

U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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WEDNESDAY
MAY 17, 2023

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The Advisory Board met at the Holiday Inn and Suites Idaho Falls, Snake River Room, 3005 South Fork Boulevard, Idaho Falls, ID, at 9:00 a.m. MDT, Steven Markowitz, Chair, presiding.

SCIENTIFIC COMMUNITY

AARON BOWMAN
MARK CATLIN*
GEORGE FRIEDMAN-JIMENEZ*
MIKE VAN DYKE

MEDICAL COMMUNITY

MARIANNE CLOEREN
STEVEN MARKOWITZ, Chair
MAREK MIKULSKI*
KEVIN VLAHOVICH*

CLAIMANT COMMUNITY

JIM H. KEY
GAIL SPLETT
DIANNE WHITTEN

DESIGNATED FEDERAL OFFICIAL

RYAN JANSEN

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ALSO PRESENT

KEVIN BIRD, SIDEM
KEVIN DRESSMAN, DOE
CHRIS GODFREY, DOL
GREG LEWIS, DOE
CARRIE RHOADS, DOL
JOHN VANCE, DOL*

*Present via video teleconference

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

(9:00 a.m.)

MR. JANSEN: All right, let's get started. Good morning, everyone. My name is Ryan Jansen and I'm the Designated Federal Officer for the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

I'd like to welcome you to today's meeting of the Advisory Board here in Idaho Falls, Idaho. Today is Wednesday, May 17, 2023. We are scheduled to meet from 9:00 a.m. to 5:00 p.m. Mountain Time.

At the outset, I'd like to express my appreciation for the hard work of the Board members in preparing for this meeting and their forthcoming deliberations. I'd also like to thank Kevin Dressman, Director of the Office of Health and Safety at the Department of Energy and Chris Godfrey, Director of the Office of Workers' Compensation Programs at the Department of Labor for being here today.

I'd also like to thank John Vance,

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Policy Chief with the Energy Program at the Department of Labor for joining the discussion virtually. Finally, I'd like to thank Carrie Rhoads from the Department of Labor and Kevin Bird, our logistics contractor, who are both with me here today for their work organizing the meeting.

The Board's website, which can be found at [dol.gov / owcp / energy / regs / compliance/advisoryboard.htm](http://dol.gov/owcp/energy/regs/compliance/advisoryboard.htm) has a page dedicated to this meeting. The page contains all materials submitted to us in advance of the meeting and will include any materials that are provided by our presenters throughout the next day and a half. There, you can also find today's agenda as well as instructions for participating remotely in both the meeting and the public comment period later today.

If any of the virtual participants have technical difficulties during this meeting, please email us at energyadvisoryboard@dol.gov. If you are joining by Webex, please note that

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outside of the public comment period this afternoon, this session is for viewing only and microphones will be muted for non-Advisory Board members. So the public may listen in, but not participate in the Board's discussion during the meeting.

If you are participating remotely and wish to provide a public comment, please email energyadvisoryboard@dol.gov and request to make a comment. Be sure to include your name in the request. If you are participating remotely and need to provide your public comment via telephone, not Webex, please include the phone number that you will be dialing in from so that we can unmute your line when it is your turn to make a public comment.

The public comment period opens at 4:15 p.m. Mountain Time this afternoon. Please note that the public comment period isn't a question and answer session, but rather an opportunity for the public to provide comments about topics being discussed and considered by

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

A transcript and minutes will be prepared from today's meeting. As DFO, I see that the minutes are prepared and ensure that they are 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, but if they're available sooner, they'll be posted sooner. Although formal minutes will be prepared according to the regulations, we also prepare verbatim transcripts and they should be available on the Board's website within 30 days.

During the discussions today, please speak clearly enough for the transcriber to understand. When you begin speaking, especially at the start of the meeting, make sure that you state your name so it's clear who is saying what. Also, I would like to ask that our transcriber

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please let us know if you have trouble hearing anyone or any of the information that is being provided.

I'd also like to mention that there is currently one vacant position on the Board. As such, we have invited interested parties to submit nominations for individuals to serve on the Board. The selected nominee will serve as a member from the claimant community under the Board's statute and charter. Nominations for individuals to serve on the Board must be submitted by May 27, 2023. For further information, including details about how to submit nominations, please visit the Board's website.

As always, 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 suitable for public disclosure and cannot be shared or discussed publicly including during this meeting.

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Please be aware of this throughout the discussions today. The materials can be discussed in a general way which does not include any personally identifiable information or PII, such as names, addresses, specific facilities if we are discussing a case, or a doctor's name.

I'm looking forward to working with everyone at this meeting and hearing the discussions over the next day and a half and with that, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health and I will turn it now over to Dr. Markowitz for introductions.

CHAIR MARKOWITZ: Thank you, Mr. Jansen. And I want to just echo his welcome to everyone who is attending either virtually or in person. We're going to have a really interesting meeting, I can assure you of that. It's hybrid, so we have four Board members who are online, actually we can see you, but I'm not sure we'll be able to see if you indicate that you want to speak. I'm speaking to those online. If you

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indicate that you want to speak and we, for some reason, don't see that on the screen, then just jump in at any point when you want to raise some topic.

A thank you to Mr. Jansen and to Ms. Rhodes for all the arrangements and especially to Mr. Bird for all the detailed arrangements for today's meeting.

I want to go over the agenda in a bit, but first we do introductions, which includes everybody in the room and also the Board members online. I will start. Steven Markowitz, I'm an occupational medicine physician epidemiologist. I run the largest Former Worker Medical Screening Program at 14 sites in seven states, DOE sites, and have done so since 1997. Ms. Whitten.

MEMBER WHITTEN: Hi, Dianne Whitten. I am the Hanford Atomic Metal Trades health advocate. I work at Hanford. I've been there since 1988 as a radcon tech and I'm happy to be here.

MEMBER BOWMAN: Good morning, my name

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is Aaron Bowman. I am a professor and head of the School of Health Sciences at Perdue University. I am a toxicologist by training.

MEMBER VAN DYKE: Good morning, Mike Van Dyke. I am an associate professor at the Colorado School of Public Health and an Industrial Hygienist.

MEMBER SPLETT: My name is Gail Splett. I worked at the Hanford site for 45 years. I am now retired.

MEMBER KEY: Good morning. I'm Jim Key, representing the labor community on the Board. I am also President of the United Steel Workers International Union Atomic Energy Workers Council in Washington, D.C. As a Cold War veteran and having served 48 years at the Paducah Gaseous Diffusion and Uranium Enrichment Facility, I look forward to the Board's interactions, discussions and recommendations today.

MEMBER CLOEREN: Hi, I'm Marianne Cloeren. I'm an occupational medicine physician and internal medicine. I'm associate professor of

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medicine at the University of Maryland School of Medicine. I've been the Medical Director for the Building Trades Medical Screening Program, one of the former worker programs that works with construction trade workers, and I've been on the Board just for the last year.

CHAIR MARKOWITZ: Thanks, Mr. Catlin?

MEMBER CATLIN: Thank you, Dr. Markowitz. My name is Mark Catlin. I'm an Industrial Hygienist, currently retired. I spent 40 years in the field and over the years have worked both at Hanford and Los Alamos, and happy to be here.

CHAIR MARKOWITZ: Thank you. Dr. Vlahovich?

MEMBER VLAHOVICH: Good morning, I'm Kevin Vlahovich. I'm an assistant professor at the University of New Mexico and a physician.

CHAIR MARKOWITZ: You look like you're in a nice place, Kevin. Dr. Friedman-Jimenez? You're on mute, George.

MEMBER FRIEDMAN-JIMENEZ: Okay, I tried

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to unmute. Can you hear me now?

CHAIR MARKOWITZ: Yes.

MEMBER FRIEDMAN-JIMENEZ: Hi, I'm George Friedman-Jimenez. I'm an occupational medicine physician, Director of the Bellevue/NYU Occupational Medicine Clinic and I'm also an occupational epidemiologist. I've been on the Board almost since the beginning, I think.

CHAIR MARKOWITZ: And, Dr. Mikulski?

MEMBER MIKULSKI: Good morning, this is Marek Mikulski. I'm an occupational epidemiologist with the University of Iowa Occupational and Environmental Health. I also run a former worker program for the former DOE workers from the state of Iowa.

CHAIR MARKOWITZ: Okay, thank you. We're going to do members of the audience here, members of the public and also leadership from the Department of Energy and Department of Labor, so, if you could start, Kirk.

MR. DOMINA: I'm Kirk Domina. I'm a retired Hanford worker.

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MS. HUNT: I'm Annette Hunt. I work with United Energy Workers, I'm a benefits specialist.

MR. TEBAY: Calin Tebay, Hanford Work Force Engagement Center representative.

MR. ARTZER: Josh Artzer, Hanford Work Force Engagement Center representative.

MR. MARCINKO: I'm Bob Marcinko. I'm retired from the INL for 31 years. I was essentially the first Industrial Hygienist that was hired at the INL.

MR. LEWIS: I'm Greg Lewis with the Department of Energy, Office of Worker Screening and Compensation Support, which is part of the Office of Health and Safety at DOE.

MR. DRESSMAN: Good morning, my name is Kevin Dressman. I'm the Director of the DOE Office of Health and Safety.

MR. FISHER: Good morning, I'm Miles Fisher, the Assistant Director of the Building Trades National Medical Screening Program, one of the former worker programs that screens

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construction workers that worked on DOE facilities, as Marianne pointed out.

MR. GODFREY: Good morning, I'm Chris Godfrey. I'm the Director of the Office of Workers' Compensation Programs at the United States Department of Labor.

MR. HANSON: Gaylon Hanson, local coordinator, Worker Health Protection Program. I worked 35 years at the INL.

CHAIR MARKOWITZ: Okay, thank you. Hopefully there are members of the public who are online, we're not going to ask you to introduce yourselves, but let me ask Ms. Rhoads, how many public commenters so far do we have for this afternoon?

MS. RHOADS: Four.

CHAIR MARKOWITZ: Four. So, let me encourage people who are both present here and those online, if you wish to make a public comment, you're free to do so, that begins at 4:15 today. Those of you who are online if you could email Ms. Rhoads at

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energyadvisoryboard@dol.gov, did I get that right? Yes. We always welcome comments from the public. We read those comments, we listen to those comments, and we try to integrate those issues into our discussion.

So, the agenda. We're going to get welcomes from Mr. Dressman and Mr. Godfrey and then we're going to get an update from Mr. Vance, who is online. He's the policy chief at the Energy Compensation Program. Then we're going to discuss a couple of different topics that working groups have worked on since the last meeting. One on the issue of significance and the other on the issue of Site Exposure Matrices. We're probably going to rearrange the agenda a little bit in the afternoon to see how this discussion is following this morning in order not to break up the flow, but we will have on the agenda review of cases that the Board has gone over, review of past requests for information that the Board has made to the Department, feedback on a recommendation that we made at the previous meeting, a new topic

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that Mr. Key has raised on hearing loss and dementia. Then, a public comment period from 4:15 until 5:00.

Tomorrow, we'll continue the discussion with additional case review. We may move the issue of the quality of the contract medical consultants, the CMC reports, we may move that to today depending on the flow of the discussion. But we'll see how it goes.

Any questions, comments on the agenda? Any additions that the Board members would like to propose? Okay. So, let's move on to the next, which is we welcome Mr. Dressman, who is Office of Health and Safety Director at the Department of Energy, who has a few words for us. You're welcome to sit up at the table with the microphone.

MR. DRESSMAN: Good morning and thank you for the opportunity to share some remarks with the Advisory Board. As Dr. Markowitz mentioned, my name is Kevin Dressman. I'm the Director of the DOE Office of Health and Safety.

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Among many different programs and responsibilities, we administer the Department's Former Worker Program as well as fulfilling DOE's statutory obligations under the EEOICPA statute.

I am relatively new to this organization and this role, having been in this position for about 18 months, but I have spent the better part of my 15 years in DOE working in the Office of Enforcement, more specifically spending a significant amount of time in the Office of Worker Safety and Health Enforcement. So I am quite familiar with many of the health and safety challenges that both our current workers as well as our former workers have faced as part of the work that they've done for the Department of Energy.

I and the organization are fully committed to fulfilling DOE's statutory obligations for providing information and access to records to the Department of Labor as part of this process, but I think more importantly is DOE is committed to providing the services and

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support that's necessary to help workers who may have faced health concerns or health issues as a result of their service to our country. We feel that there is a moral and ethical obligation to those workers and so we are fully committed to providing the information necessary for DOE to make a fully informed decision regarding claims that are submitted.

We also recognize the partnership that we have with the Department of Labor and OWCP in this program. We have regular communications on issues to make sure the process flows as smoothly as possible and our office also regularly monitors DOE's response rate for records requests that come to us. As you may know, the records are provided through DOE's sites. We have points of contact. We have agreements with all DOE sites to ensure that whatever records are needed or required for this process, that our contractors that we use are providing those records as expeditiously as possible.

I look forward to the discussion

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today. This is my first public Board meeting for this particular Board and so still in the learning mode, but I appreciate the opportunity to talk with you this morning and I will be available all day to discuss anything that I can from DOE's perspective.

The last thing I'd like to do is thank Greg Lewis and his team for the outstanding work that they've done for many years in support of this program. Without that team, without that commitment, I don't think we would be as effective as we are, but we are always looking for opportunities to improve, so please feel free to share those opportunities with us at any time. Thank you.

CHAIR MARKOWITZ: Thank you. I also would like to thank Mr. Lewis for the excellent site tour that we had yesterday. We went up to the lab. They opened up the EBR-1 Museum, I guess, for us early and we saw a number of different reactors and sites. It was an excellent tour so thank you very much for arranging that

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for us.

The Board recognizes the crucial role of the Department of Energy in providing really the underlying data for the exposure information that's used in claims evaluation and establishing, modifying, improving the Site Exposure Matrices, so we understand the critical role of the Department of Energy.

Next, we would like to welcome Mr. Chris Godfrey, who is the Director of the Office of Workers' Compensation Programs, who would like to say a few things.

MR. GODFREY: Good morning, I'm Chris Godfrey. I'm the Director of the Office of Workers' Compensation Programs at the United States Department of Labor. It's an honor to be here to speak with all of you today and to have the opportunity to meet with you and to take part in this event and also the site tour yesterday. I want to thank Kevin and Greg for the opportunity yesterday. It was a unique opportunity for me to be able to be exposed to the site visit and more

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importantly, just have the opportunity to meet with all of you to establish relationships that I wasn't able to create during virtual meetings in the past. So, this opportunity to come here today and to be with all of you and to meet with you and hear from you is really, really important.

At the Office of Workers' Compensation Programs, the Energy Program is a program that is very near and dear to me. It's one of the reasons that I'm glad that I'm at OWCP. The program is one that someone that I worked with and had a real opportunity to engage with, Senator Tom Harkin, throughout my early days in Iowa, this was a program that was very important to him and so I'm just really honored that I can play even a small role in the work of this program.

I also want to just thank you for the recommendations that you make, for the dedication that you have for ill workers through the Energy Program. It's obviously something that is a great focus to us at OWCP. We have made our claimant experience a very important part of the work that

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we do and hopefully we can make sure that we take the recommendations that you make back to the program and really make life changing improvements within the program.

Lastly, I want to thank the Department of Energy for their continued cooperation with us. It's a unique opportunity for us to work together to make sure that we can make positive improvements for the lives of those who have been impacted through the work at the Energy Program. So, thank you again for the opportunity to be here and I look forward to the discussion today.

CHAIR MARKOWITZ: Thank you. So, next we're going to hear from Mr. Vance, who is the Policy Chief of the DEEOIC. Are you on the phone? Oh, you're more than on the phone, you're here on video.

MR. VANCE: I'm right here on video.

CHAIR MARKOWITZ: Welcome.

MR. VANCE: Welcome to the post-COVID video reality, I think. Hopefully everyone can hear me. Good morning to you folks out in Idaho

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and everybody joining on line.

Again, my name is John Vance. I'm the Policy Branch Chief. I have participated in these in the past and it's always exciting to sit and listen to the conversations the Board has and to work very hard in responding to some of the recommendations and the input that we do get from the Board.

I do want to say that the Director regrets not being able to attend today, but she was attending an outreach event and so I get the honor of getting all of our program updates to everyone. We've got a lot that I sort of put together as a summary to review. I'm just going to march right through some updates. I sort of cherry picked information I thought the Board might be interested in. I know that as we go throughout the meeting, there might be topics that we will cover and I will be certainly available throughout the entire meeting today and tomorrow to help answer questions or provide any clarifications of issues that the Board is

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discussing.

I think the first thing that I always want to do is just talk a little bit about the production of the program. The Board is well aware that we deal with a lot of very interesting cases, but our first quarter data from January to March 2023, I'm just going to run through some highlight numbers here. We received during that period, 2,902 claims. We did 1,252 NIOSH referrals, that's for the dose reconstruction process. We have, as Kevin and Greg can tell you, we submitted 1,727 requests for employment data to the Department of Energy, so this is a reflection of the very high workload that we work with DOE to try to facilitate and we commend both the Department of Energy and Kevin's and Greg's team for helping us out with that. It's a very large workload and they've been doing very well with that and I just thought it would be telling to show you how much work the Department of Energy is doing to support our program with that number of referrals.

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Of special interest to the Board, we have done 1,207 industrial hygiene reviews and again that's just for the first quarter here of the year, so you can sort of forecast out what that looks like for the year. We've issued 6,145 recommended decisions. This would encompass all of our decisions under Part B or E, that's followed by 5,976 final decisions.

We've also made 2,336 lump sum payments and while it's not on the agenda or my notes here, I just wanted to highlight the work of our staff in conjunction with making payments in certain situations, specific to a circumstance that occurred on Friday. Just to show you the dedication of the Department of Labor staff in facilitating payments, we had a gentleman who had filed a claim for inclusion in a Special Exposure Cohort. We found out from his attorney that he had gone into palliative care, hospice care and we were asked to expedite our process to get his decision made and hopefully get a payment to him and his family on Friday.

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Just to give you an understanding of what was involved, we had staff across the country working to make a Part B decision that awarded \$150,000 to this gentleman. We also did a separate decision sequence including all the development steps needed to get an impairment award to him, all of which occurred on Friday.

This includes the issuance of a recommended decision, our processing to a final decision and processing an expedited payment. This involved well in excess of a dozen individuals throughout our program and it reflects the dedication that our staff has in making sure that when we are in a position to get payments out to terminal individuals, that we are able to do that. Unfortunately, this payee passed away on Monday. So, a very timely action on our part and I just wanted to highlight the work of the many Claims Examiners, hearing representatives and fiscal folks that were contributing to making that happen and I think it's important for the Board to understand these

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are staff with our program that really went out of their way to basically stop, drop and get this done. So, it's just a reflection of the work ethic of our folks. So I thought I'd highlight that for the Board.

I also wanted to run through some of our outreach activities. We do recurring webinar series. They are online kinds of educational experiences that we do for the public. Anyone can join them. We actually have our staff participate in many of these, where our staff are more than welcome to join and hear about program updates. These are things that any Board member can actually register for and they're maintained in our outreach calendar online through our main website.

For the past few outreach activities that we've done since the start of the year, we did a presentation on authorized representative services and the expectations of folks providing client services for our claimants. We did an exposure and causation presumptive standard

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discussion with the public and just talking a little bit about that process and many of those things that we're going to be talking about this week or the Board will be talking about today and tomorrow.

We also provided an update on some changes that are occurring with our medical pharmacy benefit program. Then we reviewed and had a webinar on all the available tools and resources that are available to claimants to facilitate getting their claims through our process.

We did several interagency joint outreach events; we did three. One was held in North Las Vegas in February. This was followed by another one in Pahrump, Nevada and then we had a very large event in Oak Ridge, Tennessee in April that I attended. It was a combination of an authorized representative workshop, where we're talking to authorized representatives about this, the processes that are involved with case adjudication. That was followed up by an outreach

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event for claimants to come in and meet with staff and facilitate solutions to any case issues that they had.

So again, now that we're sort of post-COVID, we are definitely getting back into the outreach process and really trying to work with our claimants and their representatives and educating those folks about our program and the steps needed to get the cases through our case adjudication process.

Just some really quick technology and information management updates. As you know, we have an energy case management system or energy compensation system that sort of is how we track case management activities in cases. This is constantly being updated and I've just got a couple of bullet points here that we have been doing a lot of work in developing out our medical benefit adjudication resources in that tool. They've made several changes to how we manage and track medical benefit claims and that's been a major part of the effort of our ECS development

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team.

Some other things that have occurred with regard to our electronic document portal, we used to have a file size limitation that has been removed. We can now take much larger electronic submissions and upload that documentation in the case file. We've really been pushing hard to integrate digital submissions for different kinds of forms. We now have the ability to have claimants and their attorneys or authorized representatives filing our EE-1 which is the initiated claim form for employees or EE-2 for survivors. Our employment history form is now digitally able to be submitted. We work on adding the ability to complete medical reimbursement forms, the 915 and the 957 forms. We're also seeing a lot of use and a lot of uptick in our EN-20, which is our payment processing form. That was added last year, but we are seeing a really good use of that process and that capability by claimants.

Just some real quick numbers. Since

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the beginning of the quarter, we've had over 900 electronically submitted EN-20s, which is fabulous because that enables us to make payments much more quickly and much more securely. So, we're really trying to promote the use of these digitally submitted forms. It just makes our process a lot more productive and efficient and it also is producing good effects for our claimants because we're able to move things along much more quickly.

Moving on to my usual presentation on policy and procedural updates. I saw on the agenda that there will be a discussion about our latest Procedure Manual update, so I'll just cover some of the highlights here. Now that we have moved to this new post-COVID world, we have restricted or eliminated a process that used to require face-to-face examinations. We allow for some telemedicine opportunities, but we feel that with the end of COVID, we need to return back to that face-to-face requirement for medical benefits.

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The allowance for telemedicine appointments was granted through May 11th. That's when the COVID public health emergency ended officially. I think there was some preemptive elimination of those restrictions going back with some announcements from the President's office, but as far as the program is concerned, we've now gone back to what existed previously, whereby if individuals are seeking medical benefits, such as home and residential healthcare, they really do need to have that face-to-face engagement with their physicians to assess the extent of their medical need for those types of services. That was published in a directive put out by the program so that was made available to the public.

We've also issued a Circular, this is just an update that was required by OWCP or it was affiliated with some things that were going on with regard to making sure that we have a process for notifying the public about any kinds of prescription medications that the program has determined to have no medical efficacy. While

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this process exists, we have not actually identified any of these prescription medications, but we now have the platform to exclude those kinds of medications that are found to not have any kind of medical purpose or efficacy.

That Circular, 2301, actually describes the process by which we would evaluate and make those kinds of public notifications on excluded medications.

Our Procedure Manual update, our last one, I'm certain you guys are going to take some time to talk about this. It's on the agenda, but just some things that I think are important for the Board to be aware of. We did incorporate changes to our industrial hygiene reporting on exposure levels language. That was something that was actually issued as a bulletin, but was incorporated into the last publication of the Procedure Manual.

We also had some changes to our standards for evaluating silicosis claims under Part B. We used to have a restriction with regard

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to when mining of tunnels stopped at facilities in Nevada, specific to the Nevada Test Site, but through some feedback from the Board and, I think, some other feedback that we received from stakeholders, we went back and took a look at whether or not there was continuing mining of tunnels related to experiments involving atomic weapons at the Nevada Test Site after 1992. We did find that that was the case so that date was removed from our procedures and we have gone back and reevaluated many cases impacted by that, are in the process right now of evaluating those cases and reopening any cases that we think are potentially impacted by that change.

There is a whole series of other changes that we made to the Procedure Manual, but most of those are primarily administrative in nature and if there are any other questions, I'm certain that those will come up during the Board's agenda item, talking about the Procedure Manual.

I also saw that the Board is going to

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be talking about the Department of Labor's response to recommendations, so I'm going to hold off on discussing that until the Board has had an opportunity to take a look at that and ask any questions that they have. Specific to this question of individuals that had reason to be working throughout a facility and the Department of Labor had gotten questions about this in the past and we responded a few times on that, I think it's going to be a topic of discussion later that we can certainly cover.

With regard to the Site Exposure Matrices, just some very quick highlights from our Paragon and Site Exposure Matrices team. They've received over 28 SEM email inquiries and eight public internet accessible inquiries. That information is generally going to be speaking to any kind of questions that our staff has about site issues or questions or submissions from the public about different kinds of Site Profile changes or issues and that demonstrates that we have this mechanism for the public to submit

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information that they would like Paragon to consider in changing information that's available in the Site Exposure Matrices or adding new information to the Site Exposure Matrices.

We've had in the past, I think this is from November until April of 2023, some of the big sites that we have had a lot of updates, major site profile updates included the S-50 facility in Oak Ridge, the Thermal Diffusion Plant, Savannah River, the uranium mill in Lakeview, Oregon, I think, Connecticut Aircraft Nuclear Engine Laboratory, Canoga Avenue Facility and the Portsmouth Gaseous Diffusion Plant.

As the Board is aware, we do these freezes where we have to basically freeze our internal Site Exposure Matrices and have it go through an evaluation by the Department of Energy to ensure there are no classification issues. Freeze 24 occurred in November 2022 and was available the following month. The next freeze was just conducted in May of this year, this month, and we're getting ready to publish that

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for the public.

Our current inventory in the Site Exposure Matrices as far as toxic substances are concerned, we now have information on 16,741 toxic substances used at 139 DOE sites. So, as you can imagine, that's a pretty extensive amount of information about the types of materials that were being used at these sites that are currently maintained in the Site Exposure Matrices and I'm sure there will be further discussion about that by the Working Group on that.

At the end of April 2023, the SEM Library contained over 27,000 documents related to the information that is communicated out in the Site Exposure Matrices. The SEM library contains records which include documents not stored electronically, such as classified documents and other material that is used to provide and inform the site exposure information that's available to the public.

I will highlight just that Paragon was a major contributor to that change in our

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procedure with regard to information about the mining of tunnels at the Nevada Test Site, so they did a lot of the leg work and looking at information that is available about the type of activities that are going on. The type of experimentation and tunneling that's going on actually relates to non-critical kinds of testing that's going on, but it basically is affiliated with the stewardship program that's being run by the Department of Energy just to ensure that the components of atomic weapons are usable. So, that's why that change occurred.

We also made a change to our SEM data that I thought the Board would be interested in hearing about. We have updated information about how information is reported out on silicosis. We changed the way that that information is reported to make it a little less complicated. We took it and basically changed how it was presented. There were different classifications of types of silicosis in the Site Exposure Matrices. They were all listed out distinctly. We combined all

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of those under the health effect of silicosis so that would reduce the likelihood of any kind of improper search outcomes by our staff and it would hopefully allow for the public to have a better understanding of silicosis and the different types of aliases for that disease. So, a lot of work going on with regard to our Site Exposure Matrices.

Again, I've already mentioned this, but we did eliminate this telemedicine allowance that existed during the COVID emergency. We have returned back to the face-to-face medical assessment requirement for medical benefits and residential healthcare. We've gone back to that, that's actually in place now and our Medical Benefit Examiners are now in response to cases expecting that claimants will now have to go in to meet with their physicians so that we can get a good understanding of the extent of healthcare needs by our claimants.

Another big change that has occurred is that we are moving to a Prescription Benefit

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Manager for handling and processing of prescription medications. Existing claimant beneficiaries are going to be receiving a new medical benefit card that has updated pharmacy benefit manager numbers, so that information is going to be really helpful for claimants. We're hoping that this new process, and I think it will produce really good efficiencies for making sure that folks are getting timely authorizations and quick reimbursements for prescription medications.

So those are the updates that I am providing for the program. Again, I will be available throughout the week to answer any questions or issues that come up from the Board. I'm looking forward to hearing and listening in on the discussions. Dr. Markowitz, I am sending it back to you.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: Unless there are any questions or comments.

CHAIR MARKOWITZ: Great, thank you, Mr.

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Vance. To the Board members, any comments or questions for Mr. Vance? I have some, but I'll let other people go first. Online, anybody? No? Okay, Mr. Vance, just a couple of questions. A lot of claims in the first three months of this year, about a thousand a month, have I got that right, 2,902, I think in three months? And a lot --

(Simultaneous speaking.)

MR. VANCE: -- from our Resource Centers alone it's been in excess of 200 claims a week, so it's been a lot.

CHAIR MARKOWITZ: And a lot of referrals to the Industrial Hygienist for analysis of exposure --

MR. VANCE: Yes.

CHAIR MARKOWITZ: About 1,200. Of the roughly 3,000 claims in the first three months, how many of them were radiation only as opposed to involving Part B, Part E within the jurisdiction of the Board?

MR. VANCE: Well, I don't have that

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information right in front of me, but we can certainly take a look at getting that information, but you can see by the, if anybody jotted it down, for that same period we had 1,252 NIOSH referrals, so those would be specific to Part B radiation cancer claims, if you wanted to take a look at that portion compared to the 2,900 cases in total we received. But, Dr. Markowitz, we'd have to get that specific information for you.

CHAIR MARKOWITZ: No, no, that's good enough because that lets us know there were roughly 1,800 claims that would come in for Part E or Part B, but non-radiation related. Of those 1,800, there were about 1,200 referrals to the Industrial Hygienist so that means just crudely about two out of every three claims that came in earlier this year were referred to the Industrial Hygienist for reports, which I think is useful to know in terms of our discussion about the industrial hygiene work.

A note on the silicosis clarification

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at the Nevada Test Site, actually the issue of the post '92 exposure and eligibility for silicosis claims was raised by a public commenter to this Board at or just prior to the last meeting. And --

MR. VANCE: All I can say is that's why I listen in because that was a question that I had raised with my staff when I saw that and we took the initiative based on that public comment to take a harder look at that and I think the Board did ask a question of the Department about it. So, that was what motivated us to take a look at that and that just is a reflection of our participation during these meetings, so that we can hear any issues that we think are relevant and important for us to take a look at from the public comments.

CHAIR MARKOWITZ: Thank you, so that really sends a message to the public commenters that we listen, that the Department of Labor listens and by all means, add your comments.

I have a question about -- we're going

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to talk more about the Site Exposure Matrices, but it's obviously a dynamic process, right, where the SEM is updated periodically across the complex. I'm sure it's a challenging process. As you learn new things about exposures at various sites, you add toxins or add certain links within the SEM, then you have claims that were submitted previously, perhaps years previously, that were in some cases declined because there wasn't an exposure-disease link found. But now with the new information, actually it's conceivable that you might or those links might be reversed and that with the new information those claims might be accepted, might have been accepted, if that information was known earlier.

So, the question is then how to develop a system whereby those earlier declined claims can be looked at once again for the validity of the claim. I know it's a challenging question and I'm just wondering what the current Department's thinking is about that.

MR. VANCE: Yes, we provided a written

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response to that question and I know that the Board had presented a series of questions about the Site Exposure Matrices, and we responded in writing to this particular question. I can just sort of summarize and say that that kind of comparative analysis would require information to be captured during case adjudication that would allow us to identify those types of circumstances and, unfortunately, that kind of data capture or that information about the rationale or the information that is reported in the Site Exposure Matrices that's applied in a case file that could potentially change in the future, that information is just not available in the way that we manage our case adjudication process. So, it is a very difficult challenge. We don't have a system in place right now where we can go back and do that type of robust evaluation of the impact that changes have within the Site Exposure Matrices on case files.

Where it is possible for us to do some sort of backfill operation where we go back and

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take a look at cases potentially impacted by different policies and procedures, we do do that. For example, we were able to do that for denied cases on silicosis because we were looking for any case that had employment after or on 1992. We were looking at the impact, potentially looking at that for reopening that case to revisit that and potentially look at whether that case could be found compensable. We were concurrently looking at silicosis cases because we were also looking at changes that we had done last year with regard to a change to our presumptive standard.

So, the Department of Labor will initiate reviews of previously denied cases where we have the information that allows us to do that, unfortunately the information that we have for the Site Exposure Matrices changes just is not something that we maintain that kind of data in ECS that would allow for us to do that kind of comparative analysis.

CHAIR MARKOWITZ: Right, I remember

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that written response actually. By the way, I just want to thank you for those responses. The Board submitted an information request around the SEM with essentially a series of questions two weeks ago or less than two weeks ago and the Department produced detailed written responses in a very timely way. Thank you very much for that.

It seems to me though that it's at a minimum unfortunate, maybe even unfair, that claimants, as the SEM has improved and new information is acquired, that claimants whose claims were previously denied because in part that information wasn't available, that it is now up to them to somehow track the improvements in the SEM and to consider whether their claim might now be accepted and resubmit a claim. The onus being on the claimant to do that seems burdensome and unrealistic.

I understand that the data of the claims system is not set up in a way that allows you to do that, and I don't have an answer for this because I know it's a complicated problem,

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but I just wonder whether it's a problem that deserves additional thinking and maybe some creativity to figure out how claimants who may now have a valid claim because new information has been obtained can be informed about that possibility and their claim be reconsidered in a way that doesn't leave it entirely up to the claimant, if I make myself understandable.

Other comments or questions? Okay, so let's move on then. We're ahead of schedule, that's good.

We're going to talk about the Working Group on "Significance." I just want to take a moment if I could to set the stage for this discussion, in particular for the public to see where this comes from and what it means. So in the claims evaluation process, the claimant submits information about what they did at the DOE complex. They submit a form that details their jobs, the years, the tasks, what exposures they recall and then they undergo a questionnaire, an Occupational Health

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Questionnaire. You may hear that summarized by us as the OHQ, which is done that obtains additional information about their exposures.

That is sent along to the Claims Examiner who, together having reviewed medical information, medical records also obtained for the claim, then does an analysis or evaluation through the Site Exposure Matrix to learn more about what that person might have been exposed to and quite commonly now that information is sent to an Industrial Hygienist for their analysis about the meaning of that, of what's know about exposure for that person in that claim.

That Industrial Hygienist produces a report that is often sent then by the claim examiner along with a series of questions and accepted facts to a contract medical consultant, a CMC, a physician consultant who then weighs in on the issue of causation.

So, this issue of causation we're going to discuss is did this person's exposures at the complex cause, contribute or aggravate

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their disease and there's a standard set out by the Act, which we'll go over. So this discussion is how the industrial hygiene and the medical input, how that is obtained, how it's assembled, how it's interpreted in terms of making causation decisions, which ultimately determine, in large part, whether the claim is accepted or not. So with that, let me turn it over to Dr. Cloeren, who's going to lead this discussion.

MEMBER CLOEREN: Thank you. So, a small group of us met to discuss this and came up with the following slides to just sort of help guide our discussion. Next slide.

I think the first thing is the word significant is not insignificant. It's a really important word. It's actually used in the Act and so you can see from the definition from the Act itself that it's at least as likely as not that an exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to or causing the death of such employee.

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We're not proposing getting rid of the word. The word is just really important, but it is important to understand the meaning of it and there are multiple different meanings of it. Next slide.

So in the newest version of the Procedure Manual, the word appears 99 times, but there are two different technical contexts in the Manual. One of them relates to the assessment of exposure which is typically done by the Industrial Hygienist and then the second use of it relates to the determination of causation. So, there are two different meanings and the use of the word can be misinterpreted kind of depending on your role and your perspective. Next slide.

We thought looking it up in the dictionary might help and so what Merriam-Webster says about significant, one of the definitions is of a noticeably or measurably large amount. We think that this kind of correlates with the industrial hygiene definition, right? So, this is related to exposure, high amount. Next.

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But the word also can mean having or likely to have influence or effect, important. So that definition relates to causation determinations. Then finally, the last definition kind of goes along with the Act definition, right? Probably caused by something more than mere chance. So, you can see there are three different definitions and so when somebody's reading the word, they may have in their head one of these definitions which may not be meant by the person that is using the word. Next slide.

The current procedural guidance tells the Industrial Hygienist to review various factors related to exposure and then to characterize the exposure as significant high, significant moderate, significant low, incidental and then elsewhere there's a category of somewhere between incidental and significant so not incidental, but not quite significant low, and then no exposure. So, these are the six different characterizations that the Industrial Hygienist may apply to their exposure

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determination. Next.

But the complexity of characterizing an exposure needs to account for and honestly in the industrial hygiene reports, a lot of this is often captured. The type of exposure, you know, whether it's a direct exposure to the person doing the work, if the person was a bystander and so near something that they were exposed to or that the exposure happened regularly in their work area. The route of exposure, is it by inhalation, ingestion or skin absorption. The intensity of exposure, so the concentration, the level if you will. How often is it happening? How long does it happen? So, is it every day but just for a minute or is it every day for six hours out of the day. Then, how long during the period of the person's work did it happen? If they worked there 10 years, was this ongoing during that time?

It's also important to document for some diseases the calendar timing between the exposure and the disease diagnosis because of the

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concept of latency. Some diseases take a while for the exposure to have the disease effect and cancer is the classic example of that. And then also, use of personal protective equipment, engineering controls and other mitigating factors.

The Procedure Manual advises the Industrial Hygienist to take into account these things when making a decision about significant high versus incidental, et cetera, but these details are not always presented in a way that the next consumer of the industrial hygiene report can see. So, the details can be important to determining causation but they may be obscured when applying this determination of significant high, moderate, low, et cetera. Next slide.

Our proposed recommendations are that the industrial hygiene reports more clearly include the basic metrics of exposure signs, which include intensity, route, frequency and duration, that they can be divided by facility and job because that's important too. People have

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different jobs in different facilities as relevant to the claim. And that we need some help understanding what is meant by the six different exposure categories in the context of these, and we're going to give you some examples of what we mean here.

We also think it's important to clarify how a single metric of exposure, for example, significant low can be applied when somebody has multiple medical conditions that may be related to different exposures. Next slide.

We're proposing something along these lines, it doesn't have to be this, but this is an example of an Exposure Assessment Form, could be used that would help the next consumer of the information, which would include in most cases a CMC, in all cases the Claims Examiner, in some cases the claimant, the treating doctor, et cetera, the Former Worker Program sometimes, but that the exposures be characterized with some precision, as much precision as the data allow, the type of exposure, route, intensity, et cetera

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and we have on the right kind of a key for what we mean here. And also, it would be really helpful if the Industrial Hygienist included where in the claim file they found the information, so that others can look at that and refer back to that information.

The next slide actually shows a fictional case, kind of an example, and I think it could be helpful to kind of go through this. In this case, I do a lot of work for the Former Worker Program dealing with construction workers, so this is a case of a pipefitter, which is a construction job, at Hanford claiming COPD and to show you how this type of form could be used to provide more information. Also, where it gets kind of challenging applying the grouped categories without the details.

Asbestos in this case would have been direct. Inhalation is the route. The Industrial Hygienist in this case may have said that the intensity was low during the time period '87 to '97, that the frequency was a few times a month,

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but for 10 years and that the person usually wore protective equipment and you can see that in this fictional case, there's information in the claim file on page 180 about that. Exposure two would be cement dust. So, you can go through here, the intensity would be medium, daily during the same time period, but never using PPE. Exposure three would be silica and it wouldn't be very often. The exposure would be low, et cetera and you can see welding fumes, the same.

So for each of these, they may have a different characterization of whether it's significant high, significant moderate, et cetera. So if we take just cement as an example, the fact that the intensity is medium, somebody might say that that's significant moderate, right? But it was daily and so others of us might say that that's significant high and we don't know how those categories are being applied right not. One of our recommendations is that we get some clarity about how significant high, significant moderate, et cetera, are applied in

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relation to these and that there be, if needed, some instructions that include how do you incorporate the frequency, the duration, the intensity in making those decisions.

That's it, the end of the slides. Time for discussion.

CHAIR MARKOWITZ: Okay, Board discussion. Anybody want to make a comment or pursue this discussion? Oh, by the way, if you're present if you wouldn't mind just putting up your name card so I can see who wants to speak and for those of you online just indicate somehow or jump in. Dr. Bowman?

MEMBER BOWMAN: Yes, thank you. I just want to echo and affirm the message. The slides sort of went over the long discussion that we had as a Working Group relating to the importance of having reports that are going to those that are eventually going to be making the decision of causation of having the information of these various specific individual metrics of exposure. Basically, it comes back to the potential that

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individual metrics can have importance in whether or not they are contributing to a disease that relates to these individual metrics. For example, if the route, even if it's high, if the route is wrong, it may not be ever associated with the disease, but you could have an exposure that is very low, but in the correct route would be deemed highly associated with that disease. The concern of applying a significance overall that doesn't divide this out could lead to inaccuracy in the decisions of the medical professionals if they are just looking at that terminology. So, that, I think, rests back to the importance of that.

I don't think we're saying as a group that the word, significance, isn't important to be used at all and I think, Marianne, you addressed that in your remarks already, but as divided into the routes of exposure because I can just imagine someone assessing the epidemiological data of disease risk related to exposures, they'll know routes. They'll know

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levels. They'll know durations that are associated with these risks in making a final decision at least on their recommendation about an association. Without that kind of information, there could be decisions that are not right and so this is why I definitely support this idea of keeping these metrics. These are the basic metrics that IH, Industrial Hygienists, would use anyway. These is how exposure science is done. I do find this to be very important so I just wanted to affirm what you were saying.

CHAIR MARKOWITZ: I have a comment. Actually, this slide portrays something really interesting. Suppose the claimant had submitted a claim for two conditions asbestosis and scarring of the lungs due to asbestos and separately for COPD, two distinct, mostly distinct, pulmonary conditions. Usually we're looking at a slide which hopefully contains the Industrial Hygienist's best version of the facts of the case, right, the exposure facts. For asbestosis, frankly there's only one of these columns which

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is relevant which is exposure number one that column. We see this pipefitter during that period '87 to '97 had low exposure inhalation a few times a month and the duration for 10 years. So, if you were to attach then an interpretation of how significant that is, you might not call that moderate or high significant. You might call that significant low because it was only a few times a month and it was consider low intensity during that era. With reference to asbestosis, if the IH takes these facts a step further and assigns it a significance description, that's likely where they'd end up.

On the other hand if COPD is the condition being claimed, then you'd probably not look so much at the asbestos column, you'd look at cement, you'd look at welding fumes. Cement was daily, it was moderate exposure over a 10-year period, or you have welding which was two to three times per week so pretty frequent at a moderate level, so clearly that would end up at a moderate significance or maybe even significant

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high. The point is that these facts are condition-dependent, whatever the claimant is submitting for, they aren't universal across conditions, the interpretation of those depends on what condition that is being examined in terms of the claim. So, that significance description is going to vary depending on what the condition being claimed is, so that's one aspect of, I think, a problematic aspect in terms of translating these facts into a significance description. Yes?

MEMBER SPLETT: Gail Splett. One of the things that I really like about this is as a layperson reading through some of the files, it sometimes was very difficult to follow the IHs' thought processes and the documentation seemed to say, yes, I think, or, no, I don't, I'm sure that there's a process behind that, but this documents that process and makes it easy. Again, I liked the comment about for the follow on folks who are reviewing that file whether it's a CMC or the Claims Examiner or the FAB, they've got this all

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out in writing.

The other question is who would fill out this form? Would this be the Claims Examiner filling out the top with the overall exposure then the types filled out by the IH? Would the claimant be consulted on any of this? Is there an interview to get all of these or is this something the Claims Examiner would fill out or the IH or all of the above?

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: Sure, I'll take a stab at that. I think others within the Working Group could contribute to that as well. The basic premise of the recommendation is that these metrics of exposure are what all the IH's should be doing anyway and they're just being obscured by this pulling together. So, these should all be coming in anyway so I would think this would be done by the IH in that context, but I'll let others chime in if there's something I'm missing about that.

MEMBER CLOEREN: I think, Gail, the top

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information would come from the statement of accepted facts that would go from the CE to the IH, I think.

That's what would make sense. The actual exposures of those top four that you're showing here are the ones that right now that the Claims Examiner is sending the top seven over that they would identify that from their review. Then, the IH would fill in the specific data, but again, I really like your comment about that thought process being available for follow on reviewers. It's very well done, very impressive.

CHAIR MARKOWITZ: Let me just add one before we move on. The IH has to take an independent look at the EE-3, the Occupational History Report, from the claimant and a look at the Occupational Health Questionnaire and not rely entirely on the Claims Examiner's interpretation or distillation of the exposure because it's the IH who understands best what those forms and what that questionnaire contains, not the Claims Examiner, however good they might

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be, it's not their training. So yes, the statement of accepted facts can send along whatever number of toxins, but the IH really needs to take a look at the primary information in order to get it right. Mr. Key?

MEMBER KEY: Yes, I agree with your statement, Dr. Markowitz. The Claims Examiners by and large have no historical knowledge of these jobs at these sites. And also I appreciate Gail's comment; an interview process with the claimant needs to be incorporated simply because at a lot of the SCC's and it was the intent of Congress, who came up with the language. It is as likely as not that that exposure was the reason for causation of the illness or disease because at many sites, records and documentation and personal monitoring was never performed up until mid-1990's going into 2000.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: Mike Van Dyke. Adding onto Dr. Bowman's comments, you know, this is how the Industrial Hygienist is thinking about this.

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I don't think this is a significant change to how an Industrial Hygienist is doing things. I really think this is just a language thing that Industrial Hygienists and occupational medicine physicians don't necessarily speak exactly the same language, so really making sure that the Industrial Hygienist is getting across what they mean to the occupational medicine physician.

We see these words in the reports from the IHs, but then it gets distilled down into those significant low, significant medium, significant high sort of words that make less sense. I think it's just a clarification of the language more than anything else.

Now, if I was to really go a bridge too far, I would say we also don't know what low, medium and high necessarily mean, but I think that's a conversation for a different day.

CHAIR MARKOWITZ: Oh, you mean tomorrow? Maybe not, we'll see. Just a quick comment on that and then we'll move on. The fact is, the industrial hygiene reports currently

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generally contain a table of data about their understanding of the exposure and what we're proposing or what this slide proposes is just an amplification of that table. It's considers a broader set of varieties, more systemically and perhaps more clearly. There are some people in the room who want to speak, but I do want to give the opportunity for board members online if anybody wants to say something, now's a good time.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. One comment. The question of the work flow, how does the work flow occur? Who fills in what part of the table, I think is an important one and we may want to distinguish the different fields in the table by who should fill them out. For example, maybe the Claims Examiner or even a clerical person can fill out all of the demographic information, the name of the condition that we're considering and we need to discuss if a separate exposure assessment needs to be done for each medical

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condition. Spoiler, I would say yes it does, but I think we can discuss that. The point is that I think it needs to be an iterative process and the people that know the toxicology and the causation fill out part of the form, but people that are doing the administrative set up can fill out a good part of the form also. I think it would be useful to define what order the fields should be filled out and by whom.

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER CLOEREN: Thanks. I have a couple of followup thoughts. One is, I believe, I'd have to check the Procedure Manual, but I believe that there is flexibility for the Industrial Hygienist to identify additional exposures that were not included in the Claims Examiner's statement of accepted facts. If that's not the case, then that definitely should be something that is permitted for the Industrial Hygienist to use their knowledge to identify things that maybe were not identified by the claimant or included. So, that's comment one.

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CHAIR MARKOWITZ: Okay, so that's a factual question and, Mr. Vance, if you could weigh in on that. I'm not sure whether you heard it, but the Industrial Hygienist gets the statement of accepted facts from the Claims Examiner, includes a number of toxins for which some research in the SEM has been done. Is the Industrial Hygienist allowed to modify or add to the list of toxins that are looked at in terms of their IH report?

MR. VANCE: Yeah, I'm going to start by saying generally speaking the Industrial Hygienists are going to be responding to questions about individual exposures identified by the Claims Examiner. Now there is a process that we have that allows a Claims Examiner to reach out to an Industrial Hygienist when they have a multitude of exposures that they have to sort of prioritize or identify in order to sort of filter it down to something of the best targeted toxins to evaluate and that's a pre-screening process. But, if the Claims Examiner is

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looking at information in a case file and they're pretty confident that they've targeted two, three, four, five or whatever number of toxins and they're the ones that decide these are the ones that I want the Industrial Hygienist to profile, then the Industrial Hygienist is going to profile those toxins. They're not going to go back and reassess the case file to determine are there other ones in there.

Is it possible that an Industrial Hygienist would identify some glaring anomaly that really should be brought to the attention of the Claims Examiner? Yes, that mechanism does exist where the contract Industrial Hygienist would reach out to our federal IH person and then that person would feed comments or questions back to the Claims Examiner. But I would say generally speaking if there is no pre-screen, or if the Claims Examiner asks the IH to do sort of a preliminary review of what toxins to profile, the Claims Examiner has the authority and the discretion to identify the toxins that they want

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profiled and then the Industrial Hygienist will respond to those referrals that identify the toxins the CE is exploring.

One other quick comment from the slides, our Industrial Hygienists would not classify somebody as having no exposure. Their lowest level of profiling that they would do is generally going to be incidental levels of exposure. I think that that might be getting confused a little bit about the initial screening process that the Claims Examiner goes through, because if they cannot identify any targeted toxins that are related to a particular disease, that's where it could possibly stop, but the Industrial Hygienists are never going to be in a position to say no exposure. I've talked with our Industrial Hygienists team and they would never do that. The lowest they can ever go is incidental. Hopefully that answers your question and I just wanted to make that extra comment as well.

CHAIR MARKOWITZ: Thank you. Ms.

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Splett?

MEMBER SPLETT: One of the things, and not foregoing the conversation on claimants, I reviewed a file where the Industrial Hygienist responded to the elements that the Claims Examiner sent, but did not respond to any of the exposures that the claimant had identified. So, it could even be some sort of subset those toxins or exposures that the Claims Examiner in the statement of accepted facts, plus an interview or even reviewing the OHQ, which in this particular claimant, was not. They didn't look at any of those elements, neither did the IH. The IH was not requested to do so. It was only requested to look at the ones that the Claims Examiner identified.

CHAIR MARKOWITZ: Ms. Whitten?

MEMBER WHITTEN: Thank you. The few claims that I have reviewed for respiratory, the IH reports to me and to a claimant might seem confusing and vague. Usually they'll just say they had incidental significant exposures, but I

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like this because if, in fact, they do get denied, they can request their complete case file. This will be in it and then they can have it reviewed to see if it's actual factual for their job that they did back in the '80s and '90s.

CHAIR MARKOWITZ: Okay, Dr. Cloeren?

MEMBER CLOEREN: I have an interesting example of a case. I don't actually remember the claim condition, it might have been COPD, but the job title of this person did not match with welding fumes at all in the SEM and the claimant identified welding fumes. The doctor identified welding fumes, but the job title didn't show welding as part of the job. So that was kind of dismissed and when I talked with the claimant, whatever their job title was, it wasn't what they did and they actually had documentation. They kept documentation of 10,000 welds or something like that and so they were able to follow up with documentation of that and get acceptance, but if the Industrial Hygienist had reviewed the OHQ or

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interviewed the person, then that probably would not have been denied. That would have been an opportunity for the IH to let the Claims Examiner know that there may be something missing in the SOAF. That's just sort of a concrete example of a real case.

CHAIR MARKOWITZ: Other comments or questions? Steve Markowitz, I'd be surprised if the Industrial Hygienist didn't look at the OHQ and the EE-3 when writing their report. I'd be surprised if they relied wholly on the statement of accepted facts by the Claims Examiner. I don't know what actually happens, but it strikes me if you're a professional and you're weighing in on an important issue to people, in terms of understanding their exposures, that you'd want to and you'd need to look at what very limited primary data you have, which is the EE-3 and the OHQ, in order to do that. It would be nice in the IH report if in the listed references, things they looked at, if they included whether they looked at the EE-3 or the OHQ, because I don't

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think that's currently done that listing and I think it would be helpful to understand the process. Dr. Van Dyke?

MEMBER VAN DYKE: To respond to that question, in the cases that I reviewed, I do think that the Industrial Hygienists look at that EE-3 and OHQ, in terms of describing the nature, extent and duration of the exposure, but I don't think they're going to add exposures from that, that they weren't asked to classify. I think the reason is because they rely on, and this is just my interpretation, they rely on the Claims Examiner to really identify those exposures that kind of fit that intersection of their job and their disease. I think the Claims Examiner identifies those and forwards those on to the IH. So, the IH, I don't think they're going to add too many exposures because they're not asked to.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I have a question, how is it determined which exposures to focus on? For

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example, does the Claims Examiner review, given the medical condition that is being requested for compensation, does the Claims Examiner review the SEM for listed substances that may cause that medical condition or do they respond to the exposures that the treating physician thinks may be related or are related or do they review the OHQ and look for exposures that may be toxic and see if they are related to the condition? What is the general process that actually happens? What is the work flow here and how does this list of exposure one, exposure two, exposure three, exposure four get generated? Because I think that's a key element in the overall process of determining causation and this is the first step that sounds to me that it doesn't really get reconsidered very often if something is missed on the first step. I've reviewed a number of cases in the past that a critical exposure was missed and wasn't listed and wasn't assessed and then when you go back and look for it, it's actually there sometimes. So, I'm asking the question what

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is the reality, how does this list get generated? The list of exposures that get assessed.

CHAIR MARKOWITZ: Well, so for reality questions, we turn those over to Mr. Vance, so if you could address that.

MR. VANCE: That's a good way to put it. Let me put everybody in the shoes of a Claims Examiner. Let's start by saying, Dr. Friedman-Jimenez, the answer is all of the above. I'm a claims adjudicator, we have 1,207 cases that are going to an Industrial Hygienist, but the role of the Claims Examiner is to facilitate the adjudication of a case and we have to maintain some expectation of pursuing these cases in a timely manner.

The Procedure Manual lays out a process by which the Claims Examiner is going to start looking at this and say okay, what is my condition that I'm evaluating here? Has it been established as a diagnosed condition? So, for the case on the form in front of you, it's COPD. One of the most common kinds of diseases that we

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actually encounter.

The Claims Examiner begins by evaluating all the available information about the type of activities, work processes, labor, whatever information is available about that individual in the case. They're going to look at the EE-1. They're going to look at the EE-3 which is the employment history data. They're going to look at the Occupational History Questionnaire and hopefully get a feeling of the framework of the case. They're going to look at the document acquisition information, that's the information coming in from the site.

Once they have a good, robust understanding of the picture of this employee then they begin looking at what can I tell about COPD and this employee. So, we know that they are a pipefitter at Hanford. The first thing they're going to look for is what do we know about exposures that are linked to the pipefitting labor category at Hanford. They're going to go to the Site Exposure Matrices. The Site Exposure

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Matrices is going to start identifying information that creates that relational connection to specific types of labor, work activities, and specific substances related to COPD. More than likely for a pipefitter, you're going to come up with this complement of exposures. You're going to see asbestos, cement, silicon dioxide and maybe welding fumes.

The next thing that they're going to do, is they're going to say okay, do I have an abundance of exposures for a pipefitter related to COPD? Because what we have to do is try to prioritize these cases, because each one of these represents a time commitment. The more work that you're asking to be done by the Industrial Hygienists, the slower it goes. We try to maintain this seven toxins or this framework of seven toxins, but we can go beyond that. The Claims Examiner in this particular case would probably get these identified and targeted toxins from the Site Exposure Matrices. More than likely, a lot of this information may be

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complementary to information from the employment records. In other words, the employee could be reporting incidents that involve asbestos or they could be talking about activities relating to cement dust or silicon dioxide or just dust and other types of materials that they were working on. All of this information gets fed into that exposure profile worksheet that the Claims Examiners try to construct to frame out what they want the Industrial Hygienist to look at.

It really is a matter of filtering down to try to prioritize the targeted toxins, that's the role of the Claims Examiner. This information for COPD is generally going to be reliant on the Site Exposure Matrices, but we could have situations where you're dealing with a unique disease, a unique circumstance where we have nothing in the Site Exposure Matrices, so then the Claims Examiner will turn to other resources, such as like what is in the occupational history records that we're getting from DOE? What is that a physician is saying is

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an exposure that the doctor feels is a concern for this particular disease?

For example, one that I was looking at last week was degenerative disk disease. A physician was arguing that lead exposure is contributing to this arthritic kind of process. Because the physician is identifying lead as your targeted toxic substance, that's the one that the CE would go to the Industrial Hygienist and say what was the extent of this individual's exposure to lead? So that when we go back to the physician, we can say here's better, more accurate data for you to inform your opinion because that's the function of this proposal that the Board is making, is you're trying to make sure that the physician who is looking at the question of significance is accurately informed so that their opinion can be weighed as probative.

So the function of the Industrial Hygienist process is to give that physician a good clear understanding of what it is that's

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going on so just keep that in mind. A physician can look at this in 30 seconds and say okay, this is what I get from this and here's my take on it, but other physicians will spend more time looking at it, but our process is set up to give that physician, whoever it may be, either the claimant's physician or an internal CMC, the opportunity to see that accurate characterization of exposure. So hopefully that answered your question.

CHAIR MARKOWITZ: Thank you. There seems to be a general agreement among the Board members about this form that we're looking at, about the contents, how it represents some improvement from what's being done presently. There are questions about who exactly fills out what part of the form. There's a question on intensity about what low, medium, high actually means. We might refer to these elements here as facts, but in fact, they are really the IH interpretations of what the record shows.

Having general agreement on this, then

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the next question becomes the translation of these metrics, these findings into question of significant exposure. This is the incidental, more than incidental but less than significant, significant low, medium, high and we've sort of acknowledged that if that additional step, perhaps a bridge too far as Dr. Van Dyke says, is made that it at least should be medical condition-specific because the same metrics mean different things for different claimed conditions.

But setting that aside for the moment, what do we think of this moving to the next step and then sorting this into levels of significance? That process, whether it needs to be altered in any sense, defined better or the like. Can we focus on that for a couple of minutes? I'm sure we can. Dr. Bowman?

MEMBER BOWMAN: Thank you. I'll kick this off. This will be a lively conversation I am sure. I think there is value if these terminologies are mapped onto the context of the

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metrics that we identified that are sort of the key metrics in exposure science. At this point I don't have any strong objection to the use of the word significant if it's broken down by these key metrics. If an IH says that the intensity is significantly high or significantly low, I think that can have meaning and value to the next step. Where I think that meaning and value goes away is when it's all collapsed into a single assessment, where then the consideration by the physician is then not informed by those important metrics. So, I'll start there.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: I have significant concerns about that, yeah, lively. I mean we just broke it down into something that was more interpretable and now we're talking about rolling it back up into a word that we already said was not very interpretable. I think it can be done if that's what we have to do based on language in the Procedure Manual, language in the law, if we have to stick with these terms, but I think that

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we've identified that these terms themselves cause a problem. I don't know if it's -- it's not as useful. I think this is more useful than significant high, medium or low, but that's just me being precise.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: I'm sorry, just a point of clarity, Dr. Van Dyke. What I was saying is that under the category say intensity, what does low mean? Is it significant? I was not suggesting to roll it back up, I was just suggesting within the context of some of these metrics like frequency. In intensity, it makes some sense because you can apply the word low, medium and high, it sort of implies intensity and it actually gets away from and doesn't really imply route.

Is that route a significant route? That's more of a determination from a physician not a determination from an IH. I guess I was just saying that you could apply that term to the intensity at least and maybe one could talk about

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if the frequency was very high and this is a significant frequency, it makes less sense once you pull away from that.

I think that's part of the problem with the terminology, is when you force significance to low, medium, high, it seems to focus all on just that one metric, intensity, where sometimes the other metrics are far more important.

CHAIR MARKOWITZ: Mr. Key?

MEMBER KEY: Yeah, to go along with what Dr. Bowman was saying, on the line of intensity, how are these captured? By the CE, by the Industrial Hygienist, or is this in fact information that the claimant has provided? If the claimant is not interviewed and provided an opportunity to express the intensity of each of these jobs, then clearly the other players are going to miss his/her actual exposure.

CHAIR MARKOWITZ: Just at least a partial response to that, I think what happens now and what we're proposing or what we're

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looking at doesn't disagree with that, which is it's the Industrial Hygienist who assigns it as low, medium, high in terms of intensity, how intense was the exposure.

That's drawn from whatever the Claims Examiner provides. It's drawn hopefully from a reading of the OHQ and the EE-3, but it's the IH who is assigning that word, if that answers your question. Board members on the phone, anyone want to make a comment here?

MEMBER FRIEDMAN-JIMENEZ: Yes, George Friedman-Jimenez. I have a concern about the use of the words significant and incidental, that they really do depend on the disease that we're talking about. They carry some implication of causation, so let's take for example, isocyanate exposure, inhalation exposure and let's say we're considering two diseases, say work-related asthma. So you have isocyanate exposure two or three times in a five-year employment period at let's say a medium intensity level. That would be generally considered an incidental exposure, in

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passing, something that is about as low as you could practically imagine.

However, it certainly could be a causal exposure for work-related asthma because we're talking about a sensitization process that causes someone to develop a new disease that they didn't have before and it can be caused by one or a few medium level exposures to isocyanate. Whereas if we're talking about let's say dementia or some kind of longstanding neurotoxic disorder and considering isocyanate as a solvent or a neurotoxin, that would be an incidental exposure that there's just no way that it would be enough to be causal for that outcome.

So, incidental exposure could be a causal exposure for one disease and not a causal exposure for another disease, so that kind of breaks the one-to-one mapping between these four metrics and the significance level.

And that's my concern, that what is a significant exposure for one outcome for a given toxin may not be a significant level of exposure

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for a different outcome. So in that case, I think it's better for the CMC or the people who are judging causation to have access to essentially the raw data or a summary of the raw data like there is in this table that they can see just what kind of exposure occurred, when did it occur and at what levels.

And then they use their own knowledge of that particular disease and causation process to determine whether it's likely or not that it could have been causal in the question of determining work-related causation. So, that's my concern with keeping the use of the words significant and incidental as part of strictly the exposure assessment process.

CHAIR MARKOWITZ: Steve Markowitz. So, that I think, is an argument for recommending that what we're looking at now and those of you who can't see it, we're looking at our proposed Exposure Assessment Form that details for a given person what their route of exposure was, intensity, frequency for a set of toxins.

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This Industrial Hygienist's version of the facts of the case, that their assessment ends here and that that information then returns to the Claims Examiner ultimately, most likely, sent to the physician for them to determine the significance of these exposures. That's, I think, one argument or one position that we could take. Leave it here and move it on, right? An alternative position is that we might accept or recommend changes in the Procedure Manual in this classification of incidental, significant low, significant medium, significant high, et cetera.

So, the question is obviously there is some degree of discomfort in the way it currently reads, the Procedure Manual, the current process, the question is, is there any alternative proposal or some modified significance assessment that the Board members feel that we ought to examine and consider.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez again. Yes, I think there is and getting back to what John Vance presented,

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we're talking about impressive numbers of decisions that have to be made every month by a very limited number of staff, so we need something that works smoothly and can be done fairly quickly. So I think the idea of presumptions is something that we should talk about.

There are many cases in which there is a clear one-to-one mapping, it's sort of a linear dose response, right? Where a larger amount of exposure leads to a much higher probability of causation than a lower level of exposure. It's not idiosyncratic like in asthma, for example, with allergens. So, there is a subset of exposures which is probably a fairly large subset, for which I think that the old method could work.

In other words, big exposure, higher probability of causation, significant. I just think the word significant kind of clouds things, but I think that there is room for a presumption-based decision making system that will work for

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the majority maybe of exposure-disease pairs and will really expedite the decision making for many or maybe most of the claimants, but there's an important subset of people for which the exposure needs to be considered much more carefully and there is a lot of room for making mistakes in these subtle cases.

Ad so I think we should talk about setting up presumptions for the most obvious cases and one by one, case by case evaluations of exposure and causation for the ones that don't meet the presumptions of the most extreme and obvious causal relationships.

CHAIR MARKOWITZ: This is Steve Markowitz. Yes, so just a brief history of this in terms of the Board work. The Department has invited us to assist them with developing presumptions between exposure and disease that would expedite claims, in particular, claims acceptance, but claims decision making and over the last six years or so, we have helped them expand and develop presumptions which I think has

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been very useful to the Department. I think Mr. Vance would agree with that.

So the presumptions are sort of a separate stream of decision making because there you're not looking at the individual's exposures and their condition, it's a more expedited way. So, this separate stream here that we're trying to help improve, I think we should try to assist in developing further presumptions or expand the current presumptions, but for a moment, we're looking at the non-presumption stream of decision making, right, where the individual facts are really seriously considered and looked at.

MR. VANCE: Dr. Markowitz, can I jump in real quick and just add a comment for consideration?

CHAIR MARKOWITZ: Sure.

MR. VANCE: So I understand the conversation about the definition of significance. Now, I'm going to add a complexity because that's what I'm really good at here. The comment about the presumptions is very good

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because we struggled with recommendations from the Board before about this very question of significance and how to characterize exposure. Remember that many of the causation presumptions require a level of significant exposure, not significant low, moderate or high, just significant. So the question would be, does this document represent significant exposure, because you remember as part of our process, you want the Claims Examiners looking at any kind of input that they're getting and saying this triggers one of those causation standards.

So the comment I will just have is just remember however the IH is looking at this, you're still going to have to figure out how to integrate what the IH is doing in this type of scenario to trigger that presumptive standard. So you're still going to struggle with this significance question because if our presumptions are based around significant exposure, what is that versus not significant and will this process that's being discussed by the Board address that

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administrative reality that we have with regard to those causation presumptions or are you going to be changing those presumptions in some way to identify that the level of intensity needs to be low, moderate or high or whatever you're going to use in your characterization.

So the impact that you are talking about on this needs to be considered in conjunction with those presumptive standards that require that level of significant exposure and that's how we characterize all those presumptions. So I think this is a good point that was discussed, but I wanted to make that and highlight that, there is sometimes a bleedover from what the Industrial Hygienist is doing in their assessments to our application of those presumptive standards, so it's just a good point I wanted to make.

MEMBER FRIEDMAN-JIMENEZ: Can I respond?

CHAIR MARKOWITZ: Sure. Dr. Friedman-Jimenez?

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MEMBER FRIEDMAN-JIMENEZ: The presumptions often use the word significant, but there's a circular logic here because really what they mean by significant is sufficient to cause the disease. That's the meaning of significant that they're using in the presumption. So the presumptions I'm thinking about are the ones, for example, I think solvents and hearing loss. It requires a certain number of years of exposure to a particular TCE or whatever the chemical is and it's an objectively defined level of exposure that doesn't use the word significant, but I think using the word significant there's a danger that it really means that when you use the word significant, you're assigning the possibility that that chemical can cause that disease implicitly.

So the question is, who assigns that? Who makes that causation judgment? Is it the IH, should it be the CMC, should it be someone that has training in causation analysis or could it be a Claims Examiner that's just looking at the Site

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Exposure Matrix and seeing the association that is summarized there? That's why I'm uncomfortable with the word significant because of this dual meaning that it has and it's kind of slippery and hard to pin down. And if we mean causation or probability of causation informally then we should be talking about that.

But we see all the problems of that in the Radiation Board. That doesn't entirely solve the issue either and we don't have any hope of getting that clean as they do with measured level of ionizing radiation because we don't have any kind of measurements that are anywhere near that level of precision for these chemicals.

So that's my discomfort with using the word significant even in the presumptions, but most presumptions, I think, could be stated in an objective way. The problem is that you're sort of skimming off the top of the most obvious causal relations and you leave those that are more difficult cases and I want to make sure that those more difficult cases or that second stream,

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as Steve Markowitz is calling it, is dealt with appropriately and that's where I think this table really could be a great tool for the people that are judging the causation, which is usually the CMC, I think.

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER CLOEREN: I'd be very interested in hearing from the IH contractor, what their instructions are to the IHS about how to make the determination of the significant categories, if they have specific -- we don't know how they make their decision whether something is significant high, significant moderate, et cetera and if there are any kind of written instructions to the Industrial Hygienists, I think it would be really useful to know what those instructions are.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: Just a point of clarification if I understood what John Vance was saying. Do I understand that our presumptions as currently set are based on the IH reporting the exposure level as being significant or not and so

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that is happening at the level of the IH? Do I understand that correctly?

But then if because of what we talked about earlier that if this link to causation pushes that decision down to the CMC that seems to be counter to the idea of trying to have presumptions save time, if you then have to go one more step in the process before you can meet a presumption. Just a little bit of clarification, John, did I understand you correctly?

MR. VANCE: Yes, so let me give you an example. Let's say I'm a Claims Examiner, I'm sitting down looking at this case for COPD. And I think that we have a presumptive standard that applies for asbestos, so the Claims Examiner wants to know can I accept this case knowing what I know about COPD and the presumption for asbestos exposure?

The Claims Examiner is going to want to have this question answered. Just for this table example, if you're in column exposure

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number one, the Claims Examiner wants to know does this mean that this person had a significant exposure to asbestos. They need to have that answer because if the answer is yes and they meet whatever other conditions exist for the presumption, they can accept this case.

Without that kind of understanding, a CE could look at this and say do I know that this characterization of low exposure, is that significant or is it not significant? Because if it's not significant, I can't trigger the presumption. At that point, I'm going to go forward with getting a medical opinion about this. That's what I'm trying to get to, is that the Claims Examiner has guidance that says for a presumption to be triggered, there needs to be a finding of significant exposure.

My point is just that column one, does this mean significant exposure or not. The Claims Examiner is told yes it does, the presumption could likely be triggered and we would approve that case. If not, this case is going to a

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physician to look at everything to make a judgment on the causation. Does that explain it a little bit better?

MEMBER BOWMAN: Yes, thank you.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: See, I knew the word significant was coming back somehow. I mean I think if we break it down really simply, all of these exposures here are significant according to the current guidance, because you really only have a choice of significant versus incidental.

So I think that could be easy to provide guidance on that, but I think for the CMC, significant is kind of meaningless in this context. I think they still need this kind of advice to make decisions, but from an administrative reason, there's always some reason right, from an administrative reason if we need to say significant, you only have two choices, significant and incidental, then that makes it pretty simple.

CHAIR MARKOWITZ: Dr. Bowman?

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MEMBER BOWMAN: I think there are three, it's significant, incidental or between them.

MEMBER VAN DYKE: Everybody always wants a third choice, don't they?

CHAIR MARKOWITZ: Other comments? Yes, Dr. Vlahovich?

MEMBER VLAHOVICH: Kevin Vlahovich. Is there consideration of aggravating or mitigating factors or is that only done at the CMC level? For instance, people have underlying conditions that might make them have a different outcome at a different level of exposure?

CHAIR MARKOWITZ: I think that's a Mr. Vance question.

MR. VANCE: Well, remember you're going to always look at what it is that you're being told by a physician. So, in other words, let me see if I can say this in a way that makes sense. Physicians can offer whatever opinion that they want in conjunction with the information that they're provided by the Department of Labor or

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just their own understanding of the circumstances of what the employee did and exposures that they had. The conditions that the physician can consider in rendering a causation opinion can certainly consider aggravating or contributing effects.

In other words, let's say I'm a doctor looking at this form in front of me. The presumption was not triggered. The point that everybody is making is true, different physicians will interpret what this means in their professional judgment. I'm a physician and I'm going to look at this and say I certainly don't think that the level of exposure here caused COPD for this employee, but this level of exposure over this duration of time certainly could have contributed to the development of COPD.

Now you could also have other physicians look at this and in their own professional judgment say, I'm not convinced that that duration of exposure at these levels could have caused, contributed or aggravated the

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disease. That's the challenge. Different physicians are going to look at the same material and potentially come back with different viewpoints, that's the real challenge.

No matter how you try to define it, it's ultimately up to the physicians' interpretation and their understanding of the circumstances of the case to reach an opinion of contribution, aggravation or cause. So, this is where you get to the meat of the challenge with this program is that each one of these components, whether you're talking about the Industrial Hygienist looking at the situation and the answer to the question from before was they inform their opinions based on the information that we provide in the Procedure Manual and the application of their own professional judgment.

The same dynamic exists for a physician looking at this. They will look at the data. They will interpret it however they feel is most appropriate to inform their decision and then they will render an opinion as to whether or

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not they think the data is enough to trigger that threshold of at least as likely as not that whatever exposure occurred was a significant factor in causing, attributing or aggravating a disease, that's your challenge right there.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. A question for Mr. Vance, do you think it's realistic to think about rewriting the presumptions in a way that they're based only on objective or on well-defined categories that would appear in this chart and removing the term significant?

So therefore, the presumption would be based on the intensity, the route of exposure, the frequency, duration, latency period and this is done for the World Trade Center covered conditions. It is problematic in that it can miss a lot of actual causation, but you can set it up so that it really doesn't over-diagnose causation, it just misses a lot.

`So the question is then you have to have a backup stream, people that don't make the

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presumptions then get evaluated according to a more labor intensive process using these defined metrics of exposure rather than just being made at the claims evaluator level based on whether they meet the presumptions or not.

Do you think those presumptions could be rewritten without the use of the word significant, but using these metrics of exposure that can be plugged in and quickly determined by the Claims Examiners in many of the cases?

MR. VANCE: I'll answer that as politically carefully as I possibly can. The answer to that question is anything will be considered by the Department of Labor; however, I would not want to be part of the Board's Work Group reworking every single one of those presumptions to fit into the dynamic that you're talking about with the application of this form because the Department of Labor would need to have some sort of expertise to be able to do that.

So I would just say it would certainly

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be something that could be considered by the Department of Labor, but you're talking about a pretty intensive research project to look at how you would take those existing presumptions and all the medical health science that's behind that and trying to fit it into the application of what you're looking at in the form in front of you.

MEMBER FRIEDMAN-JIMENEZ: I believe this has been done for some of the presumptions, for example, the hearing loss and chemical exposure. I'm going to look at that right now in the Procedure Manual, but I don't think that this is entirely new, but yes, I understand.

The question is, where are you going to put your resources in terms of expertise and time, evaluating individual cases or setting up presumption algorithms that can be applied at the Claims Examiner level for a reasonable minority or maybe even majority of cases? So that's the question that I'm raising.

MR. VANCE: The other question would be what kind of administrative efficacy would doing

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this have? Because I think from where I sit, just my own personal viewpoint, the existing presumptive standards work fairly well. They integrate into our claim adjudication process fairly easily and if you would change that dynamic, to what benefit are you trying to accomplish as far as changing that or what would you hope to accomplish in that process by adding complexity or more exacting information to the case adjudication process? It's that question of time versus resources kind of thing.

MEMBER FRIEDMAN-JIMENEZ: Yes, I'm looking now at the hearing loss section and I don't see the word significant in here. They just say at least 10 consecutive years of verified employment exposed to carbon disulfide, ethylbenzene, et cetera, a list of chemicals. And the CE could assign this presumption based on what's in the exposure chart, the table that we're proposing. I think it has been done for hearing loss and the question is, if it's worth the time and effort to do it for others.

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You know, your same experts that are trained in causation analysis can do this work either at an individual case level or at an algorithm presumption development level or both and I think that you can think about what is the best use of your resources. I know these are all very limited resources. What's the best use of your resources in terms of getting the work done and done as accurately as possible.

CHAIR MARKOWITZ: It's 11:01, Steve Markowitz. We're going to take a break for 15 minutes. So, we'll be back at 11:15, thank you.

(Whereupon, the above-entitled matter went off the record at 11:01 a.m. and resumed at 11:19 a.m.)

CHAIR MARKOWITZ: Okay, we're going to get started again. So one of the discussion points is, since the Board seems to have general agreement on this expanded Exposure Assessment Form as a way for the Industrial Hygienists to document in the report what they found, but, on the other hand, we don't really have agreement on

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a recommendation regarding any change in how the program addresses the issue of significance by the Industrial Hygienist, that one way to move forward is to consider a recommendation that just looks at the Exposure Assessment Form, and to postpone further discussion regarding the Industrial Hygienist's use of that information to determine significance for either tomorrow or for another meeting, or perhaps send it back to the working group to look at the issue of the interaction with presumptions to make sure that we're not harming claimants in any way.

And so that seems -- that strikes me as a useful way to move forward over the next few minutes. Any comments on that? Yes, Dr. Bowman?

MEMBER BOWMAN: I'm just going to comment that I agree with your recommendation about that. We certainly -- the intent of the working group was about having better data to inform the medical, and not about trying to do anything about the presumption. So I agree with what you're saying.

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CHAIR MARKOWITZ: Okay. And this doesn't really concede that, you know, the current description of how significance is used is correct or optimal. It's just saying we'll take a further look at that and see whether actually we have any useful advice for the Department.

So, I think we may have a draft recommendation. I think we may have one, Dr. Bowman.

MEMBER BOWMAN: Yes, we may. I believe I've sent it, and if it could be put up on the board.

CHAIR MARKOWITZ: Great. Thank you. For the Board members on Webex, can you see the screen here?

MEMBER BOWMAN: I would be happy to read this, if that would help.

CHAIR MARKOWITZ: Yeah, good idea. And remember there are public who may be in this meeting who maybe can't see the screen, so it's important that we read it.

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MEMBER BOWMAN: So, I'll do that now. So, the Board recommends that exposure assessments made by Industrial Hygienists be enhanced to specifically refer to the basic metrics of exposure science: 1) exposure intensity, 2) exposure route, 3) exposure frequency, and 4) exposure duration.

These elements can have distinct value in determining causation. The IH would select the relevant metrics for each case based on best available data. These metrics may further be divided by the facility and job under which they occurred for a claimant, as relevant.

We recommend that DOL adopt an IH Exposure Assessment Form that puts the work of the IH in the context of these four basic metrics of exposure. Further details and rationale are contained in the May 2023 working group report to the full Board, along with an example form that was in the PowerPoint presentation given by Dr. Cloeren at the meeting on May 17th, 2023.

CHAIR MARKOWITZ: Steve Markowitz. Our

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recommendations are always accompanied by rationales. I suggest we strike the last sentence and just put whatever we want in the rationale in reference to a form. Unless this is the only place where we refer to the form, then I agree with you that we should include that in the recommendation. But the details and rationale, working group report, all that goes in the rationale. Dr. Bowman?

MEMBER BOWMAN: Yeah, so, this is the only place in the recommendation where the form is referenced. So perhaps we would delete most of the sentence and start at the word "an example form" that was in the --

CHAIR MARKOWITZ: Yes. Well --

(Simultaneous speaking.)

CHAIR MARKOWITZ: We'd just say an example form is provided along with this recommendation.

MEMBER BOWMAN: Right.

CHAIR MARKOWITZ: Okay.

MEMBER BOWMAN: Okay, yeah, that's

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fine.

CHAIR MARKOWITZ: Okay, so I have a question on line four, where it starts with -- well, the IH would select the relevant metrics for each case based on best available data, end of quote.

All right, is that saying that the IH selects from among the metrics on the form? Or do we believe the IH should, to the extent possible, complete -- provide all data for all of those metrics, to the extent possible?

We don't want them selecting from those metrics and deciding which ones they think should be addressed.

MEMBER BOWMAN: I would agree. I think the wording there should be altered.

CHAIR MARKOWITZ: Okay. Okay. Dr. Van Dyke?

MEMBER VAN DYKE: Mike Van Dyke. I think you could actually just delete that sentence.

MEMBER BOWMAN: I'm okay with that, as

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well.

CHAIR MARKOWITZ: Okay. We're getting slimmer with every comment. Board members, Board members who are remote, if you have any comments or -- we're going to re-read this --

MEMBER FRIEDMAN-JIMENEZ: Yeah, George Friedman-Jimenez. I have a question that I'd like us to discuss. What do you do in the case that you have multiple medical conditions? For example, the case that I reviewed had prostate cancer, squamous cell carcinoma of the skin, and work-related asthma, question of work-related asthma?

So what exposures would be relevant? And how would the exposures be assessed? And should they be assessed all on one form, I guess with a limit of seven exposures for all three conditions? Or would it make more sense to have the exposure assessment specific to the medical condition? Because, you know, as we know, different medical conditions are caused by different chemicals, and different chemicals can

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cause some conditions, but not others. So what's relevant for one medical condition is not relevant for another.

So, that's the question I'm raising. How do we deal with multiple medical conditions that are all being proposed for compensation?

CHAIR MARKOWITZ: Kevin, could you bring up the form for a moment? I think the completion of this form is not -- doesn't depend or interact with what the claimed condition is. And so if a person has multiple conditions, this form isn't going to change. Correct me if I'm wrong. Because whether it's -- if you could just blow that up a little, yeah.

The frequency of their exposure to cement isn't going to change depending on whether we're looking at skin irritation or COPD. The frequency is the frequency of the work that the person did. This is true, I think, for all the other elements we're looking at.

So I don't think the contents of this form changes depending on the condition. I think

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the interpretation changes, for sure, and that's where they would get into the question of significance, whether it's the IH or the CMC. But the response isn't here. I don't see, George, how that changes or is dependent upon the condition.

MEMBER FRIEDMAN-JIMENEZ: Well, which exposure you assess does change. For example, what exposures are relevant to prostate cancer? Are they the same exposures that are relevant to skin cancer or to asthma? And I would say no. And so there -- different exposures would be relevant to different conditions.

You know, for the most part, I think you're right that the intensity, frequency, route of exposure would be the same independent of the conditions, in most cases.

CHAIR MARKOWITZ: And I would agree with you that the toxins may differ depending on the condition. So the IH then has to determine whether there's one global assessment form for all the conditions or whether they have a specific form -- a form specific for a condition.

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Dr. Cloeren?

MEMBER CLOEREN: I think the claimed condition up in the corner, if it happens that the exposures of interest are shared by a couple of medical conditions, you could put multiple medical conditions up there. And these are the same toxicants of interest. But a different form -- I agree with George, a different form would need to be completed if the toxicants are different.

CHAIR MARKOWITZ: Right. And so the question is: do we add that to the recommendation, to the text of the recommendation?

If you could give -- do you have a comment on the form or the recommendation? On the form? Good, go ahead.

MEMBER BOWMAN: Just a comment. I mean, I presume this is happening already under the context of the recommendation. And those might be the cases if there's so many conditions where that number might exceed seven.

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John Vance might be able to comment on that, but that would be -- if you get to seven, you haven't even touched the ones that would affect the other conditions being claimed. I would think that would be a case when more than seven would be given already.

MR. VANCE: Yes.

MEMBER BOWMAN: And so, not needed to change the recommendation.

MR. VANCE: Yeah, this is John Vance. Yes, that could, certainly, be a circumstance where you would be looking at more than seven. It's just going to depend on the dynamic of the case.

And then the information that would flow to the doctor would include all of the analysis that went into what toxic substances were being evaluated for what disease. Hopefully, that would be revealed in the Statement of Accepted Facts or the accompanying material that goes to the doctor for consideration.

Because the doctor is not just

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receiving this assessment; they're also receiving all of the medical records that are relevant to the case. They are also getting information from the case file that's relevant to what they're being asked about on the opinion of causation.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: I think what we're talking about really is an upstream problem before we get to the form. And in terms of selecting the right exposures, we're not addressing that by the form, and we're not trying to address that by the form.

I mean, I think it's, again, a discussion for another day. But I think focusing on really characterizing the exposures of the IH is given is where we're at.

CHAIR MARKOWITZ: But I think there's a simple solution here, which is to add to the recommendation that the toxins that are considered on this Exposure Assessment Form are those that are relevant to the medical condition being considered. And then the IH figures out

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exactly how to do all that. But that would address that concern, I think, if we could go back to the recommendation.

Oh, okay. Oh, Mr. Catlin. There you are. Sorry.

MEMBER CATLIN: Yeah, Dr. Markowitz, I mean, I like that modification. My look at this is we're trying to be really clear and transparent about the exposure assessment and how that's being done, so that the claim examiner and the physician can be more clear on that. So, you know, whatever can be done to make these forms so they're more clear, rather than more -- than potentially confusing. So I like what you propose.

CHAIR MARKOWITZ: So if you could blow that up a little bit, because I just want to add a friendly amendment that -- if we could just write out the sentence first and then we'll see where it goes -- that the toxins that are considered on the Exposure Assessment Form are those that are relevant to this specific medical

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condition for which the claimant is -- sorry.

MEMBER BOWMAN: I penned some, because it's easier to write it than to do it in my head.

CHAIR MARKOWITZ: Sure, go ahead.

MEMBER BOWMAN: I'll read it first, and then we can update it if there's agreement.

The toxicants to be included on the form would be those determined relevant to the claimed medical conditions.

CHAIR MARKOWITZ: Sure, that's fine. Even better that it uses the word toxicants than toxins. So, you need to repeat that so Kevin can put it --

MEMBER BOWMAN: Yeah, so, the toxicants to be included on the form would be those determined relevant to the claimed medical conditions. And I would propose it become the second to last sentence.

CHAIR MARKOWITZ: Okay, so -- and, Kevin, if you could remove the three lines that are below. Yes. Okay, so I think we should re-read this recommendation.

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Do we have another reader besides Dr. Bowman? I guess not, Dr. Bowman.

MEMBER BOWMAN: All right, I'm not shy. Was my reading not well? I could read slower or faster as --

CHAIR MARKOWITZ: It's good, it's good.

MEMBER BOWMAN: Okay. If you could blow it up a little bit. And, Steven, your head is slightly in the way. Sorry.

CHAIR MARKOWITZ: Sorry about that.

MEMBER BOWMAN: So, the current version, as just edited, reads: "the Board recommends that exposure assessments made by Industrial Hygienists be enhanced to specifically refer to the basic metrics of exposure science: 1) exposure intensity, 2) exposure route, 3) exposure frequency, and 4) exposure duration.

"These elements can have distinct value in determining causation. These metrics may further be divided by the facility and job under which they occurred for a claimant, as relevant.

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We recommend that DOL adopt an IH Exposure Assessment Form that puts the work of the IH in the context of these four basic metrics of exposure.

"The toxicants to be included on the form would be those determined relevant to the claimed medical conditions. An example form is provided with this recommendation."

CHAIR MARKOWITZ: Okay, is there a second to this recommendation?

MEMBER CLOEREN: Second.

CHAIR MARKOWITZ: Dr. Cloeren seconds it. Okay, it's open for discussion. Dr. Vlahovich, I think.

MEMBER VLAHOVICH: Kevin Vlahovich. My question is: who would determine which exposures are relevant to the medical condition?

CHAIR MARKOWITZ: Does anybody have a --

MEMBER FRIEDMAN-JIMENEZ: Yeah, this is George Friedman-Jimenez. Dr. Bowman and I were discussing this before the meeting. This is a

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really key question. The decisions on which exposures to assess are really very important to the whole process. And, as the process is set up now, I'd say they seem to rely pretty heavily on the Site Exposure Matrix.

And I think, to a large degree, they're set up by the Claims Examiner. And we should discuss this. The completeness and the correctness of the Haz-Map database on which the Site Exposure Matrix is based is important. So we should discuss, I think, maybe this afternoon in the exposure matrix discussion, you know, how that's done and what is the information that we have on completeness and correctness of the Haz-Map database.

But I think that this is done, you know -- and Mr. Vance and I discussed it before -- by a combination of processes, including the Site Exposure Matrix and the Claims Examiner, as well as the initial treating physician's proposed causal toxicant, and then the CMC and then the IH.

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So, all of them have input into this, but it seems to me, from what Mr. Vance said this morning, that it's not very common that it gets reconsidered. In other words, if the IH thinks of an additional exposure that could cause the disease, they don't generally add that.

Is that correct, Mr. Vance? That that's not commonly done?

MR. VANCE: Yeah, it's generally going to be -- the context of the referral is going to be what the Claims Examiner's asking the Industrial Hygienist to opine on. If the IH does see something that is noteworthy that they feel does need to be brought to the attention of the CE, that mechanism does exist.

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER FRIEDMAN-JIMENEZ: Yeah, typically, the CMC is the one that probably has the most broad overview on the causal literature, including the toxicology, the epidemiology, the medicine, as well as the exposure science. And the IH, to some degree, but maybe not as much as

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the physician. So this is an important question, and I think we should discuss this.

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER CLOEREN: I think that there should be an easier mechanism for the Industrial Hygienist or the CMC to identify additional exposures. And that there should be kind of an explicit invitation to do that if there was something important missed.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: I agree about the importance in the selection of the toxicants. They will -- they have a fundamental role in driving this, just like there's an importance in the further discussion about how significance is being assigned to the overall exposure.

But just in the context of our current discussion with this recommendation, I think those fall outside of the scope of this recommendation, and I would move that we maybe vote on this recommendation and open up the importance of discussing those items outside the

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context of the recommendation.

CHAIR MARKOWITZ: Yeah. Steve Markowitz. I would agree with that. I agree about the importance of the question that the IH consider the proper set of exposures. But that's not what we're discussing here, and that is a longer discussion, a probably complicated discussion, which we should get to, but not at this moment. And if we were to pursue that now, it would railroad, actually, real consideration of this recommendation.

So, is there further discussion about this particular recommendation?

Okay, is there any objection from people on -- from Board members on Webex to the separate consideration of this question that was just raised about the selection of toxicants? Can we set that aside for a separate discussion and recommendation?

MEMBER FRIEDMAN-JIMENEZ: Yes, I agree with Dr. Bowman on that. This is George.

CHAIR MARKOWITZ: If there's no

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further discussion, then we will have a vote on this. Any Board members request a final reading of the recommendation or shall we go with what we have?

Then we turn it over to Ms. Rhoads for a vote.

MR. JANSEN: Actually, I'll record the vote. Dr. Bowman?

MEMBER BOWMAN: Yes.

MR. JANSEN: Mr. Catlin?

MEMBER CATLIN: Yes.

MR. JANSEN: Dr. Cloeren?

MEMBER CLOEREN: Yes.

MR. JANSEN: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. JANSEN: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. JANSEN: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. JANSEN: Dr. Van Dyke?

MEMBER VAN DYKE: Yes.

MR. JANSEN: Dr. Vlahovich?

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MEMBER VLAHOVICH: Yes.

MR. JANSEN: Mr. Key?

MEMBER KEY: Yes.

MR. JANSEN: Ms. Splett?

MEMBER SPLETT: Yes.

MR. JANSEN: Ms. Whitten?

MEMBER WHITTEN: Yes.

MR. JANSEN: All yeses.

CHAIR MARKOWITZ: Okay, thank you.

So these other -- these additional issues of selection of toxicants and the importance of significance we will postpone. If we have time this meeting to come back to this discussion, we will. Otherwise, I would suggest that we put that back into the working group for further work.

And now we're going to move on to the next topic, which is the Site Exposure Matrices. And just to review for a moment, the working group submitted a series of questions, requests for information. The Department provided in mid-February a series of attachments from the

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contractor regarding the operation of the Site Exposure Matrices. And then, over the last few days, provided additional information and responses to the questions that were asked.

So we're not really going to review all that, but we're going to proceed further, and either address additional questions or areas that require clarification.

So, Ms. Whitten?

MEMBER WHITTEN: Thank you. At our November Board meeting we were made aware that there was some information missing from the SEM.

So, since that time, we formed a subcommittee -- myself, Gail, and Lorna -- and we came up with some questions for Paragon. And we were hoping that they would be here at the meeting so that we could ask them, but instead they did send their responses to us. I think we got them last night.

We do have some additional questions, though. And we were hoping we could get some answers today, maybe. I guess I'll start.

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The first one is, I was reviewing their standard operating procedure SEM03, Section 3.5. And it mentions a closure spreadsheet. I don't know how they determine a site has met their closure data, and I don't know why it would be any different than their operational chemical listing, but we do have some examples. And I was hoping Kevin could pull one of them up for us on the SEM, kind of do a live showing of what we're dealing with.

So one of the issues that we were first noticed was 105-N Reactor building at Hanford, it was listed as a museum, and it only had a handful of chemicals on the SEM, whereas three, four, five years ago it had hundreds of chemicals. And, currently, it has, what, 12?

Okay, go to Hanford. Okay, and then on the right, it will say "building information" about halfway down. All right, then arrow down to 105-N. In 105 there's B, C, D, DR. That just means 105 means reactor building. So, if you scroll down a little bit, you'll see you there's

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12 chemicals.

So, this was an operating nuclear reactor. It doesn't even list boron. It doesn't list graphite. And it used to list all of these chemicals, and I don't know where they went. I don't know who made the decision to delete them.

And, also, if you go down a little bit farther, it will show the worksite process activities. So, my job -- I worked there for 12 years. My job's not even listed on there. If you go back up to the top, there's many jobs not listed on there.

So you can go down to labor category and it will show you the only ones that are associated with that building. So, I mean, this kind of all goes back to the whole, how are the CEs going to get the toxic information to send to the IH if the list isn't even complete when they go and look up the building that somebody worked in for 25 years?

So, I don't know if Mr. Vance can answer what happened to all of that information.

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And we can look at many, many other buildings. I have a whole stack of them here that are similar situation. Every single one of our reactor buildings has a different list of chemicals. And I don't know why that is because they were all pretty much cookie-cutter facilities.

But this is what Lorna and I came up with, and if she has something to add, go ahead.

MEMBER SPLETT: And this is Gail. I was interested in the Plutonium Finishing Plant because, obviously, anybody who's aware of Hanford knows that's a very, very significant facility and there was a major incident, what, in 2018? It's not in the SEM. And it talks about the PFP being an active facility. It is now slab on grade. And it is not showing any of the D&D that's occurred in there, which, obviously, because of several things made national news.

And I had talked to Mr. Lewis yesterday about whose responsibility is it to keep Paragon or DOL apprised of changes in the facility, as well as some of the information that

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we have seen that has been deleted from the SEM at some point, as well as never been added.

One of the claims I reviewed, an individual worked in the building for 16 years and his job category was never listed, and accordingly did not get considered for those chemicals.

So it looks like it's a relatively generic, consistent problem. One of the things that the sub-team had talked about is having an assessment team go in and look, whether it's one facility or one site, and perhaps utilizing a subcontractor to do that. Or we turn to the Department of Energy and ask them to do that.

I mean, it's clearly a large undertaking. There's no question about it. And we've also we talked about whether, Mr. Vance -- and I think it's the case, because I think I was the point of contact at Hanford. When they start out, they come out with a plan. Is there an overall plan for data capture for every facility?

MR. VANCE: Well, this is John Vance.

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What I can say is that, you know, the Department of Labor and Paragon do do planning for data capture and collection of information.

Hanford is one of the sites that we have a huge amount of information on. I know it's one of the most -- the biggest site for which we have records. Like I would say in any other type of situation involving the Site Exposure Matrices, it's a data collection that is constantly being updated as we get new information.

As far as specific questions relating to why something is there or why it changed, that would be something that we would have to get that question and work with Paragon to try to understand what occurred. And we generally would be able to explain exactly the rationale for what changed in the Site Exposure Matrices.

The other feature that I'll reiterate about the Site Exposure Matrices is that the information that populates the Site Exposure Matrices has to tie back to actual documentation

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about the materials that were located at particular sites within Hanford or were involved with a work process that connects to employees that were at the site.

So, you know, we have a continually evolving process to collect information about all of these sites, and clearly it sounds like, you know, we need to continue to look at Hanford, which I know is an ongoing project for Paragon, not just for Hanford, but for a variety of different sites.

So I think we'll probably need to get that submitted as a specific question that we can then take to Paragon and ask them to give us a better understanding of what occurred.

CHAIR MARKOWITZ: Steve Markowitz. I have a question for Mr. Vance. So, if there's information that Ms. Whitten described that had been in the SEM removed from the SEM -- and probably very well documented by the Paragon because we read their procedures for documenting things, so we're sure it's documented. It no

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longer exists in the SEM, wouldn't be accessible to the Claims Examiner if they're looking around looking in the SEM for it.

So the question is, if that information has been superseded by more recent information -- not corrected, but simply superseded by a more recent characterization of what's true of that particular building or whatever -- but the old information exists, is that even available to the CE when they're looking for what important toxicants there are?

MR. VANCE: No, I would say probably not because the Site Exposure Matrices represents the best understanding of the toxins associated with whatever the relational parameter is. So if it's building, work process, labor category, or incident, you know, that information that's communicated in the Site Exposure Matrices at the time that the Claims Examiner is accessing it, is going to be the best information that Paragon can communicate based on the evaluation of the records that they have in their possession.

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You know, this would be a question we would have to look at and say, well, what was the rationale for changing or modifying the information on the Site Exposure Matrices? And, you know, each one of those questions requires Paragon to go back and look at their versioning to figure out what was the reason for why it may have moved from this relational parameter to something else.

Because, generally, it's not just being removed from SEM; it's because they're changing it. Like, it's not really supposed to be associated with this location; it needs to be associated with this.

So, there can be any number of reasons why things change and we have to look at the dynamics for each specific question.

MEMBER SPLETT: But, again, this is Gail. My concern is the N Reactor, for example, those toxins that Ms. Whitten had referred to, those are relevant for today. They aren't relevant for 1960. And some of our claims are

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still from 1960.

So if the Claims Examiners don't have access to them, they're not being referred to the CE, and they're certainly not going to a CMC.

And we're just looking at facilities that she and I and Ms. Zaback are intimately aware of. I don't have any way of knowing what -- if the same issues are happening at other sites and what that structured process is.

So, Dianne, do you have any --

MEMBER WHITTEN: Well, this is going to be a big undertaking, because I did pull up some Savannah River buildings, too, and I believe they're having the same similar problem there. So, if it's happening here and there, it's got to be happening everywhere. And I don't know how we get Paragon to sit down with us and explain the rationale and how to put things back to where they were.

MEMBER SPLETT: Mr. Vance, how many people -- are your folks at Paragon assigned to specific facilities? I know we had one gentleman

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in particular that came to Hanford on a regular basis. Do they sort of specialize by facility or location? And how large is the staff?

MR. VANCE: Yeah, I mean, I don't know the number of staff off the top of my head, but I think we did provide a lot of that information in the questionnaire that we provided.

I do know that Paragon will try to assign their researchers based on specific knowledge that someone may have about a particular site, or people that have that type of expertise, knowing what was going on at a facility. But their internal assignment of the researchers or the folks that are doing this work is really up to the Paragon management.

So, again, for questions like that, we'd have to go back to Paragon and ask how to best answer any kind of questions about those kind of dynamics that exist.

MEMBER SPLETT: And, by the way, I do want to compliment you. Although I'm sitting here criticizing, we recognize this is a very hard

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process. I remember having the discussions with your staff about we don't keep records by work processes. Show me your work process. We don't -- we have a million cubic feet of record storage and we don't keep them by work processes.

So it makes it a little -- clearly, it makes it difficult. But that doesn't mitigate our frustration with it when we're looking at some of the issues with trying to help some of these claimants.

MR. VANCE: Yeah, I mean, the Department of Labor's view is that, you know, this is an important, but evolving system. And, you know, the records that we obtain, it's continuous. You know, they just found a whole trove of records for South Albuquerque Works that we're looking at right now. So, I mean, it's amazing that these records keep popping up and that, you know, we need to go out and take a look at them.

And, you know, they've revisited these sites over and over again. And each time, they're

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getting more information. So it's frustrating, and I can understand that, but it is a process by which we are trying to do our best to collect that information.

And the other big feature here is the Department of Labor really does need to have the SEM be as robust as possible, because it's singularly used to adjudicate these cases. And it's an important resource the Department of Labor sponsors to do that. Otherwise, claimants would be left doing this all on their own.

So I think that the Board has well within its discretionary authority to ask good questions, to make recommendations about improvements that could be accomplished within the Site Exposure Matrices.

And Paragon is very responsive to any questions that we put to them, and is always willing to look at issues relating to the communication of information in the Site Exposure Matrices. So, I'll leave that to the Board to ponder.

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CHAIR MARKOWITZ: Mr. Key?

MEMBER KEY: Yeah, Mr. Vance, again, as we brought up in November's meeting and Ms. Whitten has brought up today, how do you justify or explain the removal of a labor category out of this building? I don't know how you or Paragon, either one, could adequately justify the removal of a labor category of someone who has worked 20 years in this building.

MR. VANCE: Yeah, my response to that is: it's generally going to be reliant on material that has been received and assessed by Paragon in clarifying that there needs to be a change in how the information is reported.

The Site Exposure Matrices is a broad-based exposure database. It's not -- it does not maintain good temporal data. It provides some information about the closure versus the production periods of time.

But any question regarding what specifically changed, if it can be identified that this was there and it was removed, we can go

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back to the Paragon folks and ask them, you know, what was the basis for making those changes? And they're able to explain what occurred and what documentation changed.

And, again, it's an evolving process to try to figure out what's the best, most accurate information to communicate in the Site Exposure Matrices. And so, you know, whatever information that could be provided when asking about why a particular change occurred in the Site Exposure Matrices, that's something that we can take back to Paragon and ask clarification. And that can certainly lead to additional consideration by the Board about that process.

CHAIR MARKOWITZ: Ms. Splett?

MEMBER SPLETT: Dr. Markowitz, is it in the Board's purview to ask for an independent assessment, separate from the Department of Labor, utilizing a subcontractor to do an assessment where they're picking one site, one facility, one area of a site to actually go in and, in-depth, do some analysis?

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Because we're just finding things just hit and miss in facilities that we happen to know about. I think it would be much more on a factual basis to do an in-depth assessment. And then, based on one, then I think there could be some much more detailed recommendations to the Department of Labor.

CHAIR MARKOWITZ: Providing advice to the Department on issues relating to the Site Exposure Matrices is within the realm of the Board's charter, sure. Dr. Bowman?

MEMBER BOWMAN: Just one, I was looking through the response to the information request. There's a lot of details, and, Dr. Markowitz, as you point out, there seems to be good documentation of any changes with removal.

But I'm trying to -- I was not able to pull out, from looking over the information provided -- there's a point in which there's a deletion that is approved. And I'm just wondering the underlying philosophy behind those approvals.

If there is a documented case where a

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chemical or a work status was present until a certain date and then was clearly not present after a date, would the decision be to keep or not keep in a case like that?

CHAIR MARKOWITZ: I don't think that's a question any Board member can answer. I don't know whether Mr. Vance wants to weigh in on that, or whether --

MR. VANCE: The best answer that I can provide to that would be, you know, what we don't want -- and I don't think Paragon operates like this -- is an arbitrary and capricious, kind of willy-nilly change. So there's going to be some sort of clearance process that exists within a review of the documentation to decide what needs to change and for what reason.

Now, the Department of Labor allows Paragon to manage this in a way that is going to be reporting accurate information. So, again, the question would be, what specific change is someone concerned about, and can they provide -- you know, or can Paragon explain what the

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rationale for that was?

And it's one of these devil in the details. We wouldn't know what specifically someone's concerned about until we look at it and provide a response as to whether that change was justified or not in the view of the Board.

So it's just a matter of identifying what you want Paragon to report on and then taking a look at that rationale. And that will paint a picture of their process for reviewing these changes and updates. But, again, any change that they're going to make is going to be based on information and documentation in their possession.

MEMBER BOWMAN: Right, sorry. I think I understood that. My question was, in the case where, say, it's rather clear -- because the justification can go both ways. If something was there until 1980 and is clearly not there after 1980, you could justify its removal because it's not currently there, therefore current employees would not be exposed to it. You could justify its

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inclusion because former employees were exposed to it and were there. But it could either only be there or not be there, and both are true.

So I would think the Department of Labor might advise Paragon on what to do in such a very -- such a circumstance where it is clearly there and then clearly not there. Do we keep or don't keep?

MR. VANCE: Well, this is where it gets complicated, because once it's there and once they've established that there was a toxic substance associated with, let's say, a labor category -- again, this is not reporting temporal data.

So it would be removed only in the sense that they have information that would suggest through the history of the site this labor category actually didn't use this material, or if there was some reason why it was reported in the past in error and it needed to be rectified or changed because of some new, accurate data about that particular toxic

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substance.

That's why this is so difficult is because we just don't know until we ask what was going on here. And it could be a question of just accuracy and error based on some misinterpretation of prior documentation.

But if it is established clearly that this toxic substance was associated with the labor category or work process or what have you, then it will remain in the system and it will remain available.

The only way that it would be removed would be because there was a mistake in how that information was evaluated in the past. And, also, it could be removed because it was not taken totally out of the Site Exposure Matrices; a better understanding of that material was obtained and that exposure's associated with other relational parameters in the Site Exposure Matrices.

So it really is going to be dependent on looking at the specific question about what

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change has occurred, or some deficit that the Board might see that they want clarified as to why this information doesn't exist or has been changed over whatever period of time.

MEMBER BOWMAN: Okay, thank you.

CHAIR MARKOWITZ: Ms. Whitten?

MEMBER WHITTEN: So, according to their standard operating procedure SEM-02, which is "Compiling and Entering Toxic Substances," it also applies to deletion of chemical profiles. Changes to the chemical profiles per the procedure can only be performed by the SEM Chemical Profile Manager.

Could we request from the SEM Chemical Profile Manager all previous versions of the SEM for Hanford? According to N Reactor, it was updated September 27th of last year. Can we review the previous chemical listing to see if it was complete then, or maybe even the one previous to that and that?

According to their procedures, if the SEM gets too large, they have a process to

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minimize it. Because these are all Excel spreadsheets that are probably humongous. And maybe something happened during that process, I don't know, but I would like to draft a letter or request to the Profile Manager to get some information from him, possibly.

CHAIR MARKOWITZ: Steve Markowitz. So, there's sizeable gap between the experience of some Board members with the SEM, and probably members of the public because we've heard this before, in terms of how information is dealt with. Or not just how information is dealt with, but the fact of changing the SEM in ways that don't make sense, given their own experience at Hanford, perhaps other facilities.

And so what we need is clarification. And we've gotten a certain amount in writing, which has been very useful. But we need further clarification because there's still pending questions.

So I would propose to the Board that we request that one or more personnel involved

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with Paragon appear before the Board so that we can -- and we can submit the questions ahead of time so that it's clear what information we're after -- but that a person appear, or people appear, before the Board so that we can interact directly and get more detailed answers to questions and further clarification.

And that's my own opinion. I, obviously, would need the opinion of other members of the Board. I would remind the Board members that part of the Act says that the Department of Labor will make "make available" to the Board the Medical Director, the toxicologist, Industrial Hygienists, and support contractors for information provided to the Board. "Will make available to the Board."

So I think a request for Paragon personnel to appear before the Board to engage in clarification and interaction would be useful. And I'd like the opinion of other Board members about that. Dr. Bowman?

MEMBER BOWMAN: Thank you, Dr.

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Markowitz. I agree with you. I think that would be very useful to have them here. I think it would be most useful if we, as a Board, submitted questions ahead of time so that they could be prepared to answer them. It will be less useful if they're not.

I think including some very specific examples for which Board members have intimate knowledge, as was mentioned, and to get those details back would be helpful in that case. But then submit it ahead of time, because they're very detailed and I doubt any one person would know them off the top of their head.

CHAIR MARKOWITZ: Other Board members?

Dr. Cloeren?

MEMBER CLOEREN: I agree with both of you.

CHAIR MARKOWITZ: Well said. Mr. Key?

MEMBER KEY: Totally agree.

CHAIR MARKOWITZ: Board members who are participating by Webex, do you have any comments or opinions?

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So, I think, actually, we should take a vote on this. It's not a recommendation; it's not a specifically a Board request for information, which are our two mechanisms for making requests to the Department. But I propose that we actually vote on this request that one or more members of the Paragon staff appear before the Board to answer questions, many of which will be submitted ahead of time to the Department, for the purpose of helping us understand the SEM and clarifying aspects of the SEM.

So, that's a proposal I think that needs a second.

MEMBER CLOEREN: Second.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I second.

CHAIR MARKOWITZ: Okay. In this case, three seconds. Is there any further discussion about this?

MEMBER FRIEDMAN-JIMENEZ: No.

CHAIR MARKOWITZ: Okay, so let's take a vote, if we could. And the minutes I think will

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reflect what we're voting on, which I think is pretty clear.

MR. JANSEN: This is Ryan Jansen. I'll record the vote. Dr. Bowman?

MEMBER BOWMAN: Yes.

MR. JANSEN: Mr. Catlin?

MEMBER CATLIN: Yes.

MR. JANSEN: Dr. Cloeren?

MEMBER CLOEREN: Yes.

MR. JANSEN: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. JANSEN: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. JANSEN: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. JANSEN: Dr. Van Dyke?

MEMBER VAN DYKE: Yes.

MR. JANSEN: Dr. Vlahovich?

MEMBER VLAHOVICH: Yes.

MR. JANSEN: Mr. Key?

MEMBER KEY: Resounding yes.

MR. JANSEN: Ms. Splett?

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MEMBER SPLETT: Yes.

MR. JANSEN: Ms. Whitten?

MEMBER WHITTEN: Yes.

MR. JANSEN: All 11 Board members voted yes.

CHAIR MARKOWITZ: So is there further discussion from the SEM Working Group, additional items that were raised that might be subject to the questions that we would submit or otherwise?

I realize, you know, we've gotten recent responses regarding this that we need to comb through more thoroughly. Fair enough. But now is the time for further discussion.

MEMBER WHITTEN: I mean, I can show you more examples, if you wish, but for timewise, we can just work on --

CHAIR MARKOWITZ: Well, if you have another example, I would like to see it, actually. And while you're figuring that out, if anybody else has any comments.

MEMBER SPLETT: I did review all the standard operating procedures for the SEM, and

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there was a lot, in very good detail, on the mechanics of how to get the data, where to put it in. But it really -- it missed that key issue for me, which is when -- what's the rationale for the deletion of the material. That was not in those procedures that I read, and I did read all of them.

But I do think it will be really useful if we get some more detailed questions and some specific issues together and meet with Paragon at our next meeting.

CHAIR MARKOWITZ: But, you know, what puzzles me is that the SEM is not really about time. It's not time-dated. So it doesn't tell you any given exposure in relation to job titles, in relation to buildings, whether it was 1960 or 1990.

It's not structured that way. They didn't intend to do it that way. So, as it evolves, I understand correcting mistakes in the SEM. You get rid of the mistakes and put in information that's correct, that you have

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documentation that proves that it's correct.

And so what I don't understand though is -- the perception is that there's information that's removed that was not incorrect, but relevant to a certain time period, and still relevant to claims, and it's no longer there. That strikes me as a -- as just a puzzle that we need to figure out.

MEMBER WHITTEN: All right, well, if you want to see another example, Kevin, go to 105-K. Stay on Hanford. And then go to the building site again on the -- halfway down the -- there you go.

105-K East. And it's similar to N Reactor. It was an operating reactor. And currently it has five chemicals listed. And, like I said, years ago it had a couple of hundred. It had a lot more labor categories, more work processes, and now they're gone.

So, you know, if you were a new CE and you didn't know anything about Hanford, you didn't know about reactors, you would just have

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to go with what you found on the SEM.

CHAIR MARKOWITZ: So I think it -- that example would be a useful one to cite.

MEMBER SPLETT: Don't we have to compare that to -- have them pull up 100-B. Kevin, the same thing, but 100-B. 105-B. 105 is all the reactor buildings, so then just the numbers after them.

So, 105-B currently is a museum, but it was the first reactor at Hanford and it has more chemicals listed than the other reactor buildings. It also has mice infestation, and I will tell you that the mice didn't stop at 100 -- at B Reactor. They also went to K and N and everywhere else. We tried to put up borders to keep the mice out, but it didn't work.

Look at the labor categories there, Kevin, and see what's there. There's a few more there.

Do you guys want to see anymore else, any other examples?

MEMBER KEY: The labor categories

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that's listed under the 105-B, would you say that, in your knowledge or experience at the site, that those are the exact labor categories, all-inclusive, that should be listed?

MS. WHITTEN: No, of course not.

MEMBER KEY: Okay.

MS. WHITTEN: We had maintenance people, fitters, we had --

MEMBER SPLETT: We had our admin staff, there were accountants, there were facilities folks, there were material handlers. There were any number of other folks in that facility.

MEMBER KEY: Thank you.

CHAIR MARKOWITZ: So, any further comments from the SEM Working Group?

Okay. Well, if there are no other comments on the Board, we're going to break for lunch, I think a little early.

We'll break now at 12:15 p.m. and we'll resume at 1:15 p.m. So we're altering the agenda slightly. We'll be back at 1:15 p.m., not

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at 1:30 p.m. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:16 p.m. and resumed at 1:24 p.m.)

CHAIR MARKOWITZ: Okay, so the Board members are all present here at the meeting in Idaho Falls and I'm wondering, I see Mr. Catlin. I'm hearing myself twice.

And I see Dr. Mikulski, Dr. Vlahovich and Mr. Vance. And I thought I saw Dr. Friedman-Jimenez for a moment. Okay, well we have a quorum so we're going to get started.

So next on the agenda, we're going to review the Department's response to the recommendation that we made at the last Board meeting.

And also, their response to our information request so we had recommended -- let me read it. It's very brief. "The Board recommends that the Department of Labor provide instructions to Claims Examiners, Industrial Hygienists, Contract Medical Consultant

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reviewers, that if there is evidence that a claimant's employment led to their routine duties being performed widely across a site, this be specifically noted in the claims file and that consideration be given in establishing toxic substances exposure and causation for exposures that are site-wide and not just limited to their work area of record."

And this was turned down by the Department and I guess the largest, part of the response, let me just read their response. "Regarding the current recommendation, Department continues to hold the position that broad-based generalizations are not appropriate in the absence of specific evidentiary support for particular labor categories.

However, we want to reiterate that the Claims Examiners are trained to consider the evidence on file specific to the individual claimant and use that data to link the particular employee to potential exposures.

The Procedure Manual also provides

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clear guidance to Claims Examiners that examination of exposure is a holistic effort that considers information from many sources.

The information assembled by the Claims Examiner in the case file as described above can be considered if needed by subject matter experts like Industrial Hygienists and contract medical consultants.

In summary, the Department will consider any specific information provided by the claimant during the collection of evidence about their work, activities, locations and assigned exposure based on data that reasonably connects an employee to specific toxic substances through a labor category, work process, incident, or other factor."

So just by a little bit of history, this is actually the third time the Board has made some form of this recommendation that essentially a limited number of job titles like firefighter, security guard, health physics technician, and a few others whose jobs routinely

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took them at their particular site many different locations, that their potential exposures be viewed very broadly rather than specific. And three times the Department has disagreed with this recommendation, not accepted it, and so I think we'll leave it at that.

You know, three tries was a good attempt and clearly we're operating from a little bit of a different paradigm from how the SEM is used. So anybody have any comments about that?

Okay, let's move on. We had submitted an information request to the Department and we got a response. I think this is mid-February. I'll just review it quickly.

One of the things we asked for were the number of times in claims that Industrial Hygienists were sent the file for review and actually we heard that this morning, the data from this year.

We heard something like 1,200 IH referrals and of roughly 1,800 relevant claims, mostly Part E claims, so a very high proportion

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and the data we had requested on the same point from 2019 to 2022 showed the same results, basically.

That there were many referrals to the Industrial Hygienist, a very high proportion of claims were going to the Industrial Hygienist. So that was useful to know.

We had asked about malignant mesothelioma, which is a cancer fairly uniquely related to asbestos exposure. And the reason we had asked about that was because there had been back and forth between some recommendations we had made about presumptive criteria for people exposed to asbestos within the complex and partly in development of malignant mesothelioma.

So they did provide the data on that. And the reason why we were interested in part was could we use these data to better understand the job titles who were at risk for asbestos exposure and consequent illness.

And actually, if you could just open up that Excel spreadsheet there, Kevin, that

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would be great. So there were claims for mesothelioma under Part B that were denied, but mesothelioma is not a Part B claim. It's a Part E claim. And there were 40 during the relevant time period, I think it was 2018 to 2022, and 35 which were accepted and five denied.

So that's a very high proportion accepted, that's what we expected. That was good. Personally it would be of interest to know what the job backgrounds were of those 35 or 40 people.

But I don't think it's actually going to answer the question we had, which was in addition to -- there are about 20 or 25 job titles within the Procedure Manual in which it is presumed they had significant exposure to asbestos.

And we were looking at whether there were a few other job titles that should be added. Specifically chemical engineer, mechanical engineer and I think industrial engineer. And we thought well, could we look at the backgrounds of

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people with mesothelioma to bolster support for adding those job titles.

And I think it's extremely unlikely with these numbers of cases of mesothelioma that there's going to be enough data to support that, so personally although it would be interesting, I really don't see the point of requesting the job backgrounds of the people with mesothelioma.

Anybody have any comments on that? Okay. We can go back, Kevin, to the main document. We had requested the new quarterly medical examiner reports. So prior to 2020, the Medical Director of the program on a quarterly basis had reviewed 50 claims to look at the adequacy of the CMC report in those claims.

And we had periodically looked at the results of those analyses. And just to summarize, on the causation claims, finding a problem with the CMC report was rare.

In other words, when the Medical Director looked at the CMC report, something like 20 per quarter for causation analysis, the

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finding a problem with the CMC report error or whatever was very infrequent.

Whereas in the impairment reports that came from the CMC, actually errors were fairly common, to the tune of 15 to 20 percent. Many of those errors were minor, but it was a contrast with the causation analysis of the Medical Director.

So we noticed that there had stopped being reports and so we asked whether they could provide newer reports than 2019 and the answer was that they're working on a new system for this.

And so, just recently we received some documents, but they are still in draft form so we're not able to discuss them in public. But we will, you may recall those, those attachments we got recently and we will not discuss those just to be clear.

And then, Item No. 4 had to do with the SEM and we had requested information about the SEM and how the contractor operated the SEM.

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And you can see we received eight attachments which helped to clarify that and some of which were discussed a little bit this morning.

And then finally, if you keep going, Kevin, this is where we pointed out, so this is to the point that Mr. Vance made this morning.

We pointed out that post-'92 tunneling work should be considered at risk for silica exposure and silicosis and it had been pointed out to us by a public commenter that the program had stopped accepting Part B silicosis claims for exposures that began after '92.

But Mr. Vance has explained to us this morning that that's been corrected. The Procedure Manual has changed with respect to that. Any comments or questions on this information we received? Okay. Yes?

MEMBER SPLETT: The first item where it showed the referral to the IH 92, 94 percent, is that what you would expect for Part E claims?

It seems high, but again, not knowing whether

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there was enough information for a Claims Examiner to make the determination without an IH or a review?

CHAIR MARKOWITZ: Well I was actually focusing more on the absolute number, you know, 3,151 reviews were sent to the contract IH.

MEMBER SPLETT: But that's 95 or 94 percent of the total claims. Does that seem to make sense? I mean, it's just a question. I don't have any knowledge one way or the other whether that's about what you would expect.

CHAIR MARKOWITZ: Yes, I think the 94 percent actually is the percentage of -- the total there is 3,352. Those are the total number of IH reviews.

MEMBER SPLETT: Okay.

CHAIR MARKOWITZ: And of those 94 percent were sent to the contractor IH and the other six percent were done internally, my guess is by the national office. So --

MEMBER SPLETT: So that's what the number of claims, the percentage of claims going

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to an IH, it's just the ones that are external to DOL?

CHAIR MARKOWITZ: Right.

MEMBER SPLETT: Okay, thank you.

CHAIR MARKOWITZ: Right. And that explains why we learned this morning probably roughly two thirds of claims in the first three months of this year have been sent to an IH for review, whereas in the data we were previously given it was consistently over 90 percent, so.

MEMBER SPLETT: Okay, thank you.

CHAIR MARKOWITZ: But we did get the answer to our question which was how many claims were sent to an IH. And it must have been the vast majority of claims were sent or many, many claims.

So, on the schedule we have case review. But I would like actually to discuss something else which pertains to the topic we just discussed somewhat. And Kevin, if you could bring in the draft recommendation.

So let me read this recommendation and

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it's really a starting point for discussion, so subject to change. But that the Board recommends that the EEOICP implement a mechanism to evaluate the validity and accuracy of the opinions and rationale that are expressed in the reports of the contract medical consultants, the CMCs, in the claims evaluation process with particular attention paid to the issue of causation of disease.

This mechanism should have sufficient independence of the current method of developing and obtaining CMC opinions in order to avoid actual or perception of conflict of interest.

So let me explain the background here a little bit. We know from the Medical Director's audits that I just mentioned prior to 2020 what kinds of aspects of the CMC reports were examined, what goes into the quality assessment of the CMC work.

And so these are the issues that are considered. One is, did they send the referral to an appropriate specialty? So if it's a question

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of I guess general occupational disease, did they send it to an occupational medicine physician?

If it's an impairment claim, did they send it to someone who has expertise in doing impairments? If there's a question of cancer, oncology and diagnosis, did they send it to an oncologist who can weigh in expertly on whether that person actually had the cancer that was alleged?

And that's an important criterion, you want the CMC to be an expert in what they're being asked to review, so that was one aspect. Another aspect is the timeliness of the CMC report.

So that's good because you want to turn claims around in a timely fashion. Another aspect that was looked at was whether the report that the CMC gave was well rationalized, meaning did the CMC provide a logical and apparently complete analysis that supports the opinion, the conclusion that they reached?

And so one would look at the CMC

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report for what their decision was and then the logic of how they arrived at their decision.

What else was looked at? Timeliness, well I think the issue of references or citations, did they provide some citations or references that supported their opinion?

Another aspect was did the CMC actually address the questions that the Claims Examiner sent to the physician? So the Claims Examiner prepares the statement of accepted facts, they then assemble some questions and did the CMC actually use those facts and respond to the questions that were directed to that person by the Claims Examiner?

There may be a couple of other aspects. So those are all elements of quality and they're important. But what is I think missing from that assessment of quality is whether the CMC was correct in what they said.

The opinion they expressed, does it really match what we know from the medical literature, from current medical facts and

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thinking about the given occupational disease?

Now I appreciate that there's differences of opinions among physicians, that there are legitimate differences, that different physicians can look at the same set of facts and come up with different conclusions and emphasize different aspects of that.

And that that is acceptable, that in some instances that it's not exactly black and white what a person has or whether it's caused by occupational exposures. And so you need, in a quality assessment, to accommodate that kind of variation and opinion.

But from reviewing cases which we're going to get to and which the Board has done previously, it's also clear that there is a subset of the opinions, the reports produced by CMCs in which frankly, the opinions expressed were just plain wrong. And they just got it wrong.

They didn't understand the disease and they didn't understand causation with respect to

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that given case and they got it wrong.

And my impression is it's by no means the majority, it's a minority. It's I would think probably not a large minority, I think it's probably less than 20 percent, but I don't think it's 1 or 2 percent. I don't think it's a rare phenomenon. And let me explain sort of the background and I'd actually like other people to weigh in on this who are experienced with occupational medicine.

So our field covers a very broad set of activities and areas. And we routinely occupy very different niches of this spectrum. So my background is in internal medicine, occupational medicine, epidemiology.

I know a lot about causation, I know about research and I know virtually nothing about impairment. I know nothing about drug testing. If I had to work for a company within their environment, I would be lost, most of the tasks that would be assigned to me. And that's not a problem because it's not what I chose to do.

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Likewise, I'm in charge of the residency advisory committee at Mount Sinai so I see the new residents come through all the time.

And they pick a niche to go into and sometimes we cross niches over time, but often not. Someone who's going to be heading into consulting or corporate occupational medicine has a whole different set of areas that they're interested in.

Some of them learn about how to do proper physical examinations for truck drivers and the like, drug testing, which I mentioned before, et cetera.

And they're very good at that. And that's acceptable. I mean, that's just the nature of what we do. And so it means that you can send a case to an occupational medicine physician who occupies one niche and ask them about the other niches and although from the outside they look like they ought to have the expertise, they're occupational medicine docs, they don't.

And I think we run across that some in

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this program. I don't really necessarily need to go into the details, but I think particularly those of us who have been on the Board for a while or have reviewed these cases have seen this.

And I think the challenge is how to sort through this and how to identify instances in which the CMC opinion is not well-founded and is incorrect.

And there will be the opportunity for a more correct, accurate opinion, whatever that decision is, a more correct, accurate opinion to be expressed.

And so, what this recommendation is about is for the program to develop a way in which those errors can be detected and corrected. And I think they have that in the industrial hygiene sector.

I think there is that kind of quality review either within the contractor or by the national office which looks at all the IH reports that come back.

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I don't think they have it in medicine and it would need to be developed. So let me stop there for a moment and just open it up to discussion, comments.

Now, you give the impression that I've covered it all. That's not possible. Okay, Dr. Vlahovich?

MEMBER VLAHOVICH: Yes, I agree with you that it's difficult to figure out who to send a case to. And as you said, you could send one to an occupational medicine physician, but they would certainly not all know every different specialty within that.

I've done case reports myself and, you know, usually the Claims Examiners are very good at sending me things that I'm familiar with.

But if they send me say a cardiology case, really that would be up to me to refuse that because that's not within my scope of practice. And I would hope that other Claims Examiners do the same if they get something they're not familiar with, that they would refuse

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to do that one or pass it on.

But I don't know how to monitor that. When we were reviewing cases, I saw in the files that were sent to us the specialty was occupational medicine, but I don't know what niche within that that particular physician was familiar with.

So, yes, I agree with what you were speaking of before.

CHAIR MARKOWITZ: Yes, Dr. Bowman?

MEMBER BOWMAN: In the context of this recommendation we don't specify a mechanism, only that the mechanism should not have or appear to have a conflict of interest.

Are there mechanisms to evaluate medical decisions like this that are approved in the literature in the field? You had given some examples of clear-cut cases where there can be accepted differences of opinion.

And then there's potentially clear cut cases where there's just a mistake, but I guess there is going to be a lot of at the grade, you

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don't even know which of those two it is and is there in the field an accepted practice to determine that?

CHAIR MARKOWITZ: You know, a protocol or some sort of algorithm? I can't think of any. Dr. Bowman, can you?

DR. BOWMAN: No.

CHAIR MARKOWITZ: Dr. Mikulski, Friedman-Jimenez, Vlahovich, can you think of any exercise that we could point to that would help the Department? Dr. Cloeren, while they're thinking.

MEMBER CLOEREN: Well I wonder if the idea of the referee opinion might be leveraged for this purpose. So the referee technically is to resolve the conflicting opinions between usually the treating or more the Former Worker Program and the CMC.

But that's kind of an independent doctor that's used to reviewing these cases so I wonder if that role could be leveraged somehow.

CHAIR MARKOWITZ: Mr. Vance, the

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referee, I know it doesn't occur often, but the referee physician reports, is that done by the same contractor as the CMC reports?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay, yes, okay. Yes, Ms. Splett?

MEMBER SPLETT: Is the intent to just do an audit or is this a continual process checking every opinion that comes in?

CHAIR MARKOWITZ: Yes, I think that's up for discussion. In some respects, an audit would probably suffice, but then if you find a fair percentage, then you might have to consider a broader audit.

This recommendation uses the word validity and accuracy. Are those the right terms? Is there enough specificity in this recommendation that gets across what the intention is? Dr. Cloeren?

MEMBER CLOEREN: I don't know if you're ever going to be able to say this opinion is valid and this one's not, but maybe I think

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what we're talking about maybe is an interrater reliability almost. In which case, you might need two people looking.

CHAIR MARKOWITZ: Yes.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. Yes, you raise some important questions. In New York State the workers' compensation board has an impartial specialist unit.

And I served on that for a number of years and basically they send you cases where the treating physician's opinion differs from the IME, the so-called independent medical evaluator's opinion.

And they're unable to resolve it and the judge asks for an impartial specialist to essentially make the call. And so you have to evaluate all of the provided information, sometimes even see the patient and then come to a decision that then supersedes both decisions of the treating physician and the IME.

Now this is different because it's not

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an evaluation of the opinions of the treating physician or the IME, but it is an independent impartial re-evaluation.

The problem here with the words validity and accuracy are they sort of presume a gold standard as Marianne was alluding to. There's no absolute clear correct answer, you know, and it's a matter of evaluating evidence often that is incomplete, maybe inaccurate, sometimes not available.

And then coming to a conclusion, a forced decision under a lot of uncertainty and so different evaluators are going to come to different conclusions quite frequently.

So I agree that we're really in the space of some sort of interrater or inter-judge reliability or repeatability or agreement rather than accuracy or validity which presume that there is a known correct answer.

So yes, this is not easy. I mean, this is a whole field in itself, the causation analysis, and I think it's something that we

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should discuss and try and improve on.

I think that there are probably some improvements that we can make in the process, but it's not an easy thing and we're not going to come to a completely clear and completely accurate methodology.

CHAIR MARKOWITZ: Yes, my problem with interrater reliability and exercises like that is they apply to populations and they apply to research and perhaps a clinical activity that's structured as such.

And this is about finding CMC reports that are just plain off. You know, so I understand the underlying issues, challenge of a gold standard, but I will discuss one of the cases today in which they're just wrong. Sorry.

And so, I think if you assembled a number of experts in the area that we would all agree on that. So I agree that, you know, the absolute might be hard to achieve, but we can certainly do better than nothing at present. Dr. Cloeren?

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MEMBER CLOEREN: I had a thought about like, sampling. Maybe looking at cases where the Claims Examiner reversed the original decision where the original decision was based on a CMC opinion and then additional information came in and the Claims Examiner decided to accept it.

That might give DOL a pool of cases to review where it could have been that the CMC report was faulty. I mean it could have been additional information or it could have just been another opinion explaining things a different way, if that makes sense.

CHAIR MARKOWITZ: So you're saying cases in which the Claims Examiner received the CMC report and then based on subsequently received information decided differently from what the CMC concluded?

MEMBER CLOEREN: Where there was a denial with the CMC report and it was appealed and then accepted.

CHAIR MARKOWITZ: Based on new information?

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MEMBER CLOEREN: Based on another opinion or whatever.

CHAIR MARKOWITZ: Yes. You know, that's probably a relatively small number of cases and wouldn't really give us the look at the much broader number of TMC reports that are issued so there would probably be some real selection problems there I would think.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez again. Another model that we can think about which is used all the time in clinical medicine in a somewhat different sense is the quality assurance model where charts are reviewed or cases are evaluated looking for very specific sampling, essentially inclusion or lack of inclusion of certain things like is there a smoking history in the note, you know, did they perform the number of physical examination items that they reported they had performed, et cetera.

Similarly, we could do something like that and see whether specific items in the statement of accepted fact are clearly

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documented, accurately documented, whether certain exposures were considered, you know.

So it doesn't actually measure the accuracy or the validity of the conclusion, but it does evaluate whether the process was performed in a way that is likely to support an accurate evaluation. And it's more doable. I mean, it's more feasible.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: With the stated goal being to identify cases in which there was just a clear error in judgment by the CMC, I was thinking in the context of this recommendation and then whatever mechanism is used or method is used to assess this we probably need to advise on, basically in essence, a statistical power analysis.

To what degree is this? I mean, are we trying to find a one in 10,000 cases that has this? There must be some level that we want to ensure that there's, it's not more than I'll say, not more than 1 percent or maybe not more than .1

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percent that have this error.

And so there is, you know, statistical approaches we can do to assign how many cases need to be randomly selected to ensure that such errors don't occur at more than 1 percent.

And perhaps we should provide guidance in the recommendation as to what degree of confidence we're looking for that these things aren't happening.

If it is one case every ten years that we're looking for -- I don't think it is, that's an exaggeration -- that would be near impossible.

We should think about what is doable in the context of this request because clearly we're not to rule out that it's happening every other time. We would know that by now, right?

I think we're trying to establish a confidence that it's not happening at a level that we currently don't know. And so in that sense, maybe we should provide guidance as to, you know, we want this to be looked at so we can have confidence that this isn't happening at less

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than this percentage of cases.

CHAIR MARKOWITZ: Well, yes, Dr. Van Dyke?

MEMBER VAN DYKE: So I mean the way it's written, this is a huge task. And really, thinking about this, I mean do you want to kind of pare it down a bit and think about cases that were denied?

Because I think you might be able to, you know, get the denial letters and see the reasons that they were denied and base your sampling on that.

Because I think really what we're after is, you know, the most important thing is we want to avoid inappropriate denials. So thinking about the positive makes it a bigger task than thinking about the negative.

CHAIR MARKOWITZ: Steve Markowitz, then you're saying that we could simply add we would recommend that you apply this exercise only to denied cases?

MEMBER MIKULSKI: Another idea, and

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this is Marek, might be to begin with the decisions that have been marked as not well rationalized. In other words, the CE assessing the CMC's opinion as not well rounded.

We know of several metrics that have been used in that process and maybe those could be used in an assessment of the accuracy of those opinions.

CHAIR MARKOWITZ: So, Mr. Vance, question of fact here. When a CMC opinion is identified as not well rationalized, what happens next?

MR. VANCE: Well, the role of the Claims Examiner is to make sure that whatever medical opinion is presented is well rationalized.

The question would be how well do all of our staff comply with that. But if it is determined that the CMC has not provided a well-rationalized opinion, either they're reporting inaccurate information, they're not using the data that's been provided to them and

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characterizing it differently than let's say what the Industrial Hygienist is saying or some other defect, and I've seen this in some CMC opinions where I don't understand how it works.

Then that opinion can't be accepted and we've got to go back to the contractor and rectify whatever the deficit is in asking for clarification from that doctor.

If we feel that the doctor is unable to provide information that overcomes whatever that defect is, we're going to find another physician to render a separate opinion and that can certainly happen.

So that's the process by which we would look at it. It's really a discretionary evaluation of the opinion of the doctor to make sure that it conforms with what our expectations are for a well-rationalized opinion.

CHAIR MARKOWITZ: So, Dr. Mikulski, so those cases are already flagged, they're already identified as being erroneous. And it's the other CMC reports, the ones that don't appear erroneous

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because they appear to be well rationalized that are clearly the vast majority and I think are the challenge.

Getting back to your point, Dr. Van Dyke, if we added a sentence that said that we recommend that this process be applied only to denied claims, does that satisfy your question?

MEMBER VAN DYKE: Well, I mean I'd love to see it for both denied claims and claims that are approved. But I just think the task is too big when we start thinking about it that way.

So trying to help DOL I think denied claims would be the first target.

CHAIR MARKOWITZ: Yes, Steve Markowitz, I agree. And it's in line with I think the thrust of the philosophy of the program that they don't want to inappropriately deny claims.

So can we add then on the fourth line just before it says this mechanism? And this process should be applied only to denied claims. Dr. Cloeren?

MEMBER CLOEREN: So what if this is

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done and it's done well and it shows there's no big problem? Like at what level or benchmark would we say that's okay?

So it wouldn't necessarily need to go on, like this could start as a spot check rather than an ongoing process if it turns out that it's a very low percentage, right?

CHAIR MARKOWITZ: The program has ongoing quality assessment in multiple aspects. It's not a one off or if I understand it correctly, a temporary kind of check.

It's we want a good program and that remains good and so that quality assessment is not time limited. Isn't that right, Mr. Vance?

MR. VANCE: Yes, that is correct. I mean, as far as quality assurance is concerned, we do have multiple tiers of review, we do have instances where we worked with CMCs in the past to promote improvements in the written quality of the reports and highlighting issues that we've seen with regard to either the application of causation analysis or impairment ratings.

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So we have those mechanisms in place to work with our contractor and, you know, the oversight of that contract falls within the policy branch so I'm well aware of what we've been communicating to our contractor with regard to certain aspects of the work that they do.

So that would be what you're talking about is that the Board would be looking at the same kind of thing that the Department is looking at but maybe with a focus on a different aspect necessarily than what we do because we're not looking at correct or incorrect.

We're looking at how well rationalized and supporting of the contract expectations, you know, how well is the CMC conforming to contract expectations?

We would be looking at that well-rationalized component, but we're not going to specifically look at do we think the doctor was right or not?

Does the doctor's opinion seem well rationalized in the sense that they explain it

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well enough that it offers a compelling justification for an approval or denial?

And you've discussed how big of a challenge that would be and I agree that that would be a challenge to look at a doctor and say, oh, he's wrong or she's wrong and this is why.

Because the doctor is providing an opinion of an interpretation, so just something for the Board to consider.

CHAIR MARKOWITZ: This is Steve Markowitz. I want to return to a point that Dr. Bowman raised about whether we should advise on how to do this or for instance, how many cases they should look at in a given period.

And I think at this point I don't think it would be helpful to do that. I think if they accepted this recommendation in some version and wanted assistance in the design of that, I think, you know, we could do that.

Part of the reason I say that is we'd have to agree on what an acceptable error rate is. And that would take us a long time to agree

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on that. And I'm not sure we would come to agreement on that.

What do we accept, a 1 percent, a 3 percent? Because that's going to determine what the sample size is, how many claims you have to look at, so that's part of the reason why I don't think we should go into that detail. If they accept this and they ask us, then we can have that discussion if that makes sense.

MEMBER BOWMAN: It does. I was thinking more of like, there could be difference of opinions on how low would be acceptable. But there would probably be consensus that it shouldn't be any higher than this.

You know, some are going to say a .1 percent, .5 percent, 1 percent, at some point there will be a number where we're all lower than that.

So for example, in the case of the 25 cases we're reviewing, if there was one in which there was an egregious error, that's 4 percent.

And we're having this conversation

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because we found potentially one out of 25 so clearly 4 percent error is not acceptable to the entire Board.

And so I was thinking of some minimal -- you're right, some of us might say 1 percent is enough, but if they do the analysis and they say we know for sure it's not 10 percent or higher, that would not be satisfactory I think.

CHAIR MARKOWITZ: Right. One thought I had about this is, and this goes to the issue of conflict of interest, is whether this function should be integrated in -- and again this actually is the kind of question that the Department would address and it's their business to address, but would you integrate this set quality assessment into the current contractor who hires the CMCs? Or would it or should it be done by a separate party?

Again, this gets into how the government operates and so I sort of hesitate to even explore this, but the reason I raise it is because of conflict of interest.

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And the question is, I'm a little uncomfortable with the idea that this might be taken on by the same contractor who produces the CMC reports because I don't know how you avoid the perception at least of conflict of interest.

And I'd feel more comfortable if the Department hired a couple of consultant physicians who were experts in causation or impairment, whatever the issue is, and independent of the contractor, and had them review those and make these determinations so that the expertise was brought in house, in a sense, similar to the national office has industrial hygiene expertise.

To me that distance from the people, the entity that produces the CMC reports, it would be more comfortable in terms of conflict of interest or perception.

I'm wondering how other people view that. Dr. Bowman?

MEMBER BOWMAN: I would agree with that assessment in terms of as well as building

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public confidence in that assessment as well.

CHAIR MARKOWITZ: Yes.

MEMBER BOWMAN: I think it contributes to both of those.

CHAIR MARKOWITZ: Board members who are on Webex, any comments here?

MEMBER FRIEDMAN-JIMENEZ: Yes, this is George Friedman-Jimenez. I have two comments. I think that self-evaluation is something that we do all the time in quality assurance.

And, you know, if there's a well-defined methodology, the optics can be okay about it, but I agree with you that there is some discomfort about the perception of conflict of interest.

Similarly, I'm a little concerned about applying this only to denied claims. And I would form this as a question to the Department of Labor leadership. What do you think?

You think that there is going to be any pushback or any perception that we're one-sided here? That we're ignoring any errors that

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would tend to overcompensate and only looking for errors that would tend to undercompensate?

I know there's the mandate to be claimant-friendly, but it would seem to me that we could do, you know, a different percentage of cases of denied and accepted claims, and then produce some information that would probably confirm that most of the accepted claims are on pretty solid reasoning and that the problem is more toward the denied claims.

But that remains to be seen and what do you think? Is there any problem with perception here if we only limit this to denied claims?

MR. VANCE: This is John. Yes, let me just give you a word of advice from many years of working in the United States government. And this is just for consideration here.

The thing that I would say, this is just my own personal view and it's something to promote discussion. You have to be very careful with what you wish for.

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If you ask the question, you may not get an answer you're going to like. So in other words, if you do have individuals that are looking at this process, be aware that they could come back with recommendations or viewpoints that may not align with what you wanted or expected.

So in other words, let's say you have physicians that are being tasked to look at this either denied or accepted cases that are very conservative in their viewpoint about how this process would work, and maybe are saying that this program's way too flexible in how they are processing these cases.

So you just have to be very careful with these kinds of notions of having external auditors or what have you because they may bring in their own perspectives that may not particularly mesh with what you are hoping to achieve.

So, just something to be thinking about. I would say, Dr. Friedman-Jimenez, whatever the Board would recommend would be taken

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very seriously by the Department of Labor and we would put some real deliberation into what would be recommended as far as what the population to look at here.

Are we talking about denied cases or accepted cases or a combination of both? I think that would just play out in the dialogue that the Department of Labor would have with the Board.

So I would certainly encourage more dialogue among the Board members about this, but I think that this is something that we would just whatever the Board would recommend, we would deliberate on it and provide some feedback to that recommendation if this would be something the Board would proceed with.

CHAIR MARKOWITZ: Thank you. Steve Markowitz. One problem with doing accepted claims is they're accepted. The Claimant has been told that their claim is accepted and then a month or two or six months later they learn, no, actually we made a mistake.

Your claim is not accepted. That

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strikes me as being very awkward and probably not going to be tolerated to the reversal of an accepted claim so the error of over-accepting is a different kind of error than denying inappropriately .

MEMBER FRIEDMAN-JIMENEZ: We could do this without identifying the individual case. You know, this is essentially a quality assurance exercise.

So I don't think that we would be obligated to reverse the decision in an individual case. But we could at least say, you know, out of a hundred claims that were accepted we found problems with three of them.

Whereas out of 300 cases that were denied, we found problems with 40 of them. So, you know, we could get a sense of where the errors are and that might be perceived by Congress or by other outside observers as being more balanced.

I don't know if this is a problem that we need to address or if this is not likely to be

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a problem. That's what I was asking.

CHAIR MARKOWITZ: Steve Markowitz, one last comment and then the others who want to speak here. If you had the resources to do additional claims, wouldn't you want to do additional denied claims rather than do accepted claims so that you get that much better a handle on the problems of wrongly decided, you know, CMC reports?

Dr. Van Dyke, I think your card was up next.

MEMBER VAN DYKE: So I think that, you know, the issue of doing denied claims, you know, to do those anonymously and we identify claims that should have been awarded and they weren't, that can't be anonymous.

There has to be some action that comes from that identification, because if there isn't, it's just not a good exercise to go through.

CHAIR MARKOWITZ: I'm sorry, Steve Markowitz, are you saying is or could there be a mechanism in place to use the revised CMC opinion

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or the new CMC opinion to change the decision in the claim?

MEMBER VAN DYKE: If we find a claim that is denied in error --

CHAIR MARKOWITZ: Right. What happens?

MEMBER VAN DYKE: Yes, what happens?

CHAIR MARKOWITZ: Mr. Vance --

MEMBER VAN DYKE: Something needs to.

CHAIR MARKOWITZ: Mr. Vance, what would happen?

MR. VANCE: It would be re-opened. If we had reason to believe that there an erroneous denial, the Director would, under her authority, vacate that denial and we would likely send that case back for further development.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: As we have done in the past from instances where the Board has identified issues with cases where we needed to go back and revisit the case, we've taken action to go back and re-evaluate cases based on input from the Board.

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CHAIR MARKOWITZ: Okay, additional comments? Dr. Bowman?

MEMBER BOWMAN: Yes, two. One is, is there any chance that this process could occur rapidly such that it could be done before a decision is made that avoids this whole are we looking at accepted or denied?

CHAIR MARKOWITZ: Well, Steve Markowitz. Now you're talking, you know, timeliness. That's extremely important to the program. Mr. Vance, is there an answer to that question or, besides timeliness is important?

MR. VANCE: So it would be exceptionally difficult because you would be inserting yourself into the temporal development of individual cases. You're not going to have all of these available at the same time.

So you're talking about a moving target as cases are going through adjudication steps, you know, and that dynamic changes over time. Am I going to say it's impossible, no. Am I going to say it's possible, yes.

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I think it just would be very difficult with the time allocation available to the Board, but again, I always defer to you can always ask and you will get an answer. So that would be the answer to that question.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: And this, sorry, and the second point given the discussion we had about the perception of fairness maybe is the right word in terms of if we're stating to only do denied claims.

My understanding is the recommendation to add this for denied claims was a matter of feasibility to put the attention to something that was feasible.

So we currently have the statement on the recommendation that this should be applied only to denied claims, but if it's for the purpose only of feasibility and it's not an unacceptable thing that if some accepted ones were analyzed, perhaps this should just say this process may be applied only to nine cases,

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basically to give the Department the opportunity to restrict it if they wanted to, but if they needed to expand it, they could.

CHAIR MARKOWITZ: How about this? This process may be most usefully applied.

MEMBER BOWMAN: I like it.

CHAIR MARKOWITZ: That's why I'm up here.

MEMBER BOWMAN: Yes.

CHAIR MARKOWITZ: I'm sorry, Dr. Vlahovich, before you go, Kevin, could you just, the third line from the bottom where it says process. Then write may most usefully be applied.

And then you can take out the should be applied. Okay. Thanks. Dr. Vlahovich?

MEMBER VLAHOVICH: Sure. Kevin Vlahovich. Just considering what do we want the goal of this to be? Do we want to identify individual claims to re-evaluate or are we trying to take a broad view and just identify a potential problem that would then need further evaluation to determine what it is?

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Or to find particular CMCs who are not doing a good job and need remediation? I mean, what is the overall goal of having this review?

CHAIR MARKOWITZ: I can take a stab at answering that question unless somebody else wants to. So I think it's literally to identify incorrect CMC reports, and also secondarily to understand the magnitude of the problem.

Because if it's, if you know, in a given quarter you do 10 percent of all reports, and then you find that 20 percent of them were problematic, I think it's unlikely, but then you'd say well we've got a systematic problem here we have to address.

So I think it's both to identify problematic reports, but also to understand the magnitude. And then, you know, I think there would be some ramifications that flow from that in terms of identifying certain CMCs who may not be optimal for the program.

But that's, you know, sort of beyond certainly our recommendation at the moment. Does

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that answer the question?

MEMBER VLAHOVICH: Yes. Thank you.

CHAIR MARKOWITZ: Anybody else?

MEMBER FRIEDMAN-JIMENEZ: Yes, this is George Friedman-Jimenez.

CHAIR MARKOWITZ: Yes, go ahead, George.

MEMBER FRIEDMAN-JIMENEZ: I see the awkwardness of a disagreement between the evaluation that we would do and the evaluation that the CMC did.

And I also see that, I believe it's probably more common that claims are denied erroneously than that are accepted. One way to get around that would be to do this prospectively.

In other words, to do the evaluation of the evaluation before or at the same time that the CMC is doing it and compare them before the final decision is made.

And if they agree, obviously we would go with the agreed decision. If they disagreed,

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then it could be, you know, sorted out before the decision is made formally and avoid the awkward situation.

And it would still give us the information that we're looking for of whether there is a problem in the process of the causal analysis. So that's another option that we could do is to do it simultaneously or prospectively.

Obviously it would have to be done timely because these are people that are waiting for their compensation decision.

CHAIR MARKOWITZ: Steve Markowitz. Yes, I think that addresses the design of this kind of evaluation if it's undertaken. And it certainly would be an option you know, with logistic tradeoffs for the program which I'm sure the program would have, you know, feelings about.

So I don't think we should get to that level of detail in this recommendation, but should it be accepted and our advice asked about the design then we could certainly, you know, float that as an option.

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I would like to get back to the issue of accepted claims and so we have two choices here. One is we can leave out the accepted claim as a friendly amendment to this recommendation.

Or we can try to incorporate it in a way that the majority of the Board members would vote for. And so, for instance, one could say this process may most usefully be applied to denied claims so the Department may wish to apply it to a limited number of accepted claims, which at least puts the issue on the table.

Or, some variation of that or we could just leave out the accepted claims. So I don't really get a sense of how the Board members come down on this, which option would be approved. So think about it for a moment.

We could put in some language around accepted claim. Just vote on that as a yes/no, as a friendly amendment to this recommendation we're looking at and if it's voted up then we include it. If it's voted down then we exclude it. And then we'll revote on the core recommendation with

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or without the accepted phrase. Does that make sense? Okay, we're hitting that post-lunch period.

MEMBER FRIEDMAN-JIMENEZ: Question --

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER CLOEREN: I think --

MEMBER FRIEDMAN-JIMENEZ: Do we have any evidence from the past case evaluations that we've done, the case reviews of accepted claims being erroneous?

I don't remember any. Do you remember any that were accepted, but that we thought shouldn't have been accepted?

CHAIR MARKOWITZ: Yes.

MEMBER FRIEDMAN-JIMENEZ: I don't remember any cases like that.

CHAIR MARKOWITZ: Steve Markowitz. I don't. My reaction would have been like wow, that's generous. I don't remember having that reaction to any claim, any CMC report.

MEMBER FRIEDMAN-JIMENEZ: So we do have some evidence that supports this applying it

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only to denied claims. I mean, it's not systematic, it's not officially tabulated.

But unless anyone can remember even one case where we thought that it should not have been accepted and it was, then we have some evidence there because we probably reviewed what, about a hundred cases so far?

CHAIR MARKOWITZ: A sizeable number I would think since 2017.

MEMBER FRIEDMAN-JIMENEZ: And it's informal, but it is evidence.

CHAIR MARKOWITZ: Yes. Dr. Cloeren?

MEMBER CLOEREN: I think a potential solution could be, and I guess it's maybe getting into the design again, but for accepted cases, if it makes sense to sample some of them, to do those in a de-identified way so that there's not an opportunity really and certainly not an obligation to reverse an accepted decision. It would be handling it differently than the denied claims, but I think that the onus on, you know, what to do about an erroneously denied claim is

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different.

CHAIR MARKOWITZ: Well, Steve Markowitz. I mean, to me that gets into how the program actually operates which is probably more detail than we need to address or maybe should address at this point.

Because the Program's going to make their own decision about that, you know. Other comments?

MEMBER FRIEDMAN-JIMENEZ: Just one quick one. My feeling is that we have identified several workable mechanisms. We believe that this is feasible and can be done and I agree with you that we don't have to specify which of those mechanisms the Department should choose.

I think there are multiple mechanisms that this could be done and I feel satisfied that it's a feasible recommendation.

CHAIR MARKOWITZ: So let me ask you, Dr. Friedman-Jimenez, because you're the original proponent of considering accepted claims, do you still support including accepted claims in the

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evaluation?

MEMBER FRIEDMAN-JIMENEZ: I actually would prefer to do it prospectively to avoid the really, I agree, awkward situation where someone has already been compensated and then you decide that it's not correct.

So we could do a small percent prospectively and the rest retrospectively, the retrospective only being denied claims. That sidesteps the whole issue of the awkward reversal.

And if they want to re-open a denied claim, I think that's fine. But you definitely don't want to re-open an accepted claim.

CHAIR MARKOWITZ: So let me propose, then, that we add some language here that addresses the accepted claim issue. And so in the sentence that we just added or revised, this process may most usefully be applied, I would take out the word "only" to denied claims, but may also be applied to accepted claims, if the Department desires. Okay, capital D.

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Dr. Bowman?

MEMBER BOWMAN: Just to go with what Dr. Friedman-Jimenez was saying, might it instead it be: but may also be applied prospectively in the small number of cases? Just to avoid this issue of re-opening accepted claims.

CHAIR MARKOWITZ: So I --

MEMBER FRIEDMAN-JIMENEZ: I think that's --

CHAIR MARKOWITZ: What's that, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes, I agree. I think that would be a better way to phrase it. It doesn't even open the issue of evaluating accepted claims.

CHAIR MARKOWITZ: Okay. So you're saying that after --

MEMBER FRIEDMAN-JIMENEZ: May also be applied prospectively.

MEMBER BOWMAN: To a fraction of -- how to say it correctly? We can just say it may also be applied prospectively.

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CHAIR MARKOWITZ: To a certain number of claims.

MEMBER BOWMAN: Yes, right.

CHAIR MARKOWITZ: Okay. Yeah, to a certain number of claims.

MEMBER BOWMAN: Not that the entire analysis would be done prospectively, but a fraction.

CHAIR MARKOWITZ: And then you can take out the "accepted claims, if the Department desires."

MEMBER FRIEDMAN-JIMENEZ: Claims under current evaluation, maybe.

MEMBER BOWMAN: I guess the word "prospectively" would mean that. Right?

MEMBER FRIEDMAN-JIMENEZ: Yeah.

CHAIR MARKOWITZ: There is -- you know, we are going to have a rationale that goes along with this, so we'll have an opportunity to explain what we mean. So you can take out "if the Department desires."

Okay, any other friendly or unfriendly

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amendments to this language?

MEMBER FRIEDMAN-JIMENEZ: A certain number of claims -- it's asking for some more words here. Currently --

CHAIR MARKOWITZ: It's asking whom?

MEMBER FRIEDMAN-JIMENEZ: It feels incomplete. A certain number of -- because that could be accepted claims, that could be denied claims, it could be unevaluated claims. Prospectively should be claims that are being evaluated or currently being evaluated.

CHAIR MARKOWITZ: I see, right. Under evaluation.

MEMBER FRIEDMAN-JIMENEZ: Under evaluation, yeah.

CHAIR MARKOWITZ: Yeah, okay.

MEMBER BOWMAN: Instead of a certain number, should we just say some? That's a question not a --

CHAIR MARKOWITZ: How about a number?

MEMBER FRIEDMAN-JIMENEZ: A small sample.

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CHAIR MARKOWITZ: What's that? Some?

MEMBER CLOEREN: Why say it in one word when you can say it in four?

(Laughter.)

CHAIR MARKOWITZ: Exactly. How about just "to a number of claims" in there?

MEMBER BOWMAN: Sure.

CHAIR MARKOWITZ: Yeah, to a number of claims. Leave it open-ended.

Okay. This is the recommendation. Is there a second? We're going to have -- there's more of a chance for discussion. Don't worry. Mr. Key, I know you're dying to weigh in here.

Is there a second?

MEMBER BOWMAN: Second.

CHAIR MARKOWITZ: Okay. Any final discussion?

Okay, I'm going to read the recommendation. The Advisory Board on Toxic Substances and Worker Health recommends that EEOICP implement a mechanism to evaluate the validity and accuracy of the opinions and

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rationales -- rationales; it should be plural -- that are expressed in the reports of the Contract Medical Consultants in the claims evaluation process, with particular attention paid to the issue of causation of disease. This process may most usefully be applied to denied claims, but may also be applied prospectively to a number of claims under evaluation. This mechanism should have sufficient independence of the current method of developing and obtaining CMC opinions in order to avoid actual or perception of conflict of interest.

So it's time for a vote.

MR. JANSEN: All right, I'll record the vote. Dr. Bowman?

MEMBER BOWMAN: Yes.

MR. JANSEN: Mr. Catlin?

MEMBER CATLIN: Yes.

MR. JANSEN: Dr. Cloeren?

MEMBER CLOEREN: Yes.

MR. JANSEN: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

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MR. JANSEN: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. JANSEN: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. JANSEN: Dr. Van Dyke?

MEMBER VAN DYKE: Yes.

MR. JANSEN: Dr. Vlahovich?

MEMBER VLAHOVICH: Yes.

MR. JANSEN: Mr. Key?

MEMBER KEY: Yes.

MR. JANSEN: Ms. Splett?

MEMBER SPLETT: Yes.

MR. JANSEN: Ms. Whitten?

MEMBER WHITTEN: Yes.

MR. JANSEN: All 11 Board members
voted yes.

CHAIR MARKOWITZ: Okay. Yes?

MEMBER KEY: Dr. Markowitz, could we
have a printout before the end of the meeting of
the recommendation?

CHAIR MARKOWITZ: Yes. Okay, we have
20-odd minutes before break, and so we're going

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to start on our case review. So, two members of the Board have been asked, on each of the cases that we've looked at, to review the case and discuss the case. It's all with personally identified information obscured so no details will be provided whereby any claimant could be identified.

These cases were given to us, by way of background, in 2022, we asked for only certain types of cases. I think mostly denied cases, denied claims. But there were some cancer cases, some beryllium, some chronic lung disease, some Parkinson's disease cases. And then at that time we were also interested in impairment, and we asked for some of those cases. We're not going to discuss impairment cases today. We're going to discuss the other cases.

And any other background that people need to know that I haven't mentioned?

Okay. So, why don't we start with a beryllium case that Dr. Van Dyke and Dr. Cloeren were assigned, last four digits 2157?

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MEMBER CLOEREN: So, my challenge is I did them a week ago and I submitted the form and didn't keep copies.

CHAIR MARKOWITZ: Okay.

MEMBER VAN DYKE: I did not. I have my notes from the --

MEMBER CLOEREN: Okay.

CHAIR MARKOWITZ: Okay, so --

MEMBER CLOEREN: You take the lead and I'll chime in if --

MEMBER VAN DYKE: How about that? All right, so as Dr. Markowitz said, this is a beryllium case. This is a case that had a final decision in 2019. And, you know, just for reference, the claim was filed six months earlier. So about a six-month time from initial claim to final decision.

This was an individual who indicated they worked at a beryllium vendor, more than 30 years at that beryllium vendor. They filed the claim in 2018 after receiving two abnormal Beryllium Lymphocyte Proliferation Tests. They

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also had letters to support their diagnosis from the beryllium -- I'm trying to make sure I don't say names here -- the beryllium vendor medical director.

And then, you know, I think the most interesting thing about this case is this person had a BeLPT that was positive in 2018; however, in the early 1990s, this person had been sent to a physician and had been evaluated for beryllium disease. At that time, he was evaluated, CT scan as well as biopsy, both consistent with beryllium disease, but he had a negative Beryllium Lymphocyte Proliferation Test, which really meant that, you know, they called the diagnosis sarcoidosis rather than beryllium disease.

So this person, truthfully, met the pre-1993 criteria a long time ago in terms of having three of those potential issues related to beryllium, but it was not officially compensated until 2019 after the positive Beryllium Lymphocyte Proliferation Test.

So, I mean, I think that's the

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interesting piece about this. You know, in terms of kind of how it was handled and how it went through the process, really a straightforward case, in that you worked at a beryllium vendor and, you know, beryllium exposure was pretty well-established by a letter from the vendor.

There was no IH report. The Statement of Accepted Facts was correct, and it provided correct information to the CMC. And, you know, the CMC drew the correct conclusions, including a diagnosis date so they backdated the date of onset of CBD to 1990, rather than calling it in 2018.

Do you want to add to that? Is that enough detail?

MEMBER CLOEREN: That was great. I agreed. I thought it was well-handled, and actually kind of appreciated the vendor medical director kind of advocating also for the right decision.

CHAIR MARKOWITZ: 1990 medical record, but because they had a negative beryllium blood

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test -- because the claim was after 1992, when you needed a positive blood test, didn't have that positive blood test back then, it could only be accepted more recently when they developed the positive blood test.

MEMBER VAN DYKE: You know, I think you would have met criteria in 1990 because he would have been diagnosed under the pre-1993 criteria. But he didn't file until 2018.

CHAIR MARKOWITZ: Right, yeah.

MEMBER VAN DYKE: When he was leaving employment at his current place.

CHAIR MARKOWITZ: Interesting. Okay, thank you.

There's a chronic lung disease case that Mr. Key and Dr. Friedman-Jimenez signed up for, 2282.

MEMBER FRIEDMAN-JIMENEZ: I have not reviewed that case yet. Can we do it tomorrow or later?

CHAIR MARKOWITZ: Yeah, we'll have time tomorrow, I'm pretty sure.

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MEMBER FRIEDMAN-JIMENEZ: Okay, yeah, I've only gotten to one out of the three.

CHAIR MARKOWITZ: That's fine. I mean, if we run -- I mean, I reviewed the case so if we run short, I can fill in. But let's postpone it and do a different case.

How about a chronic lung disease by Ms. Splett and Dr. Vlahovich, 2347?

MEMBER SPLETT: Kevin, do you want to start?

MEMBER VLAHOVICH: Sure. I can go ahead and start. So this was a gentleman who worked as a Navy, at Naval Reactors Facility from 1985 to 2002, and then at INL from 2003 to 2019. He had submitted a claim for COPD, or chronic lung disease/COPD. The claim was eventually denied for emphysema, as well. So it was -- sorry, I'm reading off my notes.

I believe it was denied for emphysema, even though that was one of the -- or the diagnoses that he had submitted a claim for because there was documentation lacking from the

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medical record of that specific diagnosis.

Do you want to add anything?

MEMBER SPLETT: Yeah, I was a little -
- this is one of the claims I was concerned about
in that he was an RPT and they went to the SEM.

CHAIR MARKOWITZ: RPT, what's that?

MEMBER SPLETT: Radiation Protection
Monitor. They went to the INEL SEM and took those
eight toxins, but he worked at a specific
building for which there is a SEM, but his job
category was not listed. But his almost 16 years
was in that facility, and that facility had like
a 128 toxins and those were not considered for
his claim.

And, I don't know, I guess for Mr.
Vance, I don't know if we can ask you those
questions, whether is that normal if you get
someone, an HPT or an RPT, that we know is at a
facility that would have that function, but it's
not in the SEM, would it be more appropriate for
him to be considered under that portion of the
SEM versus INL overall, which only has eight

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toxins?

MR. VANCE: Yeah, it's really difficult for me to be able to comment specifically to the case. I mean, they're generally going to apply their analysis to the employment, the labor, or the location to the employee worked, or a combination of those, in trying to profile out and prioritize which toxins had the greatest eventual effect in the case.

Really hard for me to know without looking at the specifics, but that's how they would approach it. They would look at what information do they have that ties this employee to a job or a location or a combination of those, and then try to filter through which toxins are the ones that are most likely to be tied to whatever disease was being claimed. It sounds like it's a respiratory disorder.

So they're trying to make these filtered connections to what they need the physician to look at after it goes through that IH assessment.

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So, I don't know whether I'm answering your question, but that's how they would approach it.

MEMBER SPLETT: But, again, INL overall had eight toxins. They sent seven. He indicated a number of other toxins and the building he specifically worked at had 128 toxins, but it did not have him as a job category. They only had two categories in that building and, logically, you know, there were more.

So that was my problem, and other than that, Kevin was absolutely right. Emphysema was mentioned multiple times, but there was no documentation in the medical record anywhere, other than, you know, sort of casually, yeah, I think he has emphysema, too. But no further testing. But his lung disease was also denied.

CHAIR MARKOWITZ: Is this case an instance of someone who had one of these site-wide job titles, health physicist tech, in which --

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MEMBER SPLETT: Yes.

CHAIR MARKOWITZ: -- it's uncertain, actually, both what they might have been exposure to and the extent of exposure?

MEMBER SPLETT: He was in that one facility for 15.9 years, doing that job in that facility.

CHAIR MARKOWITZ: Right.

MEMBER SPLETT: And that's all documented. But the SEM does not have that job category, so they considered him under the INL RPT that just had eight toxins.

So, other than that, it was well-developed and what not, but I just felt that was probably a miss.

CHAIR MARKOWITZ: Steve Markowitz. You know, this is a case, like other of the site-wide job titles, that in my view might benefit from an interview by the Industrial Hygienist of the claimant to really get a better sense of what they were exposed to and the extent -- really, the extent of their exposure, because it's

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unclear from the job title.

I mean, even given what you're saying about being in one building, it's still unclear, and there's only so much detail you get from the Occupational Health Questionnaire or from the EE-3. But an interview, a direct interview, with the claimant would provide that detail. It doesn't dictate how the case is going to go, how the claim is going to go, but at least you're confident that you've got the detail about exposure in order to make a decision.

Anything else on this case? Okay.

I know, Mr. Key, you and I had a case of cancer, 0014. And while you're welcome to go first, I'm betting you may defer to me. But it's up to you.

MEMBER KEY: Yes, I'll defer for you to start and I'll --

CHAIR MARKOWITZ: Okay. This is a 60-plus-year-old person. Thyroid cancer and lung cancer, Paducah, and the person was an administrative assistant, an executive

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administrative assistant, for five years at Paducah. And said that she toured the plant, she used to give tours of the plant to visitors, and she also handled contaminated records. That was, I think, from her Occupational Health Questionnaire.

It's a denied case. The industrial hygiene report concluded that she had the potential for exposure to asbestos, but no evidence that exceeded regulatory standards, that language from a couple of years ago. So it was denied because, basically, there was no evidence that she had exposure to -- significant exposure to any agents that produced thyroid cancer or a lung cancer.

I agree with that decision. I think it's unlikely that she would have had enough exposure to cause a lung cancer or a thyroid cancer. I would have felt somewhat more comfortable if someone had probed a little bit, somewhere in the process, probed a little bit about her perceptions about her exposure giving

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tours of the plant. Personally, I'd like to know how often they occurred. When you say contaminated records, what's that mean? Again, how often it occurred.

So I'd like more information about the exposure, but, ultimately, I doubt that the decision would have been different, even with that information. As a matter of process, though, I would have felt more comfortable with more detail.

Mr. Key?

MEMBER KEY: Yeah, what was surprising to me in the review of this case was the fact that the Contracted Medical Consultant in his review of the case used the infamous wording that it is as likely as not that her exposure did cause her lung cancer. And I'm surmising that the CE disregarded the Contract Medical Consultant's opinion and denied the case, which I do not agree with.

As far as the exposure that she may or may not have contracted as her responsibilities

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of reviewing contaminated records stored in a CONEX storage container, clearly evidence historically has pointed to the fact that personnel monitoring of individuals in areas of toxic substances did not occur on a regular basis, and do not occur still today.

CHAIR MARKOWITZ: So, you and I have different memories about what the CMC said, so tonight I'm going to check to see. Because you remember the CMC accepting the case; I remember them not accepting the case. So that factual point we'll clarify.

Personally, I would like to see the Industrial Hygienist list what they reviewed on the exposure side. I want to see them write that they affirmatively reviewed the EE-3 document, the OHQ, which I think they do, but to, me it, should be in the reference list.

They have a stereotypic reference list. It's usually the same six references we see every time. I'm not sure what the value of some of those references really is, but, regardless,

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at least we should have the comfort that we know they said they reviewed pertinent exposure documents and included that in their evaluation.

Okay, anything else? No? We're good.

MEMBER KEY: No, sir.

CHAIR MARKOWITZ: Okay. There's a case by Mr. Catlin and Dr. Mikulski, a cancer case, 7539.

MEMBER MIKULSKI: Yes, and Mark, are you okay if I start and then you'll eventually pitch in?

MEMBER CATLIN: Oh, sure. It's an interesting, complex case.

MEMBER MIKULSKI: So this is a two-part claim for a 70-year-old Savannah River Site employee who claimed breast cancer and salivary gland cancer. That employee worked at the Savannah River Site for a total of almost 13 years in jobs in the custodial department, as well a painter and photographer.

The initial breast cancer claim was filed in 2020 under both Parts B and E. The claim

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was denied based on probability of causation lower than 50 percent which sparked the denial of a Part E claim, as well.

This claim has been re-opened since then based on the new designation, Special Exposure Cohort designation, for construction trade employees from Savannah River Site, but there is no updates on the status of this claim in the file.

The claimant filed a second claim under both Parts B and E for salivary gland cancer, which was eventually denied. But it seems that the Claim Examiner did all the steps in order to make sure to assure that this is not a separate cancer claim. They consulted an expert in oncology, who noted that the pathology of the initial breast cancer claim is overlapping with a common salivary gland cancer. And without any further evidence of this being a separate tumor, this may have led to a confusion in filing this claim.

An interesting issue was identified in

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the NIOSH referral for the initial breast cancer claim. The NRSD that was submitted by the Claim Examiner only included a single job title. It did not cover different job titles. They only included the claimant's work as a painter. However, the referral was made properly for the entire period of that claimant's employment, so I don't know to what extent this may have affected the probability of causation calculations.

But, in any case, this case, looks like, has been re-opened under the new designation of Special Exposure Cohort. So my guess, assumption, would be that this was eventually accepted.

MEMBER CATLIN: Thank you, Dr. Mikulski. So, there was no IH report, and you mentioned that. The part that stood out to me is the Claims Examiner used the SEM at the site looking for chemicals causing breast cancer. And the SEM came up with nothing related to breast cancer, so that didn't -- that evaluation didn't go any further. Which is a little puzzling, given

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it seems that there's, in the medical literature and the exposure literature, a growing number of studies showing that women exposed to solvents have an increased risk of breast cancer.

So that was what stood out mostly for me. And I remember, in 1989, IARC came out and said painting is carcinogenic trade for lung cancer and other cancers, and there's been growing evidence there.

So that would be the biggest part of this case that I would think someone could look into more. Hopefully, her claim on both the radiation side and on the chemical exposure side is given another review. And I hope Dr. Mikulski is right that the claim will be accepted.

CHAIR MARKOWITZ: Anything else?

Okay. Thank you. It's 3 o'clock. We're going to take a break until 3:15 p.m.

(Whereupon, the above-entitled matter went off the record at 3:00 p.m. and resumed at 3:21 p.m.)

CHAIR MARKOWITZ: Okay, let's resume.

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We have a chronic lung disease case.

Dr. Cloeren, do you have any of your notes or no? You have them? Okay. With Ms. Splett, 7716.

So, let me remind you, obviously we don't share personally identifiable information, but if the combination of gender, age, and site are unusual, and therefore is a potential for identification, if you could just omit the site, or omit the gender or the age. That way there's no suggestion that anybody could identify anybody from these cases we're reviewing.

MEMBER CLOEREN: Okay, hello. So, this was an interesting case. I'm just going to skip the site; it's not relevant, I don't think. This was a -- let me see, what was the job? Class A maintenance worker, maintenance mechanic, and also welder, who filed a claim for a new pneumoconiosis, which wasn't really clear what was meant by that. And squamous cell cancer of the lip. And, really, the development focused on the squamous cell cancer of the lip.

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This was a little bit unusual in that the -- well, the exposures of concern included -- and these are identified by the Claims Examiner using the Site Exposure Matrix, the Occupational Health Questionnaire -- uranium, isocyanates, asbestos, silica, blah, blah, whole bunch of things. But the Claims Examiner also identified arsenic as a potential exposure of concern, and that was not one that had been identified by the claimant or the doctor. So I thought that was an interesting aspect of this case.

It was referred to an Industrial Hygienist, whose report was okay. The Industrial Hygienist report was then sent to the treating doctor. And based on the treating doctor's reaction, I guess, and reflection to the IH report, the causation was attributed to the arsenic, you know, for the lip cancer and the claim was accepted.

So I thought this was interesting in that it did not go to a CMC. The Claims Examiner identified the exposure of concern, the most

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important exposure of concern, and obtained, you know, corroboration, really, by the Industrial Hygienist and then worked with the treating doctor for a determination.

I don't know, Gail, did you have any other things, too?

MEMBER SPLETT: You got all of it.

MEMBER CLOEREN: Okay.

CHAIR MARKOWITZ: There's a case on beryllium, 7755. Dr. Vlahovich and Dr. Bowman, 7755. And then, after that, we're going to do case -- while you're looking for it -- we're going to do 7016, that's Dr. Van Dyke and myself. Anyway, 7755.

MEMBER VLAHOVICH: Dr. Bowman, do you want me to start or do you want to go?

MEMBER BOWMAN: It would be great if you could.

MEMBER VLAHOVICH: Okay, great. So, this was a case for beryllium sensitivity that was denied. It was an individual at Los Alamos National Lab who worked there from I believe it

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was 1999 to 2020. And they were an R&D engineer at the explosive firing grounds. They had been exposed to beryllium, as well as depleted uranium high-explosives, radiation lasers, and other chemicals.

The diagnoses that they'd submitted a claim for were beryllium sensitivity and lung weakness. Lung weakness, I believe, was denied because there was not enough specific information as to exactly what that meant.

They had a normal chest X-ray, normal spirometry, and, from my review, they had a total of four BeLPT tests. One was normal, one was uninterpretable, and two were borderline.

And the claim was ultimately denied due to no positive BeLPT. It was reviewed and approved for occupational asthma, however.

Dr. Bowman, did you have anything to add? Or did I get anything wrong?

MEMBER BOWMAN: No, you covered what my notes had. I had the -- yeah, you covered what my notes have.

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MEMBER VLAHOVICH: Okay. So, yeah, I guess my question was if, with all those tests, because I know a year/a year and a half ago there was a recommendation to approve multiple borderline tests for positive, if this individual might have qualified had this been reviewed if those recommendations were used in reviewing this case.

CHAIR MARKOWITZ: This is Steve Markowitz. I don't think the policy or the Act has been amended and would address the finding of borderlines.

MEMBER VLAHOVICH: Yes.

CHAIR MARKOWITZ: The borderline BeLPT as equivalent to a positive BeLPT.

MEMBER VLAHOVICH: Okay.

CHAIR MARKOWITZ: Mr. Vance, anything to add to that?

MR. VANCE: That is correct. The Board did make recommendations about treating multiple borderline BeLPTs as a positive, but that would require the Department to change the statute.

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We've had that conversation. As far as the status now, that has not changed. So the position of the Department remains that statutory requirement necessitates the presentation of an abnormal BeLPT.

MEMBER VLAHOVICH: Yeah, and that was not present in this case.

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER CLOEREN: Just by way of information, there is a bill, I think it's still in Congress, sponsored by Patty Murray that would change that. So, we can look forward to that decision.

MEMBER BOWMAN: From my notes on this one, there was one borderline and then two normals. Right? Does that match what you saw?

MEMBER VLAHOVICH: I believe I saw two borderline, but I would have to go back and review it. There was a normal, an uninterpretable, and I put in my notes two borderline, but I may be incorrect on that.

CHAIR MARKOWITZ: Okay. Anything else

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on that case?

Okay. We're going to do 7016, which is a chronic lung disease case, Dr. Van Dyke and myself. I don't know whether you want to -- do you want to start?

MEMBER VAN DYKE: I can start. So, this is a chronic lung disease case that was denied. This is an individual that was diagnosed with idiopathic pulmonary fibrosis in 2020. This person had a 35-year work history as a lab tech at one of the smaller sites.

In his self-reported exposure -- I don't know if it's a he or she, actually -- this person reported a number of different exposures to things like plastics, metals, adhesives, resins, a number of different solvents, as well as exposure to powdered metals and possibly exposure to asbestos and fiberglass. So, a huge number of self-reported exposures.

Kind of the way it appears that this case went is that the Claims Examiner went to the SEM and looked up those particular substances

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that were both present at this site and linked to pulmonary -- or, I'm sorry, and linked to pneumoconiosis-other and also matched with what this person said.

So we ended up with these exposures of concern that included aluminum, graphite, silica gel, crystalline silica, titanium dioxide, and kaolin.

This was sent to an IH to do an exposure assessment and it was identified that he had significant asbestos exposure until 1986, frequent, very low to low. Post-1986, his asbestos exposure was more occasional, very low to low. And then he also had exposure to graphite, kaolin, silica gel, and silica, occasional very low to low exposure.

Do you want to do the CMC or do you want me to?

CHAIR MARKOWITZ: No, you can go ahead. I'll just wait.

MEMBER VAN DYKE: Okay. All of this information was sent to the CMC and the

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conclusion was that his employment and exposure was not a significant factor in IPF.

There was a lot of justification put forward, things like the CT abnormality were not consistent with asbestos, aluminum, or silica; titanium dioxide -- or titanium is associated with hard metal disease, and this really didn't look like hard metal disease.

Graphite, in order to cause pulmonary fibrosis, requires a high exposure, so it couldn't be related there. And then as far as kaolin goes, they really justified that, you know, kaolin is aluminum and silica, so they discussed it above.

From my perspective, I mean, I think the interesting thing about this is that, you know, this individual listed a ton of different exposures, and some of those exposures could be related to something that could look a lot like pulmonary fibrosis, and those weren't kind of carried through the process.

So, you know, whether that's a factor

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of, you know, we have a bad diagnosis, a bad description of diagnosis, a bad linkage between the different exposures in the diagnoses, or some combination of all of those, I think that's an issue.

And then, you know, what I did like is that the Industrial Hygienist did consider the information from both the exposure questionnaire as well as what was sent down.

As far as the CMC, you know, this is like that -- you'd think another occ med person is not qualified to evaluate this. I want to hear what Dr. Markowitz thinks about that.

CHAIR MARKOWITZ: So this is a 35-year lab tech and, you know, lab techs are tricky. Right? Because they work -- can work with a lot of different products that do different things that if you go back, this person worked in the '60s.

We don't know the exposure conditions and so it makes me a little nervous to actually go off a standard list of agents of the toxins

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that you listed.

Clearly, it went into the SEM through the other pneumoconiosis route because the person had pulmonary fibrosis and that's within the SEM synonymous with other pneumoconiosis and that's how they came up with kaolin and all those other things. Most of which, this person wasn't exposed to because they were a lab tech, they weren't --

But the person did send in a letter with their exposures including isocyanate. Actually and I looked up isocyanate, it can occasionally cause pulmonary fibrosis.

So I worry about lab techs about the extent and what they were exposed to over a 35-year career. My problem with this case is that the occ med doc said at the CT scans said this is what's called usual interstitial pneumonia, which is a medical term, a vague term, for essentially almost idiopathic, unknown pulmonary fibrosis. And he said this is incompatible with asbestos exposure which is false actually.

His reasoning was this, the findings

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on the CT and this usual interstitial pneumonia don't coincide with the findings in an asbestosis case. Actually they do.

I mean, that's just a factual error. But it got worse. They said it was, I don't see any scarring in the pleura outside the lung. We usually see that with asbestos so no pleural fibrosis, therefore, this can't be asbestosis of the lung tissue itself.

That's a mistake because not everybody who has asbestosis lung tissue has the, also has the scarring of the pleura. So it's a, when you see somebody with you're not sure what the pulmonary fibrosis is and you look for pleura fibrosis and you see it, yes, okay, asbestos.

But if it's not there, you can't say it's not asbestos because some people get one without the other. And I think that this is one of those instances in which they didn't have any experience with asbestosis.

Actually they quoted Medscape and something else and they just got it wrong, so

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this was one of those instances in which it wasn't just a like, this is what I think, this is what you think maybe we're both right, but factually it was incorrect. But anyway, Dr. Cloeren?

MEMBER CLOEREN: I reviewed a case with the exact same argument so it may be more of a trend than a one-off, but anyway.

CHAIR MARKOWITZ: Yes.

MEMBER CLOEREN: So.

CHAIR MARKOWITZ: Yes, I mean, look, if you did occupational medicine in Chicago, you probably learned about silicosis. If you did occupational medicine in New York, you probably never saw a case of silicosis.

And so that's that variation that I was referring to before and if you trained at, you know, in New York, the idea that you needed pleural scarring in addition to lung fibrosis is just, you know, ridiculous.

But in addition, I think that the fact that someone didn't pick up that maybe one of

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these other agents they work with, isocyanates or other could relate to this and there really wasn't looked into. I think that's a misfortune so, otherwise I agree with what you had to say.

MEMBER VAN DYKE: Can I just add one more thing?

CHAIR MARKOWITZ: Sure.

MEMBER VAN DYKE: If you trained at National Jewish everything looks like hypersensitivity pneumonitis.

CHAIR MARKOWITZ: Yes.

MEMBER VAN DYKE: Which, I mean, chronic hypersensitivity pneumonitis can look like fibrosis too, if I'm --

CHAIR MARKOWITZ: That's right.

MEMBER VAN DYKE: -- correct.

CHAIR MARKOWITZ: And a number of these agents have been associated with hypersensitivity pneumonitis, as well. So that's the first thing that popped out to me. I, you know --

CHAIR MARKOWITZ: Yes.

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MEMBER VAN DYKE: -- asbestos isn't my thing.

CHAIR MARKOWITZ: Right, right.

MEMBER VAN DYKE: So.

CHAIR MARKOWITZ: Right and it occurred to me this could be hypersensitivity pneumonitis and I think that that's what isocyanate might do actually.

How much he handled, we don't really know so we just don't know.

MEMBER VAN DYKE: I was thinking more the epoxies, as well.

CHAIR MARKOWITZ: Why not? Okay. There's a case of cancer, Dr. Friedman-Jimenez and Ms. Whitten, 7855. I feel like we're ignoring Dr. Mikulski so next we'll do 8387, the Parkinson's disease case, but right now we're going to do 7855.

MEMBER WHITTEN: George, you want me to go first or --

CHAIR MARKOWITZ: Oh, George, did you get a chance to look at this? Because if you

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haven't gotten a chance to look at this, then --

Maybe he's looking for it now.

Why don't we go to 8387? Dr. Mikulski and Ms. Whitten on Parkinson's disease.

MEMBER MIKULSKI: Sure. Diane, do you want me to start?

MEMBER WHITTEN: Yes, please. You're the Parkinson's expert.

MEMBER MIKULSKI: So this is a denied claim for Parkinson's disease in an individual who worked for almost 10 years on the assembly lines, one of the final assembly plants in the DOE complex.

They were diagnosed with Parkinson's in the early 2020s and the claim was denied almost a year later. It looks that the main issue with this claim and the Claim Examiner identified all the recently updated exposures in the Procedure Manual or rather in the SEM.

But the main issue with this claim was the CMC's review who claimed that this is, the Parkinson's disease is a disease of aging and did

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not take into account any occupational history that this worker had.

The CMC supported themselves with fairly outdated references. They did not take into the account any new research or the evidence that we have presented when making the recommendation about the Parkinson disease.

And the claim was ultimately denied. So anything else? Anything else to add?

MEMBER WHITTEN: Yes, going over his information, it appeared he worked, he worked under a top security clearance. They never took that into consideration. They didn't call a clearance specialist to review his work history or anything.

And it appeared to me that the IH actually agreed in their report that his exposures could have more likely than not contributed to his Parkinson's disease. But then the CE decided to send it to the CMC and that's where the CMC referenced one document that was put out in 2003, denied the claim.

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CHAIR MARKOWITZ: So, Dr. Mikulski, I didn't quite catch everything you said about the CMC report. Was that, the opinion expressed within sort of a reasonable degree of variation that we can accept or was it, you know, way off base?

MEMBER MIKULSKI: I believe so. Another issue was this is that the CMC was an expert in occupational medicine rather than urology. And in all fairness, the CE tried to reach out actually to the treating physician, but had not received any response from them on this case.

And hence the choice of the CMC who was not an expert in urology to make those kinds of statements.

CHAIR MARKOWITZ: Okay. Next case, Parkinson's disease, it's 9787, Dr. Van Dyke and Dr. Cloeren, 9787.

MEMBER CLOEREN: I can get started. This was somebody who -- it doesn't matter where they worked I don't think, but the work years

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were 1974 to 2008 for 33 years.

The job was a photographic lab technician and graphics leader at like many different jobs sort of increasing responsibility over the years.

And I didn't read every one of the 400 or so pages, but it appeared that there was some sort of back-and-forth about the exposures and that claimant identified a specific exposure of concern that was not found in the Site Exposure Matrix which was potassium permanganate which is a manganese-containing chemical.

And manganese can cause something very similar to manganese exposure toxicity from it cause something that looks very much like Parkinson's. So in any event, it went to the CE.

I mean it went to the IH and the IH appropriately I think determine that there would have been very frequent exposure to the identified hazardous chemical in the claimant's job even though it wasn't in the SEM.

And then it went to the -- so the

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treating doctor thought that there was a causal relationship. The CMC wrote a really short report.

Like the medical information in the CMC report was limited to six lines or six lines that sort of covered the whole medical case. And the exposure discussion was just nine lines and the CMC basically said that the parkinsonian syndrome caused by manganese would not be responsive to levodopa which is a commonly used drug to treat parkinsonism and the medical documentation in this person's case showed that they did respond to levodopa.

So therefore, the CMC's opinion was it was not manganism but rather regular old parkinsonism not caused by the manganese. And anyone add to that or correct, Mike, before I give my opinion?

MEMBER VAN DYKE: No, I think that's all correct. I mean, the thing I'd add is I think the good thing here is that there was that back and forth with the claimant --

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MEMBER CLOEREN: Yes.

MEMBER VAN DYKE: -- to try and identify appropriate exposures.

MEMBER CLOEREN: Yes.

MEMBER VAN DYKE: I mean, it feels like, you know, they've built a list of causative agents or agents linked with Parkinson's in the SEM and they said were you exposed to any of these?

It didn't really say that, but that's kind of what it felt like. And they were able to appropriately identify one of those agents that they were exposed to.

So I thought that part was, it showed a good back and forth and a good, you know, claimant-friendly environment.

MEMBER CLOEREN: And I thought that the IH exposure in determination, you know, was also appropriate which was great. I thought that -- I did a little review and, you know, and I think that the bulk of medical evidence does agree with the CMC's opinion that manganese

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reacts differently to levodopa than parkinsonism.

So as far as that went, I think that is fine, but I felt like this person was exposed to tons of things. And parkinsonism, you know, has been associated with others and it doesn't seem like there was any consideration given to other potential exposures that may be related to the disease.

But I know that the answer to the Claims Examiner's questions.

CHAIR MARKOWITZ: Steve Markowitz, was the potassium permanganate identified through the SEM or through the claimant?

MEMBER CLOEREN: The claimant.

MEMBER VAN DYKE: There was nothing in the SEM for that job --

MEMBER CLOEREN: Yes.

MEMBER VAN DYKE: -- category.

CHAIR MARKOWITZ: But if you looked at the, well maybe you didn't do it, but if you looked at the SEM for Parkinson's disease, they identified permanganate?

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MEMBER VAN DYKE: Yes.

MEMBER CLOEREN: Yes. But not his, not his job working with it. And it was denied.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: I'm just going to comment on the manganese-related parkinsonism and the non-levodopa responsiveness. This is, you know, usually the case in the context of manganism where there's a very high manganese load and you get a parkinsonian like feature that is in fact mostly, but not always unresponsive to levodopa.

In this case, of course, there's a much longer latency and I thought and from your discussion, and I had looked over this one briefly as well, the consideration of the evidence by the CMC was focused solely on these sort of acute dosing with manganese and associated with Parkinson's disease.

And the lack of the levodopa responsiveness ignoring recent work such as from the work of Brad Racette with welders and their

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exposure to manganese that shows a lower level exposure to manganese.

Chronic can increase risk for actual classic Parkinson's disease which would be levodopa responsive. And so the -- it seems to me the opinion here is rests solely on one potential weighting could cause the parkinsonian features and not all potential ways manganese could cause parkinsonian features.

CHAIR MARKOWITZ: Interesting. I think we're going to move on to the next topic. I know we still have a few cases, but I'm not sure how long this next topic is going to take.

I want to leave a little time for it. It has to do with hearing loss and dementia. And Mr. Key raised this issue so I'm going to let him or if he wants to start off the discussion.

MR. KEY: Yes, I had reviewed a medical report that linked causation.

And so I wonder within the Department, do we have individuals who routinely review outside medical reports on diseases, illnesses,

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et cetera?

MR. VANCE: This is --

CHAIR MARKOWITZ: I think this is a question, yes, Mr. --

MR. VANCE: -- yes, this John.

CHAIR MARKOWITZ: Go ahead.

MR. VANCE: Yes, we do have, we do have a federal toxicologist that is looking at health effect information. She also does research into causative standards and health effects so she's researching information on petitioners that are being put forth to establish new health effects in cases.

So she would be the one that would be looking at any kind of referral that looks at, you know, is there some new data in medical health science community that's suggesting that there is an established humanistic health effect between an exposure to a particular toxin and a disease.

CHAIR MARKOWITZ: So Mr. Key raised this issue with hearing loss and dementia and, in

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general, cognitive impairment in relation to hearing loss, and had sent me some information about that. I can't remember the source exactly. But I started to look into it a little bit. It's a very interesting issue.

I'm skeptical because I approach all new disease-exposure links with skepticism with like, you know, you've got to prove that there's a link here.

And this is not a question of a toxin causing a disease. Because we're talking about hearing loss and we're talking about cognitive impairment or dementia.

This falls into more like the, what the program would consider consequential condition. Hearing loss might be, might be caused by DOE exposures.

And a person has hearing loss they may eventually develop the question is, you know, may they develop cognitive impairment or dementia as a consequence of having had hearing loss.

And there's a class of compensated

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conditions that correspond to this consequential condition. So the question whether hearing loss, how could hearing loss cause dementia or cognitive impairment? Next slide.

I only have a couple of slides because I really didn't have a chance to look into it. But here's a more recent study and it's just one study. There are multiple studies in populations, but let me explain what this study did.

On the left side, at time zero if you look at the bottom, the horizontal numbering, years of follow up. The zero corresponds to when the study began. And then the vertical axis is proportion free of dementia.

And so I can't remember the sample size. It was significant. For that matter, I'm not, I think it was a U.S. study, but I'm not sure where it occurred.

And so they looked at time. They followed this group over 18 years. And they saw that the group who had hearing loss -- that's the lower brown line -- over time, a certain

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proportion of them developed dementia.

So the vertical axis is proportion who are free of dementia so what that means is by year 18 in the brown line, the ones who developed hearing loss or who had hearing loss, excuse me, during that 18-year period, at the end of the 18-year period, 50 percent had dementia and 50 percent did not have dementia.

So for the group that had hearing loss, there was a 50 percent dementia rate at the end of the 18-year period. And you can see how it goes down gradually over time. Right?

In ten years it was closer to a 25 percent who had dementia. The upper line, the black line is the ones -- that's the group that didn't have hearing loss. And of course, people without hearing loss also developed dementia. And you can see that at the end of the 18-year period, about 25, 27 percent of them or so had dementia. So for the group that didn't have hearing loss, a quarter of them developed dementia; the group with hearing loss about half

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of them had developed dementia. That's a huge, a huge difference over time.

So this is just one study. I didn't really get a chance to summarize other studies. And you know, this doesn't necessarily mean causality. It means a number of different studies, done different ways, et cetera. You've got to look at other factors besides hearing loss and dementia.

But if you go to the next slide, I was interested in well how could it be that hearing loss produced cognitive impairment and forgive the typo here.

But one idea is that the brain has so much capability of cognition and if a certain amount is absorbed in overcoming the mental work of hearing loss that it decreases the mental -- the reserve for other mental functions including memory and related cognitive functions that would lead to either the cognitive impairment or to dementia.

I'm not sure I really understand that

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mechanism why there would be -- exactly there would be a tradeoff between the cognitive work of hearing loss and the work of memory, but it's not my area of expertise anyway.

The second made a little bit more sense to me which is that hearing loss tends to isolate people because they have less social interaction and that can be related to cognitive decline because people use their brains differently.

A decrease -- in general, social isolation would contribute to cognitive impairment. One thinking is that maybe to have a common underlying pathophysiology or the things going on biologically which is that people have cognitive impairment have problems with small blood vessels.

And that same kind of problem can involve hearing loss so maybe they simply have like a problem with the microcirculation that is showing up as hearing loss and showing up as cognitive impairment.

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And then there's some evidence through ways of imaging the brain that some of the areas the brain that are affected by hearing loss are also -- would affect cognitive decline.

So there's some sense here, there's some plausibility to this connection. It doesn't mean that there is a connection, it just means that it's not outlandish to think that there might be a connection.

And to me it boils down more to well, you know, you study significant groups of people in different ways, can you -- what does it show?

Does it show the people who have hearing loss has impact on cognitive function or not?

So it's the kind of disease-exposure - - and it's not really exposure, excuse me, disease-disease link, consequential link that the question is, is this something that ought to be looked at by the program because there are a lot of people with hearing loss.

And maybe not that many compensated by the program because of the requirements for

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exposure to a select group of toxic solvents and a select group of occupations during a ten-year consecutive exposure prior to 1990.

But there's still sizeable numbers of people with hearing loss and obviously cognitive decline and dementia is common. So -- and expensive.

So it's not a small issue if the program were to take it up or not. The question is, should the program actually look more in depth -- is there enough here to suggest the program should look more in depth?

And I haven't -- I don't think I've really done a fair job at presenting the data there or over the last ten years or so a considerable number of studies done of sizeable numbers of people, different populations, different countries that show that there may well be something here.

So personally I'm willing to work with the other Board members if we want to just look at this a little bit more and see what we find.

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Really, as an example of whether our collective scientific expertise can contribute to an issue that may be of importance to the program. I'm willing --

MR. VANCE: Dr. Markowitz, can I add some clarification to this, to this topic?

CHAIR MARKOWITZ: Sure.

MR. VANCE: So just to sort of everybody's education, you know, the standard for consequential illness is not the same for causation under Part E as at least as likely as not and all of that.

It really is a question of medical rationale provided by a physician who is considering all the different factors that are involved in an individual that has work-related hearing loss.

It could very well be that a physician using this medical health science and other kinds of information could make a salient argument that an individual that had work-related hearing loss and dementia, that the dementia could have been

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significantly accelerated because of the work-related hearing loss.

That would be the basis upon which the Department of Labor would be able to accept that case. We would be looking for how well does a physician support an argument suggesting that the dementia is in some interpretation of the evidence in their view consequential to that accepted illness of hearing loss.

So there's not a particular presumption that needs to be made here. What just needs to be illustrated to the scientific community or anyone that's looking at one of these cases involving hearing loss is that it could very well be that if that individual does have hearing loss and there is a dementia diagnosis involved, their physician could certainly fashion an argument along the lines of what you're discussing here, as far as what is convincing that physician that the hearing loss is contributing to or aggravating or accelerating dementia because that would then satisfy the --

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if the doctor provides a well-rationalized position about it, that would be sufficient for the Department of Labor to accept that claim for the dementia as a consequential illness.

So I don't know whether this is something that we need to look at from a programmatic standpoint, but I just wanted to clarify that mechanism exists for physicians to make these arguments and to support these kinds of claims for a consequential relationship without having to have absolute epidemiological proof that dementia and hearing loss are connected.

So long as the doctor has some sort of salient basis and reason and rationale that they want to utilize including this graph that I think is a very pertinent illustration of the situation, would be something that a physician could argue and a CE would have to weigh it to determine whether or not that's sufficient and compelling to allow for an acceptance of a consequential illness.

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CHAIR MARKOWITZ: Yes, Steve Markowitz. So that's very interesting actually. But wouldn't the program want to know as a general matter -- let's say you got that letter from that personal physician making that argument, well-rationalized argument whatever that consists of.

And you got that and you were looking at that. You said, well is this a consequential condition or not? You know? Is there a relationship here?

Wouldn't the program want to know as a general matter whether hearing loss and dementia are connected before deciding whether a convincing letter on an individual person from a personal physician can win the day?

MR. VANCE: This is what the Department of Labor does already with regard to all of the opinions that we're getting from claimant physicians that are disconnected from any kind of health effect data that's maintained in the Site Exposure Matrices.

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Very similar kind of situation where a physician is looking at and then forming an opinion of in this particular situation causal relationship to a consequential illness.

It is going to always be the discretion of the CE looking at the information that's provided by the physician to determine whether or not the medical health science the doctor seems to be relying upon is sufficiently supporting the position being taken.

So in other words, if a doctor would utilize the example that you've used in fashioning an explanation as to why he or she thinks that the individual with work-related hearing loss that has dementia, that the dementia has been affected by hearing loss.

We see this in all kinds of claims nowadays where a claimant's physician is arguing some individualistic characteristics of an employee's exposure to a particular toxic substance contributed to a disease.

Not cause and effect, but contributed

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to. The example I can go back to is that degenerative disk disease that a physician was making an argument about with regard to lead exposure and the position of the physician in showing that there was medical health science in his view that supported that position.

And so, you know, the Claims Examiner has to look at and evaluate that and say, does this medical health science identify the condition? Does it, does it proffer an argument that is supporting or does that medical health science support in a reasonable way what the doctor is arguing?

So that would be something the Board could certainly look at. Is that mechanism of what the CE has to go through to weight this type of medical health science that a lot of physicians are relying on and promoting as far as this is what I'm using to support a position of a contribution relationship between either an exposure to a particular toxic substance or a consequential relationship between one disease

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and something else that's been accepted by the program as work-related.

CHAIR MARKOWITZ: That's an odd, that strikes me as a very liberal standard actually. I take it that the consequential, the whole issue of consequential condition is not in the SEM.

It's not a matter for the SEM because the SEM's about toxins and exposures and diseases. It's outside that. And within the Procedure Manual, I know during the COVID-19, that as a consequential condition, that the program decided to cover it for certain underlying conditions that people had.

Does the Procedure Manual otherwise describe certain consequential conditions?

MR. VANCE: Yes, there's entire section of the Procedure Manual that's dedicated to talking about the steps that are taken to evaluate claims for consequential illness and the thrust of the guidance to our staff is how well does the physician formulate an argument supporting a relationship between a work-related

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illness that we've already accepted and either the development or the aggravation or contribution or acceleration of some other problem, and so there is content in our Procedure Manual that speaks to that.

Our Procedure Manual also discusses this process by which we evaluate claimant submitted medical opinions from their own physician that is attesting to some sort of individualized response that an employee is having to a particular exposure so it's something that we have in our procedure that discusses this process for both causal relationship in that disease, then exposure component and also in the consequential illness component.

CHAIR MARKOWITZ: Okay, so I gather then that there would be no need for the Board to take this on, look at this issue because it wouldn't assist the program.

They don't need any sort of thorough analysis that demonstrates the link to support their decision making which is just fine.

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Dr. Cloeren?

MEMBER CLOEREN: If there were to be data among -- well, if there -- would there be a consideration of making dementia a presumptive acceptance for the small group of people that have hearing loss that's accepted and also have dementia?

You'd need to have an argument for that I know and so that might be a reason to think about it.

MR. VANCE: Yes, I mean, the Board could certainly consider that. It would be very similar to what occurred with the COVID-19, that if certain conditions are satisfied, then the program would be in a position to just accept it outright. That we wouldn't really need to have any kind of a specific medical opinion about it because if certain conditions were satisfied, you know, we would be in a position to accept it automatically.

And I mean, you would look to that COVID-19 standard that the Board recommended and

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doing something along those lines and you could do that for a variety of medical conditions. In fact, you wouldn't have to limit that to just hearing loss.

CHAIR MARKOWITZ: We should take a look at that. Okay, we have just a few minutes before the public comment period. We're just going to break for five minutes, stretch our legs.

I'm going to get the names of the public commenters.

(Whereupon, the above-entitled matter went off the Record at 4:07 p.m. and resumed at 4:15 p.m.)

CHAIR MARKOWITZ: It's 4:15 p.m. We're going to open the public comment period. I have a list of public commenters who've signed up to speak.

There are five people so far. We never know when additional ones might be added. I would ask that the public comments to try to limit themselves to about seven minutes. That means

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that I may, unfortunately, have to interrupt you a bit, but so be it.

The first one if they're available is Stephen Towler.

(Off mic comments)

CHAIR MARKOWITZ: Yes. No, no, we're giving the last word to somebody else. You want to have a -- if you could speak into the mic so we can record it that would be great.

MR. TOWLER: Is it on? I don't have to say testing or anything? No, I kind of deal with both sides of the WHPP Program. I participate in that, but I also have a mother that worked out at the site for 33 years and I deal with her under the EEIOCP and I've managed her health care for about ten years.

But I'm kind of curious and it's, you know, they're both good programs. I don't have any problem with them, but I had more of a question really than a comment, I think.

And I was curious if, as the disease progresses and other symptoms or what's the right

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word, other impairments become apparent in the process, do you re-evaluate or are you allowed to go back and say hey, we need to re-look at this now and say there's more going on here now than there was before?

CHAIR MARKOWITZ: I'm sorry, Steve Markowitz. All right so this is for a condition, a health problem for which the claim has been submitted and accepted by the program?

MR. TOWLER: Correct.

CHAIR MARKOWITZ: Okay. And then either the condition gets worse or there are other conditions that develop afterwards that flow from that original condition?

MR. TOWLER: Correct.

CHAIR MARKOWITZ: Okay. So I'm going to -- that's a question for Mr. Vance. If you want, that's a specific, targeted, and answerable question so if I could turn that over to Mr. Vance.

MR. TOWLER: Thank you.

MR. VANCE: Not a problem. Yes, I

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think the question is touching again on that question of consequential illness --

MR. TOWLER: Yes.

MR. VANCE: -- so the program does have guidance that states that in an instance where you have a condition that is worsening or has caused a separate diagnosed problem, that's called a consequential relationship.

And we have a process by which you can file a new EE-1 for an employee seeking coverage for that consequential illness. And basically what you would need to do is present the medical documentation that establishes that the condition has been diagnosed.

It does not have to necessarily have been diagnosed after our accepted condition. It just needs to be shown that the condition exists and that a physician using good interpretive analysis, the use of appropriate medical health science supports a position suggesting that new illness is in some way either having caused or aggravated or contributed to that consequential

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disease.

And Dr. Markowitz, I have sent Carrie some information about that that I'm going to have her look at and refer to you. I'm just talking about that process, but there is guidance in our Staff Procedure Manual that's available online in Chapter 23.

This is something that you can go to our website, look for our regulations and procedures, look for our Procedure Manual for administering the program, Chapter 23 has all the information that is needed to know how to file those claims and what the process is by which the program would evaluate that for adjudication.

MR. TOWLER: Okay, thank you.

CHAIR MARKOWITZ: So yes, this happened, this happens all the time and we just said that the Worker Health Protection Program, the medical screening program for Idaho workers also provides some assistance around these issues so you should feel free to --

MR. TOWLER: I am.

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CHAIR MARKOWITZ: -- contact the person who's sitting behind or David Frye, Gaylon Hanson or David Frye.

MR. TOWLER: Well, it's on my mother. It's not for me for the WHPP, because I participate in that. I don't think I have any problems yet.

CHAIR MARKOWITZ: Okay. Good, well, we hope we won't find any. Thank you very much.

MR. TOWLER: You know, it was surprisingly refreshing to find an answer when she developed breast cancer because I'd seen the advertisements on TV for the program and I thought, hey, maybe these people can help me get her back and forth from treatments and what not. I wasn't looking for anything else.

CHAIR MARKOWITZ: Right.

MR. TOWLER: And the people, were did she work at the site? Yes. Okay, what did she do, blah, blah, blah and on, on and on. And they said, oh, well you qualify for this.

And I says, okay, then we'll afford

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the rides that way. So, thank you.

CHAIR MARKOWITZ: Yes.

MR. TOWLER: It was a nice, a bonus --

CHAIR MARKOWITZ: Okay.

MR. TOWLER: -- for working out there.

CHAIR MARKOWITZ: Okay, thank you.

MR. TOWLER: Bye.

CHAIR MARKOWITZ: All right, next is speaker, commenter is Robert Marcinko.

MR. MARCKINKO: Hey.

CHAIR MARKOWITZ: Welcome.

MR. MARCINKO: Again, my name is Bob Marcinko. I want to thank you for inviting me to this as well as being able to comment. I think what you're doing is wonderful and the program is exceptional.

And being able to attend your meeting gave me a better understanding of some of the challenges you are dealing with which is extremely interesting.

I want to hit you with a little historical information. You may have heard or

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seen some of this yourselves in the past. But I started at the INL for Exxon Nuclear in 1981 and worked until 2012 where I ended up being the S&H Manager at the ATR Complex.

So I worked in a lot of different management positions and dealt with a lot of good challenges here. But my biggest challenge was surviving my first week on the job here at the INL.

Prior to being hired, I worked for Wyoming OSHA for four and a half years and then I went on to the University of Utah and got my Master's degree in industrial hygiene.

So when I walked in the door, I knew what I was doing. The first day on the job I was pretty much told by my boss, walk around get acquainted with the operation.

And the Idaho Chemical Processing Plant at that time was a huge operation. Most all of it's been demolished at this time, but there were over 1,200 employees there at that time.

As I proceeded with my first walk

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down, I came upon a pipefitter raking insulation off of a streamline with a hammer. I talked to him about it and asked him to stop and told him I was going to go talk with the supervisor.

In regard to looking for a supervisor, I was told he was in another building, walked into that building. It was a large fuel handling and storage facility.

Several hundred feet long, hundred feet wide, 50 foot ceilings, you couldn't see from one end to the other. They were doing sandblasting of a fuel storage cast at the far end. I went and stopped that job.

And again, my OSHA background. In proceeding to find the supervisors, I had no luck. Went back to my office and heard the operations manager and the maintenance manager screaming at my boss wondering who the hell I was.

I ended up in that meeting and we talked briefly. I was advised at that time in my walk-arounds, not to talk to any employees. And

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at that point a meeting was held with the president and our lawyer for the company.

And at that time it was presented that OSHA was required to be part of the contract that Exxon had to follow. So the lawyer saved my job at that time otherwise I was due to be fired.

Anyway it was a challenge from then on and obviously I survived and did 31 years. But those early days were amazing. It was a free for all. There were no controls on any of the chemical hazard activities.

I came across an instrument lab that had beads of mercury everywhere. They were using the wrong cartridges on respirators for certain chemicals. It was a challenge.

I had no budget to work with. I had no monitoring equipment. And I had support from management. Anyway, couple of years later, Westinghouse had taken over the contract.

I was put on some assessment teams. I ended up at Savannah River, Hanford, and West Valley. And what I found at some of those

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facilities particularly West Valley is they were in no better condition than the Idaho Chemical Processing Plant was three years prior.

It was a mess and it was also a surprise to their management that they had no industrial hygiene program and they had little to no controls over simple things in my mind as asbestos knowing that it's hazardous.

It was, in my mind, a surprise in that it was a fellow DOE operation and DOE was well aware what I did when I first showed up in 1981.

And that information wasn't communicated on to any of the other facilities. So in my mind, you know, DOE, you know, is embracing this program.

They imparted that it was morally and ethically something that they needed to do, but back in those early days, they were negligent. They had contractual obligations to impose on their contractors and they didn't do it.

I have acquaintances that I know that have passed away from some occupational illnesses

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from the INL. So this is, excuse me, this is somewhat of a personal thing for me.

So I really do appreciate what you guys are doing. It's valuable, there's a lot of employees out there that were exposed unknowingly and routinely. It was a free-for-all for handling a lot of chemicals so.

CHAIR MARKOWITZ: Thank you very much.

You know, this period you're discussing, the early '80s, the people who would have started either the chemical processing facility, or some of the other sites, would have been you know, 20 years older.

So meaning that now, they'd be in their 60s, you know, still reasonably young.

MR. MARCINKO: Exactly.

CHAIR MARKOWITZ: With an expected 20 year life expectancy if, if they lead normal lives.

So, that means there must be a lot of people out there who work in those conditions, and would still be at risk.

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So, thank you very much.

MR. MARCINKO: Oh, without a doubt, so thank you again.

CHAIR MARKOWITZ: Next is Robert Stanton. Sorry, Ralph Stanton. Ralph Stanton. Sorry about that.

MR. RALPH STANTON: That's all right, I've been called worse.

CHAIR MARKOWITZ: I won't ask.

MR. RALPH STANTON: This is my wife Jodi here. She is also an INL employee.

Jodi and I are both exposed workers at the INL. I'm a card carrier. Yes, I was exposed in November 8 of 2011 at the Zero Power Physics Reactor facility.

It was uncontrolled airborne release of plutonium-239, americium-241 in which I received, I was a ARS survivor.

I spent eight months down in the basement and of course, I was told that I was clean when I was sent back, and I wasn't. I wasn't even close.

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Because I filed a whistleblower complaint, another gentleman and myself that is now deceased, Brian Simmons.

And we both, we both had you know, the blood markers, the clinical symptoms, the dose dependent clinical symptoms of ARS in the hours and days following expose.

We were told that we had influenza, which we later found out we were at later able to get our blood CBC counts, and see that our white blood cells were down next to nothing after five hours, which would indicate triple digit dose.

When I was given my dose assignment, I didn't know a thing about radiation dose, but I instantly knew that my dose was falsified.

Because I started off with a dose of 256 millirem for the year, and after spending eight months down in the basement, because my urine and fecal were too hot to work in a radioactive area, I was told that I had, I ended up the year with 200 millirem.

So I think, I don't know, I just

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looked at them and they told me that with a straight face.

And I just said, hey, is it magic plutonium that you got here, is that, is that what we're exposed to, to actually takes away dose?

But anyway, so I became compelled to learn the art and science of internal dosimetry. And on November 19, 2014, they brought out dose experts, NIOSH did, and I was able to prove that my dose was falsified.

And the guy that was with me, Brian Simmons, he is also an ARS survivor, or he was. He died last, August 29. And anyway, he was also part of figuring out that our dose was falsified.

But I went in there and they stopped me about 60 percent of the way through, and they said hey, it's pretty obvious that there are serious issues with your dose calculation, and that's when I knew about 30 percent about what I know now.

I can now add medical fraud, and

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illegal destruction of exposure evidence to those accolades, not to mention with the, the lung count manipulation.

And you know, I got a lot of people that were a lot smarter than me that helped me out with this.

And you know, these kinds of themes, they affect epidemiology studies, health studies. They affect decisions on, you know, eligibility for medical help.

And something's got to be done about that. This, you know, you can't, you can't allow the same contractor -- and it was also determined that it was willful negligence, so this was a rare case where in Idaho, there's a law where we can go directly after the company, which we did when we filed whistleblower lawsuits.

But you can't, it's such a conflict of interest to allow the contractor, who is financially motivated by DOE, to show low dose assignments, to destroy exposure evidence.

Now this is not, these are not just

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accusations I'm making. These are things that I can show you with paper, with evidence. I can show it in a court, which is why they decided not to go to court with me.

But what I've done is I'm here to basically you know, offer my services to, to teach a Board how to spot this stuff.

Because I've been doing it for the last 10 years. And unless you know what to look for, you're not going to see it.

But it's a problem. If you look at the EEOICPA regulations, you know, it says in there that 98 percent of all DOE radiologically induced cancers within the DOE complex were deemed to be caused at safe levels.

Now, that tells me that there's a lot of dose falsification going on. And the INL is not the only place that it's going on.

But I would be more than happy to come in and talk to, or teach, or show you what to look for, in any capacity.

You know, also I was kind of a lucky

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guy because I had, I had a blood ferritin level, and I'm not sure if there's any physicians here or anything like that, or if they understand what a blood ferritin level is, but it's a correlation with how much heavy metal is in your body. Heavy metal in my body was americium and plutonium.

And I did biopsies of my bone marrow and my liver, because my liver and my kidneys were going south.

And they found heavy stores of plutonium. And, which I was told I lost those. I was 20, 20 percent lower in my final dose than what I started with. They don't pay attention to things.

So, anyway, you know, this kind of stuff can't go on if you're going to, if you're going to keep accurate, if you're going to keep accurate records.

If you're going to truly be able to say nuclear workers are safe, you know, you've got to be able to, to rely. You've got to be able to rely on that doctor, you know, doing his

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fiduciary commitment to his patient, which he didn't.

And you know, I've got a dead friend because of it. The guy was standing right next to me, 38 years old.

And when he, he was actually killed. But when he was killed, he had, he had been vomiting blood for three years.

He had nose bleeds. He had paranoia schizophrenia, which a lot of the Chernobyl ARS survivors developed.

Like is said, I was lucky. I went 2017 when I had all those issues. They told me they were going to keep me as healthy as they could, for as long as they could.

And she found a scientist who developed a detiered deplete (phonetic) of water that actually was able to chelate the radionuclides out of my body, which had never been medically done before.

Because if you, if all the medical science that I've read, is once that the isotope

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reaches the organ of choice, it's there until it you know, just finally kicks off.

Not true with this water. After three months, my kidneys and my liver came back on line, perfectly functioning. But my lymphocytes were still low.

Which still is in line with the Chernobyl ARS survivors. Some of their, some of them their lymphocytes came back after five years; some of them they never did.

Mine were still low after 10 years, but I met a medical scientist who watched one of my podcasts, and gave me free treatments.

And was able to bring my lymphocytes back up, which I think has never been done as far as I understand.

I've done a lot of research on it. I mean, I don't have the perfect, you know, I don't have the perfect, I haven't seen everything in the world.

But from everything that I've ever read, you know, these are things that I would be

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glad to share.

And you know, they could have Homeland Security implications because what we were involved with, was the same thing as a dirty bomb.

And this water chelated everything out of the body. And so that would eliminate a lot of the, you know, risk to people who are in something like that.

Just, just an idea.

CHAIR MARKOWITZ: Thank you. Thank you for discussing this, thank you.

MR. RALPH STANTON: Yes, but I've left my information up there so --

(Simultaneous speaking.)

CHAIR MARKOWITZ: Okay.

MR. RALPH STANTON: -- if it, that's something you'd like to do, just give me a call.

CHAIR MARKOWITZ: Okay, thank you.

MR. RALPH STANTON: Yes.

CHAIR MARKOWITZ: Next, I think we're going to hear from someone on the phone, Sandra

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Thornton?

(No audible response.)

MS. VLIEGAR: This is not Sandra Thornton, this is Faye Vliegar.

CHAIR MARKOWITZ: Okay, so we'll go with Faye Vliegar? Okay, sure, okay, Faye Vliegar.

(No audible response.)

CHAIR MARKOWITZ: Okay, so what are we doing? You think she is on the line? Okay.

MS. THORNTON: I'm on the line.

CHAIR MARKOWITZ: Okay, and is this Faye Vliegar?

MS. THORNTON: Hey, Dr. Markowitz, this is Sandra Thornton, I've been here.

CHAIR MARKOWITZ: Oh, great. Okay, okay, go ahead, Ms. Thornton, welcome.

MS. THORNTON: Thanks.

Yes, I talked a couple of times on this Board, and I really appreciate you leading the Board, and I appreciate the Advisory Board.

These are issues I've staffed over and

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over for three years personally, and I don't want to tie it to time anymore.

I sent you an email for Carrie to post for public comment and you know, I'm talking about Case 50024054.

I just decided that as good as you try, that the system probably isn't going to fix the rest of this case.

So, I just wanted to hop on to say you've got my message to post in the minutes, but thank you for an opportunity to do that.

I'm just going to go to Washington and hit up the committees I need to, to speak to the people to get some things to change, because they're not.

And they affect everybody, and I just happen to be a big mouth that points it out.

But anyway, so I won't bother tying up your time with this case. I know I've sent a lot of information to try to give constructive feedback to identify the issues.

And again, this Board is, tries really

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hard, and works really hard, but there's only so much you can do. And after that, you know, it's just out of your realm.

So, thanks again, Dr. Markowitz. I always, always appreciate you and the rest of the specialists on this team, to try to help these nuclear workers who really paid the price, and are struggling.

So again, thank you. I appreciate it and I won't bother you. Take care.

CHAIR MARKOWITZ: Okay, thank you, Ms. Thornton.

Next, we have Mr. Calin Tebay. Welcome, welcome back. You aren't ready?

MR. TEBAY: Hi, my name's Calin Tebay. Thank you for letting me speak today.

As a former board member, I appreciate everybody's participation and effort, and continued effort.

In my role, my primary role, I work at the Hanford Workforce Engagement Center, which is not primarily Hanford anymore.

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We, there's three of us at that office. We educate current and former workers and their families, on potential programs that apply to them.

EEOICPA, L&I, short-term, long-term, paid family medical leave. We get into some VA benefits.

We help people once they decide a path, how to, how to navigate those paths. The conflicts in those systems. It's evolved and it continues to evolve.

As of this last week, I think we've had 15,500 I should say communications, meaning people that walk through the door, appointments, some people communicate via phone, email, all different ways, right?

So, we deal with people that want to file new claims; people that have filed and been denied. Just you think of it, we've dealt with it.

To this day, and I, and you're not going to hear anything from me that you haven't

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heard before, and you haven't been working on for years.

But to this day, our single largest problem is still work history. We are relying on resource centers, which now is not just resource centers because we can, anybody can now get on and electronically file a claim from your own home.

And if the work history is not captured correctly, the information we all know from there, is tainted. And it's interpreted a few times from there.

Now whether we're dealing with the EE-3 or the OHQ, that information is filled out.

If you're not asking these people the correct questions, they're not giving you their full work history. Some people are just not good at communicating that part of their work history.

We have learned over five years how to, actually for me, it's my fifteenth year. But over the last five years, even more, more.

So, we've learned how to communicate

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with people to get aliases out of them. Processes out of them. Where they worked. Get this stuff documented correctly from the beginning.

But once that gets to, and they start communicating that to people that help them file their claims, authorized representatives, resource centers, we see a lot that it's not correct.

The resource center folks, and I'm happy for all their help, and our authorized representatives, but if you don't know the site that they're claiming for, or the processes that they've worked in, or the trades, or whatever it is, for that role, odds are you're not going to get that work history correct.

So, that information going in right off the bat is tainted. Then it's interpreted, and we can't expect the Claims Examiners to get this right every time if the information going in isn't correct.

We can't expect the IHs to get it right, or the CMCs to get it right, if it's not

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correct.

I really like the chart. I think we're headed in the right direction. But I don't see a way that we are going to, ever going to get it truly correct until we have some kind of an interview process that happens at the IH, or the CMC level.

I mean, really unless it's an SEC claim, there's got to be somebody that's knowledgeable verifying that information at that IH or CMC level is correct with the worker.

I know we've talked about this. I know we continue to work at it. I appreciate that. But I think that that may be the bridge that, in the immediate, can solve that problem.

Currently, we're working a claim right now for somebody that we went in and with all the aliases, right, the names, or the alias, or the job roles have changed so many times, that if you're a Claims Examiner and you did not work at those facilities, and you don't know how to interpret those aliases, and you start trying to

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verify the information, we have found that a power operator, for example, had several aliases, worked in several of the same facilities. But under different aliases, have different exposures.

Well, if we're trying to take that information, and that Claims Examiner does not have that information correct from the beginning, and they don't know how, or are not familiar -- for instance, we also have where we were pretty comfortable with the Seattle office in that Hanford area. But now their claims are being spread out through Cleveland, Florida, places like that.

Our Claims Examiners, we're struggling to set up some kind of a communication, or a history and some knowledge where they understand that site.

So, all in all, you put that all together and in the end when the recommended decision comes back for denial, and the, as Diane and I talked earlier, the claimant is basically,

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the burden's on you to come up with an answer, right.

How do I object, how do I rebut this information? What information, what doctor do I see? Who can I count on to help me verify my existence, my exposures.

The burden is nearly impossible for that worker to overcome.

If your primary care understands the minute you say EEOICPA, or Labor & Industries, for example, and I'm sure everybody here is aware of this, you're done.

In fact, normally in our area, if they find out you're coming in for any EEOICPA claim, or an L&I claim, they won't allow you to set up an appointment.

Or they'll tell you they're done supporting that appointment, or not having that discussion about that occupational condition.

So, now you've got a worker that doesn't have any resources to find that extra additional information that DOL's looking for.

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We have one individual that we know that works in that, in that world, but he services four or five states and the odds of getting in -- and some people just are not in a position to pay for that out of their pocket, right? And get that information they need, and the support.

So, I am super happy that the Board continues to have these conversations, and work this issue.

I think today we've identified some really great avenues to start closing those gaps. But unfortunately, it always sounds like we're picking holes in the DOL.

But the more we dig in, the more we find holes. And we haven't started filling those holes in that part yet, that, that's -- we have, but we haven't, and the claimant, and the claimants are still struggling.

I can tell you that's our major issue. And I think, I would hope that DOL would, would really get after this and partner with the Board,

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and try to find some ways to plug some of these major holes.

So, I appreciate your time. The HVEC is an office, we named it the HVEC because at Hanford, we like to you know, shorten everything up with some kind of a weird acronym, right?

But anyway, it's open five days a week, 10 hours a day. You can come in, you can call. We service other sites.

We're pretty good you know, most of the time the exposure, you're just plugging in different exposures to the programs.

We're pretty knowledgeable on the Procedure Manual so if anybody needs help, please give us a call.

CHAIR MARKOWITZ: Thank you.

Just a point of information, you know, there is a mechanism whereby an interview can be conducted.

There actually was a recommendation made by the Board years ago, accepted by the Department, whereby a claimant can request an

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interview around, to give additional detail on exposure.

MR. TEBAY: Yes, but we --

(Simultaneous speaking.)

CHAIR MARKOWITZ: So it's not used much, I understand.

MR. TEBAY: We haven't seen one to this day in our office, of all those that have ever been utilized.

CHAIR MARKOWITZ: But you can spread the word that it is a mechanism people can use, and they can reach out to DOL and request it.

MR. TEBAY: I do fear that if we do have an IH interview, that does not have a Claims Examiner or somebody from the DOL involved, we're not going to capture all of that information, right?

Because then the IM, the CIH is going to have potentially different information than the statement of the fact.

So, I think it takes more than just the CIH, but we do have to plug that hole.

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CHAIR MARKOWITZ: But as I understand it, that interview would be with the Claims Examiner.

MR. TEBAY: Okay.

CHAIR MARKOWITZ: That they would be, definitely be part of the process.

MR. TEBAY: Well, like I said, to this --

(Simultaneous speaking.)

CHAIR MARKOWITZ: This --

MR. TEBAY: -- to this day, that burden is put back on the claimant themselves, and that interview process is not being utilized.

CHAIR MARKOWITZ: Okay, thank you.

MR. TEBAY: Thank you.

CHAIR MARKOWITZ: Yes, take care.

Is that it? Okay, anybody else who want, we have a few minutes. Anybody else who wants to speak, you're welcome to come.

MS. STANTON: I would like to.

CHAIR MARKOWITZ: Sure.

MS. STANTON: If that's okay.

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CHAIR MARKOWITZ: Come on, come on up.

MS. STANTON: I'm a people person. I watched the reaction my husband got, and I want you to know the things that go on out there, that are not right, that are corrupt, that are wrong.

I've begged families not just as -- and our children, but they affect our parents, our siblings, something needs to be done to change the practice that goes on out there.

There cannot be another blind eye turned to what is going on. People's lives are changed and damaged, for the rest of their lives.

I have got my own health problems I'm trying to deal with, and every day I wake up with a husband who is breathing is a blessing to me. But that accident should have never happened. The Simmons family should never have lost their son the way they did.

I thank God every morning I get, I can spend one more day with my husband because it is a miracle that he is here today.

And no family should have to walk the

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shoes I'm walking in right now. I want you to hear this, and I want to see some changes.

And not just for me and for him, and our family, but for all of the other workers out there who are exposed and don't even know it.

Thank you for letting me speak.

CHAIR MARKOWITZ: Thank you.

Anyone else? Yes, come on up. Just give us your name.

MR. JACK STANTON: My name is Jack Stanton, and I'm Ralph Stanton's brother.

I'm a freelance writer. I knew nothing about what went on out there, or what goes on out at site on a daily basis.

And then he was in an accident. An accident where they falsified doses. They just happened to mishandle the urine for two days straight, both the A and B samples of the most affected.

You have 16 people coming in. There's evidence of them kicking the head of the lab out because she was complaining about it at a bus

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stop, every time their urine came in.

They flew somebody in to look at the blood counts from Oak Ridge, and he's like, oh my God. It's like historic, the exposure.

They stopped doing blood. Supposed to do it for two weeks. Why would you do that? Fecal matter. They gave him a clean bill of health. He was passing uranium. Legally, you're not allowed to do that.

At what point? Price Anderson gives contractors indemnity. They don't have any responsibility.

Several months before this accident, there was almost a Chernobyl. Contractors were allowed to write it off as something else.

Dennis Patterson's book, Whistleblower, describes what happened. These are criminal acts.

When you are hiding or destroying evidence, I hear this gentleman over here talking about aliases, and how they don't, you know, people have several aliases.

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You got one ID. Do you have several IDs, do you have several Q clearance, Sigma clearance? No, you have one.

And the simple fact is under the Price Anderson Act, government doesn't want to pay out of it, so they deny claims. They keep people ignorant.

This gentleman was talking about oh, there should be a change. Well, when somebody's in an accident, there should be a pamphlet that they're told their rights. That doesn't happen.

You have contractors who are trying to claim that medical done on workers, is work product. And that the workers aren't allowed to have their own medical. Now think about that.

And then they start sending them to psychologists. This is something, I talked to a New York Times reporter about this.

It's been going on since the '70s or '80s. You have a problem employee, send them to a psychologist who's on the take.

So you have a psychologist who sits

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there and does whatever the contractor says, so the person will lose their clearance.

Then they lose their clearance, they lose their medical, they're blackballed from the industry because they got in an accident or they were exposed. What did they do?

My brother, Brian Simmons, the other 14 people. Actually, there are more than 14 who were exposed, but 16 is the official number.

But there were actually more based on video tape and everything else, that they had to FOIA to get a hold of.

Those guys showed up to work to do their job that day. They were good employees. You had people that had Sigma clearances. You don't hear about Sigma clearances because it's top secret.

They nuked a lot of them. Wasn't your typical Q clearance. These were the best people. People who had done stuff.

And then you have the head of DOE Idaho going to meetings like this. And sitting

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there, allowing BEA and the other contractors, to sit there and lie.

They're able to sit there and keep your information from you, the FOIA guys laughing that you're never going to get certain information that you're entitled to.

And these people, all they did was show up to work. That's what they did.

Now, Department of Labor, I assume, has the ability to oversee when people are committing fraud, committing crimes. Because when you're falsifying information, isn't that a crime?

I have a time line of all the management that worked out there. It goes into their histories, their work histories, their education, their families, where they've been, what they've done.

These people who went about falsifying all this information got promotions. In the case of a former DOE head, he opened up a contractor business. He's the president, he's getting, what,

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million dollar contracts for looking the other way.

That's pretty great, pretty great. I didn't know anything about that. Now I have 100,000 pages of documents that it was a surprise to me.

I had workers coming up bringing me stuff that has nothing to do with that, that they kept after they left the site and retired.

I have maps where there are illegal dumpings that have happened. They're still contaminated, going down to Twin Falls through the aquifer.

It has nothing to do with what I'm doing, but you know, it's funny since 1957 and the Price Anderson Act that brought contractors in, I think there was one guy, one person who's actually gone to jail.

I mean, at what point do you not promote these people? At what point does the government get serious about worker safety, and prosecute people who are putting other people's

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lives in danger?

Hanford, Los Alamos, here, Oak Ridge. Why is it that they have higher incidents of cancer? Why is it that workers have higher incidences of cancer? It's because of that.

You got medical people. When they were in this accident, they were exposed to 5.5 million d per m of contamination. At 20, you should be in a suit. So, 5.5 is just a little bit more.

The DAC reading just going up, and up, and up as they're in the control room. And the contamination level is just exploding.

They were in literally one of the worst nuclear accidents since Three Mile Island, and yet the whole point of everything was to just hide the damage.

See, the thing is, if you aren't part of an accident, you're not entitled to have medical. And, that's the whole thing.

They're not going to sit there and let you go take medical tests, or pay people to see

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how badly contaminated you are. Because it will prove how bad the accident was.

At the time, BEA was coming up on their 2013 multi-billion dollar contract. And they had issues before that.

They were allowed to just like, here's the thing. People out at the site are professionals. So what are the odds that the lung count would be done wrong?

The urine would be botched? Fecal samples would be botched? And that the blood work would be stopped? What are the odds of that happening at that professional facility?

Now, either all these people that the site has hired are just horrible at their job and should be fired, or they're not horrible. They were told to do something else.

Now how is it that four tests, four tests, like seriously, would you keep people on staff who were that incompetent?

Or would you keep them on and give them promotions, because they did exactly what

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you wanted?

That's the whole thing, is math is math. How is it that all four things were allowed to happen, and get manipulated?

You've got people working out there who were exposed, who were having issues. They go to work every day because if they don't, they're not -- they're in their 40s, they're in their 50s.

If they go away, they leave that, they're not going to be able to pay the future medical. They're going to lose their homes, their houses, everything.

Because the site and the contractors, are allowed to do things that are basically illegal.

You're the Department of Labor. I used to drive. I have better protections than the nuclear workers. That blows my mind.

And also when it's proven. My brother proved in front of NIOSH, that his doses were falsified.

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At that point, there should have been an investigation into the people responsible. Because if they're doing it to him and the other 15 people, who else are they doing it to?

You read Dennis Patterson's Whistleblower book, you'll see the same names, the same people, doing the same stuff. Which is beautiful about having that book.

Because what happened to Dennis, and what happened to my brother, are two different things, but managers ultimately protected.

And by the way, this isn't about national security. Which a lot of times they say they can't do things because of national security.

It's because they don't want to admit how bad they are. They work on milestone bonuses out there.

If they don't get the work done on time, they don't get the bonuses. That's how managers make their money.

My brother filed a lawsuit along with

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Brian Simmons, because they started to get PRAF (phonetic).

They had a manager approach them a few weeks before this incident, and they wanted them to falsify 21 type-one work procedures. These are felonies, by the way.

Brian and Ralph said they're not going to go to jail for this guy, so they reported him. That manager wanted them, asked them if they could do it.

So, they reported it to the main guy who was just new on the job, and who also oversaw everything that happened later with the cover ups.

And then they sent him down to New Mexico for the accident down there. Some interesting reporting on that. It kind of follows a pattern we see.

So anyway, they want them to falsify, commit felonies. And you know what happened to those 25 type-one work procedures? I know the people they forced them to sign at the threat of

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their jobs.

Why would they do that? The work wasn't done. There's so many issues with this. So many issues.

When you sit there and you give contractors no responsibility, if they blew up the site, it's the government that's paying for it because of the Price Anderson fund.

They're going to do whatever they can to make money, but you know, for the ZPPR incident, they have a log book. Log book was present when the accident happened.

Now we would agree that that's one of the most secure sites in the world. Security does a fantastic job not letting anybody in. Or letting anything out.

Somehow, those log books just disappeared with all the information. And during that accident, they said oh, we've got them in our head.

That kind of medial information? People who aren't trained medical? But also the

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doctor out there, these guys were in a nuclear accident with horrendous readings.

In the DOE report, they put it down as all 16 people just happened to get a case of influenza.

The flu? Seriously? You're part of a nuclear accident and you just got the flu, and that's why everybody's throwing up. Not the radiation that they were exposed to, of course.

The CAM went off for the first time in five years. The outside CAM to the outside world. This is in the DOE report.

And I don't know about you, but what are the coincidences that the constant air monitor that leads to the outside world, went off for the first time in five years?

Since right after a nuclear accident, right after, somehow BEA decided it was a radon leak.

Never went off before with a radon leak. It did that day, right after a nuclear accident.

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Everyone caught the flu, right after a nuclear accident. That day. Nobody else did. No, the doctor didn't test for the flu, by the way, but that was his conclusion. It's in the DOE report.

Why would somebody at the DOE okay that kind of report? That's what happening just, I could sit there and, hate to say it, I can go on for hours because when you study something, and you research, and you have 100,000 pages of documents, you can go on forever, and you shouldn't have to.

They didn't have showers available at the facility.

I tracked down the guy who probably put the plate in that caused the exposure 30 years before. I tracked him down. He's the only one who's still alive from the people who worked at ZPPR.

Do you know one thing? They worked with contamination suits, they had showers at the facility.

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I tracked down people who said there are showers out at the site that the cisterns below, which are treated as waste, are full at the end of the fiscal year.

And they're not cleaned out because they all know contractors want to pocket the money, and then ask the DOE for more money.

Why the hell wouldn't you have operational showers? That's like, that's like nuclear accident 101.

They were swabbing my brother down with handi-wipes, the types that you get at Kentucky Fried Chicken, which closes the pores and locks the contamination in. It doesn't clean it off.

He took contamination home because he didn't have a shower. Their vehicles were contaminated. Their homes were contaminated.

The nuclear signature coincides with the nuclear signature of the accident. Meanwhile, you have BEA, you have all these managers talking about oh, it can't be from the nuclear accident

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even though it had the signature.

Brian Simmons and Ralph had to spend tens of thousands of dollars to get independent labs because you know what? The government threatens to withhold funding to most labs who work with them, if they don't follow and play with the play book.

So, anyway, there's so many issues and you've got to do something. I'll tell you one thing. Make people criminally responsible when they do things like this, because they are killing people.

We put people in jail for killing people. You deny them health care. You make it a slow death. You literally make it a slow death. That's just B.S., you know? Seriously.

Then you take away their careers. Take away, my brother's driving a truck. He's one of the smartest people I know.

It's because he's not in the nuclear field anymore. You had Brian Simmons who, when he was having issues, they were associated with the

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exposure.

They weren't going to give him any help, because to help him would be to admit it. To admit it would be to somehow lose financially.

BEA got a clean bill of health. They got their safety bonus. I think 100 percent for 2011 despite having one of the biggest nuclear accidents since Three Mile Island, in this country.

What was safe about that? So anyway, I appreciate your time.

CHAIR MARKOWITZ: Thank you, thank you.

MR. JACK STANTON: Have a good day.

CHAIR MARKOWITZ: Yes.

MR. SIMMONS: My name's Hal Simmons, Brian was my son. And if I could teach any of you about this, it is that when you go home tonight, are you an honest person?

Because evidently the people out there that were in management and in the medical profession, are not honest people.

Now, you depend on a doctor to give

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you a prescription, right? My son didn't get a prescription. He got, well, you got influenza.

For nine months him and Ralph drove back and forth together, and sat in the basement to do nothing because they were so contaminated, they couldn't be around the other people. But nobody wanted to admit that.

I'm telling you, my son was told at 27 or so thereabouts, that he couldn't have any kids. They knew that.

I don't know what I can do here today to get you to make people responsible that should be responsible for their working people.

I have a business. I'm responsible. If somebody gets hurt, I help them take care of it. I make sure they get the --

My son was an honest person, and he was pretty damn good at what he did because he, they had him help build the Mars Rover battery, which is up there evidently now, doing its job.

He was also told that when they needed to train new people, they brought them to Brian

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to teach them.

When they needed a critical thing done, they brought them to Brian to do it.

But they also had managers that got right in his face and screamed at him, and tried to tell him that he had done something that he hadn't done.

And I don't know the story, but somebody brought a teddy bear out there with something on it, and they accused Brian of doing it.

And Brian says, I didn't do it. I can tell you today, my son's an honest person. He called me the day of the accident and he says, dad, it's pretty bad.

He says, I've been in an accident and I don't know what's going to happen. The next day he says, I'll call you back.

The next day he calls me back. Meanwhile, I'm freaking out, you know, what's happening to my son?

He says, well dad, they brought a

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accident report and they want me to sign it. And I says, he says, it's not right, but he says, it's close.

I said to him, okay, Brian, my history is you either sign it and give it back to them and go along with their, whatever they're doing, or you mark out what you don't believe in, and write it back.

So I took it that he marked out what he didn't know was right and sent it back, because him and Ralph went to court on it.

You know, we talk about the, what's the air force base that they're having the contaminated water?

And they have billions of dollars set by. You know, this is basically no different than our military people coming back and not being able to get the support they need to help them, because they sacrificed.

I am saying that what would really be great and make me happy, is that if you could go after these contractors that were falsifying this

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shit, and that's what I'm going to call it, shit, and contaminating these people.

I also know some of the other people that were there at the facility. Ralph and Brian were told that they couldn't talk to them.

Well, what the heck's with that? They were all there. They all know what happened. I mean, you guys, the more you dig into this, the deeper the pile of you know what gets.

And I don't know about you guys, but my son at about 27 years old told he can't have kids, and yet he's stuck in a basement for nine months because he's got influenza.

Come on, where's the doctors? These guys are getting paid. We, the people, are paying their wages. What the crap are we paying for here?

All's I'm trying to tell you is, is yes, if I could grab them by the throat, I'd do it. And I don't care if that goes out to everybody on record.

Because they're liars, they're

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cheaters, and they're just -- if that's the way business is done, we ought to shut the whole damn thing down.

Thank you.

CHAIR MARKOWITZ: Thank you.

So, I think that's the end of our public comment session.

Thank you to all the people who provided comments. They're very meaningful to us.

And I think I turn it over to Mr. Jansen, adjourn for the day?

Oh, we have one more? Oh, okay, come on up.

Will you just give us your name?

MS. THATCHER: Yes. I'm Tami Thatcher, I'm a former safety analyst at the Idaho National Laboratory.

I remember when the accident happened. I wasn't working there, but I was very interested to follow what the doses for the workers were, and so forth.

And waited for the reports to come

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out, and started studying. And it's been a long time of studying.

And I became acquainted with Ralph, and his family. And I continued to study. And there were such strange things.

Because there were lung counts taken, and because INL did not have a procedure for translating the lung counts into a dose, the lung count reports results were then given to Oak Ridge, because they had a procedure for translating the lung counts into a dose.

Which they did. And yet that report, which the workers were never supposed to see, but did get emailed to them kind of by accident.

His first day's lung count wasn't in that report. That first day's lung count would have shown a six rem whole body dose, over the annual limit.

So, it simply was excluded from what was sent to Oak Ridge. That was interesting.

Ralph's lung count, his first day lung count was the highest of the group. Brian's was

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the second. Ralph was the closest to the material.

Each lung count I now would give, the dose would get lower. Well, the you know, intake would get lower, and lower. Each lung count that they gave.

As I studied those lung counts, there were actually error messages in the reports, peak surge errors. And other error messages.

And BEA would claim this was no contamination. There was no intake, there was no contamination.

And you had these error messages. And you have, if you start looking at them, all kinds of irregularities in the lung counts.

And the reason for it was they were so contaminated, that their normal way of manipulating the lung counts didn't get rid of the doses.

The fact is, the software for the lung counts allow the operator to input gain factors, peak delete functions, that are not documented in

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the lung counts.

And the irregularities in the lung counts, and the tweaking that went on, are criminal. And basically, NIOSH should never accept results from any site as being honest for the lung counts.

That six rem was an under estimate based on his actual nasal swabs, which were over 4,000 dpm in a single nostril for just plutonium-239, not the americium.

The fact is, they expected their lung counts would cheat successfully. And it wasn't happening smoothly, because they were so contaminated.

And the lung count process used by the Department of Energy, allows the operator to tweak it, manipulate it, and lower the doses.

That's why Ralph's whole body dose is far greater than six rem. It's far higher than the lung count showed.

And, BEA's final dose for Ralph was 102 millirem from that accident. That's 100 times

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too low.

So, you just ought to be aware of, you know, more of the dose fraud. It's real.

Thank you.

CHAIR MARKOWITZ: Thank you.

I think that concludes our public comment session.

Thank you very much for all the public commenters, and we will adjourn for today and resume tomorrow at 8:30.

Thank you very much.

(Whereupon, the above-entitled matter went off the record at 5:26 p.m.)

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