

## UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER  
HEALTH

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## SUBCOMMITTEE ON SITE EXPOSURE MATRICES (AREA #1)

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## MEETING

+ + + + +

MONDAY,  
JULY 11, 2016

+ + + + +

The Subcommittee met telephonically at  
1:00 p.m. Eastern Time, Laura Welch, Chair,  
presiding.

## MEMBERS

## SCIENTIFIC COMMUNITY:

JOHN M. DEMENT  
MARK GRIFFON

## MEDICAL COMMUNITY:

STEVEN MARKOWITZ  
LAURA S. WELCH, Chair

CLAIMANT COMMUNITY:

KIRK D. DOMINA  
GARRY M. WHITLEY

OTHER ADVISORY BOARD MEMBERS PRESENT

FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

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

2 1:05 p.m.

3 MS. RHOADS: Good morning, everybody.

4 My name is Carrie Rhoads, and I would like to  
5 welcome you to today's teleconference meeting of  
6 the Department of Labor's Advisory Board on Toxic  
7 Substances and Worker Health, the Subcommittee on  
8 the Site Exposure Matrices, or SEM. I'm the  
9 Board's Designated Federal Officer, or DFO, for  
10 today's meeting.

11 First, we do appreciate the time and  
12 the work of our Board members in preparing for  
13 this meeting and for giving us their time today.

14 I will do a short roll call just to  
15 make sure that everyone is on the line.

16 Dr. Laura Welch is the Chair. Are you  
17 on the line?

18 CHAIR WELCH: Yes.

19 MS. RHOADS: Okay. And Dr. John  
20 Dement?

21 DR. DEMENT: Here.

22 MS. RHOADS: Mr. Garry Whitley?

1 MEMBER WHITLEY: Present.

2 MS. RHOADS: Mr. Kirk Domina?

3 MEMBER DOMINA: Yes, here.

4 MS. RHOADS: Mr. Mark Griffon?

5 MEMBER GRIFFON: Here.

6 MS. RHOADS: And Dr. Steven Markowitz?

7 MEMBER MARKOWITZ: Here.

8 MS. RHOADS: Ms. Faye Vlieger is also  
9 a member of the Advisory Board. She is also on  
10 the line.

11 MEMBER VLIEGER: Yes. Thank you.

12 MS. RHOADS: Great. We are scheduled  
13 to meet from 1:00 to 3:00 p.m. Eastern time  
14 today. Since this is only a two-hour meeting, we  
15 are not planning on taking any breaks.

16 Copies of all the meeting materials  
17 and any written public comments are or will be  
18 available on the Board's website under the  
19 heading "Meetings" and the listing there for this  
20 Subcommittee meeting. The documents will also be  
21 up on the WebEx screen, so everyone can follow  
22 along with the discussion.

1           The Board's website can be found at  
2           dol.gov/owcp/energy/regs/compliance/advisoryboard.  
3           d.htm. Or you can simply Google "Advisory Board  
4           on Toxic Substances and Worker Health," and it  
5           will likely be the first link that you see.

6           If you haven't already visited the  
7           Board's website, I encourage you to do so. After  
8           clicking on today's meeting, you will see a page  
9           dedicated entirely to today's meeting. The web  
10          page contains publicly-available material  
11          submitted to us in advance of the meeting. And I  
12          know these were posted a little late. Apologies  
13          for that. The agenda is probably up there or  
14          will be soon. And we will publish any materials  
15          that are provided to the Subcommittee on that  
16          website.

17          If you are participating remotely and  
18          you are having a problem, please email us at  
19          energyadvisoryboard@dol.gov.

20          If you are joining by WebEx, please  
21          note that the session is for viewing only and  
22          will not be interactive. The phones will also be

1 muted for non-Advisory Board members.

2 Please note that we do not have a  
3 scheduled public comment session today. The  
4 call-in information has been posted on the  
5 Advisory Board's website. So, the public can  
6 listen-in, but not participate in the  
7 Subcommittee's discussion.

8 I have been asked about meeting  
9 minutes and transcripts. The Advisory Board  
10 voted at its April 26th to 28th meeting that  
11 Subcommittee meetings should be open to the  
12 public. A transcript of the meeting will be  
13 prepared from today's meeting. During the Board  
14 discussions today, as we are on a teleconference  
15 line, I would just like to remind everybody to  
16 please speak clearly enough for the transcriber  
17 to understand, and when you begin speaking,  
18 especially at the start of the meeting, please  
19 state your name, so that we can get an accurate  
20 record of the discussion.

21 Also, I would like to ask the  
22 transcriber to please let us know if you are



1 having an issue with hearing anyone or with the  
2 recording.

3 As the authority that minutes are  
4 prepared and enter the certified WebEx share, the  
5 minutes of today's meeting will be available on  
6 the Board's website no later than 90 days from  
7 today, per FACA regulations. If they are  
8 available sooner, they will be published before  
9 the 90th day.

10 Although formal minutes will be  
11 prepared, we will also be publishing verbatim  
12 transcripts, which are, obviously, more detailed  
13 in nature. Those transcripts should be available  
14 on the Board's website within 30 days.

15 I would like to remind the Advisory  
16 Board members that there are some materials that  
17 have been provided to you in your capacity as  
18 special government employees and members of the  
19 Board which are not for public disclosure and  
20 cannot be shared or discussed publicly, including  
21 in this meeting. Please be aware of this as we  
22 continue the meeting today.

1           And with that, I convene this meeting  
2 of the Advisory Board on Toxic Substances and  
3 Worker Health, Subcommittee on the SEM. I will  
4 now turn it over to Dr. Welch, the Chair of this  
5 Subcommittee.

6           CHAIR WELCH: Thank you, Carrie, and  
7 thanks, everybody, for being here.

8           Carrie and I discussed what materials  
9 we might want to use for this introductory  
10 meeting, and she had sent those in an email. And  
11 now, I do see that they are also available on our  
12 Subcommittee page.

13           What I wanted to do initially is go  
14 over the charge to the Subcommittee, which in the  
15 materials that we had before our first Advisory  
16 Board was to advise DOL on the SEM. So, it is a  
17 very broad statement.

18           And then, I wanted to review the memo  
19 -- DOL made a presentation and they have a  
20 written documentation of specific requests from  
21 them. And I think that one of the big questions  
22 I wanted get resolved with all of us today is

1 what we think our scope of work consists of, and  
2 I have some suggestions about that.

3 So, just by way of background, we  
4 heard at the Advisory Board meeting that the  
5 Institute of Medicine had already done a review  
6 of the SEM, and that document is available to all  
7 of us. It originally was provided to the overall  
8 Committee and it is on our website.

9 And that does lay out a lot of  
10 recommendations for the Department of Labor, one  
11 of which was to establish an expert Advisory  
12 Board for the SEM. The Department of Labor  
13 didn't tell us explicitly that that is the charge  
14 to the Subcommittee or to the overall Board, but  
15 the IOM report did say that the law permitted and  
16 recommended the establishment of this Board. So,  
17 I think it is reasonable to presume that one of  
18 the recommendations from the IOM was the DOL  
19 responded to that by establishing the Board.

20 What DOL has asked us to do, there  
21 were four specific points on policy guidance, on  
22 links between exposure and disease.

1           And, Carrie, this is down on page 9,  
2           if you can provide that document all the way down  
3           to page 9, the one you have open on the WebEx.  
4           There we go.

5           So, let's see. Yes, so, then,  
6           starting at the top, they are not specifically  
7           itemized, but we want the Committee to provide  
8           the DEEOIC policy guidance on linkages between  
9           toxins and occupational disease.

10          And then, there are the specific  
11          diseases for which they want guidance about  
12          causation, including whether the ones that are  
13          listed at the very bottom, and there's some on  
14          the next page as well, but don't move to that  
15          yet. These conditions somehow affect the  
16          exposure response/linkage.

17          Then, the third point was how we  
18          modify the SEM to better convey information and  
19          how to help DOL set up priorities for their  
20          contractors and adding new data to the SEM.

21          Now the IOM already made some -- I  
22          think they are good recommendations for that

1 third point, modification of the SEM to better  
2 convey information. And in their report, they  
3 did a pretty good job, in my opinion, they did a  
4 nice job of laying out for us what work needs  
5 doing.

6 So that my overview introduction is  
7 that our overall charge is to advise DOL on the  
8 SEM. And then, DOL asked us some very specific  
9 questions that go very quickly down to policy  
10 guidance on specific diseases.

11 So, Carrie, could you back to my  
12 agenda for the call?

13 I thought, on my point No. 4 here, I  
14 thought it was helpful for us to talk among  
15 ourselves and, then, clarify with DOL if we need  
16 to the issues and scope of the Subcommittee's  
17 topic area. And if this is what we get done  
18 today, that is perfect, but there are other  
19 things on the agenda.

20 We are supposed to focus on SEM, but  
21 we haven't been asked to assess the entire  
22 process by which DOL assesses exposure for the

1 claimants. IOM, and I know I, for one, on our  
2 Committee, sees there are holes in the way that  
3 the causation analysis can be done if you only  
4 use SEM. But I guess, can we on our own say,  
5 well, we want to see -- say, for example, it is  
6 the Occupational History Questionnaire; it can be  
7 in its own right a way to demonstrate causation  
8 based on things that are reported there,  
9 exposures reported there, or TACs, for example,  
10 that may not be part of the SEM. Or do we need  
11 to make sure we are focusing on the SEM? There  
12 may be a way to do both. And I think I would  
13 really like to take some discussion to get  
14 thoughts about that. And then, we will get to  
15 the "b" and "c".

16 Do people on the Committee think that  
17 we should call ourselves, instead of the SEM  
18 Subcommittee, the Exposure Assessment  
19 Subcommittee? Any thoughts on that?

20 DR. DEMENT: This is John Dement,  
21 Laurie.

22 I think we have to look at the

1       totality of the information that goes into the  
2       exposure assessment.  So, I would say that we  
3       ought to be the Exposure Assessment Committee  
4       encompassing the occupational history process,  
5       including the form itself, but also the process  
6       of obtaining that history and how that history is  
7       used in connection with the SEM for exposure  
8       assessment and what holes are there.

9               CHAIR WELCH:  Do other Board members  
10       have a thought about that, about John's?  I think  
11       John expressed what I was trying to, except very  
12       clearly.  Do other people agree or disagree with  
13       that approach?

14               MEMBER WHITLEY:  Garry Whitley here.

15               I believe I agree 100 percent because  
16       the SEM database is so large and so incomplete  
17       that we have to be that Committee and look at  
18       other things out of the database.

19               MEMBER MARKOWITZ:  This is Steven  
20       Markowitz.

21               Actually, you know, the SEM includes  
22       not just exposure, but the links to diseases by

1 encompassing this Haz-Map database. And in the  
2 IOM report, which I know we will discuss later in  
3 the agenda, they take aim not just at SEM, but,  
4 in fact, as much as the Haz-Map database, at SEM  
5 and SEM's use of the Haz-Map.

6 So, you know, one could argue that,  
7 even beyond exposure assessment, that this issue  
8 really involves the linkages to diseases. I am  
9 not saying that that should be a primary goal,  
10 but I think it was to be part of the discussion.  
11 Because if we draw the limit at exposure  
12 assessment, then we will be missing a major  
13 piece.

14 And finally, I will say that,  
15 actually, DOL in their list of requests that  
16 Laura just reviewed, the No. 1 request was taking  
17 20-odd diseases, including Parkinson's disease,  
18 prostate cancer, et cetera, and asking for our  
19 help on diagnostic criteria, but, also, what does  
20 it mean; what does the literature show in terms  
21 of causation, contribution, or aggravation? So,  
22 I think DOL sees this issue as broader than just



1 exposure assessment.

2 CHAIR WELCH: Okay. No, I think you  
3 are right, Steve. I didn't mean to say we were  
4 going to forget about the exposure disease links.  
5 I just thought if we are constrained to using SEM  
6 as a way to assess exposure, it would become  
7 complicated. It is not impossible, but it may be  
8 that exposure -- and IOM did point out that  
9 complex mixtures are not dealt well with in SEM.  
10 So, if they are complex mixtures that are  
11 suggested by occupational history, maybe you can  
12 use data on that without having to force it into  
13 the SEM model, that we could get there.

14 But, no, I totally agree it is very  
15 important to look at IOM's recommendations and  
16 see if we have others to add or how we would  
17 implement what they recommended on that  
18 disease/exposure link. Clearly, that is what the  
19 SEM is there for, and they are finding many ways  
20 in which they think it is falling short.

21 MEMBER DOMINA: This is Kirk. I have  
22 a couple of questions.

1           During our meeting in April in D.C. I  
2           asked specifically -- well, Rachel brought it up  
3           that there are two different SEMs, one that the  
4           public gets to look at and the one that DOL uses.  
5           And so, to me, not knowing what that gap is, and  
6           not having access to it because she said that she  
7           would check in to find out if we could have  
8           access to it, and we are -- what? -- two-and-a-  
9           half months later and I haven't heard anything.  
10          So, that concerns me a little bit because, you  
11          know, it could be little; it could be large.

12                 For somebody out of the claimant side  
13                 saying that you weren't exposed to chemical X  
14                 because it doesn't show up on the SEM, what SEM  
15                 are they talking about?

16                 And I agree with everything else that  
17                 was said before this, but there needs to be  
18                 something done. And then, also, if not, then get  
19                 us clearances so we can access it. Because we  
20                 know NIOSH has seen a lot of stuff, and there are  
21                 DOE sites that have Special Exposure Cohorts that  
22                 also don't have any SEMs. And so, that is

1 another concern.

2 So, you take some of these other sites  
3 that may be smaller that don't have a SEM. It  
4 makes it that much harder for the claimant to try  
5 to get their claim through.

6 CHAIR WELCH: Well, that is a very  
7 good point which I didn't know about, that there  
8 are sites without SEMs.

9 In the IOM report they do discuss the  
10 fact that there are two different databases. And  
11 possibly in the memo that we got from DOL, the  
12 one that claims examiners use has fewer specific  
13 toxins than the one that is publicly-available.  
14 And DOL was saying that is because they are  
15 trying to consolidate across brand names that may  
16 be the same toxic exposure.

17 But I agree with you. I mean, we  
18 definitely need an answer to that question.

19 Carrie, do you remember if that ended  
20 up on the items to-do list?

21 MS. RHOADS: Yes, I think it did, and  
22 they have been talking about it. I will have to

1 make sure that I get a final answer on that  
2 probably this week.

3 CHAIR WELCH: Okay. And along those  
4 lines, we had asked for some general claims data,  
5 which we haven't gotten yet, either. I mean, one  
6 of my thoughts was, if a very high proportion of  
7 current claims are for specific medical  
8 conditions, we want to make sure that we have  
9 those tightened up, so that claimants can have,  
10 whether it is by presumption or whether it is by  
11 improving the SEM, so that the whole process can  
12 work smoother for a big number of the claims.  
13 But we have not gotten yet disease-specific claim  
14 data.

15 And I know you asked them for that,  
16 Carrie, to see if you could get it in advance of  
17 this meeting, but do you have any idea on the  
18 timeframe for getting that info?

19 MS. RHOADS: We have already asked  
20 them for it. They are working on it. And there  
21 are a number of outstanding ones that I will  
22 follow up on and see how much longer it will be.

1 CHAIR WELCH: Okay. Good.

2 MS. RHOADS: But I know they are  
3 working on them.

4 CHAIR WELCH: Okay. The point b I had  
5 here under 4, the Procedure Manual lays out what  
6 items can/should be used to assess exposure.  
7 Unless there is some circular that overrides  
8 that, it pretty much says the claims examiner can  
9 use other information. They can use the exposure  
10 information from a worker program questionnaire,  
11 for example.

12 If the SEM does not show a specific  
13 exposure, but they have information someplace  
14 else, they are allowed to accept that other  
15 source. It does seem that what we hear from  
16 authorized representatives and workers is that  
17 the claims examiners seem to rely on the SEM. If  
18 it is not there, other sources aren't really  
19 showing up.

20 But that is something that I think we  
21 should reinforce from our Committee, that the way  
22 the Procedure Manual lays out with other options

1 and that the SEM may be incomplete, and something  
2 else may be probative, we should at some point  
3 reinforce that.

4 DR. DEMENT: Laurie, this is John.

5 One of the things that I noted during  
6 our discussion at the last complete Board meeting  
7 was the example that we reviewed was a COPD case,  
8 and the individual had worked at a number of  
9 sites. Probably the only thing, at least in the  
10 information that we were given that was used from  
11 the actual history completed by the worker was  
12 the occupation and site and the timeframe.

13 And then, the SEM information was used  
14 almost exclusively, it appeared to me, for the  
15 referral to the IH for the exposure assessment.  
16 And it is really circular. I will look back at  
17 the IH exposure assessment; the only thing that  
18 comes under the Haz-Map are three different  
19 exposures for COPD, and one is a biologic agent  
20 and the other two are diesel and it is cement  
21 dust. And so, the assessment by the IH was  
22 completely based on information that came out of

1 the SEM and not related at all, except for  
2 occupation and site, from the history. To me,  
3 there is a major disjoint in that whole process  
4 if this is a good example of how it is  
5 essentially being used.

6 CHAIR WELCH: Yes, and, John, I agree  
7 with you. I mean, I think you pointed that out  
8 at the meeting. I have seen that from the claims  
9 that I have reviewed, too, that the other sources  
10 either aren't even mentioned in the file or the  
11 SEM seemed to be more important. If there was an  
12 exposure reported by the worker that wasn't in  
13 the SEM, it was not considered probative. I  
14 mean, it is just definitely something we have to  
15 keep in mind along the way.

16 We are probably going to have to have  
17 some conversation with the committee that is  
18 reviewing the IH role because that is very  
19 important.

20 MEMBER MARKOWITZ: This is Steve  
21 Markowitz.

22 It sounds like where we might be

1 heading is, if we at some point look at a number  
2 of claims to see how things actually work, that  
3 we would want to identify -- and maybe this is  
4 just repeating what you are saying -- but  
5 identify the various pieces that are used to  
6 construct the exposure and, then, the role of the  
7 various personnel in using and interpreting that  
8 information from the start to the end.

9 CHAIR WELCH: Right. That's good.

10 DR. DEMENT: I agree with Steve. This  
11 is John. I agree with Steve. I think, again, as  
12 we did with the last committee that we discussed,  
13 I think we do need to look at the totality of the  
14 process.

15 The example of the COPD case I think  
16 is one. I think we need others to take a look at  
17 pretty much the algorithm, if you will, that is  
18 used to come up with determination of causality  
19 or not.

20 CHAIR WELCH: And when John and I were  
21 both on the Committee related to the Part B lung  
22 disease, then we did request that DOL pull out



1 specific cases for us to review, and I do think  
2 that would be helpful. It may be a little bit  
3 harder to figure out what they are, I mean what  
4 cases they are, although it could be the last,  
5 you know, 50 that went to the IH for review. It  
6 sounds like they are all, that a lot of them are  
7 going to NIH for review. And that is something  
8 really obvious to the claims examiner. That may  
9 be the best way to get a sense of how the inputs  
10 are being used.

11 DR. DEMENT: I know we are driven by  
12 some questions about specific diseases, Laurie,  
13 that are on that list, and I think those are  
14 important. But it seems like the work of our  
15 Committee also ought to be driven by the some of  
16 the most frequent ones that are being processed  
17 and whether or not they are accepted or denied.

18 The Part B Committee looked at some  
19 data from the claims process. It came in an  
20 Excel spreadsheet. I don't think it represented  
21 the Part E claims very well; at least what we had  
22 I don't think does.

1           So, the question to me is whether or  
2 not we really want to look at some of that data  
3 early on to try to direct us on where we might  
4 get the most bang for the buck.

5           CHAIR WELCH: Yes, you know, I think  
6 we do. I think we do, both because it would be  
7 most helpful -- I mean, during the course of the  
8 meeting, I think that Rachel Leiton had said to  
9 me just in a side conversation that a lot of the  
10 claims they are getting are for COPD. I can see  
11 ways in which their process is going to continue  
12 to fail for COPD and make it very time-consuming,  
13 even if people do eventually get their claim  
14 accepted.

15           I think very concretely, if we were to  
16 try to fix something related to these common  
17 diagnoses, if we understood the process and the  
18 inputs, we would end up probably improving the  
19 process for all the claims.

20           But we did ask for it. I mean, what  
21 we asked for was a breakdown by ICD code of the  
22 claims, of applications and accepting and

1 denials, which should be similar to the  
2 spreadsheet that we saw for beryllium. It has  
3 just got a lot more ICD-9 codes in it. But if  
4 they were able to produce that for beryllium, I  
5 am confident they could product it for us, which  
6 has got thousands and thousands of claims.

7 DR. DEMENT: That is just computer  
8 work.

9 CHAIR WELCH: Exactly. It is just  
10 John's computer work. I want to tell the rest of  
11 the Committee he did a beautiful job on doing  
12 something with that Excel spreadsheet with  
13 beryllium cases.

14 So, yes, I thought that we would kind  
15 of get our charge together, but we might not be  
16 able to do -- well, there is probably a lot we  
17 could do, but I would really, really like to see,  
18 and I am sure the whole Committee would like to  
19 see some statistics on the kind of claims that  
20 are coming in and, also, how many of those have  
21 been approved or denied.

22 I think No. 5 was already discussed,

1 No. 5, on how will our Subcommittee  
2 interact/overlap with the Subcommittee assessment  
3 role of IH. I mean, once we do what Steven  
4 suggested, look at reviewing all the inputs, who  
5 reviews it, how they use it, all through the  
6 process, that certainly would overlap with the  
7 other Subcommittee. But that is fine because we  
8 may approach it from one point of view and they  
9 may approach it from a different one. I don't  
10 think it is inefficient.

11 Does anybody have any thoughts on  
12 that? Otherwise, I will just keep going.

13 DR. DEMENT: My thought is to get  
14 pretty much the database on the claims in  
15 totality, Laura.

16 CHAIR WELCH: Yes.

17 DR. DEMENT: And then, based on that,  
18 we can look at the frequency of acceptance and of  
19 denial based on some of these ICD codes. And  
20 then, I think we ought to pull some kind of  
21 stratified sample of the ones that are by some of  
22 the major categories and take a look at them in

1 more detail.

2 CHAIR WELCH: Yes.

3 MEMBER MARKOWITZ: It is Steve  
4 Markowitz.

5 We should also look at some of the  
6 less common diseases or outcomes that people make  
7 claims for. I am sure you didn't mean that we  
8 are only going to look at the most common, but  
9 some of the less common may be looked at  
10 differently in the process. We just want to make  
11 sure we don't entirely bypass them.

12 DR. DEMENT: Yes, I agree, and the  
13 list that they gave us, some of them are fairly  
14 common, but with low-probability of occupational  
15 linkage on some of them. And some of the more  
16 rare ones may have even a greater probability of  
17 occupational linkage, if we look closely at the  
18 literature.

19 CHAIR WELCH: Yes. So, when we get a  
20 database back, we can look at some or even all of  
21 the ones on their short list. I mean, we can get  
22 a sense of, when they said the ones that are

1 associated with aging, dementia, and Parkinson's  
2 disease, you could see this whole population as  
3 aging. People are developing more of those  
4 conditions. And then, it is important to have  
5 DOL define how you could determine in any  
6 individual case whether it is work-related.

7 So, once we get the overall claims  
8 analysis by ICD code, we can -- John suggested a  
9 stratified sample to look at some illustrative  
10 cases with more detail on there around common  
11 diagnoses, but also be sure to include definitely  
12 some on their list, if not all the ones on their  
13 list which they specifically asked for our  
14 assistance.

15 MEMBER MARKOWITZ: Steve Markowitz.

16 I just want to look at the timetable  
17 a little bit in reference to this idea about  
18 looking at certain claims and when it might  
19 happen. We are waiting for DOL to produce some  
20 database, some information about what different  
21 diagnoses are, occurred within claims, the  
22 frequency.

1           We meet October 19th, or something  
2           like that, 18th, 19th, so roughly two months,  
3           three months from now. Are we hoping, is this  
4           Subcommittee, as a Subcommittee, are we hoping  
5           to, once we get the next round of information  
6           from DOL, hopefully, within a few weeks, we are  
7           hoping to request a certain number of de-  
8           identified claims to look at before the next full  
9           Board meeting, so we have a better understanding?  
10          I just want to see where we are heading. That's  
11          all.

12                   CHAIR WELCH: That would be my hope,  
13                   yes.

14                   MEMBER MARKOWITZ: Okay.

15                   CHAIR WELCH: And so, it is really  
16                   more how do we get DOL to move on that request.  
17                   I mean, there are probably a lot of requests that  
18                   went in, I mean action items, some of which are  
19                   less important than this, in my opinion. Maybe  
20                   there is some way to move this request up higher.

21                           But, yes, what we could do -- and we  
22                   do have the timeline down there -- we could

1       decide we are going to schedule another  
2       conference call, say, a month before the October  
3       meeting, with the idea that, prior to that, we  
4       would have been able to look at the database.  
5       And Carrie and I, maybe by email, we can decide  
6       which claims we want to look at, get a chance to  
7       look at them, and have at least some time to  
8       discuss at the end of September.

9                   MEMBER MARKOWITZ: This is Steve  
10       Markowitz. I mean, I'm just there, Laurie.

11                   CHAIR WELCH: Yes.

12                   MEMBER MARKOWITZ: If we have a call,  
13       this Subcommittee has a call September 20th and  
14       hasn't looked at claims, we know it is going to  
15       take them a while to prepare 50 claims, or  
16       whatever number we want, de-identify and prepare  
17       them. I am just wondering, I know we are held up  
18       right now because we don't have the database we  
19       need to sort of look at, but we, nonetheless, I  
20       think need a plan.

21                   Ideally, we would look at those claims  
22       before we talk again towards the end of



1 September. That is, I guess, my point.

2 CHAIR WELCH: Yes, that was my  
3 thought, too.

4 MEMBER MARKOWITZ: Okay.

5 CHAIR WELCH: It would be great if we  
6 had the database today and we could all choose  
7 what we want to look at, or at least discuss it  
8 and email Carrie what we want to look at.

9 Now we are kind of imagining what the  
10 database might show us when it comes to  
11 diagnoses. In abstract, we could say we want to  
12 look at so many files of the top three diagnoses  
13 and so many files of their shorter list. That is  
14 one way to approach it, so that we don't need two  
15 calls. You could leave it up to me to choose  
16 some once we get the spreadsheet and, then, we  
17 would have our call in September and people would  
18 then say, "Well, these are useful, but we are  
19 going to need more. I mean, there is something I  
20 really wanted to see." I think that might work.

21 Or we could get the data. Carrie  
22 would send it out to everyone, and people could,

1 then, respond to her with their requests of what  
2 files they would like to review. So, there are a  
3 couple of options.

4 But I agree, whether it will get done  
5 in that timeframe, but we would give DOL -- I  
6 will say we would get it from DOL in three weeks  
7 and, then, we could request cases.

8 Steven, do you think we want to try to  
9 have a conference call to discuss the large  
10 dataset? I was feeling like we can't quite get  
11 that scheduled; we can't have two calls before  
12 the October meeting.

13 MEMBER MARKOWITZ: Probably not. I  
14 mean, it requires six weeks' lead time, right,  
15 the Federal Register notice? So, probably not.

16 But I think, once Carrie finds out the  
17 timetable for getting the first round, either  
18 plan you suggest, either you selecting or people  
19 write in with their requests, then we can  
20 formulate the request for claims. And hopefully,  
21 that won't take all that long for them to produce  
22 the claims, that we could have looked at

1 something by the end of September for a useful  
2 discussion.

3 CHAIR WELCH: Yes. I'm happy to take  
4 responsibility for selecting some claims. But,  
5 if people would like to see the spreadsheet and  
6 comment on that as well, that's fine.

7 What does the rest of the Committee  
8 think? Once we get a spreadsheet with data by  
9 ICD code, would everyone like to see it?

10 MEMBER VLIENER: I think it would be  
11 helpful if we all got to look at it.

12 This is Faye.

13 CHAIR WELCH: Okay. And then, Carrie  
14 and I will formulate some questions and a process  
15 by which you would send back requests for files  
16 to review.

17 So, I guess the most important thing  
18 for there is for Carrie to figure out how to  
19 pressure DOL to get us the specific, you know,  
20 the ICD code specific data analysis of the  
21 claims. And it can look just like that nice  
22 beryllium spreadsheet. We just need all the

1 diagnoses.

2 MEMBER MARKOWITZ: Yes, this is Steve  
3 Markowitz.

4 I will help Carrie with it.

5 CHAIR WELCH: Okay. Great. Thank  
6 you. Okay. So, that's a plan.

7 And then, also, Carrie and I can send  
8 out or Carrie can send out an email asking for  
9 dates, maybe the third week in September, so we  
10 can have another call.

11 So, for my agenda item No. 6, I  
12 think --

13 MEMBER MARKOWITZ: Laura, Laura, this  
14 is Steve Markowitz.

15 CHAIR WELCH: Yes, go ahead.

16 MEMBER MARKOWITZ: I just didn't want  
17 to skip over 4c --

18 CHAIR WELCH: Okay.

19 MEMBER MARKOWITZ: -- which, for  
20 people who aren't looking at it, it says, raises  
21 the question of, having looked at the DOE data  
22 for how frequently what diseases people submit

1 claims for, would developing presumptions for  
2 frequent conditions fall under this Committee?

3 So, I just wanted to --

4 CHAIR WELCH: Yes, thank you for doing  
5 that.

6 MEMBER MARKOWITZ: Yes.

7 CHAIR WELCH: You know, the DOL staff  
8 said they would like our help, would like the  
9 Board's help with developing presumptions. So,  
10 my view is, since we were asked, we could take  
11 that on.

12 Steven, do you have a thought about  
13 that?

14 MEMBER MARKOWITZ: Yes. Steve  
15 Markowitz. Absolutely. You know, they have  
16 moved somewhat towards presumptions based on  
17 their own experience and difficulty in trying to  
18 nail down the specifics about exposure and  
19 diseases. I think that says a lot about what the  
20 program has needed, and "program" meaning  
21 administration of the program. The reality of  
22 that, plus SEMs specifically asking us about

1 input into presumptions, and presumptions involve  
2 exposure and disease linkages. So, that really  
3 is something we should move ahead on.

4 CHAIR WELCH: I did not attach it as  
5 our documents, but they did recently develop a  
6 presumption on COPD, which I can make sure  
7 everybody gets a chance to see. And they had  
8 previously developed one on the specifics related  
9 to ZEEP I think. So, there aren't a lot that I'm  
10 aware of, but I will make sure that those go out  
11 to the Committee.

12 MEMBER GRIFFON: Laurie, this is Mark  
13 Griffon.

14 I agree with, basically, everything  
15 you have been saying and the idea of looking at a  
16 stratified sample. I was curious. I mean, I  
17 don't want to make this more difficult  
18 necessarily. But, similar to what we did on the  
19 Radiation Board, we did a stratified sample. We  
20 based it more than on just the ZEEP, though. We  
21 did stratify based on site.

22 This is a different animal, but I

1 think it might be useful to stratify it on site  
2 at least. We had several other factors that we  
3 stratified, but that was different because we  
4 also had more data for the radiation side.

5 And then, the only other comment I  
6 have was, maybe I missed it, but what is our goal  
7 in reviewing these, once we get a sampling of  
8 cases to review? Are we going to review all  
9 these cases individually and go through them one  
10 by one and have findings if we disagree with the  
11 way the claim was processed or are we doing this  
12 to get a sense of how the overall procedure and  
13 how, in general, they are processing claims? Or  
14 what is our goal at the end of this?

15 CHAIR WELCH: That is an important  
16 point for discussion.

17 MEMBER GRIFFON: Sorry, I thought I  
18 missed it maybe.

19 CHAIR WELCH: No, no, no. I was  
20 presuming something already without expressing  
21 it, which was I was thinking the latter, that we  
22 need to understand how the claims process works

1 and what is going into the assessment of the  
2 individual exposure and, then, the  
3 exposure/causation link.

4 MEMBER GRIFFON: I agree with that, by  
5 the way. I think this will allow us to  
6 understand it better. And maybe, then, we will  
7 decide to go in another direction, but that is a  
8 first step. I think I agree with that.

9 CHAIR WELCH: Yes, and I would suggest  
10 that we all look at the same cases rather than  
11 doing more cases and dividing them up and  
12 reporting back to each other. Because, anyway, I  
13 think it would be easier to have the conversation  
14 if we all looked at 20 cases, five of us each  
15 look at 20 and present to the group, if we are  
16 looking at the same cases to start with, even  
17 though it will be maybe less representative,  
18 because different cases may show us a different  
19 part of the process. But I can't think of a more  
20 efficient way to understand it.

21 MEMBER GRIFFON: I totally agree with  
22 that. I think, depending on if you just



1 stratified by disease, I just think we should try  
2 to also select a representative number of the  
3 large DOE sites because I think, well, you have  
4 different claims assessors' office; you have  
5 different exposure data available from the  
6 different sites. So, they may look very  
7 different, but a COPD case from Rocky Flats  
8 versus Los Alamos may look very different, just  
9 because of what they have available to work with,  
10 or whatever. So, I think that would inform us a  
11 little bit more on the exposure side as well.

12 CHAIR WELCH: Yes, I think that is a  
13 really good point. I totally agree.

14 And Kirk pointed out that some of the  
15 small sites don't have a SEM. So, at some point  
16 we want to see how do they address those.

17 MEMBER GRIFFON: Yes.

18 MEMBER MARKOWITZ: Steve Markowitz.

19 One way is to have some of those  
20 claims that we look at come from non-SEM sites.

21 CHAIR WELCH: Yes.

22 MEMBER GRIFFON: Yes.

1                   MEMBER MARKOWITZ: But, I mean, I  
2 would also just like to propose a second goal,  
3 which is not just to understand the claims  
4 process, but also to understand what data points  
5 exist within these claims, that if later we move  
6 to a more systematic look at what they are doing,  
7 that we will understand how to structure the kind  
8 of data we are after.

9                   MEMBER GRIFFON: I agree, yes.

10                  DR. DEMENT: This is John again.

11                   I agree with Steve. And looking at  
12 the small number of these occupational histories  
13 that we have seen so far, many of them seem to me  
14 to be very incomplete. I am wondering how much  
15 these sites are supposed to be helping the worker  
16 compare these, how much guidance they are  
17 actually giving the worker with regard to  
18 preparing these occupational histories.

19                   MEMBER VLIENER: I can answer that  
20 question. This is Faye.

21                   DR. DEMENT: For example, the ones we  
22 have seen so far, I have seen very little

1 information with regard to description of the  
2 task that we actually did. As a hygienist, the  
3 task and the material really dictate pretty much  
4 what the exposure intensity would be anyway. At  
5 least somehow I would like to learn more about  
6 that process of collecting this history. Who  
7 does it, how are they trained to help the worker,  
8 and how they are trained to look at these when  
9 they are done and critique it, see if it is  
10 complete? That is just a piece missing for me.

11 MEMBER VLIEGER: This is Faye.

12 The Occupational History Questionnaire  
13 is either completed by the worker or by the  
14 worker in conjunction with the Resource Center.  
15 The information that you would expect them to  
16 know about their exposures does not exist. It  
17 doesn't exist in the worker's employment records  
18 and it doesn't exist with the U.S. Department of  
19 Energy in their records.

20 And so, the worker does the  
21 Occupational History Questionnaire to the best of  
22 their ability. The only time I have seen a

1 detailed list of what someone was exposed to is  
2 when they were one of the chemists or  
3 metallurgists in the laboratory setting and they  
4 knew what was on their lab bench, and they could  
5 report what they used.

6 DR. DEMENT: I think that is a good  
7 point. But what would help, for example, in an  
8 occupational history would be provide some cues  
9 to the worker with regard to tasks that are, for  
10 example, known to increase the risk of intense  
11 exposure.

12 In the Former Worker Programs, we try  
13 to, one, use workers to collect the information,  
14 to help the individual. The interviewers have  
15 experienced personal or collecting occupational  
16 histories now so many times a lot of experience  
17 outside. And so, I think we stimulate some  
18 better history, we call it, than I think we are  
19 getting on these histories that I have seen so  
20 far in the compensation program.

21 CHAIR WELCH: Yes, and that was the  
22 item I had. I think we have kind of already

1 answered the question already about the item of  
2 should we develop a plan for improving the  
3 Occupational History Questionnaire. And I think  
4 people have already said yes to that.

5 We have asked how it get administered,  
6 and what Faye said is what we also heard at the  
7 meeting, completed at the Resource Centers, but  
8 there doesn't seem to be any training on history  
9 interviewing. But part of the form is not  
10 designed to ask about task or exposure. It is  
11 designed to ask about where you worked.

12 DR. DEMENT: No, that's right, and ask  
13 about incidents. But I don't see much in there  
14 of asking about specific tasks. Although in the  
15 SEM there are some specific tasks that are  
16 listed, it is quite incomplete, based on my just  
17 cursory review so far. But, even there, it would  
18 be a linkage that would help the worker.

19 CHAIR WELCH: And along this line,  
20 Trish Quinn, who is the coordinator of our med  
21 Program, John Vance contacted her after the Board  
22 meeting to ask if the Building Trades Program

1 could help improve the Occupational History  
2 Questionnaire.

3 So, you must have impressed him, John,  
4 with your comments.

5 DR. DEMENT: Yes, to make sure --

6 CHAIR WELCH: But the DOL would be  
7 open to that. I think it is a pretty big task.

8 DR. DEMENT: It is. We help so many  
9 different labor categories from production  
10 through labor, our construction and non-  
11 construction. It is a pretty daunting task to  
12 have one history.

13 CHAIR WELCH: Yes. But I would think  
14 that, at a minimum, we should make  
15 recommendations to DOL, as our Committee looks  
16 forward, of how to improve it, even if we are not  
17 going to development it for them, because we  
18 could have codified the discussions that we have  
19 had about what needs to be in it and the best way  
20 to obtain that information.

21 MEMBER MARKOWITZ: Steve Markowitz.

22 So, I get involved with the Former

1 Worker Program on the production side. And I  
2 want to emphasize -- and Mark Griffon has been  
3 involved as well -- I just want to emphasize how  
4 many job titles we have at the various sites --

5 CHAIR WELCH: Yes.

6 MEMBER MARKOWITZ: -- and how they  
7 have evolved over the decades.

8 I think it would be very ambitious to  
9 get high-quality information from people's  
10 memories about job task, that it would really  
11 need to be a cadre of well-trained interviewers  
12 who know these sites and know the kind of work  
13 people have done in order to get that  
14 information. And so, I would say no one is  
15 underestimating that, but I just wanted to  
16 emphasize how challenging that would be.

17 CHAIR WELCH: Right. Yes. No,  
18 absolutely.

19 MEMBER WHITLEY: Garry Whitley here.

20 I think, first of all, the Resource  
21 Center and the claims examiner, neither one  
22 helped these people with even the SEM database.

1 They have to come back to the Worker Health  
2 Program or to us and ask us, well, what chemicals  
3 did a pipefitter or a sheet-metal worker work  
4 with?

5 Even if we have got one of these in  
6 the SEM database, neither one of those two groups  
7 will help the people at all, the claimant at all,  
8 with that SEM database. They don't pull it up  
9 and say, "Well, see, here you worked for" so-and-  
10 so. They don't do that, and they won't look  
11 under the SEM. They will make a decision on your  
12 case with the SEM, but they won't help you look  
13 it up and say, "Well, did you work with this  
14 chemical or did you not?"

15 I think, personally, the presumption  
16 thing would be the best thing we could do to help  
17 the claims examiners. Because I have got cases,  
18 have seen cases where the claims examiners tell  
19 people, "Well, if you're a sheet-metal worker,  
20 you didn't work with anything." If you go to the  
21 SEM database that we see and look at sheet-metal  
22 worker, it is there that he worked with that



1 chemical every day.

2 So, I think the presumptions could  
3 help with our claimants a lot better than maybe  
4 some other ways we could help.

5 CHAIR WELCH: I think that is a good  
6 point. I mean, when I think about COPD, I do  
7 think that writing a process, you know,  
8 distilling the literature and saying these kinds  
9 of exposures are causative or contributory,  
10 rather than trying to make it fit into the SEM  
11 matrix, which would be difficult.

12 And then, as you point out, Garry --  
13 I mean, and Steve has said the same thing in a  
14 different way -- you really need an interviewer  
15 who understands the site and the processes that  
16 are used there to get the right information out  
17 of the worker. The SEM doesn't really have it  
18 all. But you are saying that, even when the SEM  
19 has it, nobody really helps the worker bring it  
20 forward. And someone needs to bring it forward  
21 for him to put forward a good claim.

22 So, yes, presumptions would make

1 sense. We probably could link it. And again, if  
2 when we see how many claims fall into the top ten  
3 diagnoses, maybe it would be. It would certainly  
4 make their workflow more efficient if there were  
5 good presumptions.

6 The problem with presumptions, because  
7 presumptions are supposed to be the easy ones,  
8 and then, even if you don't meet the presumption,  
9 your case can be adjudicated based on more  
10 specific individual information. But you can  
11 imagine how this system meet the presumption of  
12 the yes/no.

13 MEMBER WHITLEY: Right.

14 CHAIR WELCH: And this kind of makes  
15 you want to make the presumption a little more  
16 inclusive, but, then, there is this balance of  
17 when you start including cases that clearly  
18 aren't related, but they might meet the  
19 presumption.

20 So, it is hard, but it has been done  
21 so many times. The trust funds that were set up  
22 for asbestos claims have presumptions and a whole

1 process which people can demonstrate that, even  
2 though they don't meet a presumption, they meet  
3 the intentions of the trust. And you wouldn't be  
4 reinventing the wheel on that if we made those  
5 recommendations.

6 I hate to say it; we have covered our  
7 agenda, probably because I am moving us all too  
8 fast.

9 Now we have time to go back. Because  
10 we have talked about the data information we have  
11 requested already, that we want to review example  
12 claims and challenging cases.

13 Oh, I guess, you know what? Let me go  
14 back. The IOM report, I think I am happy to  
15 summarize for people what is in the Executive  
16 Summary, if people would find that helpful,  
17 because I think they are questions that -- this  
18 is the IOM rate or many of the same things that  
19 DOL does.

20 But, again, before we do that, do  
21 people have any other thoughts about the  
22 Occupational Health Questionnaire? I think it is

1 what we said; we think it needs work. It is not  
2 collecting all the information that the claimants  
3 should be giving to the claims examiner. It is  
4 pretty clear that the worker is not getting a lot  
5 of help in filling it out. We haven't  
6 necessarily made a plan to revise it.

7 MEMBER VLIEGER: This is Faye.

8 Regardless of what a worker puts on  
9 OHQ, it is not considered probative. It is not  
10 even considered many times in the decision at all  
11 when they look for labor categories or they look  
12 for exposures. The only information that the  
13 Department of Labor considers valid is what they  
14 pull from the SEM, and the SEM is incomplete for  
15 labor categories and exposures.

16 So, what I think would be helpful when  
17 we ask for the information from the Department of  
18 Energy at the meeting was for them to say whether  
19 or not they ever monitored for these things from  
20 the workers and, if they didn't, then to say so,  
21 because they know the employee, the worker, has  
22 to say that they were exposed, has to prove they

1 were exposed with monitoring data.

2 CHAIR WELCH: Right, or the SEM. But,  
3 actually, if it is that post-'95, it is supposed  
4 to have monitoring data.

5 MEMBER VLIEGER: Right, and there's no  
6 monitoring data. And so, it wasn't in the list  
7 of things that I saw we were requesting. But I  
8 found it in the transcript of the minutes where  
9 Pat Worthington said she would be willing to look  
10 for that information, but she needed to know  
11 where to look first because, of course, they had  
12 many sites.

13 CHAIR WELCH: And which information  
14 was she going to look for? I didn't quite  
15 understand.

16 MEMBER VLIEGER: She was going to tell  
17 us whether there was monitoring data or not.

18 CHAIR WELCH: Oh, okay. I have always  
19 presumed that, if there wasn't an OSHA or a DOE  
20 standard that needed to be met, no one would be  
21 monitoring the exposure.

22 MEMBER VLIEGER: Well, then, DOL comes

1 back to the worker and says, "There's no  
2 monitoring data. Therefore, you weren't  
3 exposed."

4 CHAIR WELCH: Right.

5 MEMBER MARKOWITZ: This is Steve  
6 Markowitz.

7 Or they could take the monitoring data  
8 and say, "We have monitoring data and you weren't  
9 exposed." It cuts both ways, actually.

10 MEMBER VLIENER: Well, no, where are  
11 you going to find as many of the chemicals and  
12 concerns for these workers we never monitored  
13 for?

14 CHAIR WELCH: No, that makes a lot of  
15 sense.

16 So, I think that that memo that says,  
17 after 1995, DOL is going to presume that the work  
18 places were all completely safe, is -- I don't; I  
19 can't think of a good adjective. I disagree, and  
20 they are making it up because they have no  
21 monitoring data that shows that it is or isn't.  
22 But I think we have to keep this on our agenda.

1 I don't know that -- right, that is not the first  
2 thing we are going to address, but at some point  
3 we need to address the fact that workers will  
4 describe exposures and the SEM describes  
5 exposures linked with those, and diseases linked  
6 with those exposures and the timeframe for when  
7 the exposures occurred.

8 If DOL would like help with timeframes  
9 for exposures, then that would probably have to  
10 go into a presumption with specific  
11 disease/exposure relationships. And then, those  
12 post-'95 thing could be addressed exposure by  
13 exposure. But I don't know; I say let's defer  
14 that for our next -- maybe after the big meeting,  
15 because it would be pretty difficult to  
16 demonstrate that they are wrong because the  
17 monitoring data doesn't exist before or after  
18 1995 for many of these standards.

19 MEMBER DOMINA: This is Kirk.

20 I need a comment on that. You know,  
21 a lot of times, you know, just because they put  
22 this in the 1995 -- you have got to look at where

1 the sites were at that point in time with whoever  
2 the contractor was. Because if they are going to  
3 come in the middle of the contract and say, "We  
4 want you to start doing all this," and you don't  
5 provide funding for it, they are going to ask for  
6 requests for equitable adjustment. And if they  
7 don't do that, they are not going to do it.

8 A prime example is Hanford's last SEC  
9 from '84 to '90 for the building trades. There  
10 is a reason that one went through, because they  
11 were supposed to do bioassay sampling. They  
12 provided no funding. So, I believe there was  
13 like six bioassay samples for like 4400 workers.  
14 And that is part of the reason that one went in.

15 And it is no different with this.  
16 Like I look at these other sites that I talked  
17 about earlier that have SECs with no SEM, so they  
18 have got no rad data. You know they have no  
19 chemical data. And that would be that way for a  
20 lot of them.

21 I mean, I have been on here a long  
22 time, just like Garry was out there a long time



1 at his site. They didn't monitor for things  
2 because at that time it wasn't considered a  
3 hazard or we were in a Cold War effort. You have  
4 to look at all those things that come into play.

5 CHAIR WELCH: Right. No, that's  
6 right.

7 Steven, do you want to give your  
8 thoughts about when we can address that 1995  
9 memo?

10 MEMBER MARKOWITZ: So, we are going to  
11 need some background on this from DOL as to how  
12 they arrived at that conclusion.

13 CHAIR WELCH: That's true.

14 MEMBER MARKOWITZ: And I think that  
15 the presence or absence of monitoring data post-  
16 '95 is not going to be determinative of the what  
17 needs to be done. The post-'95, or post whatever  
18 date you want, time moves on; maybe workers need  
19 to describe from their more recent memory their  
20 work tasks and the ways in which they may have  
21 had exposure with or without monitoring. Even if  
22 they show monitoring results at no levels or low

1 levels, we are not necessarily going to trust  
2 that that represents the workers' exposure.

3 So, I think that it is part of  
4 exposure assessment that we are talking about,  
5 and I agree we are going to have to keep it on  
6 the radar and find out more before we can really  
7 kind of weigh-in here.

8 CHAIR WELCH: Okay.

9 MEMBER VLIEGER: I'm sorry, this is  
10 Faye.

11 As part of DIAB and NLAB's work, we  
12 queried Pat Worthington from DOE Headquarters and  
13 Greg Lewis about where the information came for  
14 the establishment of the post-1995 criteria. The  
15 Department of Energy responded that they did not  
16 provide Department of Labor any information that  
17 these sites had no exposures after '95. I can  
18 provide a copy of that to you all. But,  
19 specifically, the Department of Energy did not  
20 provide DOL any exposure information for the  
21 post-1995 Toxic Exposure Circular.

22 CHAIR WELCH: Well, that is

1 interesting. Okay.

2 MEMBER MARKOWITZ: Yes. Steve  
3 Markowitz. It would be interesting to see that  
4 email, sure.

5 MEMBER VLIEGER: I mean, we did say,  
6 "We at DOE are aware of the two circulars you  
7 referenced, but we are not involved in the  
8 policymaking process at DOL and we are in no  
9 position to comment on how and why these two  
10 decisions were made."

11 CHAIR WELCH: Well, they could have  
12 provided information and they are not going to  
13 tell us. So, we should probably get even more  
14 specific, you know.

15 MEMBER VLIEGER: Well, you know, I can  
16 send you this. I have very specific questions  
17 that they answered. Basically, it was what  
18 monitoring data are they saying it is from and  
19 DOE basically said, "We didn't give them anything  
20 specific. They are basing their decision off of  
21 when orders were published to make workers safe,  
22 not when workers were safe."

1 CHAIR WELCH: Okay. Well, that would  
2 be great to see that.

3 MEMBER VLIEGER: Okay. I will send  
4 it.

5 MEMBER MARKOWITZ: But this is Steve  
6 Markowitz.

7 So, we are trying to figure out how to  
8 improve exposure assessment here and how DOL can  
9 better use whatever information becomes  
10 available. Well, that is going to imply that our  
11 recommendations on that are going to apply the  
12 post-'95 exposures, just as they do to pre-'95  
13 exposures. We are not going to make an arbitrary  
14 distinction about that.

15 But I think as we make progress in  
16 sharpening, helping to improve this process, that  
17 will pertain to this pre/post-artificial  
18 distinction of '95. Does that make sense?

19 CHAIR WELCH: Yes, it does to me,  
20 absolutely.

21 MEMBER MARKOWITZ: Laurie, I would  
22 like to go back to the IOM report.

1 CHAIR WELCH: Yes.

2 MEMBER MARKOWITZ: Oh, I'm sorry, you  
3 said you were offering to summarize that for the  
4 people on the phone.

5 CHAIR WELCH: Yes, I will, and it is  
6 a very short summary at the moment, relatively-  
7 long report.

8 So, the Department of Labor asked the  
9 IOM specific questions, and they wanted them to  
10 focus on the link between exposure and disease in  
11 the SEM, which we know is derived from Haz-Map.  
12 So that they were focusing on that part of the  
13 SEM, not necessarily somewhat of how the data got  
14 in there, but not really so much where the  
15 exposure information came from, but really on the  
16 exposure. They asked what tasks and toxins are  
17 missing, and if there is other information that  
18 could be used to inform that same process, the  
19 exposure/disease link or other databases.

20 So, then, IOM noted -- the things I  
21 have read reviewing the report, again, that I  
22 thought were useful and worth repeating was that

1 the Haz-Map was not intended to be used for this  
2 purpose; that the links in Haz-Map are strong,  
3 but probably narrow; that for carcinogenicity  
4 they used it to say, if a substance causes  
5 cancer, it has to be an IARC Group 1 carcinogen,  
6 but there is no clear criteria for non-cancer  
7 outcomes, about what they establish.

8 It was based on textbooks and authors'  
9 experience, and it tends to be well-established  
10 links and established for causation and not for  
11 contribution. They noted that this Haz-Map and  
12 the SEM don't handle complex mixtures or  
13 exposures well at all, and that Haz-Map is not  
14 very systematic.

15 So, after that review, I only came up  
16 with three big points, one of which was to  
17 incorporate other information sources beyond  
18 Haz-Map. And they recommended the ATSDR tox  
19 profiles, data from EPA and IRIS, substance-  
20 specific reports from the National Toxicology  
21 Program, and some information specifically from  
22 the California EPA. And they acknowledged it

1 would be difficult to get all that information in  
2 there, but these are all expert-based reviews  
3 that have also been through a peer review. But  
4 it wouldn't be requiring DOL or the Advisory  
5 Board to be continuously reviewing the medical  
6 literature and deciding about causation if we  
7 relied on other agencies to opine on causation  
8 and level of risk, to some degree. Many of those  
9 do, like IRIS or the NTP. But DOL would have to  
10 establish some kind of process for having that  
11 done.

12           The other main point was that the  
13 functionality of SEM could be improved greatly,  
14 and they made some very specific recommendations.  
15 One point was that, if you want to look at, say,  
16 a worker who worked at multiple sites, you have  
17 to go to each one of those sites and look at the  
18 data for each one of those sites; that there  
19 would be ways to improve it.

20           They also pointed out, as far as they  
21 could tell, there has never been any quality  
22 assurance on the data entry into SEM, not a

1 review to make sure that what was on the source  
2 documents is actually what was put into SEM. It  
3 is recommended that should be done on an ongoing  
4 basis.

5 And the third point was that they  
6 should set up an expert advisory panel for SEM.  
7 I said in the beginning I think that is us.  
8 There were some specific points in that that I  
9 can bring up pretty easily.

10 Sorry, I am just finding the right  
11 page.

12 So, they said the expert advisory  
13 panel would have immediate tasks which are:

14 Establish the criteria for the  
15 evidence base for causal links. Criteria might  
16 be expanded to include a category of evidence "no  
17 association," such as the way IARC does.

18 Determine what information sources  
19 might be relied upon.

20 Develop worksheet or documentation, so  
21 that it is clear what data is going from the  
22 source material into the SEM.



1           And then, oversee revision of SEM to  
2 add appropriate fields such as chemical  
3 interactions, rad exposure, supplemental  
4 information sources.

5           And then, they said the expert  
6 advisory panel would also have ongoing  
7 responsibilities such as peer review of links in  
8 SEM, assessment of occupational diseases that  
9 result from complex exposures, identification of  
10 potential new links, including those suggested by  
11 external sources, and a periodic review of the  
12 toxic substances/disease links for both accepted  
13 and rejected claims to determine which SEM links  
14 are actually assisting in the claims process and  
15 what improvements should be made.

16           I think in the list we made we are  
17 adjusting some of those right away, such as a  
18 periodic review of sample of claims to see what  
19 links are being used. We are not yet suggesting  
20 a systemic review of all the causal links.

21           I think that the IOM report makes a  
22 very good case for having these exposure links in

1 SEM be created by more than one person and that  
2 there be a transparent process and expert review  
3 of such links.

4 And I think we, as a Committee, have  
5 to decide if -- I think one question is, why  
6 didn't DOL do that yet? It appears as if we are  
7 being asked to address the same questions or  
8 maybe even bigger ones.

9 And this document I think was 1993.  
10 Am I right? I mean, sorry, 2013. It was  
11 published in 2013. So, the Committee met in  
12 2012. It could be that the plan was to wait for  
13 the Board to be constituted, which did take some  
14 time.

15 But I also think, if there are parts  
16 of these recommendations out of the Institute of  
17 Medicine that DOL just flat out says we can't do,  
18 we should know that before we recommend them  
19 again. I mean, it doesn't mean we wouldn't  
20 recommend them again, but the process of -- they  
21 still have a contract with the physician who  
22 developed Haz-Map, and I don't think that that

1 has tended to figure out how to incorporate from  
2 these other data sources.

3 So, I am not sure of the process for  
4 that. Maybe just at the next meeting we could  
5 ask for them to make a presentation to the Board  
6 about what they have implemented and have not  
7 implemented from the IOM report.

8 MEMBER MARKOWITZ: This is Steve  
9 Markowitz.

10 That's a good idea. I think we should  
11 ask them what they have implemented, what they  
12 haven't, and what's their thinking about this.

13 CHAIR WELCH: We could get that on our  
14 next Subcommittee call. Do you think that would  
15 be helpful? We can wait until the big meeting?  
16 I guess we can wait because at our next  
17 Subcommittee call we would sort of be focused on  
18 understanding the inputs and throughputs for the  
19 claims.

20 MEMBER MARKOWITZ: This is Steve  
21 Markowitz again.

22 I would have to repeat it; it is a big

1 Committee meeting regardless.

2 But can I raise a different point on  
3 this? I think I disagree with part of part of  
4 your formulation about whether the current  
5 Advisory Board constitutes what IOM describes as  
6 needed.

7 CHAIR WELCH: Uh-hum.

8 MEMBER MARKOWITZ: The IOM called for  
9 some very big tasks, like -- and this is really  
10 just repeating what you said, Laurie -- peer  
11 review all new links in SEM. So, anytime there  
12 is enough information that a given disease is  
13 caused by a chemical, that the expert advisory  
14 panel, according to IOM, would actually do that  
15 review of all that literature and weigh-in on  
16 that link or that link would be done by Haz-Map  
17 and, then, the expert panel would review that  
18 work.

19 There are other things that they call  
20 for. These are the ongoing responsibilities of  
21 the expert advisory panel.

22 Even something, one of the immediate

1 tasks, establish the criteria for the evidence  
2 base for causal links, let me describe what --  
3 for cancer, that means the way that the World  
4 Health Organization does that, the way that the  
5 National Toxicology Program does that, is they  
6 have criteria on how we are going to decide that  
7 something causes cancer. How are we going to  
8 look at human epidemiologic studies? How are we  
9 going to look at animal studies? How are we  
10 going to look at studies in the lab, mechanistic  
11 studies, and weigh all that information in order  
12 to make a decision? That is a well-worn path.  
13 Even then, there is controversy, but at least it  
14 is a well-worn path.

15 For non-cancer outcomes, there is, to  
16 my knowledge, no generally-accepted approach.  
17 And yet, the IOM report is calling for this  
18 expert advisory panel potentially to do that for  
19 non-cancer outcomes, which is way beyond, I  
20 think, what our charge is.

21 So, I just want to point out that I  
22 think that we need to be careful about what tasks

1 we think we can do from the IOM critique and,  
2 otherwise, weigh-in on, if we believe it, how DOL  
3 could address the broader path.

4 CHAIR WELCH: I totally agree with  
5 you. This is Laurie. Yes.

6 And I think we should spend some time  
7 talking about that. I do feel like if DOL says,  
8 well, we couldn't do those immediate tasks  
9 because it would be so time-consuming -- you  
10 know, establish the criteria for the evidence  
11 base, oversee revisions to SEM, all this stuff,  
12 and peer review all the new links -- if they just  
13 don't have the money to hire people to do that,  
14 then I think we need to say, the Board needs to  
15 say, either "Yes, you have to" or "Here's an  
16 alternative that would be acceptable and better  
17 than what we have," if we can come up with an  
18 alternative that is not as work-intensive.

19 But I do think we need to find out why  
20 they didn't implement them and, then, at some  
21 point say this is an acceptable path or we agree  
22 with this essential task and you have to do it.

1 And either the Board will do it or the Board will  
2 hire someone else to do it.

3 Does that make sense to you, Steven,  
4 in terms of what you were just saying? Because I  
5 agree with you those are big tasks.

6 MEMBER MARKOWITZ: Well, yes. I mean,  
7 we should decide what we can feasibly do and,  
8 otherwise, recommend the plan that is going to  
9 require resources for them to pursue it. Even if  
10 you look at their request to us from the April  
11 meeting, one of the documents, page 9 where they  
12 list 20-odd outcomes, they say they, quote, "want  
13 to know what toxins are at least as likely to  
14 cause, contribute, or aggravate these diagnoses".  
15 End of quote. And then, they list 20 conditions,  
16 including breast cancer, neuropathy, diabetes,  
17 heart disease, very broad conditions.

18 It, frankly, is kind of an immense set  
19 of tasks. So, at the very least, we need to  
20 describe how these tasks can be accomplished and  
21 what resources are required, what the structure  
22 should look like feasibly --

1 CHAIR WELCH: Yes.

2 MEMBER MARKOWITZ: -- not pie-in-the-  
3 sky. I think IOM was a little pie-in-the-sky,  
4 frankly, but feasibly that it can be done.

5 CHAIR WELCH: I agree. I agree with  
6 you.

7 DR. DEMENT: This is John.

8 You know, we just didn't hear anything  
9 from the DOL with regard to just a work plan for  
10 addressing those comments. I think that is  
11 really sort of the missing link right now.

12 Yes, I agree with Steve, a lot of the  
13 IOM reports fall, while the recommendations are  
14 good, they are a little bit impossible to  
15 implement in a practical way without  
16 extraordinary resources. So, I think we need a  
17 little more direction maybe related to that. We  
18 have to have a little more practicality.

19 MEMBER MARKOWITZ: Steve Markowitz  
20 again.

21 I don't think we should wait until we  
22 hear from them about what they have implemented



1 since then, since it is likely, looking at the  
2 recommendations, likely they have implemented  
3 very little. And so, we should assume that not a  
4 whole lot has been done and proceed there as  
5 opposed to waiting until October to hear, you  
6 know, frankly, a modest set of things are likely  
7 to have been accomplished.

8 CHAIR WELCH: Yes. Partly because of  
9 the way I think about things, I feel like looking  
10 at examples, looking at cases will help me with  
11 this. The more the obscure the disease, the less  
12 common the disease, the less likely there is data  
13 to link it to exposure, but also the fewer claims  
14 there are that would present with that disease.  
15 And I feel like some of the process of helping  
16 them develop a process to review very broadly all  
17 disease/exposure links will end up being lost in  
18 some of these very difficult decisions.

19 I mean, I think the same way about the  
20 SEM. The SEM has already got 17,000 specific  
21 toxins in it. And the contractor is out there  
22 collecting more exposure information. It would

1 seem to me the exposure information they are  
2 finding now would be rare exposures, short-term  
3 exposures, things that may be hard to assess, and  
4 that we would be better off trying to get the SEM  
5 and the whole process to help with the claims  
6 they are having a difficult time with that are  
7 frequent. But that would mean that we are  
8 leaving some workers hanging who have relatively-  
9 rare diseases for which there is little exposure  
10 information.

11 DR. DEMENT: This is John again.

12 Looking at that list that we were  
13 provided with these conditions, a lot of them are  
14 already pretty well addressed by IARC in most of  
15 their reviews; for example, kidney cancer and  
16 TCE, benzene, cadmium, asbestos. So, it has been  
17 looked at. So, I don't quite get the reason for  
18 it being on there. Also, the non-Hodgkin's  
19 lymphoma and TCE and benzene, you know, they have  
20 been looked at a lot with regard to IARC and  
21 others. So, some of those can be referred to  
22 existing reviews.

1           CHAIR WELCH:  You're right, six of the  
2 list are cancers.

3           DR. DEMENT:  Yes, I don't quite see  
4 why those are problematic.

5           CHAIR WELCH:  If the criteria in  
6 Haz-Map, if you were using Haz-Map, now the  
7 cancers, I haven't memorized the list of cancers  
8 that are considered radiation-related.  Mark I  
9 know would look at that list and say, yes, a  
10 specific cancer, it isn't.

11           If what is on this list are the ones  
12 that go to Part E because they are not radiation-  
13 related --

14           DR. DEMENT:  Oh, yes, these are Part  
15 E.

16           CHAIR WELCH:  Yes.  So, they needed  
17 some guidance to say benzene is known to cause  
18 non-Hodgkin's lymphoma or not.  That seems to be  
19 what they're asking up there.  But there are  
20 existing reviews, absolutely.

21           MEMBER MARKOWITZ:  Steve Markowitz.

22           My guess is that Haz-Map might be not

1 quite up-to-date on some of these cancers. So,  
2 they, then, get questions.

3 DR. DEMENT: Yes, I agree, and that  
4 was one of the IOM comments about Haz-Map as  
5 well. The criteria for "causality," quote, is  
6 quite, you know, pretty much it has to be in a  
7 textbook, let's say, versus more contemporary  
8 literature.

9 CHAIR WELCH: Yes, but I think I agree  
10 with you, John, that it should be easy to say  
11 that, I mean, if IARC has done a review and it is  
12 now a Group 1 carcinogen, the link has been  
13 established and it doesn't have to appear in a  
14 textbook to get into SEM. But, again, I don't  
15 know the process. I mean, we sort of know the  
16 process. I think that probably that is  
17 happening, but what kind of delay are we getting  
18 between when there's some excellent review that  
19 comes out and it gets into SEM.

20 MEMBER MARKOWITZ: Yes. Steve  
21 Markowitz. The problem is people don't update  
22 those textbooks fast enough, right? Yes.

1 CHAIR WELCH: Oh, yes.

2 DR. DEMENT: Most of the time, by the  
3 time a textbook gets published, it is out of  
4 date.

5 CHAIR WELCH: Yes, and if you are  
6 using, you know, let's say you are using Selvin  
7 and Krieger, which is every five years. Even if  
8 you used three different textbooks, what is in a  
9 textbook would be six years' out-of-date. By the  
10 time the new edition comes out, it could be.

11 And I think that is what the IOM was  
12 saying. If you have something like the National  
13 Toxicology Program, there's no reason to wait  
14 until somebody puts that into the textbook. If  
15 you can pick other sources that can be considered  
16 probative, but the DOL could accept their causal  
17 links without additional review, you could add  
18 things more quickly.

19 I can't really get my head around how  
20 to approach those recommendations from IOM right  
21 now, though. I haven't thought about it enough.  
22 I have to listen to other people. You know, what

1 is the process for adding new data sources and  
2 what is the process for peer-reviewing new links?  
3 Is that necessary? So, those are really big  
4 topics. And I agree with you, Steven, we  
5 shouldn't just ignore them, but --

6 MEMBER MARKOWITZ: Well, you know --  
7 Steve Markowitz -- just to use a different  
8 federal compensation program, which is Agent  
9 Orange, the VA contracts with the Institute of  
10 Medicine which reviews and produces a report  
11 every few years on a single agent, Agent Orange,  
12 looking at the diseases in the literature. And  
13 they have a whole ongoing committee, led by some  
14 very well-known people, who look at this and  
15 struggle with this single agent and a limited  
16 amount of, frankly, scientific literature to look  
17 at. It is still controversial.

18 So, here we are talking about 17,000  
19 chemicals, give or take, hundreds of outcomes.  
20 And I don't say that to be discouraging. I am  
21 sure DOL did what they had to do, which was rely  
22 in 2005 on whatever existed, which was Haz-Map.

1           How to move forward with that process  
2           concretely, feasibly, it is difficult. We just  
3           have to see what can really be done there.

4           CHAIR WELCH: Yes. Well, I made  
5           myself a note to at least try to understand  
6           better the data sources that IOM recommended like  
7           IRIS, which I haven't really used much in my  
8           life. And EPA is making statements about disease  
9           causation and exposure levels for a different  
10          purpose, but it may be very useful because they  
11          do cover way more chemicals than maybe the ATSDR  
12          tox profiles do.

13          So, it seems to me it will be helpful,  
14          and I don't think we are going to get somebody  
15          else to tell us all about it, about IRIS and the  
16          National Toxicology Program and how could those  
17          be considered sufficiently develop to add them,  
18          to ask their contractor or Haz-Map to add them to  
19          Haz-Map. That is a more narrow question, but it  
20          could be very helpful to say, yes, these other  
21          data sources are informative, and if they say  
22          that it is causative, we could add it. That is

1 one way to approach one part of what IOM is  
2 recommending.

3 MEMBER MARKOWITZ: But should DOL have  
4 its own unit that does that, that monitors the  
5 literature or does some sort of expedited peer  
6 review with some supervision and, then, directly  
7 modifies its exposure/disease database so that it  
8 doesn't have to rely on Haz-Map, entirely on  
9 Haz-Map? Should DOL have its own unit to do  
10 that, which can perhaps do it in a more timely  
11 fashion and use its own criteria, not rely on  
12 whatever Haz-Map is doing? I am not saying we  
13 need to give that answer, but as an example of  
14 what might be done.

15 CHAIR WELCH: It is an idea, but,  
16 then, on the other hand, you know, the other  
17 agencies go back to CMS and do that. I mean, the  
18 Air Force wanted to know if beryllium exposure  
19 was a problem in Air Force operations and should  
20 they be screening people, and what should the  
21 medical surveillance program look like. And they  
22 asked the IOM to do that. In a way, that was a



1 more simple question than Agent Orange,  
2 definitely. But we know how expensive -- I mean,  
3 you know, those committees cost millions of  
4 dollars.

5 MEMBER MARKOWITZ: Right.

6 CHAIR WELCH: I think when NIOSH asked  
7 the IOM to do sort of an expedited review of  
8 their total Worker Health Program, it was still  
9 hundreds of thousands of dollars to convene  
10 meetings.

11 But, on the other hand, we have a  
12 program here that is paying dollars in claims.  
13 So, they should be getting it right. Yes, I  
14 think we should talk about whether DOL should  
15 have a unit to do that or they would be using  
16 existing, you know, things like the IOM and spend  
17 more money on it.

18 MEMBER MARKOWITZ: By the way, this  
19 IOM report did not recommend an IOM committee to  
20 do this.

21 (Laughter.)

22 CHAIR WELCH: Well, maybe that would

1 have been considered a self-referral, you know.

2 Well, of course, it is not, but --

3 MEMBER MARKOWITZ: Maybe or maybe they  
4 thought that it was extremely difficult to do.

5 CHAIR WELCH: Yes.

6 MEMBER MARKOWITZ: Rosie could give me  
7 some insight into that, actually.

8 CHAIR WELCH: Rosie is very clear she  
9 didn't want anything to do with this

10 Subcommittee. She could give us some insight,

11 but she said she was very tired of the topic.

12 So, I feel like she was saying, you know, the IOM

13 gave them lots of good recommendations and now

14 they are coming back and asking the same

15 questions. They already told them what to do.

16 So, I think your synthesis, Steven, is

17 good, that they haven't acted on it. We see it

18 is a very big set of recommendations. Is there

19 something that we can propose that would be

20 effective but not as complicated or as expensive?

21 MEMBER VLIEGER: This is Faye.

22 Just so you know, the recommendations

1 that IOM made have been used by claimants to try  
2 to prove your claim and the links to their  
3 diseases. But, because the Department of Labor  
4 doesn't accept those studies and reports unless  
5 someone with the appropriate degree behind them  
6 writes a letter in support of the claimant, those  
7 studies are not even considered factual. And so,  
8 even saying to the Department of Labor, "You must  
9 accept these sources" would be useful.

10 DR. DEMENT: All right. This is John.

11 Or criteria by which they may accept  
12 these sources might be useful.

13 CHAIR WELCH: The other thing about  
14 it, too, is that the claims -- so, let's say you  
15 develop the causal relationships in the SEM more  
16 fully because there aren't as many gaps. In the  
17 end, the claims examiners are sending these  
18 claims to a contract medical consultant to help  
19 them opine on causation.

20 The cases that I see are ones where  
21 the contract medical consultant has gotten, in my  
22 humble opinion, completely wrong, and there is

1 plenty of evidence to show that that case is  
2 related to exposure that DOE but the contract  
3 medical consultant really isn't up-to-date.

4           It is a different question, but it is  
5 almost as if the SEM is not enough. Having a  
6 disease link in the SEM is not enough unless  
7 there is also a presumption, because you get a  
8 contract medical consultant and the contract  
9 medical consultant is considered the one to  
10 provide the answer, or maybe the industrial  
11 hygienist can provide the answer. But the  
12 industrial hygienist tells them that the exposure  
13 occurred at a certain level that is medically-  
14 significant and, then, the CMC says, then, that  
15 is causally-related to their disease.

16           In theory, a worker could apply,  
17 provide information that is not in the SEM. It  
18 could go to the contract medical consultant and  
19 they could award the claim based on their own  
20 review process. It doesn't happen that way, but  
21 it might be happening and we don't know about it,  
22 because we all hear about the claims that didn't

1 make it through.

2 MEMBER MARKOWITZ: This is Steve  
3 Markowitz.

4 This is where, actually, looking some  
5 claims initially will give some insight into  
6 how --

7 CHAIR WELCH: Yes.

8 MEMBER MARKOWITZ: -- these medical  
9 consultants pay attention or not to the SEM and  
10 what the quality of their own review is --

11 CHAIR WELCH: Right.

12 MEMBER MARKOWITZ: -- or how they go  
13 about doing a review.

14 We will need a larger sample to get a  
15 truer picture, but even an initial review gives  
16 us some insight.

17 CHAIR WELCH: I agree.

18 MEMBER WHITLEY: Garry here.

19 I would like to see those slides that  
20 they give the claims examiners for their training  
21 and what DOL is telling the claims examiner this  
22 is what to use to deny or recommend that claim,

1 because sometimes I think it never gets to the  
2 CMEs, and the claims examiner just makes a  
3 recommendation and denies it. I believe  
4 sometimes it is only on the SEM, nothing else.

5 CHAIR WELCH: I think that was on our  
6 request after our April meeting, was the training  
7 for the claims examiners. I am going to see if I  
8 have that.

9 MEMBER GRIFFON: Laurie, this is Mark  
10 Griffon.

11 Also, just to go on with what Garry  
12 was just saying, I think it might be useful as we  
13 look at the sampling of claims to also look at  
14 the procedures that they are using, sort of the  
15 process they go through, as Steve said, in  
16 assessing a claim.

17 I mean, as far as I can tell, some of  
18 the procedures are on the website, but I don't  
19 know -- like I am looking at these Part 2  
20 procedures, and specifically one that applies is  
21 the 2-0700 establishing toxic substance exposure.  
22 There's a couple others that also probably apply,

1 including the Resource Center.

2 But I don't know if this is all of the  
3 procedures or there are other internal  
4 procedures. For instance, on this thing they  
5 mention a script that the Resource Center should  
6 follow in doing the Occupational Health  
7 Questionnaire, and I don't see the script  
8 attached as an appendix or anything. So, I  
9 wonder if there are other procedures that the  
10 Resource Center, that the claims examiners, all  
11 these different levels, if they have different  
12 procedures that they are following.

13 Because I think another thing that got  
14 raised during our discussion is, even more so  
15 than on the radiation side, I think this side of  
16 the program could be quite reliant on  
17 professional judgment. And I wonder where -- I  
18 think because we looked through these claims and  
19 the procedures -- we might think about where does  
20 professional judgment come into play and how is  
21 DOL assuring consistency in quality in those?  
22 You know, is it the luck of the draw? If I get

1 one claims examiner, I am not going to go through  
2 versus another one I am very likely to get  
3 through? I mean, that is all part of this, I  
4 guess.

5 But I think we should have the  
6 procedures along with these plans to look at. I  
7 think that would be very helpful.

8 CHAIR WELCH: Very good point.

9 MEMBER MARKOWITZ: Steve Markowitz.

10 So, to formulate the request -- I am  
11 getting this down and Carrie is committed to  
12 getting this down -- it is to request the  
13 additional materials, at least request the  
14 training materials or PowerPoints that are used  
15 specifically for the claims examiners, but, more  
16 broadly, any written sources of guidance,  
17 instructions, or procedures beyond those that are  
18 available on the website that are used by claims  
19 examiners, the physicians, the industrial  
20 hygienists, or whichever other personnel, to  
21 process claims. Is that what it is? Is that the  
22 request?



1                   MEMBER GRIFFON: Yes, that's great,  
2 Steve. That sounds good.

3                   CHAIR WELCH: And the other  
4 Subcommittee, I don't know if they have had their  
5 call yet, but it would seem like that is what  
6 they would be asking for as well.

7                   MEMBER MARKOWITZ: The IHMD? Yes.

8                   CHAIR WELCH: Yes.

9                   MEMBER MARKOWITZ: They haven't had  
10 the call yet?

11                  CHAIR WELCH: But, yes, I think you've  
12 got it.

13                  I know we have transcript and meeting  
14 minutes, but I can summarize our conversation and  
15 have Carrie see if she caught all the same action  
16 items and send it to all. And then, we can be  
17 sure we have captured everything we talked about.

18                  And then, Steven and Carrie will do  
19 their best to get the data on distribution of  
20 claims, including sites, you know, diagnosis  
21 accepted, rejected, site. I am not sure what  
22 else we would want, but we could think about

1 that. We don't really know what their fields  
2 are, but that would get us started. And we could  
3 get that fairly quickly and, then, ask for some  
4 files to review in advance of a call at the end  
5 of September.

6 DR. DEMENT: This is John.

7 In the Part B claims data file, now we  
8 will receive information that, basically, the  
9 site, the disease, whether or not it was accepted  
10 or rejected, but we never got anything with  
11 regard to the reasons for denial. Now I would  
12 request, if we did a dataset for Part E, that we  
13 specifically ask for, either in the coded  
14 fields -- and if it is not coded, the pretext  
15 description of the reason for denial would be  
16 acceptable.

17 But allow us to look at a lot more  
18 claims quickly and summarize them, as opposed to  
19 getting a much smaller list of claims to go  
20 through in great detail, I think will be a good  
21 supplement to that detailed review.

22 CHAIR WELCH: Yes. And if they don't

1 collect that information at all, that will be  
2 helpful to know.

3 DR. DEMENT: Yes. I would assume, I  
4 would hope, though, the database that was used  
5 for processing claims would also have something  
6 there with regard to the reasons for denial.

7 CHAIR WELCH: Yes, I hope so.

8 Of course, specific requests are going  
9 to be the claims data, what we just said in terms  
10 of training materials and guidance for the IH,  
11 CMCs, for processing the claims. And we are  
12 going to want them at the DOL's Board meeting to  
13 discuss did they have a plan for implementing the  
14 recommendations.

15 And then, we have a whole lot of other  
16 points that we have discussed that we will keep  
17 our eye on as we move forward through the  
18 discussions. We wanted to know, in addition to  
19 that source of guidance for examiners and claims,  
20 we also want details on the Occupational History  
21 Questionnaire, the interview. Is there a script?  
22 How do they help the worker? Is there any

1 quality assurance? And I will go through my  
2 notes and see if there is any other specific data  
3 requests and make sure to get those off right  
4 away.

5 MEMBER MARKOWITZ: Steve Markowitz.

6 Can I just mention something that we  
7 haven't really discussed? I think we ought to  
8 take a look at the examples when DOL has evolved  
9 toward using presumptions. It is a limited  
10 number of instances. It is the asthma, the stuff  
11 that is COPD. But to look at how they have done  
12 that, so that we can understand their thinking.  
13 And, also, it is helpful because it sets certain  
14 precedents. If we decide to encourage the  
15 further development of presumptions, it will give  
16 us some understanding as to how they have  
17 approached it so far and, therefore, how it could  
18 be extended.

19 CHAIR WELCH: Okay. Good.

20 And I'm just adding a note that, if we  
21 get around to developing, to talking about  
22 presumptions, we would want to outline a process

1 for that --

2 MEMBER MARKOWITZ: Right.

3 CHAIR WELCH: -- and include some  
4 external peer review in some way, even if the  
5 Board were to develop it, to be able to send it  
6 for input from others.

7 MEMBER MARKOWITZ: You know, the  
8 importance of that is that the very ambitious  
9 scientific process that IOM laid out, which is  
10 long-term and difficult to achieve, that short of  
11 achieving that level of scrutiny, us a describing  
12 a presumptions process can use limited science  
13 and at the same time inform what the intent of  
14 this whole program is, which is to give the  
15 claimants the benefit of the doubt and, also,  
16 acknowledges the fact that the exposure  
17 information is extremely limited going back  
18 decades. Anyway, yes, that's it.

19 CHAIR WELCH: All right. Okay. So,  
20 I will work with Carrie, and she is going to get  
21 the request off to DOL, and write up notes so you  
22 all can see what I think we talked about, which

1 you can completely pick apart.

2 And we will schedule a call for  
3 September.

4 Any last thoughts before we go?

5 (No response.)

6 CHAIR WELCH: Thank you all so much.  
7 I feel like I prepared and, then, just got  
8 fantastic ideas from everybody on the call. We  
9 really have a fantastic group.

10 And if anybody else wants to take over  
11 the chair, any one of you could do better than I  
12 did, but I know someone has got to do the task.  
13 So, I will keep it up.

14 But keep coming in with those great  
15 ideas. Thank you so much.

16 And we'll be in touch.

17 (Whereupon, at 2:53 p.m., the  
18 teleconference was concluded.)

19

20

21

22

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C E R T I F I C A T E

This is to certify that the foregoing transcript


In the matter of: Subcommittee on Site Exposure  
Matrices (Area 1)

Before: Toxic Substances and Worker Health Adv. Bd.

Date: 07-11-16

Place: teleconference

was duly recorded and accurately transcribed under  
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