UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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SUBCOMMITTEE ON IH and CMC
AND THEIR REPORTS (AREA #4)

+ + + + +

MEETING

+ + + + +

MONDAY,
JULY 18, 2016

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The Subcommittee met telephonically at 2:00 p.m. Eastern Time, Rosemary Sokas, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

MARK GRIFFON

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair of the Advisory Board
ROSEMARY K SOKAS, Chair

CLAIMANT COMMUNITY:

KIRK D. DOMINA
GARRY M. WHITLEY
FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

C-O-N-T-E-N-T-S

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1 P-R-O-C-E-E-D-I-N-G-S
2 2:02 p.m.
3 MS. RHOADS: Good morning or good
4 afternoon, everybody, depending on your time
5 zone.
6 My name is Carrie Rhoads, and I would
7 like to welcome you to today's conference call
8 meeting of the Department of Labor's Advisory
9 Board on Toxic Substances and Worker Health, the
10 Subcommittee on IH and CMC and their reports. IH
11 is Industrial Hygienist and CMC is Contract
12 Medical Consultant.
13 I'm the Board's Designated Federal
14 Officer, or DFO, for today's meeting.
15 First, I want to note how much we
16 appreciate the time and the work of our Board
17 members in preparing for this meeting and being
18 here today, and for all the work they are about
19 to do.
20 I will introduce the Board members on
21 the Subcommittee and do a quick roll call. And
22 could you please just say "here" or answer for

1 your name for the transcript?

2 Dr. Rosemary Sokas is the Chair of the

3 Subcommittee.

4 CHAIR SOKAS: Here.

5 MS. RHOADS: And the members are Ms.

6 Faye Vlieger.

7 MEMBER VLIEGER: Here.

8 MS. RHOADS: Mr. Kirk Domina?

9 MEMBER DOMINA: I'm here.

10 MS. RHOADS: Mr. Garry Whitley?

11 MEMBER WHITLEY: Here.

12 MS. RHOADS: Mr. Mark Griffon?

13 MEMBER GRIFFON: Here.

14 MS. RHOADS: Dr. George Friedman-

15 Jimenez is part of the Subcommittee, but he could

16 not be on the line today.

17 And Dr. Steven Markowitz?

18 MEMBER MARKOWITZ: Here.

19 MS. RHOADS: Who is also the Chair of

20 the Board.

21 Melissa Schroeder from SIDEM is in the

22 room with me.

1 We are scheduled to meet from 2:00 to
2 4:00 p.m. Eastern time today. Given that the
3 meeting is two hours, we are not scheduling a
4 break at all.
5 Copies of meeting materials and any
6 written public comments are or will be available
7 on the Board's website under the heading
8 "Meetings" and the listing there for this
9 Subcommittee meeting.
10 The documents are also up on the WebEx
11 screen, so everyone can follow along with the
12 discussion.
13 The Board's website can be found at
14 dol.gov/owcp/energy/regs/compliance/advisoryboar
15 d.htm or simply Google "Advisory Board on Toxic
16 Substances and Worker Health," and it will likely
17 be the first link.
18 If you haven't already visited the
19 Board's website, I encourage you to do so. After
20 clicking on today's meeting date, you will see a
21 page dedicated entirely to today's meeting. The
22 web page contains publicly-available material

1 submitted to us in advance of the meeting. We
2 are going to also publish any materials that are
3 provided to the Subcommittee there. You should
4 also find today's agenda as well as instructions
5 for participating remotely. If you are
6 participating remotely and you're having a
7 problem, please email us at
8 energyadvisoryboard@dol.gov.
9 If you are joining by WebEx, please
10 note that the session is for viewing only and
11 will not be interactive. The phones will also be
12 muted for non-Advisory-Board members.
13 Please note that we do not have a
14 scheduled public comment session today. The
15 call-in information has been posted on the
16 Advisory Board's website, so the public may
17 listen-in but not participate in the
18 Subcommittee's discussion.
19 The Advisory Board voted at its April
20 26th through 28th meeting that Subcommittee
21 meetings should be open to the public. A
22 transcript and minutes will be prepared from

1 today's meeting.
2 During Board discussions today, as we
3 are on a teleconference line, please speak
4 clearly enough for the transcriber to understand.
5 When you begin speaking, especially at the start
6 of the meeting, please state your name, so we can
7 get an accurate record of the discussion.
8 Also, I would like to ask our
9 transcriber to please let us know if you are
10 having an issue with hearing anyone or with the
11 recording.
12 As DFO, I see that the minutes are
13 prepared and ensure they are certified by the
14 Chair. The minutes of today's meeting will be
15 available on the Board's website no later than 90
16 calendar days from today, per FACA regulations.
17 But, if they are ready sooner, they will be
18 published before the 90th day.
19 Also, although formal minutes will be
20 prepared, we will also be publishing verbatim
21 transcripts which are, obviously, more detailed
22 in nature. Those transcripts should be available

1 on the Board's website within 30 days.
2 I would like to remind the Advisory
3 Board members that there are some materials that
4 have been provided to you in your capacity as
5 special government employees and members of the
6 Board which are not for public disclosure and
7 cannot be shared or discussed publicly, including
8 in this meeting. Please be aware of this as we
9 continue with the meeting today.
10 With that, I convene this meeting of
11 the Advisory Board on Toxic Substances and Worker
12 Health, Subcommittee on the IH and CMC, and their
13 reports. I will turn it over to Dr. Sokas, who
14 is the Chair of the Subcommittee.
15 CHAIR SOKAS: Thank you, Carrie, and
16 thanks for all the effort that has gone into
17 posting the federal notice and to making this all
18 work out well.
19 And I want to thank all of the members
20 who are able to participate and anyone who is
21 phoning in.
22 The task that we have, which I think

1 we are all pretty clear about, is trying to help
2 to ensure the quality, objectivity, and
3 consistency of the work and written reports of
4 Industrial Hygienists staff positions and
5 consulting physicians and to make sure that the
6 reports are as helpful as possible.
7 What we are going to do today is have
8 several of the Board members, Faye Vlieger, Kirk
9 Domina, and Garry Whitley, go through some of the
10 challenges that are experienced by the
11 stakeholders and really kind of frame for us what
12 the issues are for the people using the program.
13 We will then, also -- and Mark Griffon
14 is going to do the IH piece and I will do the
15 medical piece -- we are going to assess the
16 questions that were raised by the program itself.
17 I think we are also going to need to gather
18 information about potential areas for improvement
19 from additional stakeholders, that I would
20 include not only the claimants, but also the
21 Industrial Hygienists and some of the CMCs, just
22 to kind of get their perspective because we have

1 certainly heard from other perspectives. And
2 then, together we will identify the tasks and the
3 need for additional information and, then, assign
4 those tasks and, hopefully, develop a work plan
5 that we can implement before our next entire
6 meeting in the fall, the entire Board meeting in
7 the fall.
8 Does anybody on the Board have any
9 comments or questions about the scope of today's
10 discussion?
11 MEMBER MARKOWITZ: Rosie, this is
12 Steve Markowitz.
13 My only comment is, as we think about
14 things that we want to do, that we think about
15 the fact that the next meeting is mid-October.
16 We could have an additional phone call meeting
17 before then, with six weeks' notice needed, but
18 we could achieve that. And then, just think
19 about what the steps are about what we might want
20 to get done between now and the next phone call
21 meeting or between now and the full meeting in
22 October. That's all. It is just to inform kind

1 of the discussion as we talk through it.
2 CHAIR SOKAS: Right, right. So, we
3 would need a six-week notice if we were going to
4 do another phone meeting. If, on the other hand,
5 we can assign tasks and get to work, basically,
6 we may not need that additional phone meeting.
7 I was also going to ask that, Carrie,
8 when we talk about the IH review issues, if this
9 is all right with Mark, and certainly for when we
10 get to the medical review issues, I would like to
11 pull up just that one-page -- it is actually two
12 pages -- that Jeff Kotsch put together in his
13 presentation that really has the questions
14 related to the program specifically. There are
15 10 questions, I think three of them for the IH
16 and the rest of them seem to be more for the
17 medical. Because that will just let people see
18 in the background what it is we are talking
19 about.
20 MS. RHOADS: Yes, that's fine. I
21 think it is the presentation from the April 28th,
22 I think, meeting.

1 CHAIR SOKAS: Yes, and it is the top
2 of the page. It says, "CMC Contract Reviews".
3 But, then, below that, there's the advice and
4 assistance that is underlined and in bold. It
5 says at the bottom "page 6 of 7". So, it goes
6 from page 6 over into page 7.
7 MS. RHOADS: Okay. That's fine.
8 CHAIR SOKAS: I think that is probably
9 the main thing that we will be referencing here.
10 There probably are other things. And if other
11 Board members would like to pull up anything
12 either before, during, or after that, that would
13 be great. So, just shout it out.
14 All right. I would like to actually
15 move on, then. I think we have got plenty of
16 content to do, and it may be that the duration
17 that I have arbitrarily assigned to each
18 presentation might go a little bit long or a
19 little bit short.
20 But I would like to turn it over to
21 Faye and Kirk and Garry, if they would kind of
22 help us again frame what the major stakeholder

1 issues are with respect to both the questions
2 that the program itself asked, but also the
3 experiences that people go through and where the
4 trouble spots might be or where we, as a Board,
5 might be most helpful.
6 MEMBER VLIEGER: Okay. Well, the
7 majority of the people on the Advisory Board --
8 this is Faye Vlieger -- don't know the process it
9 goes through. So, you have a pretty dry
10 presentation from what we had at the D.C. meeting
11 in April and, also, the Procedure Manual.
12 The problems arise in the
13 implementation of the use of the CMC and the IH
14 in that the Claims Examiner frames the questions
15 to them. And so, you may have ended up with a
16 broad spectrum of issues that were presented to
17 the CMC, but through the process -- and it even
18 says so in that Industrial Hygiene document that
19 we have, the document on the Industrial
20 Hygienists -- that they are only allowed to
21 answer, the Industrial Hygienists are only
22 allowed to answer the questions that the Claims

1 Examiner puts to them.
2 And so, you may have actually had a
3 number of toxins that are actually appropriate
4 for the claimed condition, but, then, the Claims
5 Examiner winnows that down to two or three
6 obscure toxins, and then, the Department only
7 analyzes those in their pure form. And so,
8 classically, what happens is the chemicals in
9 their pure state are sent to the Industrial
10 Hygienists, who then opine they could not have
11 been exposed to a sufficient quantity of these
12 chemicals in their pure state to cause the
13 disease.
14 Then, the Industrial Hygienist report
15 is fed back to the CE, and the CE never questions
16 the Industrial Hygienist report, in my
17 experience. The Industrial Hygienist report
18 stands on its own with no other peer review.
19 Then, the CE, who already is
20 questioning that anything happened in the claim,
21 sends the Industrial Hygienist report to a
22 Contract Medical Consultant, who normally, in my

1 opinion, is not well-vetted for the opinion that
2 they are making.
3 The CMC, again, is given limited
4 information on the exposures and limited
5 questions to answer, instead of giving them the
6 information on the claim and saying, "Listen,
7 this is what is claimed. This is what they were
8 exposed to. Is there a 50-percent likelihood
9 that this happened?" Because, remember, under
10 this program, the standard is "as likely as not".
11 So, that is basically 50 percent or better.
12 So, the CMC never goes against the
13 recommendation of the IH. And in very, very few
14 cases is there ever a referee called in on the
15 CMC by the Department of Labor. The referee
16 decision, doctor decision, is called in by the
17 claimant, and the referee normally sides with the
18 Department.
19 So, the claimant really has limited
20 access to these experts that they want these very
21 long decisional letters on. And the doctors that
22 they do see don't have time to do that type of

1 letter. So, that is kind of it in a nutshell.
2 CHAIR SOKAS: Faye, I have a question.
3 This is Rosie. I have a question for you. I
4 read in one place where, if the claimant requests
5 it, they can get a copy of the CMC letter. So,
6 it doesn't automatically -- does any of this
7 information automatically get sent to the
8 claimants? Does the claimant get the CE's
9 framing of the question? Does the claimant get
10 the report from the IH? Does the claimant get
11 the report from the CMC?
12 MEMBER VLIEGER: Classically, even
13 when you get a request for the claim file, unless
14 you specifically stated or you knew that these
15 documents existed and asked for them in your
16 request for the claim file, you did not get them.
17 Many times the only time they see them is after
18 there is a recommended decision to deny, because
19 the Claims Examiner will state that the IH or the
20 CMC said such-and-such.
21 I understand the Department is now
22 going to include them routinely in a document

1 request, but I have not seen them being presented
2 routinely with the recommended decision to deny.
3 And that is normally at the point that the
4 claimant knows what those two professionals said.
5 I am not even going to call them "experts"
6 because they aren't being given enough
7 information to make an expert opinion.
8 It is kind of like -- I don't know if
9 you have ever watched any of the police
10 procedurals, but when the district attorney wants
11 them to answer in a certain way, the question is
12 very leading and there is only one way to answer,
13 and it is usually not the answer that would be
14 accurate. And that is the way these referrals go
15 to the IH and the CMC.
16 I think if you look at the examples
17 that we have seen and what we heard at the
18 meeting in April, that you will see that that is
19 true.
20 CHAIR SOKAS: And is there anything
21 that would prevent the pieces of information just
22 automatically being sent as they are generated to

1 the claimant?
2 MEMBER VLIEGER: No, it is not part of
3 the Procedure Manual.
4 CHAIR SOKAS: Okay. All right.
5 MEMBER MARKOWITZ: This is Steven.
6 Faye, I have a question that you may
7 or may not know the answer to. In the Procedure
8 Manual, and I'm reading it, it says, quote, "The
9 IH also reviews SEM searches performed by the DO"
10 -- the District Office -- "to determine whether
11 or not they were performed correctly and
12 accurately." End of quote.
13 Does this suggest that the IH is
14 actually not just focusing strictly on the
15 questions posed by the CE, but is also looking at
16 how good the SEM search process was? Do you have
17 any experience with that?
18 MEMBER VLIEGER: My experience is that
19 the CE forms the questions to the IH with a few
20 contaminants. The IH doesn't look beyond what
21 the CE provides to them.
22 And then, if you remember when we were

1 looking at the Site Exposure Matrix, depending on
2 how you pull it up, it can be very stinted. And
3 then, the disease has to be linked to the Site
4 Exposure Matrix, to a chemical, before that can
5 be verified and sent to the IH.
6 So, when you set up a database to use
7 as your sole source of information, and you
8 discount the input from the claimant in your
9 Occupational History Questionnaire and from their
10 physician, the only evidence that goes to the IH
11 is what the CE sets up. I have not had
12 experience where the IH actually says, "Oh, no,
13 this is wrong. A welder is actually exposed to
14 all of these things, including metal." I have
15 never seen that happen.
16 MEMBER MARKOWITZ: Well, I think this
17 is something that we really need to look at,
18 actually, not just this specific issue whether
19 the IH is looking at the validity of the SEM
20 search, but a number of different aspects, but
21 this is one aspect which ought to be in the
22 documentation of the letter provided by the IH.

1 So, we ought to be able to look at this issue.
2 MEMBER VLIEGER: Yes, and I think when
3 we had the IH in front of us in April and we
4 asked him, you know, how long it takes to do this
5 report that they do, if you look at a quantity of
6 the IH reports, you will see most of them are
7 boilerplate.
8 MEMBER MARKOWITZ: Right. Okay.
9 Thank you.
10 CHAIR SOKAS: Well, I mean, the whole
11 question of doing a quality assessment, quality
12 kind of review of the content of the reports is
13 still open; you know, one of the things we can
14 discuss as one of the requests we might be able
15 to help with.
16 But, again, I am sort of getting at it
17 from the point of view of transparency. So,
18 there is no real reason why the Procedure Manual
19 couldn't say at each step of the process the
20 claimant gets a copy of what is being requested
21 by the CE, what the IH turns up. Because,
22 obviously, that would at least speed things up

1 and, also, provide some sort of immediate review
2 for potential accuracy.
3 MEMBER VLIEGER: Yes, I think with the
4 new IH contract, I don't know if they wrote any
5 of that into the new IH contract that they
6 awarded, but we did ask these questions. The
7 advocates had a meeting with the Department of
8 Labor and the other parties to the program in
9 December -- excuse me -- in March, and we asked
10 them about this specifically: why is it that the
11 claimant has no input to any of this? And they
12 said they would look into it, but we haven't seen
13 any response to that.
14 CHAIR SOKAS: Okay. Well, that is
15 certainly a question we can raise.
16 MEMBER WHITLEY: Garry here.
17 I think we are onto something because
18 the CEs I think are not sending enough
19 information on up the line. I am going to give
20 you a couple of real quick examples I ran into
21 this week.
22 We had a sheet metal worker who the CE

1 sent him a form letter back that said that he
2 agreed that a certain chemical caused COPD, but
3 he couldn't say a sheet metal worker used that
4 chemical. Well, I went on the SEM and called up
5 sheet metal worker. There is that chemical.
6 Called up the building that said sheet metal
7 worker in. There is that chemical. Everything
8 that he needed was right on the SEM, but, you
9 see, he was filing for hearing and COPD.
10 He said he would send the information
11 for the hearing on up to the IH, but he wouldn't
12 send the COPD -- that is what the letter said --
13 the COPD on up because he couldn't find where he
14 used that chemical.
15 And I printed it out for the guy. I
16 said, "Here it is."
17 And today and the past two days, I
18 have had two people call me and say, "I was an
19 instrument technician and I am filing for
20 hearing, and my CE is telling me that they don't
21 cover instrument technicians." Well, when you
22 pull the law, right in the middle of it is the

1 list of the covered, is instrument technicians.
2 So, I really think the biggest problem
3 is the IH and the Medical Examiners are not
4 getting enough information from the Claims
5 Examiners.
6 CHAIR SOKAS: Uh-hum.
7 MEMBER VLIEGER: Yes, let's just say
8 it is the issue of very channeled, very limited
9 areas that they are allowed to answer to. And if
10 they go outside the box, we don't see those
11 intermediate responses. If there is any
12 discussion between the CE and the CMC, the CE
13 will go back to the CMC and ask them for
14 clarification, but in the file I have never seen
15 that intermediate report from the CMC where the
16 CE disagrees with something that they did.
17 So, that, too, the draft CMC report
18 that the CMC gets before they go back and as the
19 clarification are not showing up, either. And I
20 don't know if that is the internal issue with
21 their records that they get from CMCs. I don't
22 know.

1 Now the other issue Garry brings up is
2 quite timely. It is that there is a separate
3 Site Exposure Matrix that the Claims Examiners
4 look at that is not public.
5 CHAIR SOKAS: Now, Steve, I'm going to
6 bring you in on this one. Is the SEM Committee
7 looking into that?
8 MEMBER MARKOWITZ: Looking into which
9 aspect?
10 CHAIR SOKAS: To whether or not the
11 information that is available -- I mean, I'm sure
12 they are looking at the SEM, but has the question
13 been raised about whether or not the information
14 is available to the public?
15 MEMBER MARKOWITZ: Well, we are going
16 to look into difference between the private and
17 the public SEM, if that is your question.
18 CHAIR SOKAS: Okay. All right.
19 MEMBER DOMINA: Hey, this is Kirk. I
20 just have a comment.
21 MEMBER MARKOWITZ: I am not exactly
22 sure how we are going to do that, but it is the

1 intention of doing that.

2 CHAIR SOKAS: Okay. Got it.

3 Kirk?

4 MEMBER DOMINA: If you look at like

5 what we were just talking about what is going to

6 the IH, and whatever, if you look at the example

7 that was provided for us in our April meeting,

8 you will see where, like what Faye just stated,

9 the question that was asked to the IH is -- the

10 individual has worked from '77 until still

11 currently employed, put in for COPD in 2012.

12 But, when they sent the letter asking the IH,

13 they stopped at 1995, based on the fact of that

14 Circular.

15 CHAIR SOKAS: Right.

16 MEMBER DOMINA: Plus, the individual's

17 work history, there's seven years missing; well,

18 actually, 10 years, 11 now, because the last time

19 they got his work history was in 2005. And so,

20 you don't know; the guy could have been involved

21 in an accident, an incident, or whatever. None

22 of this information gets to them. And so, it is

1 a jaded report.

2 CHAIR SOKAS: Now we could get

3 explicitly -- one of the very last questions on

4 the list from the program to us is to look at

5 that Circular, the one about the post-1995

6 expectations. And I think that is going to be a

7 real task that we will be able to have input

8 into.

9 So, I think I will be interested to

10 hear what Mark has to say about, you know, when

11 he does his presentation, but I think for sure

12 that is going to be something that we will be

13 taking on as a Subcommittee.

14 I am not clear in my own mind whether

15 or not the inclusion of exposures is required

16 through the most recent, though, and I guess that

17 would be a question I would have, if anybody

18 knows it right now or if that is one of the

19 things we add to our list of questions.

20 MEMBER VLIEGER: Well, the law is

21 quite clear about Part E. The statute states

22 that, in order to be covered under this program,

1 you only have to have one day of employment to be
2 covered under Part E. And so, the Department
3 administratively made it that, if you had any
4 exposures after 1995, by magic waving of their
5 wand, that they could not have happened.
6 And I did send the Department of
7 Energy's response to me about their input into
8 those memos to Carrie for one of the other
9 Subcommittee meetings. Basically, the Department
10 of Energy did not tell them that that memo was
11 factual.
12 And so, Carrie, do you have that DOE
13 response about what their input was to DOL's 1995
14 post-exposure memo?
15 MS. RHOADS: That is actually on the
16 website for the other Committee meeting. We
17 don't have it up on the WebEx screen, but we can
18 get it up, if you would like, in a few minutes.
19 MEMBER VLIEGER: Well, it is very
20 telling because we are not quite on that topic
21 yet, but the Department of Labor decided to
22 administratively rule out exposure post-'95

1 because the Department of Energy had written
2 memos to strengthen their toxic exposure to their
3 workers. And just because the Department of
4 Energy wrote a memo and an order to their
5 contractors to stop doing it does not mean that
6 it happened. That memo, that post-'95 exposure
7 memo, is not backed up by any science.
8 CHAIR SOKAS: And in addition to that,
9 Faye -- and this is something, Carrie, you might
10 be able to kind of add to the list; I mean, it is
11 the topic of that exposure memo -- but, in the
12 late nineties, I think it was '98-99, OSHA
13 actually did a series of invited visits to
14 several of the DOE facilities. And Oak Ridge I
15 am sure was one of them. I am trying to remember
16 all of the different ones.
17 Because what they did was they were
18 actually looking to see if they were going to be
19 applying for VPP status, basically, which is
20 their high-performing stuff, on the basis of the
21 change in the central office's approach to health
22 and safety. But, in point of fact, there were

1 slip-ups all over the place, and it was very
2 clear that there were some actual impediments to
3 the implementation of that.
4 One of them, as I recall really
5 clearly, was that they were issuing contracts and
6 renewing contracts on the basis of having an
7 illness and injury reporting number that was
8 quite low. And the problem with that is the
9 minute you tie someone's contract or their bonus
10 or their performance rating to that kind of a
11 single number, you basically invite everybody to
12 cook the books.
13 So, there was a lot of concern around
14 the accuracy of the illness and injury reporting,
15 about the disincentives to reporting, and to the
16 fact that, like any organization, I mean any
17 organization, there's a difference between the
18 central office deciding something and everybody
19 in the field actually performing and having it
20 happen. So, that is true of any organization.
21 So, I think we, as a Committee, are
22 going to have a lot to say about that particular

1 memo.

2 Kirk, did you have anything else that

3 you wanted to bring up?

4 MEMBER DOMINA: Well, not at this

5 time.

6 MEMBER VLIEGER: I think we need to

7 talk about the correlating memo about hearing

8 loss in toxin exposure post-1995. It follows the

9 same issue where they just summarily decided that

10 that was going to be that way. And the painters

11 didn't change the stuff that they used. The

12 metal workers didn't change the solvents they're

13 exposed to. The instrument technicians still use

14 the same things to clean parts. Yet, the post-

15 '95 hearing loss memo has the same flaws that the

16 post-'95 toxic exposure memo does.

17 CHAIR SOKAS: So, Faye, I think we

18 should add that to the list then.

19 MEMBER VLIEGER: I would agree.

20 CHAIR SOKAS: Okay, great.

21 And Carrie has the website up. So, is

22 that the DOL memo? The response?

1 So, Faye, did you want to walk us
2 through the response from DOE?
3 MEMBER VLIEGER: Sure. If you look,
4 I had queries to the Department of Energy what
5 their position was on this post-1995 memo. And
6 they did say that they provide them all kinds of
7 information, but the bottom line on this response
8 is that they did not have, the Department of
9 Labor, that this was a factual memo. They give
10 them information, and the Department of Labor
11 made their own decision to do the post-'95
12 exposure memo basically stating that nobody has
13 any reason to claim toxic exposure post-'95
14 unless it was an incident, accident, or off-
15 normal occurrence.
16 Well, there is actually a Department
17 of Labor memo. Carrie, did we have the
18 Department of Labor's memo about how they came up
19 with the post-'95 Circular? Was that up on the
20 other page, too?
21 MS. RHOADS: I don't think so.
22 CHAIR SOKAS: No, I think we actually

1 had that, say, in our original binder from the
2 April meeting. So, there was the original memo,
3 and then, there was that second memo. It is
4 there someplace. But it basically just supports
5 the original memo, I think.
6 MEMBER VLIEGER: Yes, it does. And in
7 countering their logic for this memo -- and Kirk
8 can talk to this -- after 1995, the Department of
9 Energy continually wrote memos about the fact
10 that workers are still being exposed and they
11 were going to improve the workers' situation.
12 But it still isn't in fruition, and there were a
13 number of documentation requirements that were
14 put in place, that exposure information,
15 monitoring data, incident and accident
16 information would be in personnel records. And
17 Kirk can speak to whether or not those have ever
18 been implemented.
19 Are you there, Kirk?
20 MEMBER DOMINA: Yes. I was eating.
21 Sorry.
22 MEMBER VLIEGER: All right.

1 MEMBER DOMINA: No, I mean, the other
2 thing I talked about, too, when we were back
3 there is anytime they put some, quote, "new
4 program" in place, and we are in the middle of
5 contract -- you know, who's running the site --
6 they are going to ask a request for equitable
7 adjustment because they want more money to
8 implement certain things.
9 And so, just because they say they may
10 want to use -- or that things got safer, it is
11 not necessarily so, because if you remember
12 correctly, I think -- or maybe I didn't -- but
13 our latest SEC for construction workers from '84
14 to 1990 came into effect because they were
15 supposed to provide bioassay samples and a
16 bioassay program for the construction workers,
17 and it never happened. Even though DOE says
18 you're going to do this, it doesn't mean it is
19 going to happen. And this is the case with this.
20 And because of how they choose to
21 record incidents, events, or whatever, it is up
22 to them because it still in effect today, on how

1 things get recorded and what meets a certain
2 level or requirement in their eyes that qualifies
3 as an event when workers are exposed, as what we
4 see going on today, or in the employer's opinion,
5 not exposed.
6 CHAIR SOKAS: Uh-hum, uh-hum.
7 MEMBER VLIEGER: And remember, DOE has
8 specific reporting criteria and requirements for
9 investigation. And if an individual worker gets
10 a chemical exposure, at least during the
11 timeframe I worked at there, it didn't warrant an
12 investigation because three or more people were
13 not involved.
14 And so, the DOE criteria to even
15 investigate is not what people expect. And
16 remember, DOE is not held bound to any NIOSH
17 regulation.
18 CHAIR SOKAS: You know, I think it
19 would be interesting -- and, Carrie, I wish I had
20 a better title to ask you to request, but I am
21 wondering if, within the Department of Labor, you
22 could access the OSHA report. There was a joint

1 DOE-OSHA activity that included a number of
2 reports based on joint visits to several of the
3 sites in the late nineties. I can try to figure
4 out exactly when that took place, but it would
5 have been '98 or '99, basically. And I can also
6 try to figure out which directorate it would be
7 in, but I think putting the request through the
8 main office in OSHA ought to turn something up.
9 MS. RHOADS: I can do that. Whatever
10 details you have, just send them to me. And
11 then, I will use them in asking about that.
12 CHAIR SOKAS: I sure will. I will
13 track down a little bit more than that. Good.
14 Any other comments, Garry, Kirk, Faye?
15 (No response.)
16 We are moving right along, which is
17 great. I wanted to turn it over to Mark Griffon
18 to talk about the IH review issues. There are
19 some specific questions. Again, if we could go
20 back to those? I think the questions for IH were
21 six, seven, and eight maybe.
22 But, Mark, however you want to handle

1 this, whatever you want to talk about, the ball
2 is in your court.
3 MEMBER GRIFFON: Okay. Thank you,
4 Rosie. I am not sure just how to go about this.
5 But the main ones I saw -- and I don't
6 know if they are numbered in what I'm looking at;
7 there's a bunch of bullets -- but there is one --
8 CHAIR SOKAS: Uh-hum, many bullets.
9 MEMBER GRIFFON: -- recommendation,
10 standardization of IH reviews that Jeff Kotsch
11 had, I guess, in his presentation.
12 And I think, to me, that alone was
13 very telling, that DOL at this point in the
14 process is asking this Board to help with the
15 definition of exposure levels by employees;
16 recommendations regarding improving IH
17 narratives, and proper assessment of employee
18 toxic substance exposures in the absence of
19 Occupational Safety and Health monitoring data.
20 So, I mean, that last one is pretty
21 broad, I would think. But, as I was thinking
22 about this issue, I am just thinking, you know,

1 for this Board, for us to look at this issue in a
2 maybe comprehensive fashion -- and I don't know
3 how much -- I think we have to think about what
4 is going to overlap with the other Subcommittees.
5 But I have been thinking about, you know, we need
6 to review, or at least I do -- some others seem
7 to understand this a little -- they are a little
8 closer to this than I have been, at least on the
9 Part E side.
10 But we need to understand how the
11 procedures are used and other, in those public
12 procedures we have seen, are there other
13 directives or guidance that are given to the IHs
14 or the CEs regarding exposures? Because it seems
15 to me there's a lot of places in the process
16 where a judgment has to be made by someone.
17 If the CE is looking at a claim for
18 the first time, are they including all the
19 exposures that come up on the SEM database or are
20 they saying, based on the job title and my
21 knowledge of what a sheet metal worker does, I
22 think it is unlikely that he would have had any

1 significant levels of exposure to chemical X?
2 And then, passing that information on from there.
3 So, who is making the judgments along
4 the process? How are they making the judgments?
5 How are they making sure they have consistency in
6 the way they are applying these judgments for the
7 various claims?
8 I think we need to look and see if
9 there is QA/QC procedures. Are there peer
10 reviews in IH or are the IHs reviewing the CE
11 claims? I think there are so few IHs, I don't
12 know how that could be happening.
13 And then, another line of questions I
14 had was what is the site-specific expertise of
15 the CEs or IHs that are involved in the process?
16 Do they know these sites? Do they know the sites
17 over time? Because they have changed quite a bit
18 over the course of history of what has been going
19 on and the potential for exposures over different
20 decades on the sites.
21 Well, I mean, that is just some of the
22 things I have been thinking of, Rosie, in terms

1 of the IH side of this process.
2 CHAIR SOKAS: So, you are in a
3 position of, I think, being our only IH. So, the
4 question, the way I would kind of frame it, is,
5 which of these do you think you could actually
6 have the time to get a handle on, right? Maybe
7 part of this is to ask the -- because I was
8 having the same response when I was looking at
9 the medical stuff. I'm looking at, oh, my golly,
10 well, maybe if I had a staff of five, you know,
11 and full-time, I could do some of this.
12 MEMBER GRIFFON: Yes.
13 CHAIR SOKAS: So, some of it might be
14 to narrow and to frame it a little bit by asking
15 for more information.
16 MEMBER GRIFFON: Yes.
17 CHAIR SOKAS: So, are there particular
18 scenarios that turn to out to be problematic in
19 terms of inadequate exposure information or would
20 it be helpful for you, for example, to see can
21 examples of IH reviews for accepted cases, and
22 maybe 10 examples for denied claims, and then,

1 kind of look to see if there's any patterns that
2 you see emerge? Or do you have recommendations?
3 And one of the other things I thought
4 I saw -- and, Steve, a question for you. I don't
5 know if somebody else is going through this, but
6 there was, for example, a question about
7 revamping the Occupational Health Questionnaire,
8 right? So, there is an Occupational Health
9 Questionnaire that, right off the bat, I think
10 you get rid of the family history because I don't
11 actually think that is legal anymore.
12 And people suggested, I think, at the
13 meeting that maybe they could use some of the
14 approaches that, for example, CPWR has taken in
15 terms of collecting information.
16 So, I guess the question is, looking
17 at this, which of these do you think, given time
18 constraints and that you are kind of the IH here,
19 and others on the Committee I'm sure would be
20 happy to help, but what do you think is the most
21 realistic? And what would you need DOL to
22 provide you to be able to start addressing some

1 of that?

2 MEMBER GRIFFON: Well, I mean, yes, I

3 didn't get to that point yet, honestly. But I

4 think, you know, some questions, certainly some

5 examples. I mean, I have thought about this in

6 maybe a different -- maybe others, like I said,

7 are familiar with this, but, for me, it would be

8 good to see the procedures. In other words,

9 before I can make recommendations on how to

10 improve, I have to sort of better understand how

11 they are doing it right now.

12 CHAIR SOKAS: Right.

13 MEMBER GRIFFON: And looking at some

14 examples would be helpful, but, also, looking at

15 the procedures or internal guidance that they are

16 using to make some of these judgment calls, or do

17 they have a procedure in place? So, I think to

18 see some of that stuff first --

19 CHAIR SOKAS: Yes.

20 MEMBER GRIFFON: -- to see, for

21 instance, what percentage of claims have been

22 forwarded to the IH if the CEs say, you know,

1 "This is a technical issue that is beyond our
2 capability. We are referring it to an Industrial
3 Hygienist."? What is the percentage --
4 CHAIR SOKAS: That is a really good
5 data request.
6 MEMBER GRIFFON: Right.
7 CHAIR SOKAS: Again, this is really
8 for Steve and Carrie, because I don't know if
9 others are already doing this. But, for example,
10 if Mark wanted a list, a number, just a count of
11 what proportion of claims are forwarded to the IH
12 and, then, maybe have a sampling of, a handful of
13 claims that got forwarded, a handful of claims
14 that didn't, because you want to look at both
15 sides. Were there any that should have been that
16 weren't in that little pile, you know, that sort
17 of thing.
18 Maybe you would look at both. I mean,
19 if we wanted to, we could just say, well, let's
20 just look at the denials to see if we find
21 problems with them because we are assuming that
22 the process is specific, but maybe not sensitive.

1 I mean, that is, I know, reflection probably.
2 But, Carrie, is that the kind of thing
3 that would be relatively straightforward to get
4 that kind of a redacted series of cases and,
5 then, the numbers across the board? "X" percent
6 get forwarded along.
7 MS. RHOADS: I will ask the program
8 how long would it take them to do that. If you
9 give specific parameters for your request, like
10 maybe for a specific year or something like that,
11 that would --
12 CHAIR SOKAS: Okay. Because, I mean,
13 I think we could do random or we could do the
14 last three months, right, Mark? I mean, I don't
15 think we are looking for a comprehensive thing
16 here. Whatever is easiest for them, if they
17 collect the data monthly, that's great, if they
18 collect it annually. But we want to know, of all
19 the claims coming in, how many were handled
20 entirely by the CE, how many went to an IH. Of
21 the ones handled by a CE only, how many were
22 approved and how many disapproved? Of the ones

1 that went to the IH, how many were approved and
2 disapproved?
3 MEMBER GRIFFON: Yes, that sort of
4 thing, yes.
5 MS. RHOADS: I will start writing this
6 down, and maybe we can refine. Like I will send
7 some language and you can play with it, or
8 whatever, before we forward it to the --
9 CHAIR SOKAS: Before we ask them,
10 sure.
11 MEMBER GRIFFON: Yes.
12 CHAIR SOKAS: And we are going to be
13 asking to see the actual files at some point, and
14 it could be redacted or however. But I do think
15 that for some of this, for both the IH and for
16 the CMC, I think it is going to be a need to sort
17 of look and see what it looks like. Maybe small
18 samples, maybe five or maybe ten, you know,
19 redacted. And it wouldn't have to be the whole
20 file; it could just be the report, right, the
21 information they receive and, then, the
22 information that they give back.

1 MEMBER MARKOWITZ: This is Steve.
2 Actually, given the concerns that Faye
3 especially raised about what the CE forwards to
4 the IH or not, if we are going to look at a small
5 number of claims, we shouldn't look just at the
6 IH report, but also what the --
7 CHAIR SOKAS: No, what I was saying,
8 Steve, was that we would look at what they get
9 and what they give back, so what is forwarded by
10 the CE to them and, then, what they return.
11 MEMBER MARKOWITZ: Right, and what I
12 am saying is that could be augmented by, for
13 these small number of claims, also looking at the
14 exposure information that the CE is looking at.
15 The concern was about some of the things the CE
16 wasn't forwarding. So, if you only look at what
17 the IH gets --
18 CHAIR SOKAS: I see what you are
19 saying. Yes, got it.
20 MEMBER GRIFFON: I think, yes, Steve,
21 I think you're right. This is Mark Griffon. I'm
22 sorry.

1 I think we should, as we pick out
2 randomly, or however, claims to look at, we
3 should look at the entire claims file and, then,
4 see what the CE looked at, what they forwarded
5 on, what the IH looked at.
6 CHAIR SOKAS: I think that is
7 absolutely right. And it is true for the medical
8 information as well. So, that is right. That is
9 a good point.
10 MEMBER GRIFFON: And then, the other,
11 I mean, I was bouncing around a little bit with
12 what I was talking about, but the other piece of
13 what I am mostly interested in is these guidance
14 or guidelines or internal procedures. You know,
15 it is hard to request them when you don't know
16 what exists.
17 So, I am looking at the one on the
18 website and, for instance, it mentions a
19 questionnaire and it mentions that I think the CE
20 administers -- oh, the Resource Center
21 administers the questionnaire, and they have a
22 script that they follow, but I don't see any

1 script in the procedure that is on the web,
2 anyway.
3 So, is there a standardized script or
4 is it a site-specific script? I don't know what
5 they are using. So, are there other guidelines
6 that the CEs are using, that the IHs are using,
7 as they assess these claims?
8 Because I think part of the magic that
9 comes into play in this whole process is the SEM
10 says chemical "X" and job "X", or at least jobs
11 to chemicals, but it says nothing about the type
12 of exposure or the level of exposure. And I
13 think that is where people are making, or
14 probably have to make, some judgments.
15 This even comes into play, in my
16 opinion, after '95. These two things we bring
17 up, I don't think it is a magical line where
18 exposures at the site stopped completely. You
19 could definitely make an argument that safety
20 protocols and practices improved, but did toxic
21 exposures suddenly -- you know, toxic exposures
22 were not eliminated in '95. They might have been

1 greatly reduced in the later years, but not
2 eliminated. So, it is a degree or it is a
3 judgment of how much exposure people got. And
4 the CEs and the IHs and the medical practitioners
5 must be at some point making those judgments.
6 So, I would like to see even internal guidelines
7 to help in those judgments.
8 MEMBER VLIEGER: One of the things
9 that kind of baffles me about how anybody can
10 make assumptions on how much someone was exposed
11 to is the lack of monitoring data. There is no
12 monitoring data that was done. Yet, the
13 Department of Labor turns around and says to the
14 claimant, "Well, you need to provide us
15 monitoring data for kind, quality, and quantity
16 of exposure." Well, there is none that exists,
17 and this program exists because there is no data.
18 Yet, the Department of Labor turns it on its head
19 and says, "Well, if you can't come up with it,
20 then we have to rely on our experts." But the
21 experts don't have any exposure data, either.
22 MEMBER GRIFFON: Right, right, right.

1 CHAIR SOKAS: Well, that gets back to
2 Mark's question about whether the experts have
3 any site-specific experience or training or
4 information, you know, that kind of thing, if
5 there is some ability that they have to get kind
6 of insights into what was going on at a
7 particular location.
8 MEMBER GRIFFON: Right, and --
9 MEMBER VLIEGER: I would be curious
10 to -- I'm sorry, go ahead.
11 MEMBER GRIFFON: I'm sorry. I was
12 just going to say, you know, that, of course, is
13 a double-edged sword, too. We ran into this on
14 the radiation side. The Radiation Board, when
15 you look for experts or consultants to help in
16 this process, if they have some experience, they
17 also could have a conflict. So, you know, you
18 run into this sort of -- but we ended up using a
19 lot of people that, for instance, worked at DOE
20 or at the sites over the years because they had
21 great historical knowledge. I think NIOSH worked
22 hard on developing a policy around that conflict-

1 of-interest issue and managing the conflicts and
2 making sure, being transparent about them, but
3 also using these people that had a lot of
4 knowledge about historical operations.
5 But I think, yes, it is difficult for
6 me to understand how CIH, if they didn't have
7 much experience, I think the ones that they hired
8 did have experience, at least at some of the
9 sites, but there's so many sites that you
10 couldn't possibly be expert on all these sites,
11 especially over time.
12 MEMBER MARKOWITZ: Right. Yes, and
13 the sites themselves are very complicated things.
14 Each individual site is very complicated.
15 MEMBER GRIFFON: Right.
16 MEMBER MARKOWITZ: But, you know, the
17 thing about these judgments that the IH makes is
18 that they are inevitable, and partly because of a
19 lack of data, but, in part, because that is just
20 the nature of the work that we do.
21 And my question, then, is how
22 consistent are these judgments across the IHs?

1 Actually, that relates to what the charter of the
2 overall Board is. This task of this Committee is
3 to look at the quality, objectivity, and
4 consistency of IH and physician work.
5 Yes, we could look at how consistent
6 the judgments are. And what I am mostly
7 interested in is moving towards -- the question
8 is, can we convert these judgments to
9 presumptions, so that the whole process can be
10 simpler?
11 MEMBER VLIEGER: From my experience --
12 this is Faye again -- from my experience, it is
13 that when there is no monitoring data, the
14 decision goes against the worker. I mean, that
15 is what I have seen historically from the IH and
16 CMC reports that I have requested.
17 And when the CE refers to the CMC with
18 no monitoring data, that is what the CMC hangs
19 their hat on. There is a presumption that there
20 must be data, but it is just not here. And that
21 is an erroneous assumption that no one ever tells
22 them, "By the way, there is no monitoring data

1 because they did not monitor for this." And that
2 presumption should be changed, that just because
3 it isn't provided to you doesn't mean it was
4 there and not provided. It means it doesn't
5 exist.
6 And we have a request in to the U.S.
7 Department of Energy. They are supposed to be
8 putting a report out from our March meeting with
9 them that the advocates had in Denver with them.
10 They are supposed to be answering that question,
11 "Tell us if you have breathing space and air
12 monitoring data for the workers. And if you
13 don't, tell us that also."
14 MEMBER MARKOWITZ: Well, you know,
15 that is actually an empirical question that we
16 can look at, the decisions the CMCs are making
17 and the extent to which what Faye is saying is
18 true or not.
19 CHAIR SOKAS: So, again, that really
20 kind of implies that we will have data. That is
21 part of the data request, basically. And we can
22 certainly construct a way to look for that if we

1 have got all the records, you know, the complete
2 records. We have to decide how many we want to
3 look through and maybe how we are going to do it
4 to be able to come up with those numbers.
5 MEMBER MARKOWITZ: This is Steven. I
6 have a question.
7 If we are tasked with looking at the
8 quality, objectivity, and consistency of the IHs
9 and the CMC and the other physicians' work here,
10 aren't we eventually going to have to look at a
11 broad sample of reports and claims and look at
12 those specific factors? And if that is true,
13 what do we need to get there to better inform our
14 request around those things? What initial
15 information do we need?
16 And I think we are getting some of
17 this down on the table, you know, some of the
18 current reports on quality assurance or whatever
19 they have produced, and, also, looking at a
20 limited number of claims to understand the
21 process.
22 But I keep thinking of, what do we

1 need ultimately to answer this question of
2 quality and objectivity and consistency and,
3 then, how do we get there?
4 CHAIR SOKAS: This is Rosie.
5 I am thinking there are two parts to
6 that question. One is, what are the mechanisms
7 through DOL? And then, the other is, again, what
8 is the sample size we need, right? So, would we
9 need to look at maybe all of the denials for a
10 month throughout the country? I don't know what
11 that number would be. Again, because that is
12 where the concern is; it is with denials, not so
13 much with acceptances.
14 And I guess, Carrie, that might be a
15 question for you. I mean, even having us being
16 able to read through five charts or ten charts
17 apiece, or something like that, if we divvied up
18 how we wanted to handle this, we would need to
19 have both access to the charts, which obviously
20 is challenging -- and the question for you guys
21 is, we have taken an oath. So, does that mean we
22 could look at them with the person's identifying

1 characteristics, which, of course, then, ratchets
2 up the level of security for maintaining those
3 charts? Or would it require DOL staff to redact
4 all that information, right, which would be a lot
5 of work?
6 And, Steve and Mark and Faye and Kirk
7 and Garry, I guess the question for us is, how
8 much of this do we need to see? And then, how
9 much of this could we, then, ask for
10 specifically, look at this diagnosis? I mean, to
11 me right now, unless I missed it, I don't think
12 we have the list yet of what are the most
13 frequent diagnoses that are approved, what are
14 the most frequent that are denied, you know, that
15 level of what are the reasons for denial, that
16 level of looking at every chart and just checking
17 up the numbers. But, then, what would we want to
18 look into more in-depth, and could DOL do that
19 for us or do we? I mean, I think initially at
20 least, we need to look at them ourselves
21 probably.
22 Mark, I apologize. My computer just

1 went down. Did you have anything else that you
2 wanted to raise right now or ask for information
3 about?
4 MEMBER GRIFFON: No, I think that was
5 the main things for my part of it. I mean, I
6 don't know if it is in line with what Steve was
7 just raising, but, I mean, that is exactly what I
8 was thinking of, was this question of
9 consistency, quality and consistency.
10 I mean, here's the other question: if
11 you get a sampling of cases to review, to what
12 extent can our Board do this without some help?
13 CHAIR SOKAS: Right.
14 MEMBER GRIFFON: I mean, I think an
15 independent review is something that people have
16 asked for for quite some time, but that would be
17 more of sort of an audit of a percentage of cases
18 or something like that. So, I don't know if that
19 is something that is an option, but --
20 MEMBER VLIEGER: Mark, are you
21 thinking of somebody like SC&A to help with the
22 review of this stuff?

1 MEMBER GRIFFON: Yes, well, that is
2 the model on the NIOSH side. The Board had to
3 ultimately have a contractor to help with this
4 review. Now there was perhaps a larger number
5 that we were reviewing and pretty technical dose
6 calculations, and things like that, that were
7 involved. So, maybe it doesn't have to be to
8 that extent, but something like that, yes.
9 CHAIR SOKAS: That is a great example
10 to have, I mean to kind of frame what we are
11 looking for. I think that might be the next step
12 after we figure out what we can get from DOL
13 originally, and looking through that, I think
14 that will help us shape that request.
15 MEMBER GRIFFON: I agree, that is
16 something perhaps down the line, but I think we
17 need to get a handle on what is there ourselves
18 first. And I, myself, have to -- maybe others
19 know better -- but I have to get a better handle
20 on sort of the internal process, how this all
21 works behind the scenes. That will be useful.
22 CHAIR SOKAS: This is Rosie.

1 I agree with you, and I just think
2 that is going to be the hardest to thing to get.
3 But it will be at least interesting to see.
4 Following a couple of charts I think will help
5 with that.
6 MEMBER GRIFFON: Right, right.
7 MEMBER WHITLEY: Garry here.
8 I think you guys have that number
9 down. Let's just say, for example, we ask for 20
10 cases in the past three months that have been
11 denied.
12 CHAIR SOKAS: Uh-hum.
13 MEMBER WHITLEY: And let's just look
14 at them and see. I think it will jump out at us.
15 I really think it looks like we will have some
16 real questions: why was this done? And then, we
17 could ask some specific questions about those
18 cases, and it will give us a clue. I'm like
19 everybody else, I have got to see more of how
20 past workers have -- the Claims Examiner I think
21 is part of the whole problem.
22 On their behalf, I am using Oak

1 Ridge. It is 500 miles to Jacksonville. So,
2 there is not a very good chance that one Claims
3 Examiner down there has ever seen inside one of
4 these plants in Oak Ridge, Tennessee. So, they
5 really have no way to understand.
6 CHAIR SOKAS: So, just to follow up on
7 that, I mean, what about if we each take -- I
8 think we could do it in a way, if we each took
9 maybe five cases and, then, have access to the
10 others, I mean this might be a time when we might
11 need to have a closed conversation, and we would
12 have to discuss how and if that could happen.
13 But I think that doing that, and then,
14 being able to discuss it across our group might
15 be very helpful. I know it would be incredibly
16 helpful for me for the medical stuff, and I am
17 sure for the IH as well. It is just necessary
18 really.
19 MEMBER WHITLEY: I agree.
20 CHAIR SOKAS: So, I like that idea.
21 I think that we can move that forward before the
22 end of today with specific numbers to request,

1 and just whatever Carrie can find out for us
2 would be very helpful in that.
3 I don't want to cut this off. So, I
4 think we should keep talking about all of these
5 issues, but I would like to take us through the
6 questions starting from the top.
7 Carrie, if you wouldn't mind? Because
8 I think that first one was more of a medical
9 question. Okay, great.
10 So, I did sort of number these, but
11 Mark is right, they are just bullets.
12 The first one, this is a request from
13 the program. It is for new presumptive criteria
14 to be applied in eliminating the need for medical
15 review. And the first piece that they mention is
16 the diagnosis plus a toxin, plus a latency, time
17 of exposure, equals causation.
18 Now I immediately had some concerns
19 about the request even a little bit. I mean, I
20 think there are examples that we have seen about
21 -- I can't remember now if it is renal and
22 trichloroethylene. There are some specific

1 guidances that have come out where the real
2 question is, how do you figure the sensitivity
3 versus specificity of all of this? And what's
4 five years versus ten years versus two, you know,
5 that kind of stuff?
6 So, I think it is possible there may
7 be low-hanging fruit. What I would do, I would
8 turn this around. And then, the other question,
9 of course, is this whole concern we have
10 currently about the quality of the evaluations
11 that are going on. So, before you would want to
12 turn any more to that, we would want to go
13 through the rest of these discussions.
14 But I would ask DOL -- and, Carrie, I
15 think should be an easy request -- but I really
16 think that, for them, it would be relatively
17 straightforward for them to be able to provide
18 us, again, with a list of the top diagnoses that
19 they make, both for denials and acceptances, the
20 main reasons why they get denied or accepted.
21 And this would be for the past year probably. I
22 mean, this is just numbers-crunching.

1 And then, if there are particular ones
2 that they suggest or that they are concerned
3 might be routine enough that we could do that
4 for, right? So, I would kind of put it back on
5 them because some of these questions really seem
6 to be asking for the universe of possibilities,
7 and that is a little too broad for us. So, if we
8 can nail it down to are there a couple of
9 diagnoses that you think could be turned into
10 something presumptive if we had this, this, and
11 this information?
12 Steve, I know that you kind of
13 mentioned that a little bit. Again, I am a
14 little concerned with this whole question when it
15 gets to be too specific. I think that whole
16 being able to do the 50/50, as likely as not, is
17 going to be our challenge when we do that.
18 But I would like more information from
19 the program on which specific diagnoses are they
20 really looking at that they would like to try to
21 do this for.
22 And then, the second piece of that,

1 again, for the matrix of consequential illnesses,
2 that can be accepted once the primary work-
3 related illness is accepted, again, I think that
4 rather than to try to imagine all the different
5 possibilities, it would be very helpful to have
6 like the three major diagnoses where this comes
7 up, and then, what are the examples, both
8 accepted and denied, of the kinds of
9 consequential illnesses that people wanted to
10 claim based on the main diagnosis?
11 So, if they could come up with what
12 are your top three and what have you see and what
13 have you accepted and what have you not accepted,
14 you know, just to give us something to figure out
15 what their main concerns are, I think we could
16 work on that. But I don't want to promise to
17 imagine the universe and, then, provide it. So,
18 that is how I would handle that. It is just
19 really at this point asking them to frame the
20 questions based on their experience with priority
21 in both categories.
22 Then, the next bullet down --

1 MEMBER MARKOWITZ: Rosie, can I just
2 add something?
3 CHAIR SOKAS: Sure.
4 MEMBER MARKOWITZ: Yes, it's Steve
5 Markowitz.
6 We have seen this now on a few of the
7 Subcommittees, this issue of presumption and
8 DOL's interest in presumption. I mean, because
9 they have moved in that direction, right? We
10 learned, I think, a little bit about asbestos and
11 asthma and maybe even COPD.
12 CHAIR SOKAS: Yes, and I think I liked
13 the asthma one. I thought they did a good job of
14 that.
15 MEMBER MARKOWITZ: And those
16 presumptions have been claimant-friendly. I
17 mean, my interpretation of how they set up the
18 criteria is that they are on the generous side to
19 claimants rather than on the other side.
20 CHAIR SOKAS: I thought that was true
21 for asthma. I was not so sure about the
22 trichloroethylene. I mean, I didn't look into it

1 really carefully, but it raised a little concern
2 with me. Especially because of the latency for
3 that one, I had a little concern that they were
4 being too specific.
5 MEMBER MARKOWITZ: Right. Well, so
6 yes, and presumptions in and of themselves aren't
7 necessarily generous or not. It depends on what
8 you use as the criteria --
9 CHAIR SOKAS: Uh-hum.
10 MEMBER MARKOWITZ: -- where you set
11 the limit. For instance, they have solvent-
12 induced hearing loss which a person has to have
13 10 consecutive years of exposure prior to 1990 to
14 one or more of a select group of solvents in one
15 or more of a select number of occupations. So,
16 that is a set of presumptions, but that is too
17 restrictive.
18 CHAIR SOKAS: Right.
19 MEMBER MARKOWITZ: So, it is not
20 specifically generous, but it depends on where
21 you set the bar. But presumption is an approach
22 which can be very claimant-friendly. And so, I

1 think that their interest in moving on
2 presumption I regard as a very useful kind of
3 opening.
4 CHAIR SOKAS: Okay. I mean, you are
5 giving it a more positive interpretation than I
6 was kind of. So, I think that is fair. I think
7 that is good.
8 I still think we need to restrict them
9 to maybe their three biggest issues because it is
10 hard for me to imagine we are going to pull
11 together more than that in the next year at
12 least.
13 MEMBER MARKOWITZ: No, no, I agree
14 with you. The most frequent things that people
15 make claims for are --
16 CHAIR SOKAS: Right.
17 MEMBER MARKOWITZ: -- the things that
18 we should help them with. I mean, that would
19 both help DOL, help a lot of claimants, and would
20 be a real contribution.
21 CHAIR SOKAS: Okay. So, taking your
22 perspective, which I think is a really good one

1 because you're right, I mean, the asthma one was
2 really good, I will say it in a more positive
3 way; that we would like to kind of move forward
4 on that, but we want to restrict it. We want the
5 information about what their top priority areas
6 are.
7 And I think the same is equally true
8 for the matrix of consequential illnesses. I
9 mean, I think that there probably are about three
10 or four that come up all the time, and that would
11 be fairly easy. My concern is that we could come
12 up with a list of 10 consequential illnesses and
13 just not think of the 11th or 12th, and that
14 would be used to exclude people.
15 So, as long as it is done in the
16 spirit of this is what we have so far, that is
17 not the entire universe necessarily. I think
18 those are two things that we could actually move
19 forward on in Committee, and I am perfectly happy
20 to assign that to George since he is not here
21 today. I am teasing on that part.
22 But, Carrie, so that is a request for

1 both of those sub-bullets for additional
2 information on their big priorities based on the
3 number of requests that they get.
4 MEMBER MARKOWITZ: No, but, I mean --
5 this is Steven -- I think, is your request that
6 we learn the frequency of different diagnoses
7 that people make claims for, both on the claims
8 side and on the consequential illness side? It
9 is the frequency?
10 CHAIR SOKAS: Right. It is the most
11 frequent requests for both of those. And then, I
12 think it would be useful to also know, of those
13 most frequent requests, how many are denied and
14 how many are approved and are there problem areas
15 that pop up.
16 MEMBER MARKOWITZ: "Requests," you
17 mean claims, the most frequent type --
18 CHAIR SOKAS: Right. Right, that is
19 what I mean, claims.
20 So, then, the next item is
21 clarification/recommendation regarding the
22 assessment of a medical opinion regarding the,

1 quote, "rationalization" -- wait a minute; let me
2 just pull it back down; people can read that on
3 the screen there -- supporting a conclusion.
4 And then, there is a circle up there
5 about standardized triggers. Okay. And I am
6 just going to go into a grumpy, old lady mode
7 right now on this one.
8 So, the clarification of the
9 assessment of the medical opinion, I think there
10 is a communications issue for the medical and
11 probably for the IH that kind of threads
12 throughout all of this. I think the overall
13 challenge is that there is a need to have things
14 fit into boxes and to be able to be assessed by
15 someone who is not technically-trained, on the
16 one hand, and on the other hand, to have that
17 information presented when there is a need for
18 expertise in a way that is clear enough to give
19 that kind of almost a computerized response to
20 it, right?
21 And there was 217-15 memo, I think or
22 217-16. It is a 217 memo that we are not

1 supposed to share or discuss that was describing
2 a, quote/unquote, "informal audit". But, in it,
3 there were complaints about people providing too
4 much information. They didn't want to hear it
5 all. And I think we heard about some of that in
6 our face-to-face meeting.
7 So, I think some of this is a
8 communication issue. I had a problem on my end
9 with the communication with words like "opine"
10 because I think of opine as you opine about the
11 weather, right? For some reason, it is like
12 chalk on a blackboard to me. "Rationalize,"
13 which is in quotes here, but the idea of
14 rationalizing, I realize that what the program
15 means is to make something rational. But, again,
16 what physicians might hear is, you know, one of
17 the Webster definitions is -- and I am going to
18 quote this because "rationalization" is something
19 we don't want to attempt -- "to attribute one's
20 actions to rational and credible motives without
21 adequate analysis of the true, and especially
22 unconscious, motives." I mean, the whole term,

1 quote/unquote, "rationalize" is subject to two
2 very different interpretations.
3 And then, there was another place
4 where they were asking for opinions, suspicions,
5 or diagnoses, which, again, the word "suspicions"
6 is like "OMG". So, I think there is kind of
7 this, in the same way that there is kind of a
8 legal/medical disconnect, there is sort of a
9 bureaucratic medical disconnect in some of the
10 communications. And it goes in both directions.
11 One of the questions I had, so in our
12 task we are talking about getting guidance to
13 staff physicians. Now I don't know if that was a
14 typo, but I did want to know more about the role
15 of staff physicians. I mean, I know there have
16 been staff physicians in the past. I don't know
17 if there is a staff physician currently who is
18 engaged or if they are in the process of looking
19 for somebody. I think they might be looking for
20 somebody, is what is going on.
21 But it just seems that some of this
22 communication problem is pretty profound. And

1 the way this question is asked makes it hard to
2 be precise in figuring that out. But I do agree
3 that one of the responsibilities we can take on
4 as a Board or as a Subcommittee might be to help
5 figure out ways to foster better communication.
6 So, that I think is a realistic request.
7 When they talk about standardized
8 triggers, I am a little more reluctant and I
9 would wonder if maybe all denials should be
10 reviewed. And so, the question is whether or not
11 that is feasible or whether or not that is an
12 easy thing for them to do. So, I would just ask
13 that in the form of a question, whether they have
14 considered reviewing all denials and making that
15 the trigger.
16 When we go down to the next --
17 MEMBER MARKOWITZ: This is Steven. If
18 I could just chime-in here?
19 CHAIR SOKAS: Sure.
20 MEMBER MARKOWITZ: This
21 clarification/recommendation, what I interpret
22 this as meaning is how do we tell a good report

1 from a bad report from the doctor. And what
2 criteria can we use, whether it is a CMC report
3 or a personal physician? What criteria can we
4 use to assess those opinions or the decisions, as
5 they describe their reasoning behind those
6 decisions? I don't know really what the answer
7 to that question is, but I think that is what
8 they are asking here.
9 CHAIR SOKAS: I agree, I think that is
10 what they are asking, but I think the issue is
11 probably more upstream than that.
12 MEMBER MARKOWITZ: What do you mean?
13 CHAIR SOKAS: I think they are talking
14 apples and oranges sometimes. For example, one
15 of the complaints in that informal audit was
16 that, on the one hand, the physician went through
17 like very precisely what the toxic exposure was
18 and the expected health outcome. But, then, they
19 seemed to waffle on the language. Well, waffling
20 on the language is what scientists are taught to
21 do, basically, right?
22 So, there is that kind of

1 communication stuff. It is a matter of
2 translation almost. I don't know. I mean, maybe
3 there are things that we can say. I think they
4 already have sort of the basics. If you don't
5 have good diagnoses, then that doesn't matter. I
6 mean, you have to have clear diagnoses. You have
7 to have some clear connection between the
8 exposure and the outcome.
9 Maybe, again, we can find out more
10 once we look at a handful charts. Because I did
11 not interpret that question to be that
12 straightforward. I thought they meant that they
13 had that in place, but were having trouble with
14 it. But that is a question.
15 And, Carrie, I thought I looked
16 through this stuff, but I didn't see anything.
17 And there are very clear recommendations to the
18 CE, to the Claims Examiner, that they need to
19 have this, this, this, and this.
20 I think that pretty much explains what
21 it is they need and how they are to interpret it,
22 but if there is additional guidance that we

1 haven't seen already, that would be helpful.
2 MEMBER VLIEGER: This is Faye.
3 Econometrica did a report about the
4 most common diseases, and the Department of Labor
5 implemented some of them and, then, kind of
6 strayed from the Econometrica report. That
7 report the Department of Labor actually
8 contracted to do, and they came up with the most
9 common diseases based on their review from the
10 former Worker Screening Program. So, some of
11 this work has already been done, and the
12 Department of Labor is asking again. And I don't
13 know whether it is like when you are ask your
14 mother and she tells you no, and then, you go ask
15 your dad to see if he will say yes.
16 CHAIR SOKAS: Oh, interesting. That
17 might be something, Carrie, to ask, if there are
18 previous reports that address some of these
19 questions, what is their take on them?
20 This next one, again, so the
21 methodologies, they are looking for ways to
22 improve physician responsiveness to data

1 requests. Again, I have a clarification
2 question. Is this a question for both the
3 treating physician as well as for the CMC,
4 because it seems like there would be different
5 mechanisms for either one of those?
6 Again, I didn't get a real sense --
7 and maybe I just missed it -- of what the current
8 procedures are in place to get this information.
9 So, what are they currently doing would be
10 helpful.
11 MEMBER MARKOWITZ: Rosie, can I just
12 jump in here? Steven.
13 This same issue was addressed to
14 another Committee, the Medical Evidence
15 Committee --
16 CHAIR SOKAS: Okay.
17 MEMBER MARKOWITZ: -- which is where
18 it actually belongs.
19 CHAIR SOKAS: Okay. So, we will just
20 delete that one.
21 MEMBER MARKOWITZ: Because these are
22 IHs and doctors contracted by DOL. So, if they

1 are not responsive, they ought to have a way of
2 dealing with them.
3 CHAIR SOKAS: That's right. I thought
4 they were talking maybe about the treating
5 clinician. But that's fine. That's great. So,
6 we will skip that one, and we will just say that
7 is not part of our purview.
8 MEMBER MARKOWITZ: Right.
9 CHAIR SOKAS: You're right. I mean,
10 there was a series of these questions that was in
11 the earlier part of that same day, and some of
12 them are verbatim repeated. So, as long as we
13 know the other Committee is doing that, we can
14 just take it off of our list. So, that is off of
15 our list.
16 The next one is, what sources of
17 information exist that describe the synergistic
18 effects of chemical-radiologic interventions and
19 resulting health effects? I would ask if that is
20 actually on one of the other Committees because
21 that seems to have more to do with lungs than
22 anything else, but I don't know.

1 MEMBER MARKOWITZ: Well, no such luck.
2 (Laughter.)
3 CHAIR SOKAS: It was worth a try.
4 Okay.
5 Again, we can look around. I mean, I
6 would, then, ask, well, where have you looked
7 already? Have they identified any sources? I
8 think the answer is going to be you do a PubMed
9 search or you do a research search for each
10 particular individual where it happens.
11 But, if the DOL has anything already,
12 that would be helpful to know. Otherwise, we can
13 take a look at it. I don't think we are going to
14 come up with a magic bullet, but certainly we
15 could search and look.
16 MEMBER VLIEGER: This is Faye.
17 I just sent the link from the U.S.
18 Department of Labor site on the Econometrica
19 report to Dr. Sokas, Dr. Markowitz, and to you,
20 Carrie.
21 CHAIR SOKAS: Thank you.
22 MS. RHOADS: You sent that to the

1 Advisory Board inbox?
2 MEMBER VLIEGER: I sent to you, Dr.
3 Markowitz, and Dr. Sokas.
4 MS. RHOADS: Okay. Thank you.
5 CHAIR SOKAS: Thank you, Faye.
6 So, the next question on this -- I am
7 just going to kind of run through these now --
8 training resources for improving the quality of
9 medical reviews of medical evidence in weighing
10 conflicting evidence. I think that is another
11 one that is a repeat, Mark? Steve? I'm sorry.
12 MEMBER MARKOWITZ: I'm sorry, I'm
13 trying to get this back on my screen.
14 CHAIR SOKAS: This is the one about
15 they want training resources -- and it is not
16 clear to me for whom -- for improving the quality
17 of medical reviews of medical evidence in
18 weighing conflicting evidence. So, is that for
19 the CE? Is that for the physicians? It is kind
20 of not clear to me, but I thought that was a
21 repeated question.
22 MEMBER MARKOWITZ: Yes. Well, you

1 know, this ought to go to the Medical Evidence
2 Committee.
3 CHAIR SOKAS: Okay, great. And,
4 Steve, I am assuming you are sitting in on all of
5 those and you will just let them know?
6 MEMBER MARKOWITZ: Yes, but,
7 hopefully, Carrie is getting this down.
8 CHAIR SOKAS: And Carrie will get the
9 notes down. Okay, great.
10 MEMBER MARKOWITZ: My memory is almost
11 perfect, but not --
12 (Laughter.)
13 But, just to look at this for a moment
14 to see whether it really does relate to IH and
15 the CMC and the CCOP and all that, this would be
16 training resources really relevant to this
17 Committee would be training of the CMCs, although
18 it is to make sure that their medical reviews are
19 of sufficient quality.
20 But in the "weighing conflicting
21 evidence," you know, I don't know whether that
22 applies to the CE who is sitting there trying to

1 figure out what is going on when he or she gets
2 conflicting reports or whether that is the
3 problems faced by the CMC. I don't know what to
4 think.
5 CHAIR SOKAS: Yes, I mean, it is
6 unclear who they are referring to. Again, it is
7 a repeat question, I'm pretty sure.
8 MEMBER VLIEGER: Just so you know, the
9 CE and their supervisor, if they ask for the
10 input, are the ones who decide whether or not the
11 medical evidence is sufficient. I'm not aware
12 that there is a physician in every district
13 office looking at every claim where they have
14 questions about the medical evidence.
15 MEMBER MARKOWITZ: Right.
16 CHAIR SOKAS: So, that is a really
17 interesting point. There is a place -- and I
18 can't remember where it is -- it is in some
19 document; I wrote down what they said in it,
20 though. It was there is a place where it talks
21 about when a CMC referral may not be needed,
22 right? It is when they are telling people when

1 to refer for a CMC and when not to refer.
2 So, one of the times not to refer was
3 if there is no exposure documented. Well, okay,
4 you know, that probably makes sense not to refer
5 to a CMC if you don't have an exposure. But,
6 then, the next clause was if there is no
7 plausible scientific association between the
8 toxin and the diagnosed illness. And my question
9 was, well, based on what? I mean, that is
10 exactly why you would refer to a CMC, I would
11 think, right? Because unless you are using the
12 SEM or something else to dismiss potential
13 relationships, or unless you have kind of
14 searched the research publications, how would you
15 know? And that would be exactly when you would
16 want to have this.
17 So, I think one of the questions for
18 us is maybe we just want to encourage people, if
19 you don't know, that is when you should be having
20 a CMC evaluation. Again, based on that informal
21 audit, the problems were when they forwarded for
22 CMC where they had treating physician information

1 that didn't get included accidentally, you know,
2 that kind of stuff. So, that informal audit
3 seemed to do nicely to look at procedural
4 deficiencies, but it did absolutely nothing to
5 look at quality of the content. So, that is a
6 whole issue in and of itself, and whether or not,
7 in addition to this informal audit, they plan to
8 have a formal audit, I think we are going to be
9 the formal audit or we are going to be shaping
10 the formal audit.
11 MEMBER VLIEGER: I just want to throw
12 one more piece of information to you about the
13 CEs. Many of them are attorneys, and many of
14 them are basing their decision on their legal
15 training. And so, when we use specific
16 definitions in what they are supposed to do, many
17 of them are going to adhere strictly to the legal
18 definition, irregardless of what the Procedure
19 Manual says.
20 CHAIR SOKAS: Right. Right, right,
21 right. That's very interesting. Well, again,
22 hopefully, if we get the full charts, we will be

1 able to see some of that. So, that would be very
2 helpful.
3 Carrie, can you move that down to the
4 next page, page 7 of 7?
5 MEMBER MARKOWITZ: And while she is
6 doing that -- Steve Markowitz -- can I just make
7 a comment?
8 So, the CE, then, is looking at
9 conflicting evidence and making a decision with
10 or without the help of her supervisor or his
11 supervisor. And DOL is asking for help on,
12 presumably, training the CE and supervisor in
13 this. But we are not sending him to medical
14 school --
15 CHAIR SOKAS: Right.
16 MEMBER MARKOWITZ: -- or epidemiology
17 school.
18 And I say this as a kind of a
19 rhetorical thing, but is the answer here to have
20 more of those go to a referee, to a third person
21 who is qualified to settle this dispute?
22 MEMBER VLIEGER: Are you asking about

1 the application of the referee?
2 MEMBER MARKOWITZ: I'm asking, when
3 you have a CE who is sitting there looking at
4 what the personal provider does or says, and it
5 is sent off to the CMC. And the CMC contradicts
6 what the person's own provider says. The CE is
7 sitting there and they are inclined to accept the
8 CMC report probably, right?
9 MEMBER VLIEGER: That's correct.
10 MEMBER MARKOWITZ: That's why they
11 have CMCs. But there is some doubt. And so,
12 what DOL is saying here, "weighing conflicting
13 evidence," right, and how are they supposed to
14 make a decision? What DOL is requesting is, what
15 training resources can we inject into this to
16 help them? What I am saying is I am not sure
17 training is going to do it. Is the answer for
18 that case to go to a referee physician, so
19 that --
20 CHAIR SOKAS: For an opinion.
21 MEMBER MARKOWITZ: Right.
22 MEMBER VLIEGER: Yes. However, there

1 is some bias for the referee because it is the
2 same contractor that did the initial --
3 MEMBER MARKOWITZ: Right.
4 MEMBER VLIEGER: -- that did the CMC
5 report. And so, the referee reports that I have
6 seen seldom stray from the initial. So, I would
7 love to see referee reports that actually go a
8 different direction, but the referee is a
9 different doctor within the same contract of the
10 Contract Medical Consultant.
11 MEMBER MARKOWITZ: Right.
12 CHAIR SOKAS: Is the Contract Medical
13 Consultant national or regional?
14 MEMBER VLIEGER: The contract is
15 vetted. It is owned by QTC at this point. And
16 that is the same people that do the VA disability
17 ratings. And so, QTC vets the doctors.
18 If you wanted to talk to Dr. Welch
19 about a particular issue that she had with one of
20 the CMC doctors, if we wanted to talk to her on
21 the side, the CE discounted her expert opinion
22 letter and, then, went with the CMC's report that

1 was not fully rationalized or using current
2 medical science, and the claim was denied.
3 CHAIR SOKAS: Wow. That's
4 interesting.
5 MEMBER VLIEGER: And so, she did write
6 another, a five-page response to a CMC report for
7 a claim that is in the posture to deny, where she
8 refuted the CMC. She also questioned the CMC's
9 CV, whether or not the CMC was actually qualified
10 to be opining on the case at all.
11 I don't know what she looked at. I
12 don't know how she looked him up, but I saw the
13 letter. I saw the five-page letter.
14 So, is that something that you wanted
15 to bring her in on a Committee discussion and
16 have her discuss her experience? That is
17 something where you could talk to her with the
18 former Worker Program and her providing medical
19 opinion for the workers.
20 CHAIR SOKAS: Well, and the other
21 thing, I mean, I think we can probably do -- I am
22 not sure how to do that with a Subcommittee

1 Working Group, but, for sure, when we get to our
2 next face-to-face meeting, we could pull her in
3 for that conversation.
4 I am also wondering if we could
5 explicitly request to see the number of cases
6 that go to the second review or the referee
7 rather and the number of times that it is
8 overturned, and maybe review some of those, the
9 ones on both sides, the ones that are overturned
10 and the ones that aren't.
11 So, Carrie, that is another request
12 for specific cases. Again, it would be nice to
13 have those kind of total numbers of, out of so
14 many cases evaluated every year, "X" number go
15 for this referee, require a referee, and how many
16 of those does it change the CE determination?
17 But, also, to see a handful of those, so we can
18 look through them.
19 And, Steve, I think the bigger
20 question is, again, it is hard to almost
21 mechanize some of this stuff as opposed to trying
22 to deal with it -- oh, I don't know.

1 Let me just go to the next question.
2 So, the next couple were for industrial hygiene.
3 But, then, when we get down to the last two,
4 there is a question there that I really could not
5 interpret. I think I might have just spaced out
6 on it. So, I am going to ask everybody.
7 It is generalization of prior IH and
8 CMC findings pending adjudication actions. And I
9 am just having a hard time figuring out what that
10 means.
11 Mark, how did you interpret that?
12 MEMBER GRIFFON: I had trouble with
13 that question, too, actually. I wasn't sure
14 exactly what they were trying to get at, either.
15 CHAIR SOKAS: Steve?
16 MEMBER MARKOWITZ: Yes, this is my
17 thought about that. I don't know if it is right
18 or not.
19 So, IHs and CMCs write reports, and
20 some of those reports are going to cover the
21 similar issues. And the question is, can I
22 aggregate some the finding from the CMC and IH

1 reports and generalize from those decisions, from
2 those opinions, judgments, to use them for
3 things, other cases, presumably, so that all of
4 them don't have to be sent to IHs?
5 CHAIR SOKAS: Gotcha. I mean, I think
6 in order to even begin to answer that question,
7 we would really need to do the quality assessment
8 that we have been talking about.
9 MEMBER MARKOWITZ: Yes.
10 CHAIR SOKAS: Okay. So, I think we
11 can skip over that.
12 This last item I think is really
13 needed, and Faye has already suggested adding to
14 this. I think we could probably divvy this one
15 up and clearly be able to come up with some
16 response. So, individually, we could take our
17 own work together to respond.
18 So, Circular 1505 is the Occupational
19 Exposure Guidance Relating to Asbestos. I am
20 happy to work on that. Steve, I don't know if
21 you are interested in that, if the other team is
22 actually doing that already.

1 MEMBER MARKOWITZ: No, it hasn't been
2 claimed yet, Rosie. So, I would be happy to work
3 with you on that.
4 CHAIR SOKAS: Okay. Terrific. So,
5 that is easy.
6 And then, the next one I think we
7 would all have concerns about. So, I would like
8 to suggest whoever is the most passionate about
9 it. This is that 1506, post-1995 Occupational
10 Toxic Exposure Guidance.
11 Faye, I am assuming you are going to
12 be interested, and Garry and Kirk. And, Mark, is
13 this something that you would be interested in as
14 well?
15 MEMBER VLIEGER: Sure.
16 MEMBER GRIFFON: Yes, sure, I can work
17 with it. I think they are very familiar with it,
18 but I can definitely work with it. And I am
19 familiar with some of those OSHA reviews that you
20 mentioned earlier, too.
21 CHAIR SOKAS: Oh, great. Okay.
22 MEMBER GRIFFON: I think I actually

1 have those reports somewhere in my office.
2 CHAIR SOKAS: Oh, Mark, that's
3 awesome.
4 MEMBER GRIFFON: Yes. So, I can work
5 with them on that, sure.
6 CHAIR SOKAS: That's terrific.
7 And then, Faye, you had a third one
8 which was similar, which was the post-'95 hearing
9 loss. Would you be willing to kind of include
10 that in that group activity?
11 MEMBER VLIEGER: Yes, they go hand-in-
12 glove. There was the same rationale for both
13 Circulars.
14 CHAIR SOKAS: Okay, great.
15 So, for at least our last question, we
16 should have some nice draft responses.
17 This is a question for Carrie in terms
18 of keeping us on the straight and narrow here.
19 When we sub-subdivide into actual getting tasks
20 done, I am assuming we can communicate with each
21 other. Like I can communicate with Steve as long
22 as I keep you in the loop?

1 MS. RHOADS: That's right, yes.
2 CHAIR SOKAS: Okay, great.
3 So, we have got at least one task, and
4 we probably are going to need to plan for more
5 tasks, obviously. But I would like to propose
6 that we, as a group, plan to have something that
7 we are happy with internally, and maybe can share
8 it with the others in the group or just with the
9 people directly working on it?
10 Carrie, for example, if the group
11 working on the post-'95 Circulars wanted to share
12 that with Steve and me, is that something we
13 could do now or would that need to wait until the
14 next meeting?
15 MS. RHOADS: No, I think you can do
16 that within the Subcommittee. Just keep the
17 DFO --
18 CHAIR SOKAS: The draft?
19 MS. RHOADS: Yes, keep the draft.
20 Keep the DFO email included.
21 CHAIR SOKAS: So, I would like to
22 propose, then, that we set ourselves a timeline,

1 and maybe by the end of August the individual
2 groups have a draft that we can share with the
3 other half, you know, the other groups.
4 MEMBER MARKOWITZ: Clarification,
5 Rosie? It's Steven.
6 CHAIR SOKAS: Sure.
7 MEMBER MARKOWITZ: Draft of what?
8 What are you --
9 CHAIR SOKAS: So, they are asking us
10 to do policy guidance review for these two, and
11 now we are going to make three, Circulars.
12 Basically, we might say, "Oh, this is great as
13 is," although it is unlikely, or "We find this
14 Circular to have the following problems and we
15 would recommend changing it to the following
16 language." And maybe give the reasons why and
17 cite information.
18 But I think what we should propose to
19 give back to DOL is a review, kind of a written
20 review of what we find in those Circulars and
21 what we think might be an improvement. Does that
22 make sense?

1 MEMBER MARKOWITZ: Sure.
2 CHAIR SOKAS: And then, for the other
3 things --
4 MEMBER GRIFFON: Pardon me, Rosie.
5 Just one subtle thing here. I think that we, as
6 a Subcommittee, putting together some findings
7 and possible motion for the Board as a whole to
8 consider --
9 CHAIR SOKAS: Right, right.
10 MEMBER GRIFFON: Because this Board is
11 making recommendations; the Subcommittee is not
12 making recommendations directly to the
13 Department.
14 CHAIR SOKAS: Thank you. That's a
15 really good point. Thank you, Mark.
16 MEMBER MARKOWITZ: But let me just
17 offer a friendly amendment not to bring a motion
18 to the full Board because I think these same
19 topics, there are going to be other members of
20 the Board who are going to want to weigh-in. So,
21 I think it would be better to portray these as
22 discussion pieces --

1 CHAIR SOKAS: Okay.
2 MEMBER MARKOWITZ: -- for further
3 discussion.
4 CHAIR SOKAS: Okay, good.
5 MEMBER GRIFFON: Right, and then,
6 maybe it can be made into a motion at the Board
7 meeting.
8 CHAIR SOKAS: At the Board meeting,
9 right, if everybody is onboard with it. Good.
10 MEMBER GRIFFON: Yes.
11 CHAIR SOKAS: Okay. So, the other
12 questions, we can go through. One of the
13 questions was -- and, Mark, you are going to
14 think about this because you are sort of flying
15 solo on this right now in terms of the questions
16 targeting industrial hygiene, you know, the
17 quality measures and all of that.
18 Before you get into any of that, there
19 were requests for information that Carrie is
20 going to get about current procedures for quality
21 improvement or any forms they have to complete
22 regarding quality improvement.

1 And then, I think both for that piece
2 of it and for these other issues about whether we
3 can do presumptive diagnoses, which we are going
4 to look favorably on trying to do that, but we
5 need the information, Faye it sounds like stands
6 as the source of information on that, but, again,
7 we kind of want to know what the major ones are
8 from the DOL perspective.
9 The same thing for the matrix of
10 consequential illnesses, we will get the list of
11 the main questions that pop up or the main claims
12 that are made and what the concern areas are.
13 I think we are not responding yet on
14 this clarification of medical opinion or
15 rationalization, and all of that, just because,
16 well, I think our question is right now some of
17 this may be language-related; some of it may be
18 more than that, but what is the status of the
19 Department's internal occupational medicine,
20 occupational physician capabilities, right? So,
21 who are they using and do they have somebody who
22 is in charge of that at this point? That is more

1 of a question than anything, but we can certainly
2 ponder it in the future, but it is not going to
3 be an easy answer.
4 The next question, oh, here we go.
5 This is where I am going to talk George into
6 doing it. The source of information for
7 synergistic effect between -- so, I am going to
8 suggest that all of us look to see, spend maybe
9 an hour or two kind of looking around to see if
10 we have any good examples of sources of
11 synergistic radiation and chemical effects. All
12 right. So, that will be on all of us. We will
13 just report back at our next face-to-face
14 meeting.
15 It probably wouldn't hurt to have a
16 little opportunity to touch base before the large
17 meeting, but I am wondering if we could actually
18 do that in the face-to-face meeting.
19 Steve, what are you looking at in
20 terms of the agenda for that next meeting?
21 MEMBER MARKOWITZ: I am not looking at
22 anything yet.

1 CHAIR SOKAS: Because, again,
2 realistically, I mean, are we going to get
3 something scheduled for us in August? Probably
4 not. Does it make sense to try to do it in
5 September? I'm not so sure.
6 MEMBER MARKOWITZ: Are you talking
7 about a telephone meeting?
8 CHAIR SOKAS: I am talking about a
9 telephone meeting. It took us from April to
10 today to get one that we could all make, and
11 then, it turned out one of us couldn't make it
12 afterwards.
13 MEMBER MARKOWITZ: Right, right.
14 CHAIR SOKAS: So, I am not optimistic
15 about being able to schedule a realistic other
16 telephone meeting.
17 MEMBER MARKOWITZ: This is Steven
18 Markowitz.
19 Actually, the other three
20 Subcommittees I think are meeting by phone.
21 CHAIR SOKAS: That's because they are
22 the only good ones. And I'm willing to try it if

1 others on the phone really feel that it would be
2 necessary or helpful. I think it would be
3 helpful for us to get together as a group, but I
4 think we could do it for 30 minutes during coffee
5 at the next meeting.
6 MEMBER MARKOWITZ: But the question
7 is, well, listen, we could try to find a
8 telephone meeting time and, then, if we fail, we
9 fail. If we succeed, we succeed.
10 The question is whether we have
11 something we want to achieve by having another
12 phone call like this. And if there is something
13 we think we can achieve, then let's try. And if
14 it fails, then we will resort to something else.
15 CHAIR SOKAS: So, my question, I
16 guess, to all of us was this business about are
17 we going to be able to help them figure out
18 synergistic effects, right? Do we need to do
19 something on that before the face-to-face meeting
20 because we are probably not going to do that?
21 MEMBER VLIEGER: This is Faye.
22 There were a number of studies done,

1 and I would have to go and look and see if they
2 are up-to-date or not, but I thought IARC had
3 done a large study of synergistic effects of
4 radiation, radioactive materials, and chemicals.
5 If I can find those links, I will forward it to
6 you. It has got to be on one of my computers.
7 But there was a large database done, large
8 studies, and they may not be completely up-to-
9 date. Or they may be did they roll through them
10 to update kind of like they do with other
11 programs? But I thought IARC was the one that
12 had done that. Let me see if I can find them.
13 CHAIR SOKAS: Okay. I think that is
14 wonderful, Faye. I think that is probably the
15 best thing I have heard so far.
16 And I was thinking that if each of us
17 dedicated a small amount of time to trying to
18 find -- you know, if that answers the question,
19 then we don't need to go further. But if each of
20 us wanted to take on trying to find sources of
21 information, preferably peer-reviewed sources of
22 information, that might be useful. But the

1 question is whether we need to try to pull that
2 together again before the October meeting.
3 MEMBER MARKOWITZ: This is Steve
4 Markowitz.
5 My personal view is not that we don't
6 need to, but that is not a time-dependent
7 request. Frankly, I think that request is also
8 outside of the purview of the entire Board, but,
9 you know --
10 CHAIR SOKAS: Okay.
11 MEMBER MARKOWITZ: -- we're eager to
12 help. That's fine.
13 CHAIR SOKAS: Okay.
14 MEMBER MARKOWITZ: I want to bring
15 something back to an earlier part of the
16 discussion. We talked about looking at a certain
17 number of claims.
18 CHAIR SOKAS: Right.
19 MEMBER MARKOWITZ: And the question
20 is, at the end of this meeting right now, are we
21 going to submit a request to DOL for "X" number
22 of claims where we get to see the IH medical

1 report and the data?

2 CHAIR SOKAS: Right. So, this is a

3 request for Carrie. We talked about it a little

4 bit, but you're right, we need to formalize it.

5 And, Steve, it kind of depends. I am

6 assuming you want to do this as well. So, it

7 looks like we have six members of the Committee,

8 right, you know, including George?

9 MEMBER MARKOWITZ: Right, right.

10 CHAIR SOKAS: So, I would like to

11 propose to Carrie -- and again, this is going to

12 take some legwork within the Department to figure

13 out what all the possibilities are for doing

14 this -- but we would like to have five records

15 apiece. So, there would be a total of 30 records

16 that we would individually be responsible for

17 reviewing, but, then, would want to be able to

18 have access to the other, to the total 30.

19 So that we could actually have a

20 conversation where I could say, "Oh, I think this

21 was a problem in these three." And then, Mark

22 could say, "Oh, wait a minute. Let me take a

1 look at that because maybe you missed something,"
2 right? Or, "Yes, I've seen the same thing in two
3 others," right? And then, Faye could say, "Yes,
4 and we have got this third thing going on here."
5 So, we could all make use of the
6 original 30. That would, then, help us inform
7 what we really thought we needed to look at for
8 quality assurance, and maybe then somebody else
9 could do it, right? There could be a subcontract
10 where people could look at X, Y, and Z.
11 But we need to do that amount first to
12 really understand it. So, the question is going
13 to be, can we get 30 charts? Can we get trained
14 on how to look through those charts? Are we okay
15 with access without compromising -- you know what
16 I mean? So, do we have to be able to get onto a
17 secure site, all of that stuff?
18 I think the goal would be to have that
19 happen and to have us be able to look at those
20 charts between now and October. It is one of
21 those things where I think it is going to be
22 challenging to have the conversation. I think it

1 is a Working Group conversation, but that is
2 going to be challenging to have that public
3 because, obviously, this is going to be the most
4 sensitive stuff, right? I mean, this is
5 personal, this might be personal information.
6 MS. RHOADS: Can I just ask, are you
7 asking or would you be asking the program to look
8 at the entire case file or certain pieces of it?
9 CHAIR SOKAS: So, we are looking for
10 cases that have been referred both to an IH and
11 to a CMC, I think. Correct? Anybody else jump
12 in here if I'm overstating this. And we would
13 like the entire case file.
14 But we would like to see what the CE
15 had available to them, what they sent forward to
16 the IH, what happened. In fact, if a couple of
17 these -- maybe these could be ones that actually
18 had to go for -- I mean, I don't want to skew it
19 entirely, but a subset of these could actually be
20 ones that had to go for a referee.
21 So, we are looking for the more
22 complicated cases that had to go someplace, and

1 we would like to be able to review both the IH
2 and the CMC on all of them, and then, maybe a
3 second opinion on some of them or a referee on
4 some of them.
5 So, we are going to need to access to
6 these. I am sure these charts are huge and with
7 a lot of scanned information into them. And I
8 don't know; I mean, I am assuming there is a
9 secure website that we would be able to get
10 permission to access these particular charts
11 rather than somebody redacting everything and
12 sending us hard copies. I mean, I doubt that
13 that is going to be -- so, however DOL can work
14 that out and what we would need to do in order to
15 be able to access that information. But we want
16 all of us to be able to have done that.
17 That I think actually might be a
18 useful reason to have a phone call, Steve, now
19 that I think about it. I don't know how anybody
20 else feels. But if we could get that done -- I
21 don't know if that is going to work out by the
22 end of August, I mean, again, how challenging it

1 is going to be to actually get access to it. But
2 if we could have that done by August, then we
3 could certainly have a September phone call. Or
4 we could meet, again, for an hour at Oak Ridge.
5 And, Steve, I think the only challenge
6 for that would be your participation in all these
7 different groups. But in a lot of these meetings
8 it is useful sometimes to have time set aside for
9 the Working Groups to have a little bit of face-
10 to-face time.
11 MEMBER MARKOWITZ: Carrie, do you know
12 when the Advisory Board meets whether the rules
13 permit us to meet in Subcommittees, spend part of
14 the time meeting in Subcommittees? I say that
15 because, you know, obviously, that is probably
16 impossible to work remote public access.
17 CHAIR SOKAS: Right.
18 MS. RHOADS: Yes, if you want to have
19 Subcommittee meetings along with the main
20 Committee meeting, we would have to publish that
21 fact in The Federal Register.
22 MEMBER MARKOWITZ: Right, but, then,

1 not just publish it, but, then --
2 MS. RHOADS: Right.
3 MEMBER MARKOWITZ: -- provide the
4 technical access to Work Groups.
5 MS. RHOADS: Right, right.
6 MEMBER MARKOWITZ: Yes.
7 CHAIR SOKAS: Well, and I think that
8 it has got to be a question raised about when we
9 have this conversation about the chart audits
10 that we are going to be conducting, do we need to
11 have an exemption to our public discussion? So,
12 we need Rob Sadler, or somebody like that, to
13 tell us about the confidentiality requirements of
14 this particular task.
15 MS. RHOADS: Right. I'm writing that
16 down.
17 MEMBER MARKOWITZ: In the other
18 Subcommittees, two of them have requested claims.
19 The assumption has been that it would be redacted
20 of all identifying information. And DOL hasn't
21 told us that they can't do it or it takes forever
22 to do it.

1 CHAIR SOKAS: Okay. All right. If
2 they can redact it, then it might not be an
3 issue.
4 MEMBER GRIFFON: But, Rosie, also, on
5 the other Board, the Radiation Board, I chaired
6 the Dose Reconstruction Subcommittee for about 10
7 years and we discussed in public meetings those
8 individual dose reconstruction cases, the
9 findings, the specifics. I mean, you know, we
10 just had to be very cognizant of not discussing
11 any identifiers.
12 CHAIR SOKAS: Okay. Okay. So, you
13 could like just not use maybe even --
14 MEMBER GRIFFON: It could be and has
15 been done, is what I am saying I guess, yes.
16 CHAIR SOKAS: Okay. Okay. I mean, I
17 am sure DOL is going to pay attention to the
18 confidentiality stuff. So, if they can handle
19 that from their end, that would make life easier
20 for us.
21 Okay. Anything else that we didn't
22 cover? Anything else that we need to ask Carrie

1 for?

2 MEMBER GRIFFON: Can I ask you a

3 question, Rosie? You mentioned this informal

4 audit report.

5 CHAIR SOKAS: Well, the informal audit

6 report, we have got it in our -- I think it was

7 one of the things you had to use like an ID code

8 for.

9 MEMBER GRIFFON: Oh, okay. I will

10 have to look back.

11 CHAIR SOKAS: And it was dated

12 February 17th. I can't remember if it was '15 or

13 '16. But it is definitely worth reading. You

14 definitely want to go through it.

15 The problem from my perspective,

16 again, it was process, what came forward, what

17 came back. That is where some of that criticism

18 about, oh, all we wanted was an answer to this

19 question and, instead, we got this blah, blah,

20 blah, blah, blah. You know, I mean, they don't

21 say it in that -- you can sort of sense the

22 frustration from the Claims Examiner because they

1 didn't get what they wanted from the physician.
2 But that kind of made me think, well,
3 geez, if you had an in-house physician, that
4 would be an easy translation. I mean, you know,
5 some of the stuff, as Steve said earlier, you are
6 not going to send every Claims Examiner through
7 medical school, but if you had somebody in-house
8 to answer a couple of questions like that, that
9 might be the better way to go.
10 But, anyway, it did not address
11 content of any of it. So, it was interesting.
12 It did give you percentages by regional office of
13 the times when the CMC resulted in an acceptance
14 or a denial of the claim. And those varied quite
15 a bit by region. I mean, that was very
16 interesting.
17 So, that, in and of itself, sets up a
18 question about some of the different regional
19 stuff, which is also interesting. Say that it is
20 the same contractor. So, it is the regional
21 culture that seems to be different or maybe it is
22 the type of cases that come through in the

1 different regions. I don't know.
2 MEMBER GRIFFON: And that was what was
3 sent to us from DOL? I will have to look back.
4 I don't think I looked at it.
5 CHAIR SOKAS: Yes, it is one of the
6 ones you had -- Carrie, correct me if I am wrong
7 -- but I think it was one of the ones you had to
8 put in that -- she sent you a separate email with
9 an ID, you know, with like a password. So, you
10 had to enter the password in order to open it.
11 And it was definitely worth reading.
12 It is just not enough of -- you know, it didn't
13 really have quality in it.
14 MEMBER GRIFFON: Okay.
15 CHAIR SOKAS: I mean, it was really
16 procedural, procedural quality, but not content
17 quality.
18 I think we are at our mark now, I mean
19 at our four o'clock point. I don't want to hold
20 people up.
21 Is there any other comment, item that
22 we have forgotten?

1 Carrie, anything you need clarified
2 from us? I know we kind of threw a lot of
3 questions at you?
4 MS. RHOADS: No, not right now. I am
5 going to write them down and, then, I will send
6 you a list.
7 CHAIR SOKAS: Okay, great. Thank you
8 so much.
9 MS. RHOADS: Okay.
10 CHAIR SOKAS: Well, thank you,
11 everybody. I hope everybody has a wonderful
12 summer, and we can be in communication as long as
13 we copy Carrie.
14 MEMBER VLIEGER: And are we planning
15 on another teleconference before we meet in
16 October?
17 CHAIR SOKAS: I think it depends on
18 how fast we can get these charts.
19 MEMBER VLIEGER: Okay.
20 CHAIR SOKAS: I don't think there is
21 a point to it unless we are each able to get our
22 five charts reviewed, and then, we want to

1 discuss them. So, you know, if that can happen
2 soon, then we will try to set up another meeting.
3 And if it can't happen soon, then -- I mean, it
4 has to happen at least six weeks before, so that
5 we know that we can do The Federal Register
6 notice anyway. So, we will see.
7 Okay. Any other questions? Any other
8 comments?
9 (No response.)
10 All right. Thank you, everybody.
11 (Whereupon at 4:02 p.m., the
12 teleconference was adjourned.)
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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 IH and CMC
and Their Reports (Area # 4)

Before: Toxic Substances and Worker Health Adv. Bd.

Date: 07-18-16

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter