't have severe illness, it could go on to that. But technically, these are conditions that produce more of a risk or that's why I said the risk for severe illness. But so you're just adapting this to people who may just have symptomatic illness, not necessarily severe, but you're taking it from this data.

CHAIR MARKOWITZ: Steve Markowitz. Yeah, I mean, it's being upfront, and admitting that what the CDC has documented is for severe illness. But applying it more broadly to have, given the logic of continuum of, you know, the level of severity of the disease. But I mean,

let me say something else which is that we're going to begin our public comment session in three minutes. We have time, we have scheduled additional time tomorrow to continue this discussion. And I did that on purpose to start it today and give people time to think about it and we'll come back tomorrow and discuss it. So unless anybody has a final pressing comment on this topic, let's suspend it for tomorrow and then move to our public comment. Anybody want to make one last comment?

MEMBER BOWMAN: This is Aaron Bowman. I just happen to have one. Actually and it's a little related to the fact that I just got my second COVID vaccine shot so I'm worried that I might not make the call tomorrow if I get some symptomology. But I want to say that I concur with Rose's concern that the CDC uses the language severe, and since we're using that as our source of data, that I think reflecting that language is important for consistency. But since I believe it was Rachel that mentioned that the

application of this would be to all any way that would obviously cover symptomatic. I think it might a wise idea to continue to use CDC language given that that's our source of data, knowing that the program will apply it more broadly than that.

CHAIR MARKOWITZ: Okay. Thank you. Understood. Okay. So let me ask Ms. Rhoads, how many people do we have signed up for the public comment session?

MS. RHOADS: We have three that have asked in advance to comment.

CHAIR MARKOWITZ: Okay. And is there some way if anybody's on the phone now and decided just in the last minute that they really want to make a public comment, is there any way that they can reach out to you?

MS. RHOADS: Yes, if they're on the line, press *1, and that will alert the moderator and then we can put you on the list.

CHAIR MARKOWITZ: So even on the instructions that we're staring at on the --

MS. RHOADS: Oh, yes, the one that Kevin just put up, those. Yes.

CHAIR MARKOWITZ: Okay. Well, what time, Ms. Rhoads, what time do you have?

MS. RHOADS: It's 4:14, but we can start if you like. There are at least two of the commenters on the line already.

CHAIR MARKOWITZ: Okay. And could you tell me their names?

MS. RHOADS: Terrie Barrie, D'Lanie Blaze, and Faye Vlieger.

CHAIR MARKOWITZ: The second one?

MS. RHOADS: D'Lanie Blaze.

CHAIR MARKOWITZ: Okay. Fine, if Ms. Barrie's ready, let's start.

MR. BIRD: Great, can the Operator please open up the line for Ms. Barrie. Oh, it looks like she should be open now.

MS. BARRIE: Okay. Can you hear me, I hate that phrase but --

CHAIR MARKOWITZ: Yes.

MS. BARRIE: All right, thank you.

Hello, Dr. Markowitz and members of the Board. My name is Terrie Barrie and I'm a founding member of the Alliance of Nuclear Worker Advocacy Groups. Thank you for all the work you do and for providing this time so that the stakeholders can share their thoughts with you about the program. The Radiation Exposure Compensation Act presumes that uranium workers who develop certain diseases should be compensated. The basic requirements are that they can prove employment for at least one year as a miner, miller or transporter at a covered facility, and has a firm diagnosis of the covered illness. The diseases RECA presumes for exposure to uranium for the miners, millers and transporters are lung cancer, fibrosis of the lung, pulmonary fibrosis, silicosis, pneumocon -- I cannot pronounce that word coniosis, sorry.

CHAIR MARKOWITZ: Pneumoconiosis, yes.

MS. BARRIE: That's it, yes. Cor pulmonale related to fibrosis of the lung, renal cancer and chronic renal disease including

nephritis and kidney tubal tissue injury is also presumed for uranium millers. A report issued by the World Health Organization states, and I quote, long-term studies of workers chronically exposed to uranium have provided impairment of the kidneys, in quotes or in parentheses, proximal tubular epithelium, end parentheses, that depended on the level of exposure. There is some evidence that kidney function returns to normal once a source of excessive uranium exposure has been removed. I'd like to read thoughts that D'Lanie Blaze shared with me about a problem adjudicating claims involving uranium exposure. I have her permission to do so.

Quote, uranium is a known nephrotoxin. At work sites were NIOSH has determined that it cannot estimate uranium exposure with sufficient accuracy, it seems illogical for an industrial hygienist to opine about an employee's potential uranium exposure when NIOSH has been unable to determine the amount, frequency, or duration. Uranium has both radiological and toxicological

properties. Yet the means of measuring uranium exposure were the same. Therefore, SEC classes should be applied to those workers who may have suffered toxic effects as opposed to radiological cancers from exposure to toxic radionuclides.

I was extremely thrilled to hear that you will be getting the support contractors that you've been asking for for years. And it may be beneficial to some claimants if the Board can determine if a presumption should be recommended for the non-cancerous diseases covered under RECA as to whether the radiological or chemical nature could contribute to the development of these non-cancerous diseases. As for the lung and kidney cancer, could the chemical properties of uranium alone result in the development of these two cancers?

The last issue I want to raise is frankly, quite troubling. Certain concerns have been brought to my attention and I am working on getting an in-depth report which could show an emerging pattern of the claims examiners at FAB

cherry-picking evidence. It apparently has not been picked up with DEEOIC's new quality assurance process. For instance, take the example of the 14-year plight of a widow of a worker from Savannah River site. This was reported in the Aiken, South Carolina paper, The State. I won't go into the details about the early years of the case, but instead begin when the request for reconsideration was denied on September 28, 2020.

The FAB denied the request, quote, on the grounds that the representative's challenges were insufficient to change the June 8, 2020 decision. The AR is an attorney and he filed a timely complaint in federal court mid to late November, asserting that, quote, FAB failed to discuss or meaningfully weigh any of the evidence of employment and simply concluded that the District Office and the FAB have appropriately reviewed the complete file material in accordance with programmatic guidance, and determined that the submitted documentation does not establish

additional covered SRS employment for the employee, end quote. And then surprise, the complaint was withdrawn from the court. And on January 11, 2021, the Director of DEEOIC issued an order vacating FAB's June 8, 2020 final decision and the September 28, 2020 reconsideration denial.

The most important statement of the March 5, 2021 final decision to finally accept the claim is, and I quote, after carefully considering the entirety of the evidence in the case file, end quote. The employment evidence is already in the case file before September 28, 2020. Let me say that again, the evidence needed to approve this claim was in the case file, and the claims examiner and the FAB ignored it before a federal complaint was filed. As I've mentioned, I've heard of similar cases.

Now that the Board will have a contractor, I would respectfully ask that you audit final decisions to deny requests for reconsiderations, and decisions to deny the

reconsideration, to determine how prevalent it is for the claims examiner and FAB to ignore the evidence in the file. I will submit the report I'm awaiting on once I get it. And I thank you for your time and I will submit these comments to the website for posting to the meeting page. Thank you.

CHAIR MARKOWITZ: Thank you, Ms. Barrie. Next is Ms. D'Lanie Blaze.

MS. BLAZE: Can you guys hear me, this is D'Lanie Blaze?

CHAIR MARKOWITZ: Keep talking and then we'll tell you.

(Laughter.)

MS. BLAZE: This is D'Lanie Blaze, with CORE Advocacy.

CHAIR MARKOWITZ: Yes, we can hear you.

MS. BLAZE: Okay. Great. Thank you. I represent workers of Santa Susana, and it's related work sites, Canoga and the De Soto facility. Thank you for the opportunity to

address the Board. Today I'll talk about some major ongoing problems that I've noticed. Problems that have been repeatedly acknowledged by the National Office, but that have yet to be corrected. These issues persist and often present an unnavigable and even an adversarial situation for the claimants who rely on their claims examiners and of hearing reps for the fair and thorough evaluation under the Act that was promised by Congress.

Santa Susana, Canoga, and De Soto operated jointly under control of the same contractor and under the same Department of Energy contracts. Therefore, they present shared complexities that will require far more time than we have today. But I'm hopeful that the Board will recognize the need to engage in detailed review of the following issues which I believe have relevance to the claims process program-wide. Today, Ms. Pond and the Board discussed the 2019, decision to divert claims away from the originating District Offices. Now this has gone

on long enough at this point so that we can see exactly why this is a really bad idea.

Claims are now being adjudicated by claims examiners and hearing reps who openly admit to never having heard of the worksite. They freely admit to their lack of familiarity with site operations and history. And subsequently, they're routinely missing the significance of detailed evidence that has bearing on the claim or even that supports a favorable decision, even evidence that has been previously accepted by the originating District Office. This then results in decisions that are anything but consistent. Moreover, claims examiners and hearing reps are still pressed to be expedient and although Ms. Pond has clarified that they can call the originating District Office to ask for some guidance, here's something that has presented itself as a continuing problem.

CEs and HRs are so far out of their depth with the complexity of an unfamiliar

Department of Energy site, that they don't even know what questions to ask on the occasions that they realize the need for some adjudicatory guidance. There's now evaluative errors that blatantly contradict past final decisions resulting in inappropriate, erroneous and inconsistent decisions. And, adding insult to injury, this puts the claimant and the position of requesting and reconsideration, again, reviewed by someone who's likely unfamiliar with the worksite. This can add a year or more to process resulting in errors that are compounded and ultimately viable claims are being regularly denied unfairly.

The bottom line is that these work sites are highly complex and the evidence is frequently very detailed and specific and relies not only on a willingness to review all the evidence in the case file, but the ability to recognize the significance of that evidence, which could be as vague as job code, a building number, or reference to a particular project that

the worker participated in. Mr. Vance and Ms. Pond often tell us, rightly so, that every claim is unique. But I respectfully point out that this is largely because every worksite is unique. And that requires us to be able to recognize issues that are common among workers associated with a particular worksite.

Having District Offices that specialize and that are familiar in specific sites across the complex, complements this program and enables it to run efficiently for claimants who are often on borrowed time as it is.

Adding confusion makes it ineffective. Claimants should benefit from the expertise of seasoned and experienced adjudicators with institutional knowledge that has been gathered over 20 years of this program's administration. If we're here to serve them, we must demonstrate an eagerness to use what we've learned and to apply it to the review and adjudication of every unique claim.

This brings me to issue two: a willingness to review evidence in the case file. The case file frequently includes employment records that reflect years or decades of additional covered employment that has been overlooked or disqualified in error in case after case. At Santa Susana, Canoga and De Soto, this problem persists throughout the majority of cases that I've reviewed over the past ten years. And it's continuing in new claims that are filed today, although the National Office recognized that this was a problem back in 2014. Now I've last count of the number of claims that I've reviewed where the case file contains handwritten letters from workers who've since died, letters pleading with the claims examiners please just review the employment records.

These case files demonstrate that considerable time has been spent drafting multiple letters of denial to the worker, and later to the widow, and later to the surviving children, when evidence showing that the worker

was telling the truth, has sat languishing in the case file without review since the outset of the claims process. I've looked at cases where this scenario has played itself out over the course of 17 years. Multiple denials, but the evidence is right there the entire time. Moreover, this type of problem and relevant evidence is even less likely to be recognized by District Offices who are so unfamiliar with specifics of a worksite or even basic details of corporate contractor successorship, which brings me to the last issue that I'll just touch on today.

It appears that there's a need to make a correction in the BTComp database regarding contractor corporate successorship for Canoga. Ultimately, it has been established that Santa Susana, Canoga, and De Soto operated jointly by the same established contractors and their successors until 2005, and so the contractor information between these three sites should be consistent. The corporate verifier, which was Boeing, has provided written confirmation

indicating that North American Aviation is also known as Boeing North American, and that they were assigned the same tax identification number. These were Boeing's predecessors.

In 2016 and 2020, the originating District Office accepted Boeing's written confirmation as sufficient evidence to establish 1950s-era employment at Canoga facility. But since BTComp does not reflect that information, today these other District Offices who lack familiarity are now denying Social Security Administration records. And they're not accepting Boeing's written confirmation. It doesn't help that newly assigned District Offices are totally unaware of the shared characteristics between these three worksites. And they're often unaware of the need to review the BTComp database or the SEM for all three worksites when adjudicating one claim for a single worker who rotated between these three sites in the performance of his or her job duties.

I think this probably wraps up my time

but, in closing, Santa Susana, Canoga and De Soto, our three worksites, that operated in unison, they're likely deserving of a reclassification as a combined worksite. And I intend to submit information in the future that would support such a decision. But for now, I'm hopeful that the Board will recommend to update the BTComp database so that these sites reflect the same contractor successorship, that all records in the case file will be reviewed without exception, and that adjudicatory jurisdiction may be restored to the originating District Offices that possess the expertise and institutional knowledge befitting of established site complexities.

I know I've covered a lot of ground in just a few minutes. But as always, it is a privilege to represent the claimants and to address the Board. Thank you.

CHAIR MARKOWITZ: Thank you. Will you submit your comments in writing?

MS. BLAZE: Yes.

CHAIR MARKOWITZ: Okay. Great. Thank you. So I'd like to welcome, actually, welcome back Ms. Faye Vlieger. I say welcome back for the newer Board members because Ms. Vlieger used to be a member of the Board. But in any event, welcome, Ms. Vlieger.

MS. VLIEGER: Hello, Dr. Markowitz. Can everyone hear me?

CHAIR MARKOWITZ: Yes.

MS. VLIEGER: I'd like to greet the Board members, Mr. Chance, Director Pond, and John Vance, if they're still on the phone. I'd like to commend the Board on its extensive work, particularly with the IARC recommendations and also with looking at the audits that are done on claim files. I'd also like to commend the Department of Labor on its work to maintain the adjudication process of claims during the COVID situation. Let me give you a flyover of my experience with the claims adjudication process, despite COVID from the past year.

There are ongoing issues with the

Department of Labor District Offices, excuse me, claims examiners not reviewing the SEM data for all possible exposures to claimants, not only by labor category, but by the areas they worked. There is a direct conflict of information when it's said that this particular labor category worked in an area, yet the toxins for that area are not listed under that labor category. You have to go and look at the area itself. This is not being done. And a very cursory SEM review is being done on a number of claims. And I only see a small percentage of the claims that are processed as an authorized representative.

And just for those of you that don't know, all of my work that I do is word-of-mouth. I do not have an ad in the newspaper and nor do I want one. But from what I see, there's a consistent lack of claims examiners training in how to use the SEM when a claimant tells them quite clearly, I worked in this area, I used this chemical. SEM is also still not properly linked to labor categories. Labor categories

consistently have no toxins associated with them. Yet, when you look at the claimant's evidence that they have provided at the work areas where they were in, if you look at their personnel records that are provided by the Department of Energy, and if you look at the EE-3 where they talk about what they did, where they did it, and when they did it, the toxins are there. But there's a complete flyover by the claims examiners of any of that information.

I see a lot of issues with new claims examiners not understanding that there has to be more than a cursory review of the SEM. Then when it goes for supervisory review these errors are not being caught. So when someone would say, hey, why aren't you letting the claims examiner know? They're not going to take the information from me because it was already presented to them in the claim, nor are they coming back to me and saying, well, where you think you're getting this from. So it has to come from DOL training. And I don't see that happening.

Another one of the issues that has been ongoing for more than a year now, is the improper use of the Medical Director as a contract medical consultant opinion. The Department has weighed in on this. And they had said at this meeting that the Medical Director provides an expert opinion. But the Medical Director actually provides a memo of his thoughts on a claim. And the Medical Director is prompted to provide this memo by the Policy Branch who does a review of the claim and provides the Medical Director with specific questions on the limited information provided to him. I had experience with a particular claim that took more than a year and a half to adjudicate, and the Medical Director weighed in. Yet, the statement of facts provided to the Medical Director did not match the statement of accepted facts for the claim, and this was not caught by the Policy Branch when they referred it to the Medical Director, nor did the Medical Director find it necessary to look at the claim, to look at the

facts himself.

So the Medical Director's memo cited facts not in evidence and facts that had no bearing on what was being decided at the moment. In fact, in one particular claim, the Policy Branch told the Medical Director, that there were two other claims that had been approved for the client, and yet those claims were not approved by the client. And the Medical Director based his opinion on those claims already being in evidence and factual. So my experience has been that the referral to the Medical Director is not accurate, which leads to erroneous assumptions by the Medical Director. Because the Medical Director opinion was used as the contract medical consultant opinion, the claimant was denied a refereed contract medical consultant opinion because the Medical Director's opinion because used in its place.

While at this meeting, they have said that the Medical Director is an expert opinion. The Medical Director, per the Procedure Manual,

is not a contract medical consultant. Yes, his opinion can be sought according to the Procedure Manual when there are questions about evidence or questions about what is this disease, but nowhere in the Procedure Manual does it say that the Medical Director substitutes for a contract medical consultant report in the adjudication process. This needs to be straightened out between the Director, John Vance, the Policy Branch and the Medical Director. While the Medical Director have the place in the program, he is not a contract medical consultant per the procedure Manual.

While I have a lot of gripes from time to time. I do appreciate the ongoing improvements to the Energy Employees Program. I'm speaking from experience because I was a claimant back in 2004, and back then it took five years to get my claim approved. Things have improved immensely since that time and I wanted to commend the Department of Labor for that work. I look forward to resolving issues I have

mentioned today and future concerns. And I want to thank the Board for their work, and I miss you guys a lot. Anyhow, that's the end of my comment.

CHAIR MARKOWITZ: Okay. Thank you. You're intending on submitting written comments?

MS. VLIEGER: Yes, I had provided some of these issues to the Board in written comments last fall. And I will provide written comments to the Board again.

CHAIR MARKOWITZ: I just want to make sure you retain the last line about missing the Board. That's all.

MS. VLIEGER: I do miss the Board. I don't know if you guys miss me or not, but yes.

CHAIR MARKOWITZ: In fact, let me ask Ms. Rhoads, does the transcript include the couple of comments. It does, right?

MS. RHOADS: Yes, it does.

CHAIR MARKOWITZ: Okay. Well, then in that case, you know, we'll have a written record of the various comments so -- although when the

written comments come in, they get posted on our website, and that's not true of the transcript version. So there is some advantage to submitting written comments. Ms. Rhoads, is there any other public commenters?

MS. RHOADS: Yeah, there's one more person that we know, Jean Sisko.

CHAIR MARKOWITZ: Okay. Is she ready?

MS. RHOADS: She is.

CHAIR MARKOWITZ: Ms. Sisko.

MS. SISKO: Hello. My name is Jeannie Sisko. I'm with the Worker Health Protection Program at the Portsmouth site. I have been listening today and I just had a few comments on, I guess we'll start with the job descriptions. And it is a lot of work to get your hands around this, but that is what is really lacking in this claims process. For a person to talk about the questionnaire and I have not seen it, okay. But that the adjudicators of the claim go from the questionnaire. Well, a person that worked at Portsmouth, worked in all buildings if they were

in the bargaining unit. Our Collective Bargaining Agreement throughout the years prove that, we even had job descriptions I send in with the claims. Yet, they're not given credit for working in all buildings and around all of the chemicals.

I don't know if Mr. Vance remembers me or not, but I worked with you and Greg on adding hundreds of chemicals to the SEM at the Portsmouth site. And the way I did that is I talked to the contractor who gave me the MSDS sheets. Then you ask for the building where they were at, who was in charge. I gave you all of that. And you still wanted to know more information on what chemical a person was exposed to specifically within the building, within the classification. That contractor wrote a letter and I gave it to you in person at one of these meetings that said, all bargaining unit classifications worked in all buildings together because that's how we worked at Portsmouth.

You can look, you can take a

maintenance mechanic, okay, he's in the process building working on motors or compressors or converters. You have a process operator standing there with him, a chemical operator ready to clean it, an instrument guy working on the lines. And at our plant, we did a total change out. So that means the exposures to these chemicals, all of them, everyone had them. You evidently did not accept that letter from the contractor and it was from the United States Enrichment Corporation's safety person. I don't know how you're going to get past these work classifications, and I'm not just speaking for myself.

Paducah and Portsmouth are different in their Collective Bargaining Agreement on what they call people. You know, there's a maintenance mechanic might be called something else of Paducah. The only thing I can suggest is look at our Collective Bargaining Agreement because anybody that had a union, had job descriptions in them. They've got all of that

and I'm sure DOE has it. But because DOE has changed prime contractors so often, that's why you don't have any records. That's what I, you know, say six different prime contractors at Portsmouth. Once they're done, they take the records with them or they put them somewhere, you know, we don't even, I mean, they're not all put in one spot. DOE can't find that stuff. And it's extremely important because people are losing claims because you've got a claims examiner that he just reads all buildings and he thinks, oh that guy he's just trying to get as much exposure as he can. But it's the term. They don't, I don't know how to get anybody to believe us. That's one thing.

Two is, the -- changing the claims around to the other, you know, to all these centers. I think we lost what little bit we had of the knowledge of the plant by changing that. I understand you want them trained and cross-trained and all that. But I think the claims should stay, say like ours stay with Cleveland

and if you want your claims examiners to be trained, move one of them somewhere. You know, just keep rotating the claims examiners, not the claims. They can learn that way.

And what else was I going to say? I didn't write anything up. I'm thrilled that the Department of Labor has taken the position that they're going to allow a COVID class for COVID claim as a consequential illness or something to a claim if they have a lung, you know an approved lung condition. That's wonderful.

And I was listening to your talk on severe versus symptomatic. In workers comp, and I have a lot of experience in that, I don't think anything has to be severe as long as it could contribute to it or aggravate it. And so if a person had COPD, one condition through Department of Labor, they get COVID, their COPD is going to be worse, you know. So I hope you go with the symptomatic language and not the severe. And I want to say this, I know our union halls will help the Department of Labor figure out the job

classification and how to get their arms around that if you would let us. I don't know how else to say it. I've said it more than once. And the Board's doing an awesome job. I really appreciate your work and I thank you for your time.

CHAIR MARKOWITZ: Thank you, Ms. Sisko. Ms. Rhoads, anybody else who volunteered to speak?

MS. RHOADS: No, that was it.

MR. BIRD: Carrie, sorry, this is Kevin. We did have Gary Vanderbilt just raise his hands, so --

MS. RHOADS: Okay.

CHAIR MARKOWITZ: Okay. You want to put them on Mr. Vanderbilt?

MR. VANDERBILT: Yes, I'm here. Can you hear me?

CHAIR MARKOWITZ: Sure.

MR. VANDERBILT: Okay. This is Gary Vanderbilt from Paducah Gaseous Diffusion Plant, authorized representative for workers here and

across the nation. What I wanted to reiterate, I really wasn't going to make any comments, I've been delayed to get on the call, but I appreciate what you all are doing today. And I got word that I still had time to get on the call. Thank goodness. But what my counterpart there in Portsmouth has just especially emphasized what we have been preaching here at Paducah for the last, well, looking at my time frame is almost going on 20 years since I started helping people and representing people as an IARC since 2006. Or that's what the classification was back in those days through the resource center. So we are the site and I have got the claimants that filed the false claims that led to the sick worker program nationwide.

Those people are my claimants now. They gave testimony with the Department of Justice. And now we're looking at situations where we know we were processing plutonium from spent reactor fuel. But when we brought this up a couple of years ago to the Director during a

presentation here in Paducah, that was not emphasized. When I asked the Director who decided to set the dates of February 1992, for the plutonium exposure termination date. Ms. Leiton Pond did not have a response other than that's what we were told. Now in our investigation, we're a company that I'm project delivery-trained for Lockheed Martin. And so when we did this job for 14 years, we've got thousands of workers at the Paducah Gaseous Diffusion Plant and our sister plant, Portsmouth. If you interview any of them working for multitude contractors like Bechtel, Four Rivers Partnership at this point, we then find that there's apparently somebody had their mute button on when these workers were interviewed.

In Illinois, we've discovered contracts that DOE and Fernald had with the company. And as you all know, they're not classified as a DOE facility. But now with the litigation going on that I'm not involved in at Metropolis, Illinois, these issues are very

important because we've got workers and the depositions have indicated they were processing and importing spent reactor fuel from Russia. And that material was fed into the systems without any personal protection. And even the NRC admitted that hearing in Paducah before the attorneys filed their lawsuit.

My point is, how do you do a dose reconstruction and you never bring up the plutonium exposures that Paducah, Portsmouth, and Honeywell, and Oak Ridge, and Savannah River? That's where the material is stored right now, the spent reactor fuel, Dr. Markowitz. You came to Paducah. We had witnesses that testified their claims are being blocked. They met the statutory criteria. They're all breathing beryllium every day. They had all the beryllium CBD requirements. The statutory requirements then were blocked and denials were issued. And it appeared, let's hope this is not the case, because Gary Vanderbilt is a nuclear worker that's sick when I've got illnesses now, myself.

We had to have them.

When I worked in the 720 building, there wasn't any record of anybody coming to bat for any worker in the 720 building. But I've organized a thousand nuclear workers here. And Portsmouth has the same footprint of contamination. For somebody to not even understand how the process worked, and I'm saying the nuclear enrichment process. In came the Russian plutonium. It was uploaded, taken in by USEC. USEC then, then loaded over a thousand cylinders of plutonium. The Board doesn't want to hear that. But that's where this whole process fails because you're not considering the toxic chemicals that I've just heard Terrie Barrie talk about, Faye Vlieger and the other young lady.

What we've got to do is figure out what does it take to convince the Director and Mr. Gerard O'Hara to allow his people to do their job. Because obviously, whenever my claims come in, they go straight to the Washington National

Office. And Mr. Vance, you were in Paducah, you, you heard the testimony, you promised the worker that was from Carlisle County, and he was a jailer and had a gun on which we allowed him in the room, but his testimony was shocking. You never called him back. The testimony of Minnie Donald. You did take care of Minnie's complaint, but ironically, going back to what Terrie Barrie said, her claim was reinstated. She met the criteria, I decided to pull back and not be the AR. Donna Hand then filed and made the same application that I did. And when I look further back into her records in 2004, nothing changed. Her x-rays were there in '04, they were there in '12 and Minnie Donald is a witness to this, and you all heard her personally.

So these are things that are frustrating. I appreciate the Board being in existence. Kirk was sitting right there, he said, he blurted out that you only had to be exposed to beryllium in Paducah plant one day. We'll try for years in the 720 building with it

raining down on your desk. That happened to me. I knew I would become a victim and now I'm on steroids because I can't breathe. But see, there's no sympathy for nuclear workers as we all can see. All I can say is we need other people running the program that aren't issuing procedures as soon as we catch them in a violation. Procedures, according to Ed Whitfield, Mitch McConnell, and Malcolm Nelson, procedures don't override the statutes or the regulations.

There's numerous cases, and we were successful in an arbitrary secretions ruling. Ms. Barry's on the phone, she had the other one. Mine was chronic beryllium disease, Stone versus DOL. A federal judge in Paducah, Kentucky, ruled against the DOL that they were arbitrary or capricious. Now, when Gerard O'Hara got that ruling, his comment was and I want this on the record because, Judge Thomas B. Russell is not going to like it, he said, we don't care what the federal judges say. Now that makes me think the

government has already decided all of these cases. Now we got a new -- now we've got somebody besides Mitch McConnell as a majority leader. And yes, I live in Kentucky and I don't believe Mitch McConnell does anything to help the nuclear world.

That's all I've got to say and I appreciate it. And I will submit these comments back to you. And I would like to request that John Vance communicate with David Nelson and Nelson Todd from Carlisle County. The claims have gone on too long. I'd say 14 to 20 years for Minnie Donald is absolutely atrocious. But she got paid. She's happy now because Gary's not involved. How's that? But I did it. I'm the one that did. I wanted to make sure we could show the biased treatment of claimants, unequal application, and loss of constitutional rights. But the Constitution does not fit. None of this is -- we're being forced into federal court on every claim.

That's not what the Lasero decision

said. You shall compensate. There's no shall in Paducah, Kentucky. My thought is Ron Ballard, Chuck Dechelle, Bud Jenkins and Don Gilson are the reason Paducah Gaseous Diffusion Plant workers are not getting compensated, especially if they belong to the wrong political party. Thank you, Dr. Markowitz.

CHAIR MARKOWITZ: Thank you. Okay. I think that concludes our public commenters. We will adjourn. I think I may have to turn over the Mr. Chance to officially adjourn. But we're going to adjourn now and we will resume tomorrow at 1:00 p.m. On the schedule tomorrow, we'll continue the COVID discussion, so Board members, please take a look if you haven't already at the very short asbestos document sent to you. The relatively short but chock-full of information, six-minute walk test, these are available on our website so the public can also take a look at them. And then we'll further our other discussions. Any questions or comments or shall I turn this over to Mr. Chance to adjourn?

MR. CHANCE: Steve, I'm here.

CHAIR MARKOWITZ: Okay. Good. All yours.

MR. CHANCE: Okay. So I wanted to thank the members of the Board, members the public, for taking their time out of their day to share their thoughts. And the Board, I hope we've had a chance to format a little bit, so I hope that the more concentrated afternoon session proved useful. So we will see. You know, we're always kind of seeing how we can improve things. So thanks, Steven, and with that, we will adjourn.

(Whereupon, the above-entitled matter went off the record at 4:57 p.m.)