UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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WEDNESDAY
NOVEMBER 14, 2018

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The Committee met in the Room S-4215, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C., at 8:46 a.m., Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN DEMENT
GEORGE FRIEDMAN-JIMENEZ (via telephone)
MAREK MIKULSKI
KENNETH SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
VICTORIA CASSANO
STEVEN MARKOWITZ, Chair
CARRIE A. REDLICH

CLAIMANT COMMUNITY

KIRK DOMINA
RON MAHS
DURONDA POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICER

DOUG FITZGERALD

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

(8:46 a.m.)

MR. FITZGERALD: Good morning, everyone. My name is Doug Fitzgerald and I would like to welcome you to today's meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

Sorry for the delayed beginning. We just had a few technical difficulties that we've worked out. I'm the Board's designated federal officer or DFO.

And before we begin I'd like to go over some general housekeeping items that, to make sure everyone is safe and comfortable throughout the next two days. First, restrooms are located immediately outside of this room to your right and left.

The restrooms to your right are handicapped accessible. And next to each set of restrooms is a water fountain.

There's also a snack bar on this floor in the C4500 corridor just to your left and

there's also a cafeteria on the sixth floor of the building which is accessible by the elevators just outside this meeting room.

In the unlikely event of an emergency you will hear an announcement over the PA system and we will be instructed to use the stairs located both to the right and the left of the conference room. We will guide everyone down and exit through the same building entrance on the first level where you came in until we receive an all-clear announcement.

I think that covers the most crucial housekeeping information for now. But before we begin I'd like to express my appreciation for the diligent work of our Board preparing for this meeting and for their upcoming deliberations.

I also want to thank my many colleagues here in the Department for all their efforts in preparing for today's meeting, in particular, Carrie Rhoads, our Committee staff and alternate DFO who makes my job so much easier and Kevin Bird and Melissa Schroeder of our SIDEM

contract staff who always do a fantastic job arranging for everyone's travel, preparing briefing materials and running our virtual meetings.

I'd also like to thank Zeke Winfred of our conference management center for his assistance in arranging for this room set up and handling much of the A/V logistics. Now I'd like to say a few words about my role as the Board's DFO.

As DFO I serve as the liaison between the Department and the Board. I'm responsible for approving meeting agendas and for opening and adjourning meetings while ensuring all provisions of the Federal Advisory Committee Act or the FACA are met regarding the operations of the Board.

I'm also responsible for making sure that the Board's deliberations fall within the parameters outlined in the enabling statute and charter.

Within that context I work closely with the Board's Chair, Dr. Markowitz, and OWCP

Director Hearthway to ensure that the Board, as an advisory body to the Secretary, is fulfilling that mandate to advise and it's addressing those issues of highest priority and of greatest benefit to the Secretary of Labor who is ultimately responsible for the administration of the Energy Employees Occupational Illness Compensation Program and to the people it serves.

And finally, I also work with the appropriate Agency officials to ensure that all relevant ethics regulations are satisfied. You'll note that in the agenda today the Board will receive a briefing on conflict of interest laws as they relate to the Energy Employees Occupational Illness Compensation Program Act.

It should also be noted that each Board Member has been asked to file a standard government financial disclosure form.

Regarding meeting operations, we have a full agenda over the next two days and you should note that the agenda times are approximate.

So as hard as we may try we may not be able to keep those exact times. Copies of all meeting materials and public comments are or will be available on the Board's website under the heading Meetings.

The Board's website can be found at url dol.gov/OWCP/energy/regs/compliance/advisoryboard.htm, or you can simply Google Advisory Board on Toxic Substances and Worker Health and it's likely to be the first link you would find.

If you haven't already visited the Board's website, I strongly encourage you to do so. After clicking on today's meeting link you'll see a page dedicated entirely to this meeting.

That page contains all materials submitted to us in advance of the meeting and we will publish any materials that are provided by our presenters throughout the next two days. There you can also find today's agenda as well as instructions for participating remotely in both the meeting and the public comment period at the

end of the day.

If you are participating remotely I want to point out that the telephone numbers and links for the WebEx sessions may be different for each day so please make sure you read the instructions carefully.

If you're joining by WebEx, please note that the session is for viewing only and will not be interactive. The phones will also be muted until the public comment period opens at 4:30 today.

During Board discussions and prior to the public comment period, I would request that the people in the room remain quiet as possible since we are recording the meeting to produce transcripts. I would also ask those in the room to put their phones on mute at this time.

As I mentioned, we do have a scheduled public comment period that begins at 4:30 today. The Chair will note that this is not a question and answer session but rather an opportunity for the public to provide comments about topics of

interest to the Board.

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

Regarding meetings and minutes transcripts: the Federal Advisory Committee Act requires that minutes of this meeting be prepared to include a description of the matters discussed over the next two days and any conclusions reached by the Board.

As DFO I prepare the minutes and ensure they're certified by the Board's Chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, per FACA regulations. But if they're available sooner they'll be published sooner.

Also, although formal minutes will be prepared because they are required by FACA regulations, we'll also be publishing verbatim transcripts which are obviously more detailed in

nature. Those transcripts will be available on the Board's website as soon as possible.

And in closing and before I turn it over to Dr. Markowitz, I'd like to welcome all of our returning Board Members and all of our new members to the Department of Labor. I'm looking forward to working with all of you in the coming two years and listening to your deliberations over the next two days.

I also want to thank you for your dedication to the mission of this Board. And with that, Mr. Chairman, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health.

CHAIR MARKOWITZ: Thank you. So I would add to the thanks given to the various people who helped set up this meeting whom Mr. Fitzgerald named so I won't rename them.

Before I make some brief introductory remarks I'd like to do introductions including the people actually, everybody in the room. So if you could just state your name and where you

work or your relationship to the DOE complex so people have a sense of where we, what our backgrounds are.

I'm an occupational medicine physician, epidemiologist from the City University of New York. And I direct the largest former worker medical screening program in the DOE complex at 14 different sites and have done so since 1998. Kirk.

MEMBER DOMINA: My name is Kirk Domina. I'm the employee health advocate for the Hanford Atomic Metal Trades Council in Richland, Washington. HAMTC represents about 2600 active members.

I'm the employee health advocate for them and I'm a current worker and I've been out there 35 years.

MEMBER BERENJI: Hi there. I'm Manijeh Berenji, Boston Medical Center occupational medicine physician.

MEMBER CASSANO: Hi, I'm Victoria Cassano. I'm a retired Navy Undersea and

occupational medicine physician and currently have my own consulting company. And this is my second term on the Board.

MEMBER REDLICH: I'm Carrie Redlich. I'm an occupational and pulmonary physician on the faculty at Yale Medical School and I'm director of the Occupational Environmental Medicine Program, and I also was on the prior Board.

MEMBER TEBAY: Calin Tebay. I'm the site-wide health advocate at Hanford. I also work at the Hanford Workforce Engagement Center. I've been on site since the early nineties.

CHAIR MARKOWITZ: Go ahead, Ken.

MEMBER SILVER: Ken Silver, Associate Professor of Environmental Health at East Tennessee State University. Going back to the late nineties, I worked very closely with workers and families at Los Alamos National Laboratory and have continued doing evidence-based advocacy around this program.

It's my second term on the Board. I

particularly want to thank the people who put this meeting together for the comfortable seating this time. I don't know who remembers our first meeting. Seriously, thanks.

MEMBER MIKULSKI: Marek Mikulski. I'm new to the Board and I'm with the University of Iowa, occupational epidemiologist. I direct the former Iowa Nuclear Weapons Workers Program.

MEMBER MAHS: Ron Mahs with the Insulators. I'm representing the building trades.

I worked at Oak Ridge on and off over 30 years and the last 15 years as the general foreman. And I'm retired and I train for CPWR and sell some real estate, if anybody needs a house.

MEMBER POPE: Good morning. My name is Duronda Pope and I work for United Steel Workers. I work currently on the Emergency Response Team responding to fatalities and injuries on behalf of our members.

But we also, I also am a second term

and a former worker of Rocky Flats, 25 years.

MEMBER DEMENT: I'm John Dement. This is my second term on the Board at the Duke University Occupational Medicine Division. Area of interest is industrial hygiene and epidemiology.

I also work with the Building Trades Screening Program and have been for the last 20 years.

CHAIR MARKOWITZ: Ms. Leiton.

MS. LEITON: My name is Rachel Leiton. I'm the director for the Energy Compensation Program at the Department of Labor.

MS. QUINN: Hi. I'm Trish Quinn. I'm with the Center for Construction Research and Training as well as the Building Trades National Medical Screening Program, which screens construction trade workers at 35 DOE sites.

MS. WHITTEN: Good morning, Diane Whitten with HAMTC.

MS. BLAZE: I'm D'Lanie Blaze of CORE advocacy for nuclear workers. I represent

workers of Santa Susana and its related sites near Los Angeles.

MS. BARRIE: My name is Terrie Barrie. I'm a founding member of the Alliance of Nuclear Worker Advocacy Groups and the wife of a sick Rocky Flats worker.

MR. ARTZER: I'm Josh Artzer. I'm a Hanford Workforce Engagement Center specialist and also the Beryllium Awareness Group Chairman.

MS. SPLETT: I'm Gail Splett. I'm the EEOICPA program manager at the Hanford site and I've worked on the Hanford site for 45 years.

MR. BALLARD: I'm Chris Ballard. I'm Vice President of Regulatory Affairs for Critical Nurse Staffing. We provide in-home health care under the program.

MR. NELSON: Good morning. My name is Malcolm Nelson. I'm the current Ombudsman for the Energy Employees Program. Welcome to Washington.

MS. FALLON: Good morning. I'm Amanda Fallon. I'm a policy analyst in the Office of

the Ombudsman.

CHAIR MARKOWITZ: Okay. And, George, Dr. Friedman-Jimenez, are you on the phone?

(No response.)

CHAIR MARKOWITZ: So there is a Board Member, Dr. Friedman-Jimenez from New York who is an occupational medicine physician and an epidemiologist and a prior member of the Board who injured his foot in the last couple of days and wasn't able to physically travel here but I think is listening and watching and hopefully he'll be able to speak at some point.

So just a couple of opening remarks really. I want to, there are returning Members of the Board. But a third of the Board is new and I want to make sure that you feel comfortable, to the new Members, asking questions and otherwise learning about the program because you shouldn't think that the returning Members of the Board fully understand this very complex program.

We're still on a learning curve, maybe

a little bit ahead of you but maybe not all that much. So I want to encourage your participation and asking questions and the like.

So much of these two days was designed actually to try to blend the interest in integrating the new members of the Board so that they are oriented about the program. We have some necessary discussions like the FACA review and the ethics rules.

But then we, and we go into an overview that Ms. Leiton will, is going to give for us about the program. And then some updates and modifications which will be of special interest to the returning members of the Board but also instructive otherwise.

Later in the day we're going to deal with certain aspects of the Board functioning like whether we want to break into committees, to the extent which we want all of our meetings to be open meetings or not, the work methods of the Board.

But I thought we should walk through

much of the day first before we have that discussion. I would ask that Carrie Rhoads, as in the previous Board service, as questions arise that we have for DOL that aren't immediately answered or as requests for information arise that Ms. Rhoads keep a running list of those questions so that we can, we'll call those action items so that we can make sure that we keep track of them and come back to them.

We'll also discuss later in the day locations of meetings. Our first meeting of the Board previously was here in D.C. and then afterwards we went out to various sites, in large part to be accessible to the claimants and the DOE workers who have great interest in the program.

The binder, we kept the binder intentionally short. There is some necessary information. And then Sections 5 through 8 really were just the summary of the prior Board's recommendations and Department of Labor's responses to those recommendations.

There are, for the new Board Members, on the website great many more materials, resources. Some of them are organized by the date of the prior meetings.

And so you may need to look around at various places in order to find what you need. But if you have any questions or need some help with that just let us know and we can help you navigate that.

Finally, let me just say that the prior Board met five times as a board. We had some 17 subcommittee or working group meetings. So we did a lot of work and hopefully made some useful recommendations to the Department.

Some of those recommendations are still under discussion and we're going to summarize and return to those tomorrow. So those are active issues.

But even, after we do that, we're going to be addressing new issues. And then just, you know, I always say this and just to put this into perspective that this program really is

a complicated program because it is by statute such an ambitious program.

I can't think of another compensation program that takes on the whole universe of occupational diseases and vast numbers of toxic exposures such as occurred in the DOE complex and tries to figure out to what extent those exposures lead to disease and people should be compensated for those programs.

I can't think of another federal program that does that, certainly not at the state workers compensation. I'm very familiar with the World Trade Center program and I think this program is unique really in its charge to cover really sort of the encyclopedia of occupational health.

And so that's led to a complicated program which we'll learn about and continue to learn about. But it's a program that's achieved a lot in the last like 12, 13 years its existed.

It's, according to the website, paid out $4.5 billion in compensation. Additional

expenses paid for medical expenses. We focus on Part E of the statute and to a lesser extent Part B.

Under Part B another five-plus billion dollars has been spent compensating DOE workers. So it's a large program, a complicated program, a program which has performed great service to a lot of DOE workers.

And our charge, which I think we'll hear soon, is to provide advice to try to assist the program in various ways. And with that I would, those are my remarks.

Any questions or comments at this point? Okay, Ms. Hearthway, I think.

MS. HEARTHWAY: Good morning, everyone. I'll just move up here to say welcome. I just wanted to welcome all of you. Am I on now?

Okay. I just wanted to welcome everyone. To introduce myself, I'm the new director or not so new anymore. I've been director a little bit over a year, Julia

Hearthway.

I will tell you my very first foray into DOL was looking at one of your sets of recommendations that was sitting on my desk when I arrived to go through. And I will echo Dr. Markowitz's words: it is a complicated statute and it's a complicated area scientifically and medically.

So I rolled up my sleeves and dug into it and I commend all of you, the past Board and, for your future service, the new Board Members for tackling this area. It's critically important and it is a difficult area. It's an ambitious area.

But I thank you for your public service on it. And I wanted to stress that we are looking, myself and the entire program, Energy Program, are looking to have a very productive relationship with the Board.

We sat down and spent some significant time going through things that we really are struggling with and we could use your advice and

help on. And Dr. Markowitz and I have met, I think, at least twice if not three times.

And we've discussed the Board in general. At the last meeting we discussed some of these things that we are grappling with. And those will be presented to you.

But we're hoping for your advice and help on those things. And I look forward to working with all of you looking at what you have to suggest and recommend and delving into this very important work.

So just wanted to say those few words. Thank you.

CHAIR MARKOWITZ: Thank you. Any comments or questions for Ms. Hearthway? Thank you. So, Mr. Plick, is Mr. Plick here?

Actually we have a couple new people in the room if you could just, before when we did introductions everybody was introduced.

If you could just introduce yourselves. Mr. Vance.

MR. VANCE: Good morning, everybody.

John Vance. I'm sitting in the back of the room. It's nice to see everybody again.

MR. GIBLIN: I'm Tom Giblin. I'm the associate solicitor for the Federal Employees and Energy Workers Compensation. I'm on tap for 9:45. But if you want I can go now.

CHAIR MARKOWITZ: Yes, we do. Accepted.

MR. GIBLIN: Good morning. Again, I appreciate the opportunity to come today and welcome the Board. I know a lot of you have been here before and there are a few new folks. So it's, we look forward to working with you.

I'm just going to kind of give you just a little bit of an overview of what my office does, a little bit of the statute and a little bit of your -- the provision that applies to you today.

As I said, I'm the associate solicitor for Federal Employees and Energy Workers Compensation within the Office of Solicitor. That's, we of course have an acronym. That's

FEEWC or FEEWC, that's how we pronounce it, which is, you know, no easier than EEOICPA.

So I guess we're a pretty good match. The division itself provides legal support for the Energy Program. And we do all the legal support except for maybe personnel actions. That's handled by someone else.

So we provide legal advice. That includes both formal and informal opinions. We provide, we review all policies and procedures. We do all the regulatory work that's needed and we do any litigation.

I should point out that we do not have independent litigation authority. So when OWCP's decisions are appealed to federal court, we have to rely on the Department of Justice to represent us.

That doesn't mean it just goes. It means that we're heavily involved obviously with any litigation. We do a lot of the pleadings. You wouldn't be surprised if most DOJ attorneys have never heard of EEOICPA and they actually

welcome our assistance for the most part.

So that's really what we do in the division. The statute itself, as you know, was passed in 2000. It was enacted to provide medical benefits and compensation for those workers in the nuclear weapons industry.

There are two parts now under the Act that set out the compensation available for covered employees, for their survivors. Part B of the Act provides uniform lump sum payments and medical benefits to covered employees and where applicable to survivors of such employees of the Department of Energy, DOE, its predecessor agencies and certain of its vendors, contractors and subcontractors.

Part B of the Act also provides smaller uniform lump sum payments and benefits to individuals found eligible by DOJ for the benefits under Section 5 of the Radiation Exposure Compensation Act or RECA and where applicable to their survivors.

Part E of the Act provides variable

lump sum payments based on a worker's permanent impairments and/or qualifying calendar years of established wage loss and medical benefits for covered DOE contractors, employees and where applicable provides variable lump sum payments to survivors of such employees based on the worker's death to a covered illness and any qualifying calendar years of wage loss.

Part E of the Act also provides these payments and benefits to uranium miners, millers and ore transporters covered by Section 5 of RECA and also where applicable to their survivors.

While these two parts may seem very similar there are a number of differences between who is covered, what illnesses they cover and the amounts of monetary compensation that is available and how it is calculated.

As a general rule Part B is broader as to who is covered but is limited in the types of illnesses that are covered. By contrast Part E, as Dr. Markowitz pointed out, is quite extensive as to the type of illnesses that are covered but

is more limited in who is covered.

Also the amount of compensation available under Part B is flat and fixed. It's typically $150,000 or if it's a RECA, it's $50,000. And under Part E it's variable but it can go up to $250,000.

When EEOICPA was originally passed, it was actually assigned to the President of the United States to administer. By Executive Order 13179 issued on December 7, 2000, the President delegated the primary authority to administer EEOICPA to DOL and designated certain specific responsibilities to the Department of Health and Human Services, DOE and DOJ.

When Part E was added in 2004 the Secretary of Labor was given direct authority to administer that part.

As a general matter, OWCP adjudicates claims and pays benefits under EEOICPA while the National Institute for Occupational Safety and Health, NIOSH, within HHS, estimates the amount of radiation received by employees and alleged to

have sustained cancer as a result of such exposure and established guidelines followed by OWCP when it determines if such cancers are at least as likely as not related to employment.

In addition, both DOE and DOJ are responsible for notifying potential claimants and for submitting evidence necessary for OWCP to adjudicate claims under EEOICPA. In December 2014 as part of the FY 2015 Defense Authorization Act, EEOICPA was again amended a new provision, Section 7385s-16 which created this Advisory Board.

This section was again amended in 2018 again under the Defense Authorization Act and extended the Board's time by five years. It will go into 2024.

Like the original version of EEOICPA, this Board, the responsibility to establish the Board and appoint the members was given to the President.

By Executive Order 13699, dated June 26, 2015, the President established the Advisory

Board within the Department of Labor and delegated to the Secretary of Labor the authority to appoint the members of the Board, which is to consist of no more than 15 members, as well as the responsibility of the administration of the Board including funding, staff, administration functions under the Federal Advisory Committee Act or FACA, which Mr. Plick is going to talk about and the designation of senior officials of the Department as the director of the staff to the Advisory Board.

Section 7385s-16 specifically sets out the duties of the Board. First, the Board is to advise the Secretary of Labor and that advice is limited to four specified areas.

I've got about two more minutes. Is that all right? Okay, no sweat. The Board has really two functions. One is -- or it's been given two duties.

One is to advise the Secretary and that advice is limited to four specific areas. The site exposure matrices of DOL, the medical

guidance for claims examiners for claims under Part E with respect to the weighing of the medical evidence of claimants, evidentiary requirements for claims under Part B related to lung disease and the work of industrial hygienists and staff physicians and consulting physicians of the Department and reports of such hygienists and physicians to ensure quality, objectivity and consistency.

The second duty of the Board is to coordinate exchange of data and findings with the Advisory Board on Radiation and Worker Health which was established in the original part of EEOICPA, to the extent necessary.

As you know, there's also a conflict of interest provision for the Board Members regarding any financial interest related to the provisions and medical benefits under the Act. This was reviewed prior to your appointment.

As Dr. Markowitz pointed out, EEOICPA statute is complex and it involves complex development and adjudication and has the unique

challenge of applying these provisions to work that started over 70 years ago.

The Department has worked very hard to apply these provisions in a fair and equitable manner and the Solicitor's Office has been there every step of the way to help them with that. The program has gained experience over the nearly 20 years it has administered this program and understands the difficulties and challenges that are faced by claimants and the Department.

The scope of the Board's authority though limited to the four areas, as I described, can certainly assist in this administration especially with those items identified by the OWCP. That's, does anyone have any questions for me?

CHAIR MARKOWITZ: Yes, I have a question about RECA. I know it's not part of our charge.

MR. GIBLIN: Right.

CHAIR MARKOWITZ: But I think it's been raised at some point in the public comment

section because there are certain specified health conditions under RECA: pneumoconiosis, pulmonary fibrosis, a few of them.

And so are the uranium miners mentioned in the Energy Employees Occupational Illness Act and --

MR. GIBLIN: Yes.

CHAIR MARKOWITZ: So what's the relationship between the way in which they're mentioned there and then the preceding RECA? If you could just clarify that.

MR. GIBLIN: Well I don't know if I can answer that question. My --

MR. FITZGERALD: Can I interrupt for one second? This is Doug Fitzgerald, DFO. In the interest of time and Joe Plick's scheduling conflict here, can we just suspend questions to Tom Giblin for this moment and have Joe come up and give his presentation and then, Tom, you can --

MR. GIBLIN: Sure.

MR. FITZGERALD: -- pick up with the

question and answer after Joe's presentation.

CHAIR MARKOWITZ: Thank you. So I'd like to welcome Mr. Plick to discuss FACA review rules.

MR. PLICK: Good morning, everybody. Thank you for having me. So my name is Joe Plick. I'm the counsel, my title is counsel for FOIA and information law. So I cover a whole bunch of areas including the Federal Advisory Committee Act.

And I'm here today just to talk briefly about the Act and its requirements, a little bit of its history so that you understand a little bit more of the rules that you're operating under.

The purpose of FACA, it was passed by Congress back in the 70s, Congress understood that there were a lot of councils and committees that were being utilized by the government and it wanted to put some sunshine on them.

So it recognized that there was a need for agencies to get balanced outside advice and

expertise. But they wanted some rules, they wanted to make sure that the public and themselves, Congress was aware of what was going on and how this was operating.

So they established this law which creates sort of the rules of the road. It governs the establishment, the operation, the termination of committees that are established to give advice and recommendations to the Executive Branch.

It requires that the committees give relevant advice, that they act promptly and that there's accountability through cost controls and recordkeeping.

So the requirements of the Act. Committees have to be established by statute, by presidential directive or it can be authorized by statute. This obviously is a statutory committee.

Once the committee is established it has to be chartered. The General Services Administration is actually the agency that has

government-wide oversight over FACA.

I'm not quite sure how they wound up with it. I think they probably missed the meeting that day. But anyway, so they're in charge.

And they've issued government-wide rules that we follow in running Federal Advisory Committee Act committees. Committees have to be balanced, that's in terms of points of view and functions, expertise.

There may well be additional requirements in statutory committees. I think this committee has some statutory requirements on the membership. Tom has talked about some of the statutory requirements as well.

Meetings generally are required to be public. Detailed minutes are required to be kept and have to be certified. Basically any member of the public can file a written statement with the committee before or within a reasonable time following the meeting.

The FACA does not require you to take

public comment but you can and I think in this case you guys will. The minutes have to be certified by the Chair within 90 days of a meeting.

And it's the minutes, it's not a transcript. For a long time GSA had allowed agencies to use transcripts to fulfill the requirements for minutes.

But there were complaints from the public because if you've got a meeting that lasts three or four days and somebody is trying to figure out what happened you don't want them to have to read three or four days' worth of transcripts. So the minutes are a better way to accomplish that goal.

A couple of things. We ask that you don't discuss substantive matters outside the meeting unless you're in a subgroup or subcommittee that's been established. If you get together outside the group, it could be seen as a violation of FACA.

There is no statutory violation of

FACA contained in the statute itself. Rather courts have said that if there's a violation of FACA, the way that's punished is the Agency is enjoined from taking action based on a recommendation.

So it's almost like a nuclear option. A lot of good work could go to waste simply because of some procedural violations.

Media inquiries we request be referred to the DFO and the Chair and let them handle those. FACA committees are, we are asking for your independent advice. And the statute requires that we ensure that you provide independent advice.

But that has to be in the context of what you're being asked. GSA's regulations say that committee members and staff should be fully aware of the Advisory Committee's mission, limitations if any of its duties and the Agency's goals and objectives.

In general, the more specific an advisory committee's tasks and the more focused

its activities are the higher the likelihood will be that the Advisory Committee will fulfill its mission. Committees have to be re-chartered every couple of years.

This one is statutory. I know it was recently reauthorized. But there's also this requirement for the charter to be renewed. Any questions on that for anyone?

Okay. Agency responsibilities, the statute sets a couple of responsibilities for agencies. There's a committee management officer for the Department who manages all of the Department's committees.

And then for this Committee Doug is the designated federal officer and he has certain responsibilities that are enumerated in the statute. He approves the meetings, calls the meetings, he approves the agenda. He's required to attend. He can adjourn it if he determines that it's in the public interest. I've never seen that happen. I'm sure it won't.

But there have been some cases where

courts have admonished agencies because a committee went way beyond its scope and then they thought it should have been adjourned. He's required to maintain the records on costs and membership.

He has reporting obligations to GSA. He has to ensure efficient operations and provides committee reports that ultimately go to the Library of Congress. He also obviously works with the Chair very closely on making sure the committee runs well and effectively and efficiently and liaisons with the Agency.

So overall objectives. Like I said, while the advice received is independent advice the agency can set its priorities and objectives, and it should be a collaborative effort.

It's a waste of everybody's time if you're focusing on something that the agency just simply cannot do either because of resource constraints or statutory restraints or whatever. Any questions about that?

Okay. As I mentioned, meetings are

generally public. There are procedures for closing meetings. We don't generally close meetings here.

There is one committee that deals with trade negotiations that does. But you can close it for reasons that sort of track exemptions in the Freedom of Information Act.

So if, for example, you were to have testimony from affected workers and you're going to be talking about medical information that might be a reason to close. But there's a process that you would have to go through.

The agency head has to approve it. It has to get legal review. The decision has to be made 30 days in advance.

Subcommittees. Right now subcommittees if you form them are not subject to the open meeting requirements. That doesn't mean that you can't hold open meetings, but they're not required.

The other big thing is to make sure that any subcommittee work is reported back to

the parent committee and the parent committee deliberates on it. If the subcommittee reports directly to the agency it in effect becomes a new committee that's subject to FACA.

Meeting, information or things that don't have to take place in a public meeting. Prep work if you task two or more of your members with going off and writing a draft of something, that doesn't have to be done in public as long as they bring the draft back.

And administrative matters, you know, if we're talking about how to get you in the building, how to get you your badges or things like that those things don't have to be done publicly.

Public availability of records. The Act generally states that the records, transcripts, minutes, appendices, working papers, drafts, studies, agenda and other documents that are available to or prepared for or by the Committee shall be available for public inspection.

The provision is somewhat subject to FOIA. If the Department is providing you with material that would be exempt from FOIA then that wouldn't have to be made public. But any of your materials are public.

You should also be aware that Congress for the past several years has been attempting to amend FACA. It's passed the House every year and then it's kind of stalled in the Senate.

I don't know obviously with the recent election how that will impact that. But that would impose some additional reporting requirements. It would in fact, I think, make the subcommittee subject to FACA requirements and so you would have to have those subcommittee meetings open to the public.

The administration has objected to some of those provisions because they would be really burdensome and really limit the effectiveness, I think, of committees.

MR. FITZGERALD: Excuse me, Joe.

MR. PLICK: Yes.

MR. FITZGERALD: Doug Fitzgerald, DFO. Could you speak to working groups versus subcommittees?

MR. PLICK: In a lot of ways they're not really different. I mean if you're breaking the work down into groups, it's not going to be subject to the FACA requirements whether you call it a work group or a subcommittee.

I don't think that matters a whole lot. Subcommittees tend to be a little bit more formal in structure than a work group.

A work group could simply be the entire committee is deliberating and you say, well why don't we have a couple people go write this up and bring it back to the next meeting.

I think that would be a work group whereas a subcommittee is generally given a task and goes off and maybe does a lot of research and may hold meetings with affected people and then brings their work product back.

MR. FITZGERALD: Okay, thank you.

MR. PLICK: Again, it's important that

the Committee, when it gets a report from a subcommittee, that it actually deliberates on it and doesn't simply rubberstamp it. Some courts have looked at that and said well it was just a pass-through and it's really the subcommittee reporting directly to the agency.

So let's see. That's basically everything I have on this. If you've got any questions, I work closely with Doug and Carrie on this. Other questions?

CHAIR MARKOWITZ: Thank you very much. Sure, so we'll return to Mr. Giblin who is here.

MR. GIBLIN: Okay. I think I understand your question now. You know, RECA, Section 5 of RECA specifically covers certain uranium miners.

And of course by statute they're eligible for benefits under both Part B and E. And when they apply for Part B whatever conditions that have been accepted by DOJ then we accept those conditions and we'll pay them, you know, the $50,000 and we'll provide medical

benefits.

They can also seek, file a claim under Part E for additional health conditions. But obviously they have to meet our statutory requirements.

So but for Part B, we accept that they've met their requirements under DOJ and the conditions that DOJ has accepted.

CHAIR MARKOWITZ: Okay. So again, we're not charged to deal with RECA so this is just for background information. There are certain conditions, I think, that the miners get compensated, named conditions.

I mentioned before pneumoconiosis, fibrosis. I think there's maybe lung cancer. I can't remember. Is that part of the RECA Act or is that part of EEOICPA?

MR. GIBLIN: I think it's part of RECA.

CHAIR MARKOWITZ: It's part of the original which preceded the EEOICPA, right?

MR. GIBLIN: Right, it's been around

for a while.

CHAIR MARKOWITZ: Thanks. Any other questions? Yes, sure, Dr. Cassano.

MEMBER CASSANO: Hi, Mr. Giblin. I'm Tori Cassano. I have a question, if you could explain for the benefit of everyone we talked about regulatory barriers or procedural barriers to enacting a recommendation and statutory barriers to enacting a recommendation.

Could you explain the difference between those two and why one may be more difficult to overcome than the other? Thank you.

MR. GIBLIN: Sure. Well the statutory barriers, if there's a recommendation that is not consistent with the statute then we really can't follow it because any agency is, has only the authority granted to it by Congress.

And that's what is set out in the statute. So if it conflicts with the statute then we would have to go to Congress and have them amend the statute to give us the authority to implement that recommendation.

If it's inconsistent with their regulation presumably we'll go under the assumption that our regulation was properly issued and we had the authority to issue it, then it's a matter of looking at the regulation and determining whether the recommendation, whether we can make the changes necessary to the regulation.

If we can, obviously if it falls within our authority, our regulatory authority then we would engage in rulemaking. That, you know, there's an internal process within the Department to get approval to initiate a reg and then you have to get approval from OMB and then of course once you have that then it goes out for notice and comments.

That's, and then once we get those then you have to review the comments and then you have to issue the final rule. It's, you know, it's not a short process but it's, if it's a regulatory issue then it's something that's within our ability to change ourselves.

MEMBER CASSANO: So, thank you. So not totally impossible, just difficult.

MR. GIBLIN: Right.

MEMBER CASSANO: Thank you.

MR. GIBLIN: Any other questions?

CHAIR MARKOWITZ: Okay, thank you very much.

MR. GIBLIN: Thank you.

CHAIR MARKOWITZ: So I don't know if -- we're running ahead of time here. I don't know whether Mr. Mancher is here or -- I'm wondering whether, Ms. Leiton, you want to just give us an overview and then that's, maybe we shouldn't ask Mr. Mancher to come early because that will run us into break, this presentation will run us into break and then we can resume with the schedule. Welcome.

MS. LEITON: Good morning. The mic is working fine and everything, good. Okay, so I don't want to, I know a lot of you already know a lot about this program.

I'm Rachel Leiton. Again, I'm the

director of the program. I've been the director since 2008. Before that I was the policy chief when the program started back in 2001.

So I've been with the program a long time and it is very complicated. There are a lot of factors that make it challenging to adjudicate claims.

And part of the reason that we're happy you can help us is we do need scientific, medical help in additional to experienced members from the DOE facility complex. So we're very happy that you're here.

Tom already went into some very basics about the program. Mine is a little bit more detailed. For those of you that already know a lot, I apologize, but I do want to make sure that you're aware of kind of the ins and outs of what our expectation is, what we believe Congress intended for us to do and how we kind of go about doing that.

So as Tom indicated, the EEOICPA is administered by the Department of Labor. We have

the primary responsibility for providing the lump sum compensation benefits, the medical benefits for adjudicating the claims and undertaking all the development actions in order for those claims to come to a final decision.

The Act itself provides lump sum compensation and medical benefits under two different parts of the Act. We do work very closely, however, with the Department of Energy, the Department of Justice and the Department of Health and Human Services. I'll talk a little bit more about their roles.

As Tom indicated, there are two paths to eligibility. There's Part B and there's Part E. There are some similarities to how we develop for both parts because there are commonalities in the type of information we need. We need, under Part B and E, we need employment information to verify their employment.

We need medical information to verify their diagnosis and causation. And then we need survivor information like marriage certificates,

death certificates to show that there's a relationship there.

But there are different criteria for each of those different categories under each part of the Act. So for employee eligibility under Part B, the individual is eligible if they were a DOE contractor and subcontractor, if they were a federal employee, an atomic weapons employee -- that's a term that's defined very specifically in the Act -- a beryllium vendor or a RECA recipient.

Under Part E, of those the only ones that are covered are the DOE contractors and subcontractors and the RECA beneficiaries. So the AWEs, the federal employees and the beryllium vendors are not covered under Part E.

In terms of medical there are very specific, specified in the Act conditions that are covered under Part B. That would be cancers, chronic beryllium disease, silicosis under very specific circumstances and the RECA Section 5 awardees.

Under Part E, however, any condition can be covered, as Dr. Markowitz indicated, as long as we can determine that it was as least as likely as not caused, contributed to or aggravated by their exposure in the workplace to toxic substances.

That's where our biggest challenges come in and I think that's what a lot of the work that this Board has done and will probably continue to do is surrounding that area because, as Dr. Markowitz said, there isn't a trail that's been blazed for us to follow when it comes to how do you determine whether or not their exposure was related to their employment.

The eligibility criteria for survivorship is also different. Under Part B there's a specific order. It's the spouse as long as that spouse was married to the employee for at least one year, adult children, grandchildren, grandparents in that order.

Part E is different. And I think, you know, the history of Part E is that it originally

was given to Department of Energy as Part D. They were trying to adjudicate claims, they were tasked with a panel of doctors that would say whether or not it was related and then they could take that to their state workers comp.

So when Part E replaced Part D they modeled it more like a state workers comp survivorship definition type. So the spouse, as long as the death is related to the condition that we've accepted, which is different than Part E which does not require a causal connection, if there is no spouse then it would be children.

But the children must be under the age of 18, under the age of 23 and a full time student or any age and incapable of self-support. So again, you're going to have those discrepancies between the two parts.

The benefits we provide or that are provided under the statute for Part B and E also are different. Under Part B we provide a lump sum compensation of $150,000 to the employee or the survivor.

Under RECA if they've been, they've received RECA benefits we pay them an additional $50,000. Under Part E unlike under Part B where it's an automatic payment if we approve the claim under Part E we approve the claim first.

We will pay for medical benefits and then we determine what their compensation might be. That can come in the form of impairment. So a doctor will review, evaluate them, review the American Medical Association guidelines, determine what their percentage of impairment was and then assign that percentage.

We take that, and the statute says they get $2500 for each percentage of impairment they have. We also pay for wage loss. And it can be between $10,000 and $15,000 per employee.

I'll get into that a little bit more. And then for survivorship if the cause of death was related to the condition we've accepted it's $125,000 to the survivor. There is a $400,000 cap on any compensation awarded.

Okay. So then in terms of our

development actions, the first thing we're going to do is when we're going to verify employment. That employment verification process starts with DOE, Department of Energy.

We ask them for, they can oftentimes provide us with verification that an employee worked at a certain facility. Sometimes they don't have the records so we rely on a lot of other resources.

We work with ORISE, the Oak Ridge Institute for Science and Education. We work with -- there are corporate verifiers that DOE identified for us that we work directly with.

We work with Social Security Administration but mainly for wage loss information. But sometimes they can help us with employment verification.

We have other sources. The CPWR is one of them. We also have, we take affidavits and then any other records that the claimant can provide to us.

So under Part B the next step is going

to be medical, trying to determine the causation under Part B if it's a Part B case. And that means that there are two paths to getting an acceptance for cancer under Part B.

One is Probability of Causation that's conducted by the National Institute for Occupational Safety and Health, NIOSH. They will, we'll refer a case to them for cancer.

They will determine the level and extent of exposure to radiation, provide us with that report and then we conduct at the Department of Labor the Probability of Causation calculation.

It's a scientific calculation of the likelihood that the radiation exposure is related to cancer. That computer system that we use was developed by NIOSH.

If the PoC, the Probability of Causation, is 50 percent or greater then they receive compensation. Again, that is a statutory mandate.

The other path in Part B for cancer to

receive coverage is the Special Exposure Cohort. Congress in the Act established four Special Exposure Cohorts, the gaseous diffusion plants plus Amchitka Island.

And then they allowed for additional SEC sites, Special Exposure Cohort sites to be established by NIOSH. NIOSH is tasked with looking at petitions for a new special exposure cohort.

They also will do, when they're doing dose reconstructions, if they don't have enough records to conduct a PoC, they will sometimes establish them on their own. They have established, I believe it's 124 additional SEC Classes since the beginning of the program.

In order to be covered under a Special Exposure Cohort you have to have worked during those periods of time when NIOSH has established it as an SEC. Normally it's, and then you have to work 250 days during that time frame.

You also have to have had one of 22 cancers that are specified in the Act. If you

don't have one of those cancers and you worked at that site even if you worked during that time period, you will undergo a dose reconstruction.

The Department of Labor will, we administer the SEC classes but we don't create them. We have no part and no say in what constitutes an SEC.

There are other parts of, there are other conditions under Part B that are covered. Chronic beryllium disease is one of them. There are very specific statutory criteria for CBD under Part B.

I'm not going to go into great length about that now because it's part of the discussion we'll have later about Part B lung conditions. But we also cover silicosis under specific circumstances under Part B.

Under Part E, we also need to undergo a medical analysis. But this one, as I said, gets a little bit more complicated. So the first thing we have to establish under Part E is that they have the medical condition.

And then we need to determine what toxic substances they might have been exposed to. And then once we've determined that we move to causation to determine whether that level of exposure was related to the condition that has been claimed.

The definition itself is slightly complicated also because the way it's laid out in the statute is that the toxic exposure must have been a significant factor in causing, contributing to or aggravating the condition that's been claimed.

Figuring out that definition has been a challenge. I think this Board has assisted us some with that as well in trying to break that down into pieces.

But there are a lot of different tools that we use to try to get to determine what that exposure level might have been. We have an occupational history questionnaire which is something that the Board has tackled and we may ask them to tackle a little bit more for us.

But that is actually an interview that is conducted by our resource centers. Initially when a person files a Part E claim they'll conduct this interview with the employee or the survivor asking where the person worked, what buildings they might have worked in, what they know.

They don't always know a lot. But sometimes they do and we'll take that into consideration in our analysis.

We also created the site exposure matrices which we'll get into a lot more detail later today. But basically that is a tool that we use to help the claims examiner determine, okay, if a person, it's in a relational database that contains information about DOE facilities, toxic substances that were at those facilities and the, there's a database called HazMap within that, that talks about the relationship between certain toxic substances and certain conditions.

We also rely on what we call document acquisition request records which are Department

of Energy records that sometimes will contain information, industrial hygiene records and things like that, that we can use.

We also go to the Former Worker Medical Screening program through Department of Energy to, we'll use those work interviews and any other medical information we can find in those records. And again, we look at affidavits and facility records as well.

Okay. So the SEM also, what it contains information about DOE facilities, it also has information about uranium mines and mills. I know that's not part of your task, but just for your information.

There is a link on our website. A lot of the information I'm providing you today is on our website. There's procedure manual regulations, statutes, the site exposure matrices, the DOE facility website. There's a lot of information there.

Okay, so a little bit, I think I mentioned impairments for Part E. So I'm not

going to go into that a whole lot. Basically it's the, it's something that we obtain from a physician who has evaluated a patient.

In some circumstances for impairment we will obtain tests from, like pulmonary function tests or a written examination report from the treating physician. But if a claimant can't find a doctor that can do impairment ratings we rely on a contract medical consultant.

I am going to talk a lot more about contract medical consultants as well later. But just as a brief overview of that, so often first we'll go to the claimant to get medical information.

We'll go to the claimant to get any other information they have. But when that -- when we exhaust that in an effort to help given that not, survivors often don't have information, employees sometimes don't have information, we will go to, we contracted with a company that has access to physicians of all different specialties: oncology, pulmonology, orthopedics,

not orthopedics so much as occupational, we'll say occupational doctors.

But anyway we will refer cases to these doctors when a claimant does not have information or if there's other information that we think we can get from a contract medical consultant that we're not getting from the doctor.

Sometimes impairment is one of those things, that that physician can provide us with information that maybe a claimant could not. Another contract that we also have and we have on board, we have an on-board medical director as well.

And we have several, we have two full time federal industrial hygienists we refer cases to as well. We've, in the last couple of years we've obtained a contract for industrial hygienists to review cases on a case by case specific basis.

So if we don't have enough information but we have some information that we can refer to

an industrial hygienist on a case by case basis, we'll send that case with specific information and ask more questions to that doctor.

Again, that will be elaborated on more later when we talk about that topic. Wage loss is basically the decreased capacity to work as a result of the accepted medical conditions.

There's a pretty complicated definition in the statute for what we pay and how we pay it. But basically for any year that an individual employee made less than 50 percent of their pre-disability annual wage they will receive $15,000 in compensation.

For any year that's between 50 and 75 percent of what they used to make they'll get $10,000 in compensation. And the methods we go about to try to determine that usually rely on Social Security records, what their three-year annual average wage was before they stopped working or had limited capacity to work.

So after we've undertaken all of this development what happens is that the, there are

certain responsibilities of the claimant. There are certain responsibilities that we have.

First, we expect that the claimant will provide us with whatever they can. And that sometimes is a lot, sometimes it's not a lot. That will determine what development actions we will then take.

We expect them to respond to letters from Department of Labor. We've taken on a lot of responsibilities ourselves. As I indicated, first we'll gather the evidence.

We have developed these partnerships with other agencies and organizations. We, after we've conducted development the district office, we have four district offices in the country in Seattle, Cleveland, Jacksonville and Denver.

And there are claims staff in each of those offices who will issue a recommended decision. That case and that whole decision will then be transferred to our Final Adjudication Branch and it's only a recommendation.

At the Final Adjudication Branch

that's where the claimant then has that opportunity to object to the recommended decision. They can, the claimant or their representative can ask for an oral hearing.

That can be conducted either in person in their area, by WebEx or by telephone. In the alternate they can ask for a review of the written record which is, they can submit letters or additional information that will be reviewed at the Final Adjudication Branch.

The Final Adjudication Branch is separated from the district office. It's made up of hearing representatives who will make that final decision on the case.

They are co-located. They have offices co-located with the district offices in the same area, but they're not in the same structure. And then there's a centralized Final Adjudication Branch here in Washington D.C., yes.

MEMBER BERENJI: Sorry, question. This is Manijeh Berenji. So who exactly is on that adjudication meeting? I mean is there a

judge? Is there --

MS. LEITON: No. So there's the recommended decision that's issued by the district offices. That's claims examiners.

And then the Final Adjudication Branch is made up of hearing representatives that work for the Department of Labor also. But they are separated in their chain of command.

They are separated in various other ways and independent from what the claims examiner is doing.

MEMBER BERENJI: Thank you.

MS. LEITON: So once all the objections or in some cases the claimant will waive the right. If it's been accepted they'll waive the right to object and we can issue a decision faster.

But every decision is reviewed whether it's an acceptance or a denial by the Final Adjudication Branch before a final decision is issued. They'll issue that final decision.

Following the final decision there are

other ways to get, you can get the case. There's a reconsideration option which means that within a certain number of days, 30 days you can ask for reconsideration by a different hearing representative.

In addition, cases can go to district court or during, at any time after a final decision a claimant can ask for a reopening of the claim. What that means is if they submit new medicals or they submit information that would suggest that maybe the case could be accepted now they can submit that to us later.

Oftentimes we'll reopen cases if there is a new Special Exposure Cohort that's been established. We'll go through all of the cases that could have been affected by it. We'll review them. We'll reopen them and accept them if we can.

That same thing applies to new policy that might affect a case that could be ultimately accepted.

MEMBER BERENJI: Hi there. This is

Manijeh Berenji again. Sorry I had another question. So how many cases have actually been reopened? Do you have any data on that?

MS. LEITON: I do, but I'll have to get it back to you. I don't have it at the tip of my fingers.

MEMBER BERENJI: Thank you.

MS. LEITON: So once the, if a decision, final decision accepts, well whether it's accepted or denied the case goes back to the district office. If it's accepted the district office will then pay the benefits, especially under B they'll pay them right away.

Under Part E, they'll develop for impairment or wage loss or any other benefits they may be eligible for and we'll pay medical benefits for whatever conditions we've accepted.

Some pretty broad statistics, program to date we've paid $15.6 billion, which is pretty, it was surprising to a lot of people who enacted the law originally. They did not expect that we were going to be paying this much money.

They thought it would be kind of a finite amount of people, a finite amount of money and we would be done. But, you know, we do a lot of outreach.

We do a lot of, there's still a lot of people out there that we want to reach because while this program is well known to major facilities, Hanford, you know, SRS, Oak Ridge there are still little facilities everywhere that we're still trying to reach out to.

There are still survivors. There are still a lot of medical benefits. So this program is not going anywhere and we are continuing to pay benefits.

We've paid $6.5 billion under Part B, $4.5 under Part E and $4.5 billion under medical benefits. We do also have resource centers. I mentioned those briefly when I was talking about the occupational history questionnaire.

We've got 11 resource centers nationwide. And basically they're contractors that work for us. Many of them have been with

the program since the very beginning.

They assist with claimants filing claims. They will help people with walk ins, people who are, they are located in some of the more rural areas and they assist us with a lot of, help claimants with questions, help do outreach with the occupational questionnaire and a lot of other functions that really kind of give claimants, particularly if they're located around these resource centers a face to face conversation, assistance if they need it.

And that is my overview. I will, as I said, there is on the agenda there is going to be time later for going into each, delving into each of your mandates so there will be a lot more information.

I will talk about chronic beryllium disease. We're going to talk more about the site exposure matrices, weighing of medical evidence and Part B lung conditions.

So we'll get into that a lot more later. But if there are questions now I'm happy

to take them.

MEMBER BERENJI: I have a question. This is Manijeh Berenji again. So in terms of the education of your claims examiners, I mean is there a certain educational paradigm by which you train these folks because I feel this is very complicated even for occupational medicine physicians, epidemiologists?

I feel like there needs to be some sort of baseline education provided at the get go. But I wasn't sure what that procedure was.

MS. LEITON: So our claims examiners are given training when they first come on board. And they're trained in how to be claims examiners.

They're not medical doctors. They're not industrial hygienists, epidemiologists, experts in those fields. That's why we have experts in those fields to help us.

But they are trained in the statute. We have a very, very detailed procedure manual that gives them step by step instructions on what

type of development to do.

We also have, we do training modules so they can do online training. We do classroom training, particularly when something new comes up if there is a refresher that needs to be undertaken.

And we do a, you know, orientation. Sometimes that consists different, it's different depending on the district office. Sometimes like we might have a mentoring program.

One claims examiner will help the other one. Some of them have five to six week kind of orientation moving into a caseload type of thing.

But we also have a training lead now in national office. We're working to kind of make that training more robust and more consistent throughout the country.

But it's a big part of working with our claims staff to make sure that they understand.

MEMBER BERENJI: Thank you.

CHAIR MARKOWITZ: Are there other questions? Dr. Silver.

MEMBER SILVER: I remember about a decade ago there was a big controversy over Social Security claims administrators having a strong preference for web conferences and telephone hearings to the point where claimants were being denied in-person hearings.

I know administrative law professionals across the federal government communicate with each other. Has there been any movement in this program to favor electronic conferences to the disadvantage of in-person conferences?

MS. LEITON: So we will do in-person hearings when requested. I have heard from some stakeholders that they've gotten the impression that we are trying to deny those or move towards WebEx or telephone conferences.

That's not our intention. We do have that capability because we have resource centers that have WebEx equipment available. We have,

I'll talk a little bit about our centralization of our Final Adjudication Branch assignments recently.

And that may be the impetus for some of what I've been hearing about whether or not people are traveling around the country to hold their hearings.

But to answer your question plainly, no, we do not have any impetus or requirements that hearing representatives tell claimants that they shouldn't have in-person hearings.

They have that right. We want to allow the claimants or their representatives to have that right. But we will entertain telephone conferences or WebEx conferences.

Sometimes that easier for some representatives or claimants who don't want to leave the house.

MEMBER BERENJI: Hi there, this is Manijeh Berenji again, sorry. I'm new to the Board so I'm just trying to get some understanding.

MS. LEITON: No problem.

MEMBER BERENJI: So I understand that you have four regional offices, correct?

MS. LEITON: Correct.

MEMBER BERENJI: And do you actually have a medical doctor as well as a toxicologist at each one of these branches?

MS. LEITON: No. We have a medical director here in the national office. We have a toxicologist here the in national office as well and then we have the industrial hygienists that they can refer cases to.

We have the contract medical consultants that can assist with claims. But we do have nurses at the district offices. Some of them are located, we've got a couple in the district offices but they're also available for consultation, et cetera. But they're not co-located necessarily.

MEMBER BERENJI: I have a follow up question. So in terms of, you actually have nurses at each of these local branches. If there

is a question that needs to be escalated to the medical director is there a current procedure for that?

MS. LEITON: Absolutely. I mean anytime a claims examiner has a question that, you know, isn't either, a nurse can't help them, we have a Policy Branch, John Vance who stood up earlier is our policy chief.

And they can refer any questions they have to our Policy Branch. That can be referred to the medical director. And we take any questions or concerns claims examiners have very seriously and we'll help them with them.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: Yes, I don't think we've ever met the medical director. Is that possible?

MS. LEITON: Yes. I don't know if we can do it this week but we'll definitely make sure that happens.

MEMBER BERENJI: And the toxicologist too, I mean that would be great to be able to see

these folks in person.

MR. FITZGERALD: This is Doug Fitzgerald. Yes, there was a late request to have Dr. Armstrong speak at the Board but it came in yesterday.

Again, it was just a little too late in the agenda setting process. But he did say he would be happy to attend any future subcommittee or committee meetings where he could provide prospective help for the Board.

MS. LEITON: And the toxicologist, we'll talk about that as well.

CHAIR MARKOWITZ: Steve Markowitz, I have a few questions. Where do you get your epidemiologic expertise from?

MS. LEITON: Well basically we rely mostly, when you're talking about expertise we rely on industrial hygienists for the type of toxic substances. We rely on our occupational medicine doctors for the medicine side of it.

But when you say, is there something specific you're asking about?

CHAIR MARKOWITZ: Well when a claims examiner is puzzled about a relationship between exposure and disease there's a procedure for them making a request to the toxicologist to review the topic, I think, or at least to receive the question and express an opinion.

And toxicology is one thing, it's very useful. But some of the, much of the answer to that question actually relies on epidemiologic expertise.

So I'm just wondering where, how that, how you access that expertise.

MS. LEITON: Well I believe that she has, our toxicologist has some expertise in epidemiology. But just to be clear a claims examiner will go to the toxicologist when we have a medical article or scientific articles that suggest that there might be a relationship to a disease that could be applied program-wide.

She's not to be relied on for a medical determination on causation on specific cases. She's there to help us research any of

these articles that come in, conduct additional research to help us find those links.

But right now she's the resource we have for that research side of things.

CHAIR MARKOWITZ: Thank you, another question. So we'll hear public comments later and we have access, the Board Members should access the ombudsman's annual reports because they are very informative.

But from your point of view, what are the most common frustrations of claimants or what are the active issues that you need, that you're dealing with that seem to be more common at this point because I'm sure they evolve over time?

MS. LEITON: I think that causation is the biggest challenge for them. And we hear, you know, it's difficult to establish what they were exposed to. It's difficult to establish what, whether or not this condition was related.

They get frustrated if they have a physician that comes in and says, yes, it's related to their radiation or it's related to

their toxic exposure which are very general statements from physicians. And then we ask further questions delving a little bit more deeply.

Okay, well this was the length of exposure this person had. This is what we've determined they were exposed to. Can you provide us more information?

Doctors get frustrated with that. They feel like, you know, they just want to treat their patients. They don't really want to go into a whole paperwork about whether or not it's related and a lot of doctors don't know.

So there's that frustration because claimants can't find a doctor that will provide us with the information we need or we'll go to a contract medical consultant who might have a different opinion from their doctor but they'll rationalize it more or provide us with more information so claimants get frustrated because they say well my doctor says this and you've got this other doctor saying that.

It's a struggle that we continue to battle because where is the line between well rationalized and not well rationalized, seeing a patient, not seeing a patient. So that's a big thing.

You know, the use of specialists can be a double edged sword sometimes because well if they say, yes, then it's good but if they don't say what is going to help a claimant's benefits get paid or, you know, there's questions about that it becomes frustrating, I think.

I think right now Part E is the most frustrating part. I mean Part B is clear. The statute is clear. There are very specific lines drawn in the sand and Congress laid it out a certain way.

That might be a good way or a not very helpful way in some cases. But it can be explained. Part E is a little bit more gray. There is a lot more areas where people become frustrated.

I don't know if that helps with any.

But that's where I'm seeing the most difficulty.

CHAIR MARKOWITZ: Thank you, that's good. Dr. Cassano.

MEMBER CASSANO: Yes, I'm sure I learned this at one point. But I'm of the age where I forget things a lot.

If you have a well-rationalized opinion from a personal physician and you get conflicting evidence from your own medical consultant how is that adjudicated?

MS. LEITON: Well if they are equal reports we have a process for a referee that we can send the case to another doctor who will examine the patient depending on the type of referral, what the issue is and provide us with a third opinion, and that is considered a referee examination or medical opinion.

MEMBER CASSANO: Thank you.

CHAIR MARKOWITZ: Dr. Mikulski.

MEMBER MIKULSKI: Yes, hi. This is Marek Mikulski. I have a quick question about the Department policy for accepting worker's

affidavits in case there is no employment information existing for the worker.

MS. LEITON: So we will accept affidavits. But we usually require additional information. We will look in all of our different, all of our other ways of finding information like Social Security to help us back up an affidavit.

As I said, we've got corporate verifiers. We've got the Center for Construction Trades former worker programs. We'll look everywhere to kind of back that up.

An affidavit standing all by itself usually we will require additional information. Sometimes if we've got an affidavit from multiple different people, you know, but one affidavit by itself is not usually going to stand alone.

CHAIR MARKOWITZ: Yes, Dr. Dement.

MEMBER DEMENT: Sort of a follow up question to the one Steve had with regard to the causation which is obviously a major issue for many of the cases. And it really gets back to

the issue of some of these are policy decisions that have come down.

Some are presumptions and some are not. It seems that, we've tried to address it in the former Board with certain sets of presumptions.

Some of them have been accepted, others not and some I guess have sort of been in the till. But some of the rebuttal of the Board's recommendation has been the causation that is the epidemiology. So where does that expertise come from within the Department?

MS. LEITON: Well, as I indicated we do have, we rely on our toxicologist, our industrial hygienists, our health physicists to look at the information.

But sometimes when we're reviewing articles and references that have been provided to us we look through it from various different aspects whether it's legal aspect or a scientific one.

But we have to determine that the

citation that's provided to us has a connection to the type of work we're looking at. So we're looking at Department of Energy facilities.

Obviously there's not going to be a lot of research on that specifically. But that's different from studies that talk about occupational health in general.

So we try to look at the articles, the background information from a policy aspect, a legal aspect, scientific aspect and medical aspect. We have physicians as well that review these.

And as I said, we have the experts we have on our side. And oftentimes it's just trying to find that link between these articles and the work that we do.

And those are the kinds of things we look at when we were looking at those references. We'll summarize a little bit more further the specific recommendations I believe you've got on the agenda tomorrow.

CHAIR MARKOWITZ: I have a question.

So the website it's a very nice succinct summary of the number of claims, number of cases, the amount of money paid out Part D, Part E.

But what's the difference between a claim and a case and how do they differ between, and there's little asterisks about unique individuals.

So I'm sure you've gone over that with us. But if you could just do that again that would be helpful.

MS. LEITON: I will do my best. So a case when an employee files a claim we create a case. And that employee's Social Security number used to be the case number.

We've changed to case IDs now. But that employee is what we're basing a case on. A survivor could file a claim after that employee has filed a claim or multiple survivors could file a claim for that employee who may be deceased at this point.

But it's still, that case consists of any survivor that's filed because of that

employee's employment at a DOE facility. So there could be multiple survivors in a case.

In addition, sometimes people will file multiple, they'll file multiple EE1 forms which is a claim for compensation for multiple conditions. Each claim form that they file for a condition is considered a claim.

So you can have multiple claims in a case because that case is for an employee. That could mean multiple survivor claims or it could be multiple conditions.

So that's, the claims are individual claims that are filed whether it's from different survivors or if it's from, for different conditions. So that's the difference between a case and a claim.

When you start mixing B and E into that and you've got a combination of B and E statistics the unique individual employee number becomes relevant because then you're trying to say, or unique individual, I think it says employee unique individual.

I don't have it front of me. But that becomes how many people, I think it's paid I think is under, that asterisk is under paid but I would have to double check, have been paid on a unique individual worker.

So the unique individual worker we've got descriptions on the website. I would rather quote that and come back to you with it then try to explain that. But I can very clearly describe case and claim for you.

CHAIR MARKOWITZ: But so does that mean a person can be multiple cases? That's what it looks like. Maybe it's in a B versus E, a different case.

MS. LEITON: B and E is where that duplication comes from.

CHAIR MARKOWITZ: Okay. The other information on the website is the amount of money paid out and it's cumulative over the life of the program.

And I couldn't find, maybe it's there if you could point me or if you could provide

this information is over the last three or four years the annual numbers of cases, claims, perhaps individuals and the annual payout under, I guess mostly under E but B to the extent that it's relevant to this Board.

And the reason I ask is just so we get a sense of the dynamics of the program, sort of the recent history, the evolution of activity of the program.

MS. LEITON: Sure. There are annual reports to Congress which contain that information when we gather it. We're currently in the process of updating that. So I can provide you with what we have.

CHAIR MARKOWITZ: Okay, great. Thanks. I have a follow up question and we're going to break in a minute.

But on, going back say when a new Special Exposure Cohort comes along or the case of to the extent to which any of our recommendations were accepted and you need to retrospectively go back and reopen cases, does

your data system allow you to do that effectively because I would think that's challenging?

MS. LEITON: Well for SECs we've been doing it for a long time and so there's very specific criteria. NIOSH also has information. Oftentimes if we've sent a case to NIOSH and it got denied or it was PoC that was less than 50 percent they will help us with the list.

We have a list and we can track those. And we pull cases that have been denied at certain sites. Oftentimes we, sometimes we can break it down into periods of time, sometimes we can't.

But we will pull any case that could possibly be related to the SEC for your, for the presumptions we are currently pulling that list it's a little bit more complicated because they could be at any site.

But if we can pull it by condition. So for the asbestos presumptions that you guys recommended we're pulling cases for asbestos that had been denied and we can do that.

So it depends on the presumption. It depends on the circumstances. Our data isn't perfect by any means. But we can pull information out to reevaluate some things. Other things are more complicated.

CHAIR MARKOWITZ: So then you can search by diagnosis?

MS. LEITON: Yes.

CHAIR MARKOWITZ: Okay. Any other questions because we're due for a break now? Okay, thank you very much.

MS. LEITON: Thank you.

CHAIR MARKOWITZ: We'll reconvene at 10:30.

(Whereupon, the above-entitled matter went off the record at 10:21 a.m. and resumed at 10:42 a.m.)

CHAIR MARKOWITZ: I would like to welcome Zachary Mancher, the ethics counsel.

MR. MANCHER: Thank you. So welcome, everybody to this committee. I'm Zach Mancher. I'm one of the ethics attorneys here at the Department.

And I'm going to talk to you guys for the next half hour or so about the ethics rules as they apply to each of you as an SGE or a special government employee. And likely you are going to be serving under 60 days in the calendar year.

And so the way that it works for SGEs is that there are different rules depending on how often you are here, depending on how much you serve in the year.

And so there's a bar of 60 days that basically says if you're under that 60 days the rules don't apply to you as much as somebody who is serving more than 60 days in a year or somebody who is a full employee serving, you know, kind of the full year.

CHAIR MARKOWITZ: We'll try to keep to the 60 day limit.

MR. MANCHER: Sure. So I'm sure you're all glad to hear that, that you won't have to work on it that much. So just on Page 2 you should all have this packet, Ethics for SGEs.

Hopefully everybody received this packet as part of their materials. Just a couple things I want to point out on this page.

So every agency has what's known as a designated agency ethics official or DEAO and an alternate designated agency ethics official or ADEAO. And these are the two people who by law are responsible for the Ethics Program at the Department.

And so here Kate O'Scannlain, the solicitor of labor is the DEAO and Peter Constantine who is the associate solicitor for legal counsel which is the head of my office, is the ADEAO. And so their contact info is here.

In addition, Rob Sadler the counsel for ethics and myself, our contact info is here as well. That is all of the ethics attorneys we have here at the Department so you have all of our contact information.

In this presentation what we want to do is make you familiar with the rules. You don't need to know the ins and outs of every

rule. We need to, we just need you to be aware of the types of things that you should come ask us.

If you lose our contact information you can contact Carrie and Carrie can get in touch with us. She's your general contact person so she's somebody who can certainly get you in touch with the right people and can help get your questions answered should you have them.

If you have any questions kind of throughout the presentation feel free to ask. That's what we're here for.

If you have questions that you don't want to ask in the kind of public setting but, you know, it deals with a particular conflict that you may have you can ask me afterwards or send me an email or call me and again, that's what we're here for is to, we're really here to help keep you out of trouble.

We're not the got you people. We are here to help make sure that you follow the rules and we're here to help make sure that this

committee is following the rules and that the actions that this committee takes cannot be questioned based off of appearances of any optics issues or any other ethics issues because that is something that often comes up is that people who don't like an agency action will use ethics as a way to try and prevent the agency from taking that action.

And so really what we want to do is protect the Committee and protect the Department's actions by making sure that everything you do is above board and everything that you do really is very clearly within the rules and following the ethics rules.

So with that I'm going to move on to the actual rules. The first rule which is kind of the main ethics statute, I would say, is the financial conflict of interest rule.

And this is a criminal statute, so very important. And this rule says that you may not participate as a government official on a matter that will have a direct and predictable

impact or effect on your financial interests or those that are imputed to you.

So your financial interests could be stock holdings or other financial holdings that you have. They could be your job. They could be other types of contractual relationships you have.

And also, like I said, those that are imputed to you. There are some people that are so closely related to you that their interests count as your own.

And those would be your spouse, your minor children, if you are a part of a general partnership your general partner, your employers if you serve as an officer or director or trustee or employee the business.

And there was one other I think. If you are a director or a board member, you have some fiduciary responsibility to some sort of outside organization that organization's interests count as your own.

So you are in general not allowed to

work on things that affect, that will have a direct and predictable impact on the financial interests of those outside things.

This committee is likely not going to get into the types of specific, certainly not party matters but even specific matters that would really have a direct and predictable impact all that often.

If it does, however, these are the things that we are looking for. There are, however, a number of exceptions that will be helpful here.

First, holdings that are in a broadly diversified mutual fund. A broadly diversified mutual fund, those do not create a conflict of interest.

So if something is in an S&P 500 fund or it's in a large cap fund or something like that, it's broadly diversified across a number of sectors those things will not create financial conflicts for you.

So the fact that you're invested in a

mutual fund that has holdings in a particular company and that company could be affected by the work you do, that's not going to create an issue for you.

Similarly, for sector mutual funds as long as your holdings and the holdings that are imputed to you, so your spouse and minor children's holdings, add up to less than $50,000 within that sector or within, if it's a regional fund that focuses on particular state.

So let's say there's a fund that focuses on companies based in Indiana. As long as there's less than $50,000 total in holdings in that sector then you're fine and you don't need to worry about any conflicts created by that particular holding.

In terms of specific party matters, you are allowed to have stock holdings up to $15,000 without it creating a conflict. And in terms of policy matters it can be up to $25,000 without creating a conflict under this rule.

That being said, you never want to act

on matters that are, if you have holdings that are close to those limits because stock prices change and, you know, in the morning you might have $24,000 of stock and you act on a matter and that night you go and see that you now have $26,000 because the price went up.

So if you are in a situation where you need to act on a matter and it, you think it could affect the company you should ask us and say, you know, I have "x" amount of stock, right, and we may tell you, you know, either don't act on it or you should, you know, get rid of that stock or sell some of it in order to stay below the limit and make sure that you're not coming in conflict with that rule.

MEMBER BERENJI: I have a question. How do you guys come up with these limits, like these dollar amounts?

MR. MANCHER: So these limits are either, some of them are statutory and some of them are created by the Office of Government Ethics which puts in the, the Office of

Government Ethics creates the federal regulations that implement the statutes.

MEMBER BERENJI: So is this like updated yearly, biannually?

MR. MANCHER: So these are government-wide and some of the numbers are updated yearly. Some of the numbers only change whenever the Office of Government Ethics redoes their regulations which can range in time.

So some of the numbers are updated yearly. Some of them are more set. One word of advice on this, this rule is not a way to get out of work.

My supervisor used to work at the Department of Commerce and under the Department of Commerce they have the Patent and Trademark Office. And there was an employee there who didn't like working on a particular type of patent application.

And so any time he saw one of those patent applications come in he would go out and buy $15,000 worth of stock in the company. If

his boss assigned it to him he would say, sorry, I'm not allowed to work on this.

I have a conflict and then they would assign it to somebody else. He would go sell that stock and then wait to see if another one came in and then they quickly picked up on this pattern, as you might imagine, and he lost his job and was prosecuted.

Like I said, this is a criminal statute. So I don't imagine anybody here was planning on doing anything like that. But just in case you were, not a good idea.

Does anybody have any questions on financial conflicts of interest?

CHAIR MARKOWITZ: Why was he prosecuted? He declared his conflict.

MR. MANCHER: Because he was prosecuted because there is a rule under the statute that actually says basically that you cannot purposefully create conflicts in order to get out of this rule.

MEMBER CASSANO: This was a paid

employee?

MR. MANCHER: Yes, yes. So moving on, on Page 4 now we're on the appearance of bias. So where the previous rule talked about conflicts it was talking about financial conflicts this rule is kind of the corollary but talking about relationships.

So this rule says that you may not work on a, may not participate on a matter involving specific parties if you have a covered relationship. And kind of the hypothetical person, the hypothetical reasonable person with knowledge of the relevant information would question your impartiality in the matter.

And so there are some people that are specifically covered, that the rule specifically mentions. Close family members, your employer, anybody with whom you have a close business or financial relationship and this includes clients.

So anybody beyond kind of routine consumer transactions. So if you're an attorney kind of clients, things like that. It also, like

I said, has that catch all of reasonable person test.

And so under that we generally say that close friends are covered by this rule. So they're not specifically mentioned. But the catch all says if a reasonable person would think that you couldn't be impartial in the matter.

So it's not whether you think you could be impartial. It's whether this kind of reasonable person. And we really use kind of a reasonable reporter test.

So if the Washington Post or Fox News or CNN or anybody else was to get a hold of kind of, you know, what you were working on and who it was affecting would they be able to write a story that would make it into the paper that would make it on TV that would be the, you know, talk of the day kind of a thing.

And so really, so this is not going to cover, you know, somebody who you had a class with in college and haven't heard from since. But it would cover somebody who, you know, you

see at the holidays every year or you go out to dinner with every couple of months, you know, a close friend.

Maybe somebody who is in your wedding party or something like that and now you're working on something that affects them. That's going to be somebody who would be covered by this rule.

Additionally, there's a special rule for former employers. For one year generally or two years if you received, basically if you received some sort of severance payment.

There are rules for severance payments and some severance payments create an additional two year recusal period. Basically some people leave jobs on good terms. Some people leave jobs on really bad terms.

And either way there's a potential for bias against, either in favor of or against that former employer. And so in order to avoid that we have this one or two year cooling off period depending on some of the situations.

And so any work involving anybody you did work for in that previous one to two years come ask us to see whether it would be something that you could work on. Does anybody have any questions on this rule?

All right, moving on, non-government activities. So first general rule regarding non-federal employment, for you this is not going to be an issue.

You are allowed to keep your outside jobs which is really good because if you're not getting paid here we want to make sure, you know, you can still get paid elsewhere. Again, the only thing is making sure that you're not purposefully creating a conflict.

For all of you your financial conflicts have been checked and your outside jobs have been checked ahead of time. And so I know Carrie has worked with our office to make sure that the outside job you have will not create a conflict with this position.

So there's not generally something

that you need to worry about there. Outside speaking and writing. This is somewhere where there's a potential for an issue in that you cannot receive pay for outside speaking or writing that is related to your official duties.

Now for you as special government employees that rule is somewhat limited versus what it would be for a normal employee. So this covers things that you are asked to do kind of because you are on this committee, because of your government service.

So you cannot be paid to speak if they are inviting you there as a member of this committee, the invitation was extended because of your government position or it was extended to you by somebody whose work, you know, whose interests are, you know, very closely affected by your service here and it could be somewhere where they are trying to curry some favor with you based off of your work here or if it, the information that they want you to speak or write about is based off of non-public information that

you have gathered based off of your service here.

We will get into that a little bit later on. But clearly non-public information you cannot then go around sharing for your personal gain.

Additionally, so something, there's a rule that says that the general subject matter is covered by the area of the operations of your agency.

For you as special government employees that rule is narrowed to really the types of, you cannot be paid for speaking on matters that are assigned to you as part of this committee. So it's, you can't go out and speak for pay on things that are assigned to you here.

So it's really things that affect your duties here. And that applies to both speaking and writing.

There's a somewhat separate rule for teaching that says that you may accept compensation for teaching even if it relates to your official duties as long as it is part of an

accredited, it's part of the regular curriculum at an accredited institution or training program of some kind and you speak on multiple, the teaching is on multiple occasions.

So this is really what separates speaking from teaching. So going in as a guest lecturer in somebody else's class is considered kind of speaking and you couldn't be paid for that.

But going and teaching a multiple part course, that's considered teaching and that falls within this exception for teaching. Are there any rules, are there any questions on that rule? Yes.

MEMBER REDLICH: I apologize. As an occupational lung specialist, I mean I do see patients from all over the country. People have asked me would I be willing to evaluate one of the workers who, you know, has applied for benefits. I have declined in the past.

MR. MANCHER: So I might need to think about this a little bit. But so these rules were

really about, I guess about the outside activity rule.

I'm not sure. That may apply, have something to do with the special rule for this committee and I can get back to you afterwards about this. I can follow up afterwards.

But in general that wouldn't be an issue. I do know that this committee has a special rule that may affect working on particular matters on the outside involving people applying for benefits under this program.

So I can get back to you about that. But in general the kind of overarching ethics rules would not prevent you from working on those individual matters on the outside.

The next part of the outside activities rule is political activities. So under the Hatch Act you are covered by the Hatch Act which limits the political activities by federal employees.

So you are covered by it while you are serving here. So on the days that you are a

federal government employee you may not participate in partisan political activity.

And this, partisan political activity is anything aimed at supporting or opposing a current political candidate, a current political party or a political organization. So this is not issues. This is not legislation or a specific bill.

It is not some referendum that happens to be in your home state or locality. It is really limited to current partisan political candidates, parties or organizations that support parties or candidates.

With the election having just passed there are far, far fewer current candidates right now. That being said, the President, the Office of Special Counsel who enforces this rule has said that the President has officially become a candidate for 2020.

So things in support or in opposition to the President's reelection would count as violations under the Hatch Act. So you may not

engage in political activity during government hours or while you are on government premises.

So this would involve, this could obviously involve speaking in favor of or against a candidate. It could also involve wearing a pin.

We have had this issue in the past with Members of FACA committees who have come in wearing material in favor of or against certain political candidates or parties. So we ask that you do not do that.

It would involve kind of having a sign or putting things up in your, I don't think you have government offices so that's not going to create an issue. But in general that's the type of thing that this would prevent.

You are not prevented from running from government office which is something that full government employees kind of, every day government employees are prevented from doing. You also may not solicit or accept political contributions on days that you are here as a

government employee.

But unlike full government employees you are allowed to do that on other days because you serve on an intermittent basis. Does anybody have any questions on political activities?

All right. Services as an expert witness. So this rule does not generally, does not apply to you the same way as it does for people who serve more than 60 days.

But you may not serve as, but it still does apply somewhat to you. You may not serve as an expert witness in any proceeding before a federal court or agency if the Department of Labor is a party or has a direct and substantial interest in the case or in the matter unless you, and it affects the work that you do here.

So if you are asked to serve as an expert witness in a case you should come check with us ahead of time to make sure. We can kind of go over the rules with you about that. Is there a question, yes?

MEMBER CASSANO: Yes, does that

include deposition and attorney work product for cases?

MR. MANCHER: Yes. And so come check with us. We can kind of go over the rules. The rule applies differently to employees who are under that 60 day threshold much more narrowly.

So it likely will not create an issue unless it's something that's affected by this committee. But certainly you can send us questions and we can go over, you know, certainly a specific individual case or the, and then kind of the more general what cases that would affect.

MEMBER MIKULSKI: Does that also affect FAB hearings?

MR. MANCHER: Sorry, what was that?

MEMBER MIKULSKI: Final Adjudication Branch.

MR. MANCHER: If they are before a federal agency, yes. State agencies or local, you know, state or local government agencies are not affected by this rule. But federal agency hearings could be, yes.

MEMBER FRIEDMAN-JIMENEZ: If I may?

MR. MANCHER: Sure.

MEMBER FRIEDMAN-JIMENEZ: George Friedman-Jimenez, another related question. Would this include a workers' compensation deposition for one of my own patients who is a federal employee, federal workers' comp?

MR. MANCHER: Sorry, could you repeat the question?

MEMBER FRIEDMAN-JIMENEZ: Would this include a workers' compensation deposition for one of my own patients who is a federal employee with federal workers' compensation?

MR. MANCHER: It could. Again, I would need to go to take a look at the specifics for individual cases for you. And I can certainly do that.

But, yes, if you are serving as an expert witness and it's a federal court or agency it could be affected by this rule. I'm just going to make a note that I'm going to follow up on the expert witness rule.

MEMBER FRIEDMAN-JIMENEZ: So a treating physician is considered an expert witness then?

MR. MANCHER: It depends. It really depends kind of in the case. Often treating physicians sometimes are treated as fact witnesses.

But sometimes if they are providing expert testimony as well they could be considered expert witnesses in some cases. But I can certainly follow up with you on that.

MEMBER FRIEDMAN-JIMENEZ: Thank you.

MR. MANCHER: And I can send some follow up information on this to Carrie to be sent out afterwards to the entire committee. Yes.

MEMBER SILVER: I'm not a physician. But in defense of some of the activities of the physicians on this Board I think of ethics as balancing goods against each other.

And I think back to maybe the second edition of Industrial Toxicology edited by Dr.

Harriet Hardy who was one of the first doctors to stand up for workers in the atomic industry. The last chapter is all about the ethical duties of physicians to participate in the workers' comp process.

So as you look at these issues please keep that in mind. They don't get paid a great deal of money when they're involved in the process. They do it for ethical reasons.

And it would really be a shame if their service on this committee were to interfere with their follow through.

MR. MANCHER: Certainly. And we certainly take the approach of trying to figure out, you know, we are not here to say, no. We don't like to say, no.

We are here to try and find legal ways that protect the Department and that protect the individuals to keep you out of trouble. But if it is possible under the rule we certainly don't kind of, we don't say, no, just to say, no.

Some of these rules, you know, like I

said are criminal statutes and so we don't want to put people at risk of violating criminal statutes. But in general we will search for ways to do things if there is such a way.

Moving on, next we just want to cover lobbying the federal government. This likely will not affect you very much. But essentially Congress created a rule where they said that they did not want the money that they spent to come back to annoy them.

And so basically there's a rule against the federal government spending any money on the encouragement of grass roots lobbying. So the Department has ways of contacting Congress, has formal processes of contacting Congress if the Department wants specific statutory changes of some kind or specific legislation of any kind.

But what the Department is prohibited from doing is asking the public to go contact their Congressman, go contact their Senator, go contact their State Representatives about, you know, in order to change a specific law or how to

vote on a specific law.

So again, if the Committee decides or Committee Members want to, you know, think that there is some sort of legislative fix that needs to happen in some area there are official ways to do that.

And what we need to avoid is basically something where we are telling the public to go contact their Congressman. A question that I often get on this is sometimes members of the public will ask a question at some sort of public hearing where they will say, you know, why don't you make "x" change that would be beneficial.

And the answer to that is that it would have to be a legislative change. And so what we have said is allowed is the civics lesson is allowed.

So you can say, you know, that is the type of thing that, you know, we don't have the authority to make that change. That type of change would need to be made through legislation.

But what you can't do is kind of the

follow up of so then, so you should contact your legislator or you should contact your Senator or something like that.

As long as you limit yourself to the civics lesson of that would need to be a legislative change then you're not going to kind of come in conflict with that rule. Are there any questions there?

CHAIR MARKOWITZ: I have a question. So I don't think, I would doubt anybody here lobbies the federal government. But if some of us are involved with the Former Worker Program DOE and some Congressional representatives are very interested in that program.

And sometimes there is some interaction, not that frequent. If they were to ask an additional question about the compensation program or the activities of this Board that's not, that kind of interaction is not prohibited.

We're not representing anyone. We're expressing our own opinion.

MR. MANCHER: Right. So you're

talking about not kind of federally registered lobbying.

CHAIR MARKOWITZ: Correct.

MR. MANCHER: There is not an issue with that. You are not allowed to represent anyone before a federal agency or court in a matter, in a specific party matter that you personally worked on.

But again, because you are not working on specific party matters here that's not going to create any issue for you. So if this committee was looking at individual cases and was making some sort of decisions on individual cases you couldn't then go on the outside and represent a client in that particular case.

But because this committee is not taking those types of actions and acting in those types of cases there's not an issue there. Are there any other questions there?

All right. So the next section, bribes, gifts, salary supplementation. These are a few rules that are somewhat interrelated. And

I'm going to draw some of the distinctions between bribes and gifts and salary supplementations.

Bribes are a no. They're not allowed, you might imagine. This is the simple quid pro quo. You know, if you take this action I will give you "x" amount of money.

I think we all know this is wrong and that you should report this immediately if somebody offers this to you. I don't think we need to spend any more time on bribes then that.

Salary supplementation is where somebody else is paying you for your government service. So it's not that they are specifically saying take this action.

But they are saying, you know, we like that you serve on this so we want to give you some sort of pay or it could be like we talked about earlier they are paying you to speak in, when you are also being, you know, also speaking in your government capacity.

So generally you cannot be paid by

the, by anybody outside for your service here. There is, however, an exception for SGEs that allows your regular employer to continue to pay you on the days that you are here. And so that is not going to create an issue.

Gifts, gifts is actually where we get most of our questions in general. The gift rules should not likely affect you all that much.

The general, however, so the general gift rule is that you may not accept a gift that is either because of your official position or from anybody whose interests could be affected by the work of your Agency.

Unfortunately here at the Department of Labor that's just about everybody because we regulate all employers, employees, potential employers, retirees. So pretty much everybody is covered.

That being said, there are a lot of exceptions and those exceptions will cover really all of the general, all the places that you would expect to receive gifts. So generally if you get

a gift and you think there's nothing kind of ethically wrong with it you can ask us and there will generally be an exception.

So the types of gifts, gifts can cover anything of value. So they can be physical items. They could be meals. They could be paying for services. It could be a cab ride. It could be tickets to a show or an event or a sporting event or something like that.

It could be a discount. A discount counts as a gift. But there are several, like I said, several exceptions. And I'm just going to go through a few of the exceptions and these are places that you would generally see.

So gifts of $20 or less as long as it's less than $50 from the same source over a calendar year. So $20 on a single occasion, $50 over the calendar year from that source are okay.

So gifts that are available to the general public. So, you know, your $10 coupon at Bed Bath and Beyond or some sort of event, you know, promo at a restaurant or something like

that, that's available to everybody that you don't need to worry about.

And you don't need to worry about going over that $50 in the year for something like that. If it's available to the general public, not going to be an issue.

So gifts based on a personal relationship. So earlier we talked about the appearance of bias rule. We talked about kind of your family and, close family and friends.

Gifts from your close family and friends are going to be okay. Like we said earlier, you shouldn't be working on things that affect them so it's okay to accept gifts from them.

But if somebody is reaching out to you, you know, is offering you a gift who has never offered you a gift before and, you know, now that you are on this committee they are offering you a gift you might want to think are they really offering this gift because they're a longstanding friend of mine or are they offering

this gift to me because I am now on this committee.

Right, so this is separated from bribes because it's not I'm asking you to take a specific act. This is I'm trying to curry favor with you so if something comes up in the future that you might be able to affect in my benefit you might think, you know, you might fall on my side a little bit more.

That's the type of thing that we're trying to prevent with this gift rule. So we really want to look at gifts from people who, you know, generally were not giving you gifts before and now that you're on this committee are offering you gifts now.

Free attendance at meals at an event where you are officially presenting, so you're presenting something on behalf of the government, you are speaking you can accept free attendance on that day and any meals that go with that. If you are presenting or speaking on behalf of the Department you need to get that approved from the

Department.

Similarly, there's an exception that allows you to accept free attendance at widely attended gatherings.

However, widely attended gatherings there must be a diversity of views there and there must be an Agency determination which I assume would come from Carrie, an Agency determination that your, that basically your attendance at that event is in the Agency's interest and that interest outweighs kind of your personal, outweighs the kind of ethical or optical concerns created by accepting that.

Items of little intrinsic value again are fine, cards, plaques, trophies, things like that are not going to create an issue. Any meals, lodging, transportation or other things that are offered to you because of your outside business because of the work that you do on the outside or your spouse's outside business are going to be fine.

So those types of things you don't

need to worry about. And those are really the exceptions that are going to be covered by the gift rules as they apply to you.

One thing, the optics. So this is something that we had long advised and then was actually put into the rules in the last, the last time that they updated these rules a couple of years ago which is basically there's now a part of the rule that says even if a gift is acceptable under an exception, so even if a gift fits an exception and therefore would be legal under the law if the optics of the situation weigh against accepting the gift you should not accept it.

I don't foresee that happening in any case with your committee. This generally would happen in the case of employees who again can kind of affect the work, can affect the financial interests of specific parties.

But we've had this come up with, you know, attorneys who are in an office even if they are not working on a particular case. But let's

say an attorney is in an office that is in litigation in a big case and they have a friend, a longtime friend who works for, who is the opposing counsel or works for the firm that is the opposing counsel.

That friend says, hey, you know, my firm had two extra tickets to tonight's Wizard's game, you know, in our company box, in our firm box. Do you want to come with me?

This is the type of thing that generally would be acceptable under the personal relationships gift exception. That being said, while they are in litigation against this firm it could look really bad for this attorney to be seen in the box of the opposing counsel, you know, in the opposing counsel's box at the Wizard's game.

Even though it was a gift from the friend that's something where we might say, you know, given the totality of the circumstances the optics weigh against it. We've had some situations also like this with some of our PAS or

Presidential-Appointee Senate-Confirmed employees officials.

So these are kind of the highest ranking officials here at the Department who are our public faces. And so sometimes we've told them not to accept gifts or offers to attend certain events because they will be around and, you know, could be photographed or otherwise seen around people who have matters before the Agency that could be affected by their work.

And so that's the type of thing. So if you think the optics of accepting a gift might be problematic that might be something where you want to check with us ahead of time even though technically under the rule there is not an issue there. Are there any questions on the gift rule?

All right. Next, misuse of government resources or government position. So the general rule here is you may not use your government position or any of the government resources for anything other than authorized government activities.

So I'm not sure how much access you have to government computers or government IT resources, copiers, printers, et cetera here. But if you do those are to be used for the purposes of this committee.

They are not to be used kind of for your personal services. The one place we have seen an issue with this is in terms of staff. So there are Department of Labor staff who are here to help you with your service on this committee.

They are not here to do personal errands for you. They are not here to do your personal work for you or kind of help you in any ways outside of the business of this committee.

They are here, they can set up the logistics as far as those logistics affect the work of this committee. But beyond that they are not here to kind of serve you personally. And that is something that we have seen as a problem in the past.

Additionally, you may not use your title as a member of this committee to serve you

personally or your connection to the Department to serve you personally. Another fun story that we've had.

We once had a -- a few years ago an employee in the Wage and Hour Division here at Labor whose dog ran away and so the employee put something on social media saying, you know, my dog ran away. If anybody sees my dog please contact me here.

And a local business owner happened to find the dog and sent this employee a message over the social media, you know, saying I found your dog. You know, seemed like everything was going well.

For whatever reason it didn't, it then went downhill and there was an argument about when the dog was being returned. I think there was something about the business owner wasn't sure about the proper treatment of the dog.

Whatever it was it went downhill and then the employee sent in public over this social media something saying I am a Wage and Hour

employee and if you do not return my dog to me by "x" date I will bring an investigation against your company.

Clearly this was not allowed. Clearly this employee lost their job and, you know, faced disciplinary action and lost their job because of this action.

Do not hold yourself out as a Department of Labor employee or as a Department of Labor official or as having the ability to act on behalf of the Department in any way other than what this committee gives you.

You cannot hold yourself out as a member of the Department. You should not be kind of putting it on business cards.

You should not be, when you speak at an event if you are speaking at some sort of event that is not related to your service here, you're not speaking officially, it can be included as part of your bio. But it should not be, you know, the thing on your name tag or your main introduction.

You should not be, you know, Department of Labor, FACA Committee Member or Chair or something like that as kind of your position. You shouldn't be, if you were on the board of an outside organization on the website it shouldn't refer to you as representing the Department of Labor or this committee on that board.

Again, it can be mentioned as part of a written bio. But it may hold no more weight than any other biographical information.

Other misuse of government resources, and I mentioned this earlier, non-public information. You may be privy to non-public information that the Department has in order to assist you with your service here.

You may not then go and use that non-public information for your personal benefit whether it is through financial transactions, but for yourself or by telling other people to make financial transactions that you know would be beneficial based on this non-public information.

You may not go, you know, in some way sell that information or sell your access to that information by, you know, some sort of consultancy where you say, you know, I can assist you based off of this information that I know.

Non-public information as long as it is non-public must be kept secret. Are there any questions on that?

Okay, post-employment restrictions. These won't affect you all that much again, with you not serving in, with you not working on specific party matters. I do want to talk about here a little bit about seeking employment that I didn't talk about earlier.

So the financial conflict of interest rule while it covers your current employer it also, if any of you are, you know, for whatever reason seeking new employment either instead of or in addition to the jobs that you currently hold, if you reach out to a potential employer or a potential employer reaches out to you the ethics rules count that employer, count seeking

an employer that you are seeking employment with the same way as they count a current employer.

So you could not work on something that would affect the financial interests, that would have a direct and predictable impact on the financial interests of that outside employer or that potential future employer the same way that you can't work on something that would affect your current employer.

And so this is if somebody reaches out to you or you reach out to somebody, you know, anything more than kind of asking for an application. So if you send them a resume, you apply for the job, you reach out to them about a potential job there.

It does not cover, you know, networking or informational interview type things. So if you reach out to somebody to have really an informational interview to ask them about their field or about their line of work or about the types of things their company does or, you know, but you're not really looking at a

position at that particular company, something like that, that won't create a conflict of interest for you.

But if it really is like I am looking for a job at your company, what is available, that would create a conflict. And that conflict runs that, that recusal would run until either they say they are not, you know, the company says they are not interested in you or you say I am not interested in working for your company or I think 60 days pass.

So if you send in an application and you don't hear back for 60 days you then can consider it to be the company is saying, no. If the company then later gets back to you and brings you in the recusal period starts up again. Are there any questions on this? Yes.

MEMBER CASSANO: Actually, yes. I'm a private consultant. And so if I were to leave the Board or not get renewed obviously if somebody asks me now to write a medical opinion for somebody in this program I say, no, thank

you. I can't do that.

How long am I barred from doing that after I would be off the Board?

MR. MANCHER: So you would not actually be.

MEMBER CASSANO: I would not be, thank you.

MR. MANCHER: So the rule basically says that you cannot represent somebody back to the government on a specific party matter that you worked on here.

Again, as you guys, you are not working on specific party matters here there aren't going to be then restrictions that prevent you from coming back because there aren't specific party matters that you're working on here.

It's again, it's preventing the side switching on those specific matters. It's not preventing you from coming back on future matters that are similar.

It's really about the same specific

matters that you were making decisions on here. Are there any questions on that?

So that is the end of my presentation. That is the ethics rules as they apply to you. I expect I will be following up with some more information on the expert witness question.

If there are any other questions that people have you can either, you know, let me know now so I can kind of go back and follow up. Other than that, if you have any questions about your personal participation in any particular matters or in any instances or situations either officially or personally and you think it might be affected by some of these rules feel free to reach out to me.

If you can't find this packet reach out to Carrie and Carrie can put you in touch with me. Are there any questions?

CHAIR MARKOWITZ: Did he get his dog back?

MR. MANCHER: I'm not sure. That happened, that story happened shortly before I

came on board here.

CHAIR MARKOWITZ: Thank you so much. So we're a little bit ahead of schedule. I think we should probably break for lunch instead of starting into the statutory areas for the Board. So it's 11:30 now. Let's return at quarter of one, thank you.

(Whereupon, the above-entitled matter went off the record at 11:30 a.m. and resumed at 12:57 p.m.)

CHAIR MARKOWITZ: Okay, we are reconvening.

There has been some attention paid to the temperature of the room. We don't know how effective it is, but at least there's being attention paid.

George, you want to introduce yourself?

Give Dr. Friedman-Jimenez -- yes, good.

MEMBER FRIEDMAN-JIMENEZ: Hi, yes, I'm George Friedman-Jimenez. I'm an occupational medicine physician and an epidemiologist at

Bellevue NYU Occupational and Environmental Medicine Clinic in New York City.

This is my second term as a Board member. And, welcome, everybody.

CHAIR MARKOWITZ: So, you know, when you have questions, just feel free to break in, we'll hear you.

Also, I'd like to welcome Greg Lewis here from the Department of Energy. Greg, you want to just introduce yourself briefly?

MEMBER LEWIS: Sure, I'm Greg Lewis, Director of the Office of Worker Screening and Compensation Support for DOE. So, we provide a reference to DOL and NIOSH as they complete trying to reconstruct dose.

And, we also support Dr. Walker in the training program. So, if you all have any questions about how we provide records, what we do out on the sites, I'd be happy to help you out.

CHAIR MARKOWITZ: Okay, great. Thank you.

Okay, so, Ms. Leiton?

MS. LEITON: Okay, I hope everyone found lunch and, hopefully, the room will warm up a little bit.

So, I'm just going to cover a little bit about the four areas that the Board has been tasked to review and provide recommendations on.

Tom went into it a little bit earlier, but I'm going to go into it in a little bit more detail.

Some of this will be repetitive for you because, those of you who have already been on the Board, we did this the first time. But, so I won't probably go as lengthy as we did the first time.

The four areas are the Site Exposure Matrices of the Department of Labor, medical guidance for claims examiners for claims under this subtitle with respect to the weighing of the medical evidence of claimants, evidentiary requirements for claims under Subtitle B related to lung disease and the work of industrial

hygienists and staff physicians and consulting physicians of the Department and reports of such hygienists and physicians to ensure quality, objectivity, and consistency.

So, I'm going to go into each one of those individually.

The site exposure matrices, I'm not going to go into a lot of detail only because John Vance is going to give a 45 minute discussion about that tomorrow. So, I'm going to just kind of give a brief overview of the SEM itself and he'll go into further detail tomorrow.

CHAIR MARKOWITZ: Will there be a demonstration of the SEM also, John?

MS. LEITON: We can, yes.

CHAIR MARKOWITZ: Great, great.

MS. LEITON: Okay, so the SEM was created in 2005 as a tool to help claims staff, our claims examiners research toxic substance data relating to employees working at DOE facilities.

And, the reason we found it necessary

and appropriate to do that is to create this database was because simply employees and especially survivors don't always know what they were exposed to in the workplace.

So, we wanted to give some sort of a tool that would help our claims staff and the claimants at the end of the day determine what possibilities were out there in terms of exposures at these facilities.

And, you know, a lot of the time, without it, we might have found that we had to deny because we didn't have enough information.

So, this is an inter-relational database. It contains a large data set relating to evidence that a substance was present or used in operations at a facility.

It doesn't provide temporal data on the use of toxic substances. In other words, the use of toxic substances at different times, it doesn't have dates in it.

It does have filtering capabilities that allow for searches based on different

variables including health effect, facility, work process, labor category, building area and incident data.

This database is more useful, depending on how you search it and what data -- the strength of the search results depend on how the evidence, how strong the evidence we have is, if there's information that goes to the building level, there's information that goes to the labor category, that sort of thing in the claims file itself we'll use that to research information on these.

We don't use SEM as a decision tool. It is something that is used to help in the development of a claim. It doesn't provide us with extensive exposure, the amount of exposure, but it can provide as a guidepost to use to further develop the claim.

When we're looking at this information on a claim-specific basis, the SEM isn't going to provide us with individual information about employees, it will provide us with general

information. When we get to specifics, we refer it to an industrial hygienist.

The contractor for this SEM who developed it is called Paragon Technical Services. They have been working on this project for a long time, since it was -- since the beginning of it in 2005.

The staff members have extensive experience working at DOE facilities. They have Q clearances. They consist of an engineer, chemist, industrial hygienist and operations management.

Keith Stalnaker, you have -- we may have mentioned him the past, but he's the program manager for this.

He worked for 32 years in DOE facilities at Portsmouth, Oak Ridge, and Paducah.

He's a registered professional engineer, certified safety professional. More of his CV is online and I think we've provided it in the past.

In terms of data collection, it's an

ongoing process. There is so much information out there and we have a contract, but we don't have an unlimited amount of resources to do this research.

But, at the very beginning, what Paragon did was they held 53 worker roundtable meetings at 37 different DOE facilities, met with about 950 workers requesting input on the SEM in terms of toxins, work processes, labor categories and suggestions for document research.

Since that time, Paragon continues to research documents, look for additional information that they can put in terms of toxic substances, alias for toxic substances, labor categories and aliases for labor categories.

They work with Department of Energy. They've been able to go to various Department of Energy sites, look through literally boxes of records to find what they can in terms of toxic substance exposures, buildings, labor categories, all of those different types of information that may be available.

As of September of this year, 16,400 toxic substances used at 128 DOE sites are in the system. We've got about 4,000 additional RECA sites, they're looking at trade name substances and again, some aliases to those.

Recently, we have looked at the CEDR, the DOE Comprehensive Epidemiological Data Resource, taking out of that what we can or what they can to put into the SEM.

There's been a lot of gap analysis, so, you know, initial research was done in 2005, 2008. We're going back to facilities or going back to DOE to try to obtain more information.

In the last year, we've been looking at Pantex, Kansas City plant, Portsmouth, Battelle, LANL and been able to add information. Again, sometimes, it's just labor category information, sometimes it's more toxic substances.

Another area that we do obtain information is through the SEM mailbox. We've received information from advocates about various

facilities that we've been able to use in the database.

Sometimes, we get information from the document acquisition requests that go into case files. So, if claims examiners find information that may be helpful or useful in the SEM database, they'll forward it to Paragon for their use or research.

There is a SEM library that contains the references that have been used in the database.

In addition to the toxic effects in the labor category aliases and that sort of thing, there is also health effect data and that is based on HAZMAP, which is -- it's a database that was put together by Dr. Jay Brown based on peer reviewed epidemiological data establishing a causal relationship between a toxic material and a diagnosed illness, for example, asbestos causes asbestosis.

The one thing about his database, and we use it in the SEM and we use it as a

reference, is that it's on causation. It does not take into consideration contribution, aggravation, those sorts of things.

So, if it's in the database, there's a lot of the research is based on IARC and, you know, even the use of the NIOSH pocket guide, various other resources, peer reviewed literature, that goes through the National Library of Medicine who will then publish it.

Once it is published, we use it for our SEM database.

Outside of the SEM, the HAZMAP, we have developed our own presumptions of sorts, either a presumption of exposure or presumption of causation.

But those are outside of this database which is solely really causation.

So, in the adjudication of claims, what a claims examiner will do is go to, in the course of development of the case, obtain as much information as they can from DAR records, from the claimant, and then they'll reference the site

exposure matrices and see, you know, if they're in this building, what toxic substances could have been there, were those linked with any specific conditions.

They'll go to an industrial hygienist in some circumstances to find out if there were -- what the extent of that exposure might have been and this is -- they conduct these analyses based on research, the data they have available to them and provide an opinion of high, medium, low levels of exposure at various facilities.

And, that report will go into the case file to be used for further assessment on causation.

That's the kind of long and short of SEM. But the shorter version of SEM because there will be much more detail provided tomorrow.

I'm happy to take questions about that now or we can wait for tomorrow.

CHAIR MARKOWITZ: Are there questions?

So, I have a question about HAZMAP, so HAZMAP is a library -- a National Library of

Medicine activity linking exposures with diseases.

And, do you know to what extent HAZMAP is kept up to date? And, then, as it evolves, how those improvements are integrated into SEM?

MS. LEITON: So, it is continually being updated by Dr. Brown and then, once it gets published, it's incorporated into SEM.

We did have the latest publication, 10/25/18, so that's very recently.

I think it's every quarter or so that it's updated or at least published into the -- through NLM and, at that point, we just -- we tie it to the SEM and keep those same health links if they're new or additions, they will go into the SEM.

CHAIR MARKOWITZ: And, what percentage of -- roughly, what percentage of cases now go to an IH for, you know, exposure refinement?

MS. LEITON: I don't have that offhand, I can look --

CHAIR MARKOWITZ: Okay.

MS. LEITON: -- and see if we can determine that. But, a good amount of them are now at this point.

CHAIR MARKOWITZ: Yes, I mean, the reason I ask is, when we started a couple years ago, the contract was just coming on board.

MS. LEITON: Oh, yes, there's a lot more now.

CHAIR MARKOWITZ: It was a new activity, because SEM is a guidepost, not a decision making tool. Presumably, some of those decisions are made or there's significant input from the IH and --

MS. LEITON: Yes.

CHAIR MARKOWITZ: -- wanted to know whether that's 20 percent or 70 percent?

MS. LEITON: Of the claims that are Part E claims where an assessment of exposure is required, it's probably up to 50 percent, John? Maybe more than that.

CHAIR MARKOWITZ: Oh, okay. Thank you.

MS. LEITON: Mm-hmm.

CHAIR MARKOWITZ: Other questions? Comments?

Dr. Silver?

MEMBER SILVER: What's the DDWLP and how does that relate to the SEM?

MS. LEITON: That's called the Direct Disease Work Link Process, I believe. That's Direct Disease Link Work Process, something like that.

What that is, is sometimes, we can link certain toxic substance exposures to work processes. Instead of a labor category, we can say this person worked doing a particular process at a facility.

That process working on soldering or working with -- there are various examples and I'm sure that we -- he can walk you through that tomorrow.

But, a claims examiner can go, and if they've seen in the Occupational History Questionnaire or if they've seen in other

documentation in the case file that somebody did a particular activity, then you can look up that activity in the database and find what types of exposures there may have been versus only being able to look at a labor category or a certain facility or a certain building.

Does that help?

MEMBER SILVER: But, it has no special advantage in a causation determination, it's still used just for case development?

MS. LEITON: It's used for exposure.

MEMBER SILVER: Okay. Thank you.

CHAIR MARKOWITZ: But, it links the task with the disease directly?

MS. LEITON: It links the task with an exposure. The exposure is then where we go into look at linking that with a disease. Correct?

Okay, I will move on to the next category, weighing of medical evidence for claims examiners.

I'm just going to kind of talk about what the current process for how claims examiners

look at medical evidence in general. So, it will just kind of give you an idea of what we're dealing with when you talk about this particular topic.

So, there are various sources of medical evidence that come into the claims examiner. The claimant's doctor, their treating physician is one of them. We have consulting experts and then medical facilities like hospital records, test results, things like that.

We do try, first and foremost to go to the attending physician if we can when we have questions.

As I indicated earlier, it is not always easy to -- for a physician, just a general practitioner, to provide us with opinions on causation. But we do, first and foremost, go to them when we can.

We also review Department of Energy's medical monitoring programs, the screening and former worker programs, ORISE, has -- they have beryllium testing, so sometimes we can get

results from that, contract medical consultants, I'll talk about a little bit more in a minute, second opinion physicians which they're also contracted -- they're on the same contract, but they're actual physicians that can evaluate the claimant in person rather than a medical consultant who just reviews the documentation and case file.

And then, there are the referee consultants and they'll provide a rationalized opinion, provide an opinion regarding resolving any conflict of medical evidence that's in the case file.

So, in more detail, when a claims examiner is looking at evidence, they'll look at treatment records. These are records made during an evaluation, of diagnosis and treatment of the patient, usually just narrative notes.

Sometimes there's chart notes reports, these could include reports from other consultants that were involved in the case, evidence of diagnostic testing. This becomes

very important when we look at chronic beryllium disease particularly.

And then, treatment records, as I said from hospitals, hospices, in home healthcare, et cetera.

In terms of the medical evaluations, other than to further diagnose or treat the patient, the screening programs are a big part of that.

There's also some examinations that are required under state law or federal law like Social Security disability examinations. Those can sometimes help us.

And there are other medical documentations that are sometimes submitted with regard to litigation under state or other federal rules of evidence.

And then, there are reports provided in response to a DOE referral to CMC, a second opinion or a referee specialist.

We also will sometimes look at cancer registry records, death certificates, any other

secondary evidence that we -- that is submitted or we can find and factual affidavits, in some cases.

So, with regard to contract medical referrals, we, as I said, we first try to rely on information submitted by the claimant, from their treating physician.

We'll first go there, ask that physician for information. If there is follow up to be conducted, we'll follow up with the treating physician is there is one.

Sometimes, there isn't a treating physician, there's just old medical records because we're talking about survivors. So, we'll take whatever evidence we can from there.

But, if we can't get any information or enough information to really make a decision on the case or we have some information, but it's not very probative or it doesn't really provide us with a lot of assessment, then we'll go to a CMC.

The CMC, as I said, will conduct a

review of the case records, the medical evidence that's been submitted from the file and there are certain time frames that they have to submit this -- to review and submit that back to us.

We got this contract and primary reason, just as with our primary reason for developing the site exposure matrices was to assist claimants in meeting the burden of proof because, often times, as I indicated, it's not -- claims have a difficulty obtaining and providing that evidence to us.

They're very case-specific, but there's a lot of different things that they'll look at and a lot of different reasons that we might refer something to a CMC.

So, here, just to give you a summary of some of the things that we might refer to at CMC, in some cases, the diagnosis itself is unclear, there's various reports in the case file, but there's no definitive diagnosis. And sometimes, we'll refer those to a CMC so they can provide us with clarifying -- clarification.

As I indicated earlier, our claims examiners are trained to review evidence, but they're not doctors. So, if they have a question, they may refer it to a CMC.

Then there's the medical causation side of it, this is, again, based on an individual assessment of a particular case file.

We'll refer what we call a statement of accepted facts to the CMC which is a summary of the factual information in a case file like where they worked, what we've accepted as verified employment, if there's any accepted conditions already, we'll list those.

We'll provide them with exposure information if it's relevant and appropriate to submit, particularly in a causation request, and any other information.

As I indicated earlier, sometimes we refer cases to a CMC for an impairment evaluation. And, that is often because there aren't enough doctors out there that can do them for claimants on their own.

So, but there are various tests depending on the condition that we're -- that the physician is being asked to evaluate, very specific information for breast cancer or lung conditions, PFT results, things like that.

So, we'll send a -- there's a sheet of paper that goes to the claimant, saying please go and get these tests, provide us with this information, activities of daily living from their treating physician and we'll submit all of that along with any other relevant information on this condition or the cases that the conditions we've accepted to the CMC for an evaluation of impairment and they'll provide us with a report.

Those reports from a treating physician -- from a contract medical consultant, if they're used in a recommended decision in the last several years, we've developed a policy where they are to send those reports to the claimant along with the recommended decision so that, at the final adjudication stage, they can provide additional information if they want to

and see what we relied on for our decision.

Sometimes, we'll go to a CMC for a wage loss determination. And, basically, if the evidence is unclear in the case file or there's some information but not really enough, we'll go back to -- we'll go to a treating and provide them with the information we have or a CMC and say, did this person lose wages as a result of the condition that we've accepted?

Sometimes we'll go with regard to necessity for certain medical care like durable medical equipment, and home and automobile modifications. More often, it's for home healthcare requests, we get a lot of those.

Sometimes we -- often times, we have sufficient evidence from a treating physician or whomever asked for it to move forward with an authorization, but other times, it's in a situation where there's a request for ongoing or increased care. We may go to a CMC for that.

We also have consequential conditions that are claimed sometimes and, again, a lot of

times, we'll have sufficient medical evidence for consequentials from the treating saying, this is definitely related and here's how and here's why.

Other times, we don't, but we have some indication it might be related and we'll send that to a CMC.

And then, for the second opinions, if we're going to get a home healthcare assessment, we will go for an in person second opinion. Those are usually not record reviews.

The referee examinations are also slightly different from a regular CMC referral or a second opinion because we're providing them -- they're randomly chosen as impartial examiners to review all the evidence or find an opinion.

So, with regard to the development of the medical evidence, it's the claimant's responsibility to provide us with as much information as they can, first and foremost, diagnosis. If we don't have a diagnosis, there's not much further we can go.

And, if they're claiming a particular

condition, any evidence they have to support that they actually have that diagnosis is really critical for us to move forward in a case.

The claims examiner does go to great lengths, though, to develop the evidence further after that point, try to explain what the deficiencies are in the medical evidence that's been submitted already, requesting additional supporting documentation, communicating with treating physicians.

As I indicated earlier, we did recently get nurses. I mean, we've had a couple of nurses on staff for some time, but we've increased that I think to four at this point.

And, the role of the nurses is really to help facilitate. Sometimes, when we're trying to get information from a doctor's office, if they get a call from a nurse to a nurse, it's more likely that we're going to get information.

A direct conversation can go a long way. And so, our nurses sometimes help with obtaining that type of information.

Then, what will happen, after we've gotten all the information from the treating or a CMC is the claims examiner will review the contents of the medical report to see what type of information is in this documentation, subjective complaints, objective findings, assessment and plan for follow up or treatment.

We'll look at any lab findings, diagnostic procedures, physical findings and any assessment that is provided by the physician whether it's opinion, suspicions and diagnosis along with medical rationale, depending on the subject that we're looking at.

Weighing of the evidence is always a challenge. But, it is something that claims examiners are trained to do, looking at various documents in the case file whether it's employment records, medical records, et cetera.

But, one of the things they're going to look at is was the doctor familiar with this person's history. And, sometimes -- often times, the treating physician, if they've been treating

an employee a long time will.

Do they have a factual background to base their opinions on? And, that becomes important when we're talking about somebody who says, well, this person told me they worked at Pantex for 30 years and, therefore, I think there's -- their exposure is related.

Now, that may be based on what the claimant's saying, but, in some cases, the evidence is -- shows they were there for, you know, less time or they were -- there's a different work history that we have on file. So, we try to make sure that that information is in the report.

And whether it's based on what type of information?

We also look at an opinion based on a definitive test and that includes the physician's findings over an opinion based on an incomplete or a subjective or inaccurate information.

So, somebody with records, prior history is probably going to have a better or

give us a more thorough assessment than somebody who's only evaluated the patient once and hasn't -- doesn't have any of the records.

So, we look at well rationalized, meaning reasoned, basically meaning that the information that's provided is supported by medical findings on examination, a thorough review of the records, in some cases, references to scientific articles where appropriate and a thorough medical explanation.

You know, trying to determine whether something's well rationalized or not can be a subjective analysis.

However, if somebody's making a plain statement, I believe this condition's caused to his exposure in the workplace versus, I know this person worked there for ten years. They were exposed to asbestos and, you know, silica or whatever else they might have been exposed to and this is the condition that they have.

I believe for these reasons that this condition was related to the exposure in the

workplace. That's going to go further than the one statement.

And, as I indicated, we are trying more and more to provide things like this Statement of Accepted Facts, the exposure information that we obtain, both in SEM and maybe through an industrial hygienist referral to a treating doctor, if there is one.

Because, again, they've got a history of the claimant, they've got a relationship with the claimant and might have a better understanding of that causative analysis.

Often times, the opinion of an expert over a general practitioner is going to be weighed more heavily. It, you know, a pulmonologist versus a general practitioner is usually going to carry more weight.

We do require board certification for all of our -- in order for it to carry weight at all.

And then, there's, you know, an unequivocal opinion over one that's vague or

speculative. It's going to be more probative compared to an opinion that waivers such as could, may or might be.

I know we've had this discussion at these board meetings before because, it's not always easy for a doctor to say absolutely I'm sure this is what happened.

So, we have to weigh the evidence behind those statements along with the statements themselves to figure out, you know, how this can be used legally in our final determination on the case.

Those are the main aspects of what we look at when we're weighing medical evidence, the types of medical evidence we look at, the referrals that we make and why we make them.

I'm happy to answer questions.

CHAIR MARKOWITZ: Questions? I have a few questions.

MS. LEITON: Mm-hmm.

CHAIR MARKOWITZ: So, this is an area for the committee. When you talked about

weighing medical evidence, it wasn't just what's the diagnosis, you also talked about the issue of causation. So then, that's within the charge of the committee.

MS. LEITON: Yes, I mean, weighing medical -- basically, medical evidence for claims examiners for claims under this Subtitle with respect to the weighing of medical evidence of claimants.

CHAIR MARKOWITZ: Right.

MS. LEITON: Yes. So, I mean, you're talking about the causation is where we weigh the most evidence, frankly.

CHAIR MARKOWITZ: Okay, thanks.

The statement of accepted facts, so the claims -- that's what the product of the claims examiner is when -- after they've reviewed the case before they move it forward.

That includes a diagnosis. If I were a claims examiner trained but not an expert in health necessarily, I would heavily rely on whatever diagnosis the private personal

physician, the hospital, whatever that they list. And, I would accept that diagnosis.

I wouldn't, you know, if a person's labeled as having diabetes, I wouldn't necessarily go look for the evidence their sugar levels or whatever.

The same for COPD, I wouldn't necessarily go look for the pulmonary function test if I were in that position.

MS. LEITON: Mm-hmm.

CHAIR MARKOWITZ: So, is that normally what happens is they rely on a diagnosis -- diagnoses of the treating -- I'm not talking about causation, I'm just talking about what's wrong with this person.

MS. LEITON: Right.

CHAIR MARKOWITZ: Is that what they normally do is rely on those diagnoses or are they customarily digging underneath and looking for the proof that that person has that diagnosis?

MS. LEITON: So, there's a very --

there's a lot of -- a fine line there. I mean, sometimes there's conflicting evidence in the case file about what the diagnosis is.

You've got one doctor saying this, you've got one medical report saying another thing. And, our claims staff do know some -- have some information about PFTs and levels, but we ask them not to do too much analysis of that because they're not doctors.

CHAIR MARKOWITZ: Mm-hmm.

MS. LEITON: And, I don't want them trying to diagnose, you know, a condition. They need to rely on the treating.

That's why if we -- they have questions about diagnoses, they can go to our medical director, the nurses, go back to the treating and say, you know, you've indicated this, there's conflicting evidence in the file.

However, we have had instances where we'll go to a physician, a CMC for example, asking about a causation and they'll come back and say, but you're saying this person's

diagnosis is X and I don't think it's X based on the information in the case file and we've seen that happen.

And, in those circumstances, we ask them to clarify, the CMC to clarify. You know, if we've accepted a diagnosis already, it's not going to be easy to go back and say it's not the case.

But, if we can clarify a diagnosis, make it more precise, that's a different story.

You know, once we've gone all the way through a final decision process and said this is the condition that this person has, this is the information we were provided, in order to go back and question that is -- we'd have to have significant evidence to show that it wasn't actually that diagnosis, it's something else.

Or we could add a diagnosis if there is evidence to support that diagnosis and that diagnosis is related.

We run into this the most when we're dealing with impairments because they're, you

know, different diagnoses are going to come out with different impairment ratings.

CHAIR MARKOWITZ: So, when you take a set of finished SOAFs, right, in which the claims examiners are fairly confident they got the diagnosis right, and so they're not asking the CMC any questions about the diagnosis, they may be asking about causation.

Have you ever looked at those to see whether the claims examiner -- how often they make a mistake on -- specifically on the medical -- not the causation, just the medical diagnosis?

Because they're the ones looking at the record, they're not asking a question further of the CMC. They've decided on what the diagnoses.

Have you looked at how -- whether they ever make mistakes or what the rate is?

MS. LEITON: Well, we do have an accountability review process which -- and we do have a Part E causation section on that which, you know, the auditors which are -- consist of

policy analysts and other claims staff that didn't work on the case around the country will do annual audits of each office and each claims examiner, or not each claims examiner's work, but claims staff work to determine, you know, what it was -- whether it was done correctly.

We haven't found a lot of incidences in those in that area.

Now, have we focused on whether or not the diagnosis was wrong, I can't say that we have, I don't know that we could, specifically based on our data.

But, we do look overall at causation specifically and the analysis conducted by the claims examiner in their development and in their final or recommended decisions.

CHAIR MARKOWITZ: Could we see those reports or those audits?

MS. LEITON: The accountability review findings are all on the web, they're on the public reading web.

CHAIR MARKOWITZ: Okay, so I guess the

answer is yes. Thanks.

MS. LEITON: Yes.

CHAIR MARKOWITZ: Any other questions?

MEMBER MAHS: I had one for the gentleman from DOE, I forgot your name.

MS. LEITON: Greg Lewis.

MR. LEWIS: Greg Lewis.

MEMBER MAHS: The building trades work their way out of a job all the time so they may be on a project for six months, may be on it for two years at the plant and they go somewhere else and come back when another project comes up.

And, they may work for a dozen contractors during the course of their career and work in a 100 different buildings between the three plants.

And, they don't remember where they were or what they were a lot of times and they've got an illness and they're trying to remember or they don't know what they worked around because, a lot of times that's classified. We'll let you know if you're in danger.

So, would your office be another resource where they could find some information to go with an affidavit?

MR. LEWIS: Well, yes. I mean, my office responds for pretty much all workers who apply to the program. You know, DOL is going to send us a request for information.

Subcontractors and building trades workers are our biggest challenge, to be honest. I mean, for all of the reasons you just mentioned, they are a huge challenge when compared to people who worked for a prime contractor or even a subcontractor for the prime, the big subcontractor.

So, we do the best we can to find the records that exist. Obviously, things are much better in recent times, historically, it can be a challenge.

What we'll do is we'll look at sort of non-traditional employment records, so things to prove site presence, not exactly employment because there's going to be no HR file for these

folks typically.

We'll look for like a medical record if they, you know, fell off a ladder. You know, whether it's illness related or just, you know, anything that puts them on site.

So, a slip, trip and fall will at least show, hey, they were on site at a particular time. If they wore a dosimetry badge, most times we are, you know, that should be retained by the site.

If there's industrial hygiene, that's, you know, particularly the older you go, the less likely it is to find that, but we'll look for that.

When we have, you know, at some sites, we've retained site access badge type records, sign in sheets, gate logs, things like that, for the most part, the records retention on those was very short, five to seven years.

But, sometimes, just through inertia, it was saved by the site when we do have that, we will incorporate it into the records that we

check for particular claims.

But, again, it is a significant challenge for us to find those records. We do everything we can to find them, we are not always able to verify employment or site presence for the building trades type folks.

MS. LEITON: We do have a contract or we work closely with CPWR, the Center for Construction and Trades, and they can often do some research to find subcontractors. That is a reference that our claims examiners use to determine whether there was a subcontract at a particular facility and that sort of thing.

So, it is another resource that we use.

MEMBER MAHS: That's nice. And, a lot of contractors are out of business and, though they're supposed to, don't have the records and it's hard.

Like I say, I'm on a learning curve so I didn't know he was involved in that so heavily, I was thinking going along with your affidavits.

MS. LEITON: Sure.

MEMBER MAHS: Thank you.

CHAIR MARKOWITZ: I have a question, actually, about consequential conditions because the SEM doesn't address that.

So, and I haven't looked at the procedure manual around this, but the CE is looking at consequential conditions. They look at whatever the personal physician writes. But, what tools does the CE use to decide whether something's of consequence of another condition or not?

MS. LEITON: Well, consequentials basically, it's of the physician's opinion, that's only what we rely on because we don't have to look at whether it's related to toxic substances, because we've already accepted the original diagnosis.

So, first and foremost, we're going to go to a treating. Often times, we get it from a treating automatically. They say this is a result of this other condition.

Other times, they'll say it's a result of a medication that was prescribed.

Sometimes, claimants will file them on their own and then we develop for it. But, often times, we'll see it in medical evidence before a claimant files for it and then they'll file for it.

CHAIR MARKOWITZ: Thank you.

Oh yes, Dr. Silver?

MEMBER SILVER: I'm a little distressed that this segment never used the word epidemiology. I'm a little distressed that this segment hasn't used the word epidemiology.

There are a lot of shreds of evidence in the claimant files that I've seen that make the most coherent sense when one acquires epidemiologic papers and reads the discussion section and looks at things related to the time course of the illness, typical age at onset.

I was contacted by a New Mexico legal services after a janitor's case for renal failure had been denied. And, I have special assets in

terms of where uranium was used in his work environment and other renal toxicants.

But, what I think really turned the case around on appeal was when I got my hands on five epidemiologic studies of uranium miners and millers and found that there was ambiguity in classification of the disease outcome in the days of old.

And, when he was lumped together with all genitourinary diseases, the effect measure was much greater.

I found that in reading the discussion that the albumin dipstick test was insensitive back in the day.

There was data on the average age of onset after exposure and he fit right in. And, you all awarded the survivor claim on appeal.

And, it was only really through the epidemiologic literature that this widow who stuck her neck out even before there was Part E to testify at a public meeting got her claim.

So, I think we're going to keep

getting back to the idea that you have to grab the epidemiologic literature by its roots and let a qualified epidemiologist shake the fruit out.

CHAIR MARKOWITZ: Thank you.

MS. LEITON: Okay, the next topic is Part B lung conditions, diseases, just trying to make sure I'm good on time.

CHAIR MARKOWITZ: We're good, we're good.

MS. LEITON: Okay.

CHAIR MARKOWITZ: We're good, thank you.

MS. LEITON: Okay, so Part B lung diseases, beryllium disease and silicosis. I'm first going to talk a little bit about beryllium sensitivity.

And, this is something that is a requirement of the statute under Part B in order for a person to be -- for us to accept a beryllium sensitivity, there must be one abnormal beryllium lymphocyte proliferation test or one beryllium lymphocyte transformation test

performed on blood or lung lavage cells which shows abnormal findings.

They can also submit beryllium sensitivity or establish that through a beryllium patch test which is old fashioned and usually isn't necessary unless the records are old.

But again, this is a statutory requirement which means Congress specifically put in there that they have to have an abnormal.

There are -- has been one set of circumstances where we've been able to use a lung biopsy in lieu of a positive beryllium sensitivity test when there is evidence of steroid use.

Those -- that was a very specific set of circumstances that allowed us to do that. But, in general terms, this is the test and it's the test that's provided to us under statute.

Once we've established beryllium sensitivity under Part B and we've accepted that condition, we will pay for additional test results for the development of chronic beryllium

disease.

Medical monitoring which, you know, could be any test for CBD treatment and therapy for the condition effective the date of filing that progresses later to CBD, we can accept the case for CBD.

Beryllium sensitivity does not result in a lump sum award, it's just medical monitoring at that stage.

So once the -- from beryllium sensitivity or sometimes -- often times chronic beryllium disease is just claimed outright without it first being beryllium sensitivity.

But, there are very different criteria, very specific criteria under Part B to accept chronic beryllium disease and these are legal criteria that are also in the statute.

And, it makes it a little bit challenging for physicians because of the fact that this is a legal definition, it's not a medical definition.

But, I am going to outline what the

law states about chronic beryllium disease.

And, we have to make -- there's a determination that we have to make whether it's -- we're going to us a pre-1993 test which is provided by the statute or a post-1993 test.

The decision -- we have to make that decision based on the date of the first evidence of a chronic respiratory disorder. Depending on the answer to that question, we'll use either of those tests.

So, for a pre-1993 CBD, an individual must have any three of the following criteria, characteristic chest radiography or a computed tomography CT abnormalities.

This includes a variety of patterns, conditions such as non-caseating granulomas, nodules, interstitial fibrosis and honeycombing.

More clear guidance on chest radiograph abnormalities consistent with CBD is looked for -- the claims examiners will look for that.

Restrictive -- the second of the three

criteria is restrictive or obstructive lung physiology testing or diffusing lung capacity defect.

The third is lung pathology consistent with CBD.

In most instances, a physician's statement that it's with rationale confirming that the tests are consistent with CBD is sufficient.

And then, they have to have a clinical course consistent with a chronic respiratory disorder.

Oh, I'm sorry, there are actually five, but you only have to have three of the five. So, the first three I just mentioned.

The fourth is the clinical course consistent with chronic respiratory disorder.

And the fifth is immunologic tests showing beryllium sensitivity like the skin patch test or the abnormal beryllium blood test.

The post-1993 CBD criteria, you have to establish beryllium sensitivity as we've

already discussed and a lung pathology consistent with CBD including lung pathology showing granulomas or a lymphocytic process consistent with CBD, computerized axial tomography, a CAT scan showing changes consistent with CBD or pulmonary function or exercise testing showing pulmonary deficits consistent with CBD.

A physician's rationalized opinion nothing that biopsy findings are consistent with CBD will take precedence over the diagnostic data.

These are challenging diagnostics. The criteria is challenging because we -- for post-1993 we do need a physician to tell us that it's CBD or it's consistent with CBD but it's something that is required by these criteria.

The benefits for Part B is the $150,000 for CBD and it's either to the employee or to the survivor.

Under Part E, chronic beryllium disease is different because they didn't give us a legal definition of CBD or criteria for that.

So, we will -- we still -- since there is a legal definition provided in the Act for beryllium sensitivity, we require beryllium sensitivity as defined there and then other information provided by a physician that establishes chronic beryllium disease.

And, that's not as specific as it is under Part B. So, we do face challenges there.

Beryllium exposure is usually assumed, it's not like some of the other conditions where we have to do extensive research. Beryllium disease comes from beryllium exposure.

And then, we have chronic silicosis and this is a -- there are certain very specific criteria for chronic silicosis under Part B as well.

The evidence required is, again, it's statutorily set. They have to have been exposed silica in the performance of duty for a aggregate of at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska.

They have -- there's a latency period of 10 years between the date of initial silica exposure and diagnosis date for chronic silicosis. And, there has to be a written narrative from a qualified physician that includes a diagnosis of silicosis.

With regard to diagnostic evidence, any of the following criteria, a chest radiography interpreted by a physician certified by NIOSH as a B reader, classifying the existence of pneumoconiosis of Category 1/0 or higher, results from a CAT scan or other imaging technique that are consistent with chronic silicosis or lung biopsy findings consistent with chronic silicosis.

So, again, that's very limited under B, they will get $150,000 if they meet those criteria, it's only for those two facilities.

If you're looking at chronic silicosis under Part E, it's going to be different because you're going to look at it like you would typically look at any other condition.

So, those are the very specific statutory criteria for B lung diseases.

Questions?

MEMBER TEBAY: Are we going to have time to have this conversation about beryllium at some other point or is it now an appropriate time to have about specific testing?

CHAIR MARKOWITZ: We have time, but feel free to ask a question.

MEMBER TEBAY: And, Rachel and I have had this conversation before, but just to Hanford at this point, I'll just speak to Hanford and assume it's the same at other complexes as well.

We have this, obviously, in the room, this borderline test requirement at this point.

At Hanford, I believe we have the most borderline test results of any other site. We have a significant amount of people that have been diagnosed sensitized to be at the borderline test.

Which, there's other programs that accept the borderline as a diagnosis criteria for

sensitivity, but what we've seen lately is these people that were diagnosed via borderline test have moved on to chronic beryllium disease.

Obviously, that creates a challenge because not only have they been denied at the Department of Labor because they don't meet the abnormal standard, but now they are diagnosed at chronic beryllium disease but they can't get accepted there because they never met the original diagnosis, dose sensitivity.

So, we've got these folks stacking up at this point with, you know, diagnosis of sensitivity and chronic beryllium disease that have no other option.

It seems to me, whether it's statute or not, your National Jewish, your Cleveland Clinics, I think Dr. Redlich has shared some input as well that the borderline test, whether it be -- I believe the borderline test is abnormal.

I think we're talking, if it's not normal, it's abnormal. But, we're kind of in

this hurdle that we can't get over, yet we know the diagnosis criteria and the statute is out of date and it's not accurate, what do we do?

Where do we change that? How do we get over that hurdle for these folks?

MS. LEITON: I've been advised and we've looked at this in great depth that the statute says what the statute says and we must abide by it as an abnormal.

So, in order for us to change it at this point would require a statutory change.

MEMBER TEBAY: So, if we keep hinging on this abnormal test result, I mean, it is a borderline test and people that are more educated could help me here, but is a borderline test abnormal?

MS. LEITON: And, there are articles and we've received research and various other -- I believe the board has a recommendation with this regard and that's why we've had our legal analysis conducted and have been advised that an abnormal has to be an abnormal based on the

statute.

CHAIR MARKOWITZ: So, I have a question related to this. If a person doesn't make the criteria on silicosis under Part B, are they eligible to submit under Part E for the same diagnosis.

MS. LEITON: If they did -- do not meet the statutory criteria for B?

CHAIR MARKOWITZ: Correct.

MS. LEITON: Yes, they can file under E.

CHAIR MARKOWITZ: So, can the same thing happen for beryllium?

ME. LEITON: Absolutely, yes.

CHAIR MARKOWITZ: So, a person who has borderline, two borderlines and evidence of lung disease consistent with --

MS. LEITON: But, we do have a requirement under or -- under Part E that they have these -- that the requirement for beryllium sensitivity that's under Part B also applies under Part E. This was also under the guidance

of the Solicitor's Office.

CHAIR MARKOWITZ: But, that's not in the statute? The statute --

MS. LEITON: The Part B criteria is, but being inconsistent in that specific area is something we've been advised against.

CHAIR MARKOWITZ: Right, okay, okay. So, the Part E assessment of beryllium is not driven by the statute in the same way, but it's a decision within the Department.

Dr. Cassano?

MEMBER CASSANO: Yes, going back to the abnormal lymphocyte proliferation test again, the statute says abnormal, correct?

MS. LEITON: Yes.

MEMBER CASSANO: It doesn't say positive, but so, it is the interpretation of your legal department that borderline is not abnormal, correct?

MS. LEITON: That's correct.

CHAIR MARKOWITZ: So, we should move on, but we -- unless there are pressing questions

directly on this. We will have time to come back if you want, if that's all right?

MS. LEITON: Okay, the last area for review by the Board is the work of industrial hygienists and medical expertise.

So, to establish that an employee was exposed to a toxic substance, the evidence on file must show evidence of potential or plausible exposure to toxic substance and evidence of covered DOE contractor, subcontractor or uranium employment at a DOE -- at a covered DOE RECA facility during a covered time period.

So, under the regulations, in order to establish an employment related exposure to a toxic substance, we have to have proof of exposure to a toxic substance present and we do, as I said, we use the site exposure matrices where we can to show that there was a toxic substance present.

But, we also look at the nature, frequency and duration of that exposure of the covered employee, evidence of the carcinogenic or

pathogenic properties and opinion of a qualified physician with expertise in treating, diagnosing or research the illness, claimed to be caused or aggravated by the alleged exposure and any other evidence that demonstrates a relationship between a particular toxic substance and the claimed illness.

The industrial hygiene reviews, I've gone into this a little bit, I'll talk a little bit more about it.

But, as I indicated, we have two federal employees that work on this and then we have a contract of industrial hygienists that recently, I guess about two years ago, we hired these contractors to help because we realized there's a lot of these assessments.

Probably not going to belabor this since we've talked about it a bit, but the industrial hygienists are certified by the American Board of Industrial Hygiene in the comprehensive practice of industrial hygiene.

So, what they will review is

historical occupational safety and health data which may or may not include employee specific industrial hygiene monitoring, depending on whether or not we could get it from a DAR or otherwise along with their application of their specialized knowledge related to the field of industrial hygiene.

The IH referral from the district office consists of the CE will first identify an exposure issue. They'll look at the site exposure matrices and everything else in the case file to determine what they need to refer to the industrial hygienist.

This could include facility exposure records, DAR information, the occupational history questionnaire, the employment records verified affidavits, former worker program screening records, NIOSH site profiles in some cases, any employee submitted information and other evidence that establishes a toxic presence at the site.

And then, we'll put that in a

statement of accepted facts for the industrial hygienist referral.

The IH will then review the evidence submitted, review the SOAF, anticipate, recognize and evaluate hazardous conditions in occupational environments and provide their expertise to an evaluation that is then submitted to the claims examiner for review in the case file.

Part of the IH's input may include identification of specific chemical or biological toxic substances to which the employee likely had an exposure, work process, presence within a particular work building, area or site or as a result of an occupational accident or incident, identification of specific description of the nature, extent and duration of exposure to specific toxic substance that employee likely encountered because of his or her covered employment.

They'll do an evaluation in some cases and comparative analysis of opinions presented by claimant experts that respond to questions of the

nature, extent and duration of employee exposure to toxic substances.

The IH will also review SEM to verify searches that may have been conducted by the claims examiner or to verify that they were done correctly.

The IH will then render an expert opinion in the form of a memorandum that addresses the issues as specifically as possible.

They'll reply to any specific questions that were asked by the CE and then they'll make a determination based on their expertise.

The opinion from the industrial hygienist is usually based -- they've identified specific chemical or biological substance, they've been informed by the work history of the employee as accepted by the CE, predicated on the recent application of available data and scientific information. And then they'll communicate that in a clear narrative.

I think that we've submitted, and

you've -- and many people on the board have seen examples and we may have examples of an IH opinion on the website.

But, basically, they'll talk about, as I said earlier, duration, exposure levels, high, low, intermediate, in passing only, these are the terms that are often used in the IH assessments.

The -- I talked quite a bit about the CMC, so I won't go into too much detail about that. But, as I indicated, there are several different reasons we would go to a CMC and they are used when we don't have enough information in the case file or when we can get information that will clarify other information ion the case file.

There are some -- there is some oversight of some of these activities. We do have a CMC and second opinion audit that's conducted by a medical director every quarter. Those are now published on our public reading room.

And the purpose is to assess the quality of district office and physician work

products and referral packages through the contractor to determine if the CMC review includes all the right information.

We'll look at the quality of the medical review and opinion. The questions in this category can -- the medical director will look at various issues.

A lot of it, sometimes, if there's a lot of impairment ratings in a quarter, I think he reviews like 60 a quarter, is that right? And, he'll come out with a report at the end of that quarter explaining exactly what he found, if there were deficiencies.

We will look at it in policy to make sure that it's consistent, that we don't see any factual inaccuracies in what he was looking at. And then, that will be published.

We also do accountability reviews, as I indicated. Part of that accountability review process is looking at whether or not the district office referred it correctly, whether their SOAF was accurate, whether they've submitted the

correct information to the physician, asked the right questions, that sort of thing. And those are also published and put in our accountability review findings.

We have done a specific audit, I think it was in February of 2015, I believe we submitted that to the board on just more targeted towards CMC reports and CMC referrals specifically.

And, we always are constantly revising our accountability review process every year, pretty much determine what we want to look at in each given year.

Sometimes we'll do spot audits and, you know, that is under -- our whole process for accountability reviews is under consideration for this new year whether we want to look at things a little bit differently, whether we want to look at more targeted information. But, it's an analysis that we undergo each year.

MEMBER POPE: I have a question.

MS. LEITON: That --

MEMBER POPE: Is there data to show during your audit review the number of CMC audits, those cases gone back to be reviewed?

MS. LEITON: I'm not sure I understand the question. Are you saying, once we've identified cases, have they been looked at again?

MEMBER POPE: Right.

MS. LEITON: Every case that were identified an error in will go back to be re-reviewed. In some cases, it'll go back to the CMC to ask follow up questions. In other cases, we have to make a -- take a different path, depending on really what the problem was with it. But, we'll definitely address that case if there were problems with it that we found.

MEMBER POPE: Okay, thank you.

MS. LEITON: I don't have anything further on the particular issues.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: It's been a few months, would you refresh my memory please as to the accountability and audit procedures for the

work of the industrial hygienists?

MS. LEITON: That -- since we've recently gotten the contract, that's something that we're going to do probably quarterly as well, but we have not begun that yet. So, we're going to work out a process for doing quarterly reviews of the IH reports as well.

MEMBER SILVER: Would you welcome the board's input into establishing that process?

MS. LEITON: Absolutely.

CHAIR MARKOWITZ: So, on the website, the up to the third quarter of 2017, the medical audits are available. If it's available, could we look at either the fourth quarter of 2017 or anything into the 2018?

MS. LEITON: Yes, if they're not on the website and we have them completed, we will provide them to you.

CHAIR MARKOWITZ: And then, when those 50 per year, excuse me, per quarter are randomly selected for audit, they seem to be divided 20 into causation, 20 impairment and 10 other. So,

that means that you can identify which of the -- sort of the main purpose of the CMC reports in that selection?

MS. LEITON: Yes.

CHAIR MARKOWITZ: Okay, thanks.

MS. LEITON: Other questions?

CHAIR MARKOWITZ: Has there ever been an exercise looking at consistency between two CMCs or among the CMCs? In other words, if you submitted the same causation question to a different -- one, you know, to multiple CMCs, would they come up with the same decision?

MS. LEITON: Since we're usually -- I mean, the purpose of the referrals are to adjudicate claims. We don't -- we're not going to take the time to do that for an individual claim.

Now, if we were to go and do it like, I mean, it's possible to do an audit like that that doesn't -- we would want to hold up a claim to do that --

CHAIR MARKOWITZ: Sure, sure.

MS. LEITON: -- in other words. But, you know, we have not done that specifically.

CHAIR MARKOWITZ: Right, okay. You know, I didn't mean to hold up at all --

MS. LEITON: Right, right.

CHAIR MARKOWITZ: Questions? Comments?

(No response)

CHAIR MARKOWITZ: Okay, thank you very much.

MS. LEITON: Thank you.

CHAIR MARKOWITZ: That was great.

Next, I think we have Mr. Vance, Procedure Manual Modifications and Other Changes.

MR. VANCE: All right, well, good afternoon everyone. My name is John Vance. I'm the Policy Branch Chief for the program. I'm talking about the procedure manual today, so I see that somebody bribed somebody, I only have ten more minutes according to schedule.

CHAIR MARKOWITZ: Yes, but you speak quickly, so that's okay.

MR. VANCE: Yes, I do. So, I will

try to be quick so we can get back on schedule here. But --

CHAIR MARKOWITZ: No, actually, the schedule -- we have some flexibility.

MR. VANCE: All right, well, then I'm just going to talk until I can't talk anymore.

CHAIR MARKOWITZ: Okay, okay.

MR. VANCE: So, again, I'm the Policy Branch Chief so I oversee the drafting and publication of our procedure manual which is the topic of this conversation.

Let me give you a little bit of background about my staff that works on the procedure manual.

So, I have seven policy analysts. I have a group of folks working for me in the medical health science group. I have three industrial hygienists, I have two health physicists and I have a toxicologist and nurse consultants.

Our working team collaborates on considering, evaluating and deciding how we're

going to make changes to our procedure manual.

The procedure manual itself is a very large document, for those folks that have had the opportunity to be exposed to it in the past. It is available on our website so if you just look on our main page and go to policy program procedures and the program manual, it's right there.

It is a 600-page document. It is a very lengthy treatise on everything that you need to know about how to process claims through our adjudicatory process.

It is essentially an employee handbook. It basically tells staff how they go about doing the job of evaluating cases. So, it is a very detailed description of the work that our staff does in developing cases and evaluating evidence and making judgments in our process.

For those folks that have not had exposure to our procedure manual before, there's lots of material that's available in it. For the board, things that I would suggest that you

really want to focus on is Chapter 15, which is our toxic exposure causation analysis chapter.

We also have Chapter 18 which talks about non-cancerous conditions. For folks that just want to know our adjudication process, Chapters 24 through 26 is the basic claims adjudication process discussion. So, if you wanted to sort of start somewhere if you're new to this, this is probably the suggestion I would give you.

Again, the procedure manual, it's a very large document, it's a PDF. It's available online. The publication of the procedure manual occurs by version, so we are currently in Version 2.3. We are working on Version 3.0.

The content of our procedure manual is described -- or the changes to our procedure manual is described, when you go to the website and you go to the procedure manual, you will be presented with some different information.

You'll have the actual whole working published document of the procedure manual, then

you'll have a transmittal that describes what edits have occurred to the procedure manual for that version.

We also have a library of all prior transmittals and then also some archival material that is available online. So we try to be as transparent as we can with the publications of each update to the procedure manual.

Some of our publications are very weighty in the sense that we cover a lot of material. Others are very point of fact, we've got a quick change that we have to make. So, we do do substantial edits and then sometimes we do relatively minor changes.

MEMBER DOMINA: Can I ask you a question real quick?

MR. VANCE: Mr. Domina?

MEMBER DOMINA: Because you said you're working on the new version, the 3.0 or whatever, and I don't know if you can comment on this or not, is there anything in that that you can think of that could affect what this Board is

going to work on so that maybe we don't need to work on something in great length that maybe is going to get changed in the next version? Or can you comment on that or not?

MR. VANCE: I can't comment on it right now because, let me talk a little bit about how we go about identifying issues for the procedure manual for us to even consider.

And, right now, we're in the editing stage. So, let me give you a sense as to how the procedure manual actually operates through publication and that might answer your question.

MEMBER DOMINA: Thanks.

MR. VANCE: So, a lot of times people will ask, you know, well, this is an employee handbook. This instructs staff as how to do certain things. How do you get guys - decide in policy what you're going to actually change?

And, we actually generally make changes based on the input from lots of different sources. The primary source is generally feedback from claims staff that they've run into

case situations that don't generalize very well to the procedure manual.

And then we have to look at that and make a decision, is that particular case scenario presenting us with a challenge in our guidance in the procedure manual that requires a change?

Is it a one off scenario that we really can't prescribe a solution in the procedure manual, we're going to have to look at the specific nature of that case and resolve it?

Or, is there just some issue in the procedure manual that our staff are struggling to understand how to apply? Or that the process is developing in such a way that it's not administrative feasible to continue to do it in that manner anymore?

So then we have to take a look at that and make a decision as to, okay, what is the process that we have to go through to evaluate the impact, the language that would fix that and also, you know, are we on solid ground in order to make that determine within the scope of the

law and the regulations?

The other sources of feedback that we get is from my policy analyst staff who are basically the principle folks dealing with a lot of incoming policy questions and other issues that come up in case adjudication activities. They will identify items that they think are qualified for inclusion in the editing process and vetting process.

We also initiate program initiatives where we're going to go out and do something different than the way we've done before to hopefully create efficiencies and a process or to address other work processes such as input from the Advisory Board. So, I'll talk to you a little bit about some of the things that went into Version 2.3 that are direct consequences of input from the Advisory Board.

We also get input from stakeholders just through general correspondence that we get and congressional inquiries or folks that are communicating with the director on concerns or

problems or complaints about the process. So, we also will consider those.

We also make changes based on the effect of litigations. It's very rare that that occurs, but it does. And, when we have a policy that's been ruled improper by a judge, we will make those changes.

So, we do have one example that occurred in the past few years where we had to make a modification based on the outcome of litigation. And we also take input from the Solicitor's Office where there are issues that come up in ongoing litigation.

So, those are generally the sources of changes that we get for changes to the procedure manual. Again, this is an internal document. This is a Department of Labor document that we provide to our staff so it's not something that the public has access to to provide formal comment to. It is something that we will evaluate and consider input from lots of different places and provide guidance to our

staff.

The process for evaluating edits is a really cumbersome process. So, we have input that we collect and we make decisions as to what changes and edits need to occur. We will assemble that. I have one staff person who is my Editor in Chief who collects all of the input for changes and edits.

We will then assign that out, or I will assign that out to policy analysts who will then do the research necessary to determine what impact that change will have in the procedure manual and to our adjudication process and formulate the language that will convey how the staff is to implement this particular procedure or process.

Once that's done, it's got to get through my unit supervisor who is going to evaluate that. I have to evaluate and certify that I feel that that's an appropriate addition for the procedure manual.

Then it has to actually go out through

subject matter experts evaluating and determining whether or not the final work product is sufficient.

We also have to go through a legal review by our solicitor who's going to evaluate and certify that any content complies with the legal and regulatory standards that exist for the program and that it's a defensible position.

We also then have to have other certify it. So, if it's a medical health science issue, we'll have the medical director review and certify it. If we have other types of areas of expertise that we need to have specialists look at, then they will also certify off on that.

And then, we're not done. It still then has to go through clearance with the director and then it's on and upwards to the employee union that has to actually evaluate that because this is an employee guidance document.

The federal employees union has an opportunity to review that and comment or provide feedback as far as their agreement or

disagreement with any kind of process changes.

So, it's a very cumbersome process. It does require lots of effort on the part of our staff. We do a lot of research in conjunction with how processes will change based on edits to our procedure manual.

And, I would say one of the big things that I will always say about the procedure manual is that words matter and we take a lot of time in making sure that the words communicate clearly our expectation for processes.

So, specificity is very important and we oftentimes get into very long and arduous struggles over wording and phrasing to make sure that people are understanding exactly what we're trying to convey in the procedure manuals.

So, that's just something that I always think is important to mention because I've struggled trying to make that work. That's the constant struggle for procedural writing.

So, I was asked to just go through a little bit about our last update to the procedure

manual because it encompassed a lot of input from the Advisory Board.

The procedure manual -- go ahead.

MEMBER REDLICH: Just before you get to that, just clarify one thing. You mentioned in terms of revising the manual --

MR. VANCE: Yes?

MEMBER REDLICH: -- what expertise you have?

You mentioned just in terms of revising the manual, you mentioned the expertise you have in house in terms of industrial hygiene.

I didn't hear a physician with expertise in --

MR. VANCE: Yes, our medical director will provide approval for things that relate to the field of medicine or the application of medicine.

So, he reviews -- and he's actually usually involved up front in the drafting stage because it's not where we're getting to him at the tail end. We usually involve him up front

and say, when the analyst is actually preparing to make a suggested edit, they'll generally be working with the medical director to make sure that he is in agreement with whatever editing that they're proposing before it even gets into the final publication.

But then, if there is a medical component that he's got to sign off on, then he'll be part of that formal clearance process.

MEMBER REDLICH: Okay. Because, I mean, I realize that the manual is huge.

MR. VANCE: Yes.

MEMBER REDLICH: And it involves all different areas of expertise. But, having not met the medical expert, does he have expertise in, let's say, chronic beryllium disease?

MR. VANCE: He is -- well, he's the physician that we utilize for all issues relating to the field of medicine in the application of this program.

So, you know, he would be the one to speak to his different levels of expertise. But,

I -- as far as I am concerned, he is someone that I think is very well versed in all aspects of occupational medicine for the application of this program.

MEMBER REDLICH: Okay. And then, you mentioned that you have subject matter experts review individual areas?

MR. VANCE: Yes, they're generally going to be involved with the actual formulation of the policy.

So, in other words, if I have a policy analyst that's asked to evaluate a recommendation of the board, for example, then we're going to evaluate what that recommendation is. We're going to turn to the person that will evaluate that and give us feedback and thoughts about the information that's been submitted in conjunction with that.

And then, once we get a consensus built around that, then they'll propose a change or an edit to the procedure manual. And then that has to get vetted through that entire

clearance process.

So, there's basically a drafting stage where we involve the subject matter experts and then there's also a clearance stage where their input is going to be vetted as part of the editing process and certified for publication, public publication.

MEMBER REDLICH: Okay. Because, it's just for, you know, some conditions like asthma and COPD, you know, lots of physicians have expertise and experience with that condition.

But, something like chronic beryllium disease, there are probably just a handful of physicians in the entire United States who've actually evaluated, diagnosed and in addition to knowing the literature actually have the clinical experience in diagnosing the disease.

I happen to be one of them, but I think that for any physician, even a pulmonologist who does not have specialized experience and training in that area, they would not be able to, you know, accurately diagnose it

for an occupational medicine doctor who handles more injuries or other aspects of occupation medicine.

So, it really is a very specialized area and I just bring that up because, I mean there are lots of other aspects of, you know, although I'm internal medicine, pulmonary and occupational medicine, you know, I depend on others with more expertise in other areas. So, I am, you know, wondering exactly what is the expertise since it is a big component of this that has to do with chronic beryllium disease.

MR. VANCE: Yes, my only comment to that is, I agree. There are lots of areas of expertise needed in this program and I think that's one of the reasons why we turn to the assistance of an advisory board because this program, like Rachael and others have mentioned, is complicated and touches on some very difficult and challenging medical and epidemiological issues that requires a great deal of specialization in lots of different areas and

subject matter.

It's hard to have one person that can encompass it all, but, you know, we have to work with what we have and make the best possible decisions we can based on the information that we're presented with.

MEMBER REDLICH: Well, you know, maybe moving forward, just to use everyone's time best, we have made some specific recommendations as far as the manual.

There may be very good reasons why you can or cannot implement that. Rather than my going, you know, searching through it looking for different words in the text, I think it would be helpful to get feedback, yes, we are able to incorporate this or no for whatever reasons.

MR. VANCE: Right.

MEMBER REDLICH: And just so that we know where things stand.

MR. VANCE: Well, let me just go through the changes that we did agree to because I think some of those were probably a direct

consequence of some of the input you personally had, especially in the asthma area.

So, we did make a change in our --

CHAIR MARKOWITZ: On this issue?

MEMBER REDLICH: Yes, especially on this issue. Yes, and you may be about to answer this, but I remember last year, and I'm a little fuzzy on the details, but you were revising -- doing a revision of the old manual at the same time we were reviewing it.

And, we had made some recommendations that it sounded like you had accepted at that point, at least verbally, thought it was a good idea but didn't need to go through the whole process.

And, yet, when that revision was promulgated, there was stuff in there that was almost diametrically opposed to what we had agreed to.

So, I'm wondering if it's not possible, especially for Chapter 15, I think it is, that before it gets promulgated, that this

Advisory Board have -- look at -- I mean, we've looked at the old procedure manuals, you asked us to look at the regulation about before it was going to go out.

So, I'm wondering why we couldn't look at that chapter just to make sure that we don't have any tweaks that we might want to make to that.

MR. VANCE: Yes, I think that my comment, you know, my response to that is that, you know, we have an internal process for vetting policies and procedures for our program. And, we're looking for input from the board with regard to the areas of its mandate.

It's certainly something that I think we can consider, but I don't want to give you a definitive answer on that. So, it's something that I think we're going to consider.

MEMBER REDLICH: And one follow up to that. The other thing that we saw was also a dichotomy between what was in the procedure manual and what's in the training documents that

related to that procedure manual.

How concurrently do you update the training docs with the procedure manual?

MR. VANCE: Yes, generally, when we do updates to the procedure manual, we'll have a sequence of interactions with the field offices in our final adjudication branch talking about changes to our process.

And, often times, we are amplifying existing processes that were already there, it's just that the wording is providing more detail and more uniform and consistent guidance as to how they should be doing their job in the first place.

So, you know, I think that's my feedback on that.

With regard to --

MEMBER REDLICH: And, I do --

MR. VANCE: Go ahead.

MEMBER REDLICH: -- appreciate, I did notice the changed wording --

MR. VANCE: Yes.

MEMBER REDLICH: -- as far as the diagnosis of asthma and I do appreciate that.

MR. VANCE: So, yes, let me get into some of the changes we actually did take from the board.

So, just to give you complete confidence, everything that the board provides to us undergoes a very rigid and very thorough evaluation by many folks. And there are lots of scientific and legal issues that we have to sort of march through in evaluating this.

So, it's not a matter of us just offhandedly not accepting recommendations. And, for anyone who is unfamiliar, we have, Carrie, I know, has all of our responses to all the board input we have for responses that the Department of Labor has provided.

And, that will provide a little bit of the rationale for some of the things that we have looked at and some of our thoughts on different issues that the board has commented on.

With regards to some recommendations

that we did accept, we did make changes and I'm primarily focusing on Exhibit 15-4 in our procedure manual, which is our presumptive standards for evaluation of cases that sort of bypass our normal adjudicatory process for evaluating both exposure and causation.

So, these are basically exceptions to the process that gets claimants directly to a positive claim outcome when they meet particular criteria.

So, for Exhibit 15-4, one of the changes we made was modifications to our asthma language that the Board recommended. And I believe we changed that word for word.

We -- this was not a recommendation of the Board, but I just thought I'd mention it because our industrial hygiene and epidemiologist made this recommendation which is adding Benzedrine to the list of toxins associated with bladder cancer.

So, again, the board is working to identify positive health effect features as is

our folks. And so when they identify things that we can add into the procedure manual, we do do that. So, that was added into our presumptive standard for that condition.

We added two new toxins to the hearing loss standard, carbon disulfide and n-hexane. We added a series of presumptive changes to pulmonary diseases, so we added a new presumptive standard or criteria for lung cancer. The entire component was added and included evidence relating to the exposure to asbestos latency and duration of exposure.

We added and changed latency periods for mesothelioma. We made the same similar type of change to ovarian cancer. We modified latency period for plural plaques.

And so, all of those recommendations were direct consequences of input by the board.

As far as other changes and recommendations of the board, and there are still things that we are considering. There are still issues that we have encountered that we're still

looking at and that are actually weighing on us as we begin looking at additional edits to the procedure manual.

So, it's not a finished work product by any means and I certainly think that the board's going to have plenty more to say with regard to any of the areas that you have commented on before.

And also the responses from the Department of Labor.

CHAIR MARKOWITZ: So, I have a question, if I could --

MR. VANCE: Sure.

CHAIR MARKOWITZ: -- about the asthma changes, because I see there are some changes in the language.

It says, and this is page 3 of 12, Exhibit 15-4 in the asthma section that the claims examiner doesn't apply a toxic substances exposure assessment to a claim about asthma because any dust, vapor, gas or fume has the potential to affect asthma.

Since the statute requires linkage to a toxic substance, how can you escape that statutory requirement and apply this standard here to asthma?

MR. VANCE: So that -- there's actually language in there that does specifically specify that a physician has to identify the triggering agent to that --

CHAIR MARKOWITZ: Well, that was my next question.

MR. VANCE: Yes.

CHAIR MARKOWITZ: But, just sticking with -- and I don't mean to interrupt you, but it does say here, the CE doesn't apply a toxic substance exposure assessment.

MR. VANCE: Right. It is strictly a medical question. So, we have a standard in the procedure manual that speaks to -- the standard is basically a question that a physician must answer. That the physician has an understanding of the work history of that patient, has an understanding of their medical status or whatever

medical information exists and is able to offer essentially a rationalized opinion explaining how a specific triggering mechanism of exposure to a toxic substance is associated with either the onset or the development of asthma or an aggravation or contribution to existing asthma.

And the standard lays out, and I don't know it off the top of my head, but it's basically, you know, is there evidence that this person was suffering from an aggravation or asthma at the time of their exposure to whatever the triggering mechanism is, or is the physician able to offer some sort of rationalized opinion based on a current understanding of the patient's status and then applying an historical evaluation of exposure or an understanding of that exposure.

So, it gets very tricky, but it is up to the physician essentially to make that judgment. The claims examiner would be looking at has the doctor offered what I would argue to be a compelling and convincing argument that identifies the mechanism of exposure at the time

and provide some sort of linkage between that exposure and the asthmatic condition.

CHAIR MARKOWITZ: But, that -- the expectation is not that the doctor identify a specific chemical substance, toxic substance that led to the asthma because you acknowledged earlier that any dust, gas, vapor or fume can to do that.

The requirement -- it's a question, the requirement is that the physician say there was a workplace contribution in the form of some inhalation exposure that aggravated, contributed or somehow to the -- is that the expectation?

MR. VANCE: The expectation, or the way that I understand it is that we recognize that asthma can be affected by so many different things.

CHAIR MARKOWITZ: Right.

MR. VANCE: It's impossible for us to profile it and say, just look at these things.

So, basically, we leave it to the physician but the physician must identify the

toxic substance that they feel is triggering that causal relationship.

CHAIR MARKOWITZ: They have to name that it was chlorine or they have to name that it was chromium --

MR. VANCE: They have to simply -- because the toxic -- the definition of a toxic substance under our statute is that it has to be a chemical, biological or radiological agent.

CHAIR MARKOWITZ: Right.

MR. VANCE: So, we do have a language that sort of specifies that a triggering exposure to a toxic substance needs to exist. So, the doctor does have to identify it in some way or some explanation of what that mechanism from a toxic substance context is that's associated with that asthmatic condition.

CHAIR MARKOWITZ: Well, okay, I'm going to -- it's a little contradictory, but I'll let others step in here.

(Off-microphone comments)

CHAIR MARKOWITZ: Yes, we can revisit,

I don't mean to pursue it too much, but --

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez, I have a related question.

In the procedure manual, Section 13(b) on page 123, it says a physician's opinion that relies on inaccurate factual findings, especially speculative exposures not supported by the evidence cannot be considered well rationalized.

So, my question is related to this, what information on exposures is available to the treating physician?

For example, can they get the site exposure matrix? Can they get employment records for the specific patient? Can they get exposure determinations that were already completed for other coworkers who were in the same job and location?

Because since there's so much weight put on identifying a specific exposure, my question is, how can that be done by a physician in the community that's treating this patient and

writing their opinion?

MR. VANCE: Yes, and that's one of the challenges of looking at this particular standard is that we have no way of necessarily -- I mean, when you're looking at all the things that can be associated with asthma, we generally rely on the physician to use whatever judgment he or she wants in evaluating that patient and looking and understanding the information that's available.

And, that often times relies on the physician's physical examination and interview with the patient. They have access to the site exposure matrices if that's part of the evaluation of the claim.

They can certainly ask for any medical records. But, my general sense of it is, is generally it's going to derived from a patient explaining the situation with regard to the work that they were doing and identifying the things that they were encountering that they are feeling is contributing to the asthmatic condition, whether that's either the development of that

condition or the aggravation of that condition at the time of employment.

And, often times, you know, where we have cases where the condition is documented to have been affected by something in the workplace, that's a fairly straightforward thing where we can accept that right off the bat.

So, asthma is a very interesting and complicated one simply because it's such a -- it's so wide open to the type of toxins that can be affecting that kind of a condition.

MEMBER FRIEDMAN-JIMENEZ: So, do the physicians have access to those sources of exposure information, the site exposure matrix and exposure determinations done by EEOICPA or other coworkers in the same job and location?

Because the number of exposures for which we have tests that we can actually measure from the patient like an antibody, is vanishingly small for asthma and for most other diseases.

So, there's the need to have available exposure information for the physicians to make

these judgments.

MR. VANCE: Yes, I mean, they would have access to the site exposure matrices, that's a publically available resource.

But, again, we're dealing with physicians that are going to have to rely on whatever information they can obtain generally from the patient.

If they would ask the Department of Labor to provide any information, we can certainly do that, and we do oftentimes engage with physicians in providing information on these cases.

But, from my experience, it's generally left to a physician to make the best possible decision based on whatever information is available.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I think, John, I understand the rationale for asthma because it is multi-factorial and complex.

However, I would also argue that the

same principles apply to COPD. And it's one of the big ticket items, just one of the large issues facing these workers.

The Board made a recommendation on vapors, gas, dust and fumes which wasn't accepted. And, I'm not quite understanding the rationale for rejecting that but also taking the issue of asthma and accepting a more broad definition of exposure.

Also, in the SEM, there are mixtures in the SEM. There are many of them in the SEM. COPD, for example, has cement dust, coke oven emissions, they're all complex mixtures just as VGDF is.

And, the literature -- the published literature for the last ten years has really supported a broad response -- COPD response to a broad number of different toxins as a mixture.

I mean, I get -- I'm trying to understand sort of the big dichotomy and the rationale.

MR. VANCE: Yes, I mean, I -- the way

I would respond to that is that, you know, the Department of Labor evaluated -- you know, we have to look at each specific issue that we're presented with.

Asthma is its own issue, COPD is something completely and separate in our view. And when we provided our written responses, we explained what our rationale is for our asthmatic condition and we also had a response to how we evaluated and considered the recommendations of the board.

So, I mean, we did evaluate and respond to both those things, and that's something that I'm certain that if the board so wishes, we could certainly revisit.

CHAIR MARKOWITZ: Sure, probably tomorrow actually.

Yes, Dr. Redlich?

MEMBER REDLICH: So, I think I want to just clarify one thing I said earlier from my reviewing the most recent version of the procedure manual.

The criteria to diagnose asthma were updated. The criteria to diagnose work related asthma, I think, were the same as before.

MR. VANCE: I -- all I can tell --

MEMBER REDLICH: I thought maybe --

MR. VANCE: -- you is like we did make modifications based on input from the board. And, I thought that it may have been -- I can't be certain, but I do know that we made substantive edits to the language based on input from the board.

But, I don't know if it all occurred at one time or based on input from different recommendations. Because I remember there was some recommendations that Dr. Markowitz had made that I think that we accepted at a different point and when we looked at some of the language that you had supplied.

MEMBER REDLICH: And I just wanted to just -- I -- in case you're not aware, there is starting on page 533, the matrix for confirming sufficient evidence of noncancerous covered

conditions, and a lot of people look at tables and matrices.

My read is that those are -- have not been updated and are not consistent with the text.

MR. VANCE: Yes, you are correct and that is actually something on the list for editing.

So, our medical director is going to be involved with evaluating and reviewing that. That's something that has been flagged for review.

MEMBER REDLICH: Okay. Because I think it is confusing when there are --

MR. VANCE: Oh yes.

MEMBER REDLICH: -- different versions.

CHAIR MARKOWITZ: I know, I think actually, since they -- may of those pertain to some of the outcomes we've been discussing over the last year or two, we could probably be helpful in that process.

MEMBER REDLICH: You know, I think tomorrow the question of mixed exposures for outcome COPD hopefully we'll get back to.

CHAIR MARKOWITZ: Sure, we will, yes.

Do you have anything else?

MR. VANCE: That's it unless there are any other questions.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: Someone asked me recently have I read the updated procedures manual. And my --

MR. VANCE: And, you said, absolutely it's the best read I've had in a while. It's almost Stephen King level quality.

MEMBER SILVER: Well, my first thought was what do I say to students who are assigned a 700-plus page textbook in one of their other courses and that is, contact the publisher and see if there's a workbook that goes along with it so that you can take your mind off the broad generalities and apply them to realistic problems and cases.

You mentioned that you have training materials. To what extent are your training materials approaching a workbook?

I mean, I could sit down and read the tax code in the CFR, but without those boldfaced examples that the IRS puts in their tax publications regarding, you know, realistic families and people, I wouldn't learn anything.

MR. VANCE: Well, I mean, you know, I hope that the procedure manual is written in a way that conveys information that allows our claims examiners to know exactly what they're role and function evaluating evidence is.

I also would say that we write the procedure manual in a way that tries to promote the culture that we want to convey to not only our staff, but to the public, which is that we are actively engaged in trying to find ways through this very complicated process.

And, as, you know, to the greatest advantage of our claimants and that we really do apply a lot of different resources and tools to

making sure that our process gives every possible favorable consideration to a claim.

It's not something that is easy, and that's why you guys are asked and tasked to help us with that process.

We are dealing with some very challenging and difficult epidemiological issues, medical issues, medical health science issues. And the procedure manual is designed to try to give a framework about how claims examiners do their job and I know it's very challenging and complicated.

But, often times, we also will find reasons why we don't want to include very specific guidance because we want to leave it to the circumstances of case and the judgment of that examiner in looking at all of the different information in there and making as well of an informed decision as they can based on the specifics of that individual case.

CHAIR MARKOWITZ: I would just say that you should -- to the board members, you

should definitely read parts of the manual because that's where the rubber meets the road.

Chapter 15, 16 and 18, they're not that long. They're infinitely easier than many things you've read in your lifetime. And they're very informative.

And so, if you think that, okay, I'll never get through a 700-page document, just focus in on those chapters because they really address the issues that we care about.

MR. VANCE: And I would pay particular attention to Exhibit 15-4, that is our exhibit that talks to the presumptive standards that exist under the program.

It's pretty comprehensive. We used to have that fragmented all over the place and we consolidated that on one place. And so that's our one really important resource that we are constantly looking to improve and add to.

CHAIR MARKOWITZ: By the way, in that 15-4, the only presumption for COPD relates to asbestos, is that right?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay, thank you.

Dr. Dement?

MEMBER DEMENT: Just another comment on COPD, there's a direct disease link in there for COPD and it goes over, if you look at it, it has cement dust, coal dust, coke oven divisions, welding fumes --

MR. VANCE: Right. Yes, and so, okay, so just to make sure everybody understands what that exhibit is talking about, that exhibit is basically saying that the program has made a determination that if you satisfy those criteria, okay, there are exposure presumptions, but there's also causation presumptions.

And I'm talking about causation presumptions. So, in other words, if you meet specific exposure, latency and medical diagnosis criteria, the program is basically saying, then we are accepting that it is at least as likely as not that that exposure was a significant factor in causing, contributing or aggravating that

disease. Okay?

Simply because you don't satisfy one of those presumptions does not mean we deny your case. That means that the case goes through the normal adjudicatory process. And we have a lot of information available about known toxins that have a COPD health effect.

And so, when I talk a little bit about the site exposure matrices tomorrow, you'll see our assembly of all of the known toxic chemicals that are known to be a health effect for COPD.

And then, that plays into the causation analysis and looking at, you know, a physician having to make a judgment as to whether or not the level and extent or exposure as established by the program and evaluated by industrial hygienists is enough to meet that compensable threshold under Part A.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: I think that -- I think this point was made before and I just -- I have been reading the different versions of the

procedure manual, in particular, the now Chapter 18.

And, I realize that you feel that you have experts reviewing the terminology, but my last read of it before this meeting last night, it was still inconsistencies and things that I would say were just medically --

MR. VANCE: Right.

MEMBER REDLICH: -- inaccurate.

And, if you actually go back to the original wording of the congressional act, it doesn't start getting into mediastinal lymph nodes.

And, some -- almost feel that in each version sometimes gets more convoluted and complicated than a prior one. And, I -- you know, we have offered our expertise I think just to really be accurate.

I still found, yes, there were changes to include, I mean, the lymph node, but whoever edited it really didn't have the understanding fully of I think some of the subtleties in ways

that could actually be worded in a simpler, clearer way that I don't think would not be, you know, opening the doors for every disease but, just sort of internal consistencies.

MR. VANCE: I, you know, I'll say two things to that. Okay?

The -- as the chief person who looks at all of this stuff coming through this process of drafting and editing and publishing, two things stand out.

One, we get input from a lot of different sources, a lot of different physicians over the course of this program. We've had lots of people providing us input.

You're now looking at it, you're not the same person that gave us that input.

MEMBER REDLICH: And, I realize -- I know I'm not and I know --

MR. VANCE: And so --

MEMBER REDLICH: -- some people --

MR. VANCE: Right. So, you know, my advice and my biggest recommendation for anybody

working on this kind of stuff is specificity. Okay?

If you were looking at our procedure manual and you're saying, I don't like that, saying to me, I don't like it, you know, okay, what is it specifically that you think is inappropriate and what would you specifically recommend as a change?

You know, specificity is the key thing for our procedure manual.

MEMBER REDLICH: Okay, well, you know, I would be happy to spend the time to do that if I felt that it would -- there was a reasonable chance that it would be incorporated or, if it wasn't incorporated that there was just a good reason for that reason.

MR. VANCE: Okay, that --

MS. LEITON: So, we do -- we looked at the main -- you did provide us very specific information, some of it we took, some of it we didn't.

The review process goes through a lot

of different layers. We don't always end up taking exactly what you said word for word.

Going back and forth to determine whether the words we used was the words you would have chosen to use, that's not going to be useful time.

So, we do have a process. We go through that process, it goes through legal, it goes through our medical director, it goes through a lot of other various administrative functions that need to be -- to be undertaken for our procedure manual chapter to get published.

We're not going to be able to go back and forth about why did or did not change a specific thing in our procedure manual. We'll take what we can, we'll incorporate what we can and then we'll publish it based on the guidance and the process that we have and that's as far as we go with it.

MEMBER REDLICH: Yes, I understand and I don't want to micromanage, but I think you also just want to be medically accurate.

MS. LEITON: I believe that the process that we have, we are -- I mean, we do have medical people reviewing them. You know, we've had experts, as John indicated, on CBD help us with this.

You know, at the end of the day, we can become more vague and then the doctors can tell us. That's our options there. So --

CHAIR MARKOWITZ: Okay, thank you very much, Mr. Vance.

Let's move on. Ms. Leiton's on again, program updates over the last 12 months or so.

Hold on, it's been raised whether we should take our break now. Do people want to take their break now?

Okay, we'll go on break, let's -- 3:00 we'll resume.

(Whereupon, the above-entitled matter went off the record at 2:49 p.m. and resumed at 3:10 p.m.)

CHAIR MARKOWITZ: We're going to get started. At 4:30 -- a couple minutes before 4:30

actually, we're going to stop because we need our public comments. So, we are going to stick to the schedule here.

Well, we're doing well so far, I think we're up to Ms. Leiton to provide program updates over the past 12 months.

Thank you.

MS. LEITON: Sure.

Okay, I'm going to just talk in general about some of the things we've been up to, what we've done policy wise, organizational wise, just in general, not all of these things are going to be specifically related to your tasks, but just so you're aware of some of the things that we're doing.

So, one of the main things that we've done in the last year is we've reorganized our national office. John told you a little bit about his branch. His branch used to also include a unit of medical bill processing, a little bit of program integrity.

And, what we've done is we've created

a new branch in national office, that is the branch of medical -- the medical branch basically.

And, what that consists of is, we're looking -- we've hired people, mostly claims examiners, from taking them away from doing just claims examiners -- their main duties of claims examining, we've created medical benefits examiners.

The reason we've done this is we've had a lot of -- an increase as we have an elderly population, we have more and more requests for additional medical equipment, but also specifically home healthcare.

And, that increase, it has been kind of overwhelming and taken over in the past couple of years some of the focus on adjudicating claims by claims examiners to now we have a whole other process to adjudicate.

So, we've centralized the medical bill processing into one unit, one branch. We've got a unit full of medical benefits examiners. Their

primary focus is to look at ongoing requests for medical care, not typical like if we've got -- you know, if we've accepted a condition, we're going to pay for normal, typical treatment of that condition through our treatment suites, through our medical bill processing. But we do require pre-approval for certain things.

And so, they're looking specifically at the influx of home healthcare requests that we've received, making sure that we're being consistent in the way that we adjudicate those claims, making sure that we're following up appropriately, that we're doing it timely and that we're doing it accurately and to the benefit of the claimants, ultimately, hopefully, in that when you centralize something like that and give that -- we're writing more and more procedures to make sure that the process for doing that is thorough, consistent and focused.

So, that kind of relieves claims examiners who are adjudicating claims to do just that. So that's one thing -- one of the units.

We've got a unit focused on medical bills, assisting with ensuring that the payments are going through, working with the contractor for our medical bills to ensure that the changes or any changes that need to be made that are specific to our program are made, troubleshooting any problems with medical bills.

We've had that for some time along with a fiscal section that deals with general payment issues and overpay, things like that.

And then we have a program integrity unit. That unit is focused on -- they do some audits of medical bills, make sure they're being submitted properly, paid properly and just looking at overall accuracy and integrity of the way that whole process, whether it's home healthcare or it's other medical bills or whatever it is that they're taking a look at those issues.

This is something that is also being done in the federal employees compensation program. They've got medical benefits examiners

that are more focused on that was well due primarily to opioids and that whole issue that's going on in the medical community.

So, we do have a new branch chief of that unit, Toni Eason. And then we have branch supervisors for the different units in that branch.

So, I think it's going to be a good change. It's, again, we've developed a backlog of some home healthcare requests that we've been able to get through and now we're, you know, streamlining processes.

The other thing that we've done this last year is we have centralized our assignment process for our final adjudication branch.

In the past, we had -- we've had -- and we've developed this from the very beginning. We've had units of FAB examiners and hearing representatives in -- co-located in each of our district offices.

We still have those units but the process was a certain percentage of cases that

came out of the district office, say, in Jacksonville would go to that Jacksonville unit, a certain percentage in the Denver would go to Denver, certain percentage in Cleveland, et cetera.

As our caseloads in the various regions changes, getting fewer cases in some areas than other areas, it has made sense for us to change the assignment process from a regional-centric assignment process to a centralized assignment process.

It also provides more variety for different hearing reps to look at different cases throughout the country instead of just hearing reps in Jacksonville looking at just Jacksonville types of cases.

You're going to find perspectives around the country.

We've undertaken an extensive training process because one of the reasons we originally did this was there are very specific site interests. There are certain verification

processes that occur at Hanford or Santa Susana that are going to be different from those that are out in Paducah or Oak Ridge.

So, we've developed guides for the hearing reps to follow specific information about facilities. We're still in the process of doing that.

We've got PoCs in each of our FAB offices that used to be focused on those types of facilities to provide information to the other hearing representatives.

But, it will allow us to assign cases more equally, more transparently and have a variety of larger pool of hearing representatives to look at different types of cases throughout the country.

And, ultimately, you know, in hiring, we can hire wherever we need to.

We have had a national office FAB since the beginning that has looked at all of the different types of cases and that's here in D.C. They're not co-located with any district office.

So, this has been done and it has continually been done but now it's just being done nationwide.

I think some of the feedback we've received regarding hearings and scheduling of hearings this last year is a result of this centralization process because we're -- they're still getting used to going from Seattle to, say, Paducah for a hearing instead of just to Hanford to do a hearing.

And so, we're working through the logistics of that now, but I think ultimately having this ability to disburse the cases to a wider set of hearing representatives is going to be beneficial to the program and, as I said, the assignment process will be a little bit more -- a little smoother and transparent.

We've done a lot of work on outreach in the last year. We have -- well, we started with authorized representative workshops.

Denise Brock, who works for NIOSH, she's their Ombudsman, she'd done a couple of

these in the past and they were very small group presentations.

Instead of an outreach event where we just provide an hour-long presentation or we work with the joint outreach task force group to do, you know, a couple of different outreach presentations in a day, we're trying to go around the country and do two- to three-day workshops where --

And, we are, first, focusing on authorized representatives since sometimes you'll have an authorized representative that will represent multiple people to learn about the process.

So, we worked with the joint outreach task force group which consists of Department of Energy employees, former worker program and NIOSH, the Ombudsman for our office, for DOL and then the Ombudsman for NIOSH are all involved in the JOTG.

And, we've worked together with them to create these workshops where they'll -- each

of -- each component will provide a presentation on the first day about their roles, what they do, what their resources are.

And then, we'll have a more detailed instruction by section. So, for example, we'll have a supervisor provide information about specifically how to file impairment, what that consists of and we'll do for -- we've done it for impairment, wage loss, survivorship.

We've got a records, a tool -- a session on how to look for information on our website. We've got a session on specifically hands on session on how to use the SEM, what it looks like, what it means.

Stu Hinnefeld from NIOSH has done an hour-long presentation on the dose reconstruction process.

And so, we're trying to do them in different areas around the country. We've done three in the last year in Jacksonville, Kennewick, Washington and Cincinnati. And we're looking to probably go another -- maybe out west

in the spring, see how that works.

We just feel like if we could -- and it's really 20 to 30 people and it's a little bit more hands on, a little bit more discussions rather than us kind of speaking out at people.

Not that we've stopped general outreach. We've done other events, 15 over the year between 17 and 19 about SEC classes, a general JOTG event, and then just general information that we've provided.

We also do outreach to the medical community, as I indicated, it's a growing part of our program so we try to target providers in various areas to talk about the medical benefits we provide.

That's open to anybody, but it can be doctors, providers, claimants, whoever is interested in that particular topic, we get into a lot more detail about those benefits that we provide.

CHAIR MARKOWITZ: And who ends up showing up at those?

MS. LEITON: At the provider ones?

CHAIR MARKOWITZ: Right.

MS. LEITON: Well, we get various different groups. I mean, we don't get that many physicians because oftentimes they're not going to go to those themselves.

But we will have home healthcare companies that will come and listen. Sometimes we'll have administrators for physicians' offices go. And claimants, we still get claimants who are interested to find out what their benefits really are.

The authorized representative workshops, they -- you know, we're still -- it's a work in progress. We're still trying to figure out the best way to do that, the best way to reach out to people to do those.

Director Hearthway did a stakeholder meeting this year in D.C. this last month to try to reach out to any -- it was open to anybody who could come to D.C. and she did a presentation talking about her mission and her, you know,

direction for the programs.

And then, we had individual presentations from myself and John Vance and Toni Eason and our outreach person, Josh Novak, to provide more information about those particular branches.

So, that -- those have been our ongoing outreach.

Oh, we also have done -- we started email blasts to providers. It's actually to anybody, but they're email blasts specific to medical benefits and particular topics.

We've got a lot of subscribers, or hundreds of subscribers to that at this point. And, it's just blasts. If you submit your email, we'll send you information from our medical.

We're starting to do that just this year for policies. So, if we have new policy that's out there, we can send email blasts to people who subscribe to give them an update on what new policy is out there, whether there's a new bulletin or circular or whether it's just a

general something that's bigger that we need to -- we'd like to get the word out about.

We also hold quarterly conference calls at our -- they're for, again, for medical providers but they're -- and this we do get, if not -- sometimes we get physicians on these calls, sometimes we get nurses from the physicians' offices.

But, we'll send out information about the types of -- we'll have a series of questions or a topic that we'll look at, like one of them was conflict of interest in home healthcare, one was about the bulletin for rehabilitation therapy services, one was about ancillary medical services, tips on how to submit prior authorization.

So, we'll have these on a quarterly basis as well. They're just phone calls people can call in for.

In addition, we've had the electronic document portal out for quite some time, but we've seen a tremendous increase in the use of

that which shows us that the internet is being used more than it was originally.

People are looking at the internet more. There's just been -- people are realizing that they -- instead of using mail, they can upload their documents directly into their case file and it'll go directly to the claims examiner for immediate action.

And, I've seen that be really beneficial.

We've talked about in the past to this Board and we're continuing to work on additional access for claimants specifically to have direct access to their case file and it's a lot more complicated than it seems.

Unfortunately, there's levels of privacy, verification of who you are and those sorts of things that really need to go on before we can get that access.

I know it's something that has been looked at in our other OWCP programs to get some sort of an access direct to the case file so that

they don't have to ask for paper copies or get them on discs and sent to them.

So, that's something we're working on, we're not quite there yet.

CHAIR MARKOWITZ: So, what -- I know we discussed this in terms of one of our recommendations and it seemed like it wasn't just EEOICPA, but it was an overall effort.

MS. LEITON: Yes.

CHAIR MARKOWITZ: Are any of the other compensation programs a little bit further along that the EEOICPA is -- can tag along or --

MS. LEITON: Well, we're working with them directly. So, as soon as one of us gets there, we're going to try to --

CHAIR MARKOWITZ: When Doug gets there?

MS. LEITON: Doug might be able to answer that question.

MR. FITZGERALD: I can -- I think I can shed a little light on that.

I think that the FECA program, because

it's a closed system, it's a lot easier to manage the personal information easier and know who the users are.

For any entities that, and within OWCP, that have external parties involved, you have to make sure that the people are who they are -- who they say they are and that that person actually should have access to the information.

So, maintaining that data is very complex when you start going outside of a closed system. So, that's the biggest impediment for where I think the other three programs are in FECA right now.

MS. LEITON: Because federal employees, so it makes it a lot easier.

CHAIR MARKOWITZ: So, is there any sort of rough time table for success?

MS. LEITON: I don't want to give you any promises here. I hope in the next couple of years.

The site exposure matrices are continually updated. There have been 15

revisions to the SEM website since March of 2010 that we'll talk more about tomorrow, but we've talked about already.

We're continuing to do accountability reviews. We -- the results of the last year's reviews, we do them for the district offices. We do them in the final adjudication branch. They've done pretty well in the quality of the cases, the decisions we've reviewed.

We have various topics we look at from the quality of the written decision, whether it's a recommended decision or a final decision, to the development process, to the referrals that are being made.

Those sorts of things are looked at. I do think there's always room for improvement when you're auditing yourself because, you know, sometimes it's a training issue, but sometimes it's not. And, oftentimes, the fallback is, well, we'll train them more.

Sometimes it's just there's a particular person in a unit that's, you know,

that needs to have additional training.

And so, we're trying to find ways to enhance or improve that so that we can get to really where any problems might be and how we can address them.

We did -- we had a lead training analyst who left at the beginning of last year. And so, we had a lot of plans for enhancing our training which came to a halt and then we had hiring, you know. It's always -- hiring freezes and hiring issues to get new people.

But, we did hire a new training analyst who's being tasked with trying to do more -- well, first of all, update current training to make it consistent with our new procedures, our procedure manual.

Second of all, to try when there's new procedures to come out to provide a training to go along with it, whether it's a very specific topic or it's a very specific issue that requires a little bit more in-depth discussion, that's where we're trying to focus.

And, I think one of the areas right now that our training lead is working on is the actual presumption changes that we're making as a result of the recommendations from the Board.

We are going to -- we've developed a list of cases to be reviewed. We're going to walk them through the best way to review them for these causation analyses that need to be done.

And I think that's going to -- it's a big project because, you know, going back and looking at cases that are already adjudicated can take away time from doing incoming cases. But, we're going to work it into the workload, work it into the current process.

And so, I think training, we're going to try to build it up more and more as we go forward.

Dr. Silver mentioned the procedure manual and one of the -- it's one of the things that we hear about and that it's -- there's a lot of information, claimants and others who are trying to -- they can access -- we've made it

searchable which is helpful.

There are, you know, now you can go to a chapter and you can click on the link and it'll take you to the chapter.

There are some improvements we've made, but we're working on our website to make it so that it's process-driven.

So, for example, if you want to file a claim, you can go to this section, it'll tell you here the forms you're going to need to do that.

If you want to do impairment, here's what you, you know, you're going to need. It'll take you to that resource by section.

While the procedure manual does that, it's not as easy to navigate. And so, we're trying to come up with a website on our website that will help with that.

And that I do hope will be done within this year in the next couple of quarters.

Those are the things we've done in the last year that really are the big-ticket items. We continually are looking at our procedure

manual to try to make updates as well.

And, there's just -- there's, you know, we do look at what we've -- we try to do and what we've been doing more and more is look at the ombudsman reports and for, you know, issues that have been identified.

One of them, of course, that is always recurring is that we're not reaching enough people, so that's why we've been trying to be more robust in our outreach.

It's difficult because we don't have lists of current employees; we have lists of current claimants.

And so, that's why we're able to work with DOE and the joint outreach task force group to reach some of those people that aren't being reached. They have some lists of former worker programs that we can't take anybody else's lists, that's part of the problem because of the Privacy Act.

We can only ask them to help us by mailing things out and getting the word out about

the program.

We're trying to do more advertisements as resources allow, more targeted, like, fliers and getting the word out about events.

We have one this week I believe it's in Lynchburg maybe where we've done a lot of advertising and kind of trying to get the word out where we can and we'll see how that works out.

But, there's also the training issue. Some of these -- whatever comes up, whether it's an ombudsman report or stakeholder meetings or, you know, board meetings, we try to -- we're trying to look at those to see what we can do better.

And that's kind of where we are.

CHAIR MARKOWITZ: Thank you. Any comments or questions?

(No response)

CHAIR MARKOWITZ: Okay, great, thanks.

I think we're in for a return performance from Mr. Vance.

MS. LEITON: We're both going to stay up here for this one.

CHAIR MARKOWITZ: Oh, okay.

MR. VANCE: Yes, this is the really fun stuff.

CHAIR MARKOWITZ: Uh-oh. For you maybe, John.

MS. LEITON: Not really.

MR. VANCE: All right, so, we're moving on to some suggestions that the program has with regard to specific areas of needed attention.

And we, just to give a little bit of background, so, you know, with my discussion about the policy analysts and the medical science unit, we're privy to lots of issues that come up from case adjudication activities.

And so, you know, we made an effort to try to identify areas where we have struggled and identify areas where we really could use some medical health science expertise, epidemiological expertise, medical health science expertise in

evaluating certain topics and subjects.

And, I canvassed my staff and I was looking for areas where we really had some issues. And, I was looking for things that would have a direct positive effect if we had better or more clear guidance as to how to apply processes to the evaluations of certain types of cases or certain areas where we could really use some assistance and helping affect positive change for claims, claims that we see, things that we see fairly frequently.

And so, I think the Board has been presented with a set of four areas where we have identified a need for assistance.

And, the first one is on one that has been around for a long time and it may have been part of the original batch of issues that we had submitted for Board consideration which is this very challenging issue of Parkinson's disease and its association with chemical exposures.

And, we have encountered a lot of cases where we are presented with claims for a

variety of problems regarding the interchange between Parkinson's disease, Parkinsonism, manganism and other forms and various types of aliases being utilized by physicians.

I've seen Parkinson's syndrome and all these sorts of things.

We have created, and it's been out there for quite a while in our presumptive Exhibit 15-4, a presumption relating to Parkinsonism where we're talking about what we had done in the past with looking at exposure criteria, you know, the type of toxins associated with the development of Parkinsonism or Parkinson's disease.

And, you know, some of the work processes that are associated with this.

This is felt by my team to be woefully out of date and in need of revision. There has been additional epidemiological information that has arisen from this.

There is ongoing debates about how to define or categorize this type of disease

process. In other words, is it proper to say that somebody with a true blue diagnosis of Parkinson's disease, is that an occupational disease or is that something that should be reclassified or recharacterized as some sort of occupational disease process such as manganism where you have a direct connection to manganese and then that's what's really the causal factor in the development of that.

So, it has presented itself in lots of different ways and we think that our guidance is just out of date and it needs to be looked at and evaluated, particularly with regard to diagnoses.

You know, what is the proper diagnosis for an occupational type of Parkinson's syndrome or disease? What are the appropriate aliases? Are we looking at Parkinson's disease as its own entity or should we be separating these out?

Manganism is something unique, Parkinsonism, Parkinson's disease is something separate.

What are the appropriate linkages,

health effect between particular exposures to specific toxins and the development of these categorizations of Parkinson's disease or any of its associated syndromes?

And any, of course, presumptions that we could apply. Our existing presumption has, and I'm not going to spend a lot of time going through the existing presumption, but it does go through a relatively linear set of things that we've done to try to apply a presumptive standard.

According to my folks, this is a very challenging area and the epidemiological literature in this area is all over the place.

And so, it's -- it would be very helpful for any kind of I think framing of this or some guidance that we could use to apply in a process to generalize from one case to the next.

And, when we're presented with claims for this disparate type of stuff associated with these types of conditions.

Any questions?

CHAIR MARKOWITZ: Sure. Any sense of how many claims you get per year over the last few years for this spectrum --

MR. VANCE: We do --

CHAIR MARKOWITZ: -- and how many are accepted or denied?

MR. VANCE: I think that we -- when I -- we didn't do a specific statistical analysis and I think we can get that information.

MS. LEITON: If we've done it for other Boards.

CHAIR MARKOWITZ: So, Carrie, that's on the request list.

MR. VANCE: So, this was -- this is the issues that my staff identified as things that they have encountered and they have struggled with.

My personal view is that most of these do get through a process where we end up accepting it because it's just so challenging and our process lays out a pretty -- it's a process by which we can, you know, make a presumptive

determination in the case and most physicians understand that, but we don't know whether our -- the evolution of science is complying with how we present it.

So, and there are challenges when we ask physicians to try to get them to understand their application of the diagnoses and applying it in our process. It's just a challenge for physicians to understand all of this when you're dealing with someone who has a trembling type disease.

Are we talking about manganism? Are we talking about Parkinsonism? Are we talking about Parkinson's disease? And what is the association with an occupational exposure or toxin?

It's just a very big challenge. And, I think that we've generally -- I think that my view is that we generally accept a lot of these cases but we don't know whether that, you know, whether we should be adjusting our process in any way or making it easier or more difficult or what

based on the current epidemiological literature of medical health science.

Other questions?

CHAIR MARKOWITZ: Not now, I mean, we're going to turn to these requests tomorrow when we've figured out our agenda. But go ahead.

MR. VANCE: Great.

Second area of assistance or a suggestion was the re-drafting and editing of the occupational history questionnaire.

So, this was a topic that actually the Board had made recommendations on the in the past, but the feedback was viewed as being overly broad and we were hoping for a more encapsulated set of recommendations as far as taking our existing draft occupational history questionnaire and giving specific feedback as far as what changes to that specific draft you would recommend.

There was some conversation and input from the Board with regard to assimilating features of the former worker screening program.

That was felt to be very broad, so we're hoping for specific recommendations about what you specifically change in our existing draft.

MS. LEITON: Now, I know this has been something that you guys have worked on and have addressed to a certain extent.

I think we, you know, we've got such different types -- we've got construction workers and then we've got these other types of workers.

And, I don't know if it's something where we should modify it depending on what type of work they're in and have a certain set of questions, what those questions might be.

If there is specifics that we could really work with to give to our resource centers and say, these are the types of questions, you know.

We don't want to be just -- we don't want to give them a list like we have or we do sometimes of here's these chemicals or substances you might have been exposed to, pick them.

But, at the same time, you know, is

there a specific question that'll get them to, this was the work process I was involved with or this is what -- we can lead them to giving us information that will help us get the information we need for toxic substance evaluation.

And, just as specific as we can be on that, we have -- we do have a lot of leeway on this one. We just want to make sure, if we need to tailor it more, if we need to do something more specific with it or we can --

It's hard to generalize an OHQ, as you know. So, maybe we need to think of different ways to do it, depending on what they're claiming or where they worked or, I don't know.

But, those are the kinds of things we're kind of grappling with.

CHAIR MARKOWITZ: So right now, you have a draft of a revised questionnaire?

MS. LEITON: Mm-hmm.

CHAIR MARKOWITZ: So, can we get paper copies of that we can look at by --

MS. LEITON: Absolutely.

CHAIR MARKOWITZ: -- mid-tomorrow morning so that we can discuss it and figure out what --

MS. LEITON: We have it.

CHAIR MARKOWITZ: -- we can do?

MS. LEITON: We can get it to Carrie tonight or tomorrow. Tomorrow.

CHAIR MARKOWITZ: Okay, thank you. Any comments on this issue?

(No response)

MR. VANCE: All right, and a third was a recommendation or a seeking for assistance with regard to the radiogenic substances that we often encounter at DOE facilities.

We see a lot of, you know, these were atomic weapon production facilities where there was uranium, plutonium and lots of other different types of radiological sources.

We have a dose reconstruction process in place and our special exposure cohort analysis process for evaluating radiation as a health effect from those exposures.

But, we have very little information about non-radiogenic health effects. So, in other words, what are the health effects of exposure to those toxins that are not radiogenic in nature?

And, the example is we do link uranium with acute tubular necrosis.

So, this is something that I think our SEM team was looking for input on. Are there other types of non-cancer conditions that can be associated with radiogenic sources?

CHAIR MARKOWITZ: So, you mean sort of the chemical health effects of the --

MR. VANCE: Exactly. Yes, struggling to try to figure out how to say it, but yes, basically, you know, what we could do to look at those types of things and link them to other types of medical conditions aside from cancer.

Questions?

(No response)

MR. VANCE: And the reason that's sort of a critical one, just by the way, is that we,

you know, this is a very common set of exposures that people are going to be encountering at these sites where there was production of these atomic weapons, so something you would assume there's a lot of exposure to some mix of workers.

CHAIR MARKOWITZ: So, I do have a question I guess, uranium, acute tubular necrosis, how have you previous or dealt with this issue, aside from that connection?

MR. VANCE: Well, I mean, once we have, you know, we can talk a little bit more about it tomorrow when we talk about the site exposure matrices.

But, you know, once we have an established health effect, we're able to sort of filter and create the framework for which we can then have a physician evaluate that claim for causation.

So, if you're looking for, you know, we're looking for the relationship between an exposure to a particular toxin that has the potential to cause disease. We have to profile

that and then get a physician to evaluate that claim and make a judgment of causation.

MS. LEITON: But, up to this point, which I think you're asking, we have -- it's been scarce because we just don't have enough information.

So, some of those will probably be denied because we don't have information.

MR. VANCE: Any other questions?

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: Not to complicate things, but it seems like it's somewhat related to another issue which is the non-cancer effects of radiation exposures.

MR. VANCE: Yes, I mean that's basically what we're saying is that, you know, the effects of being exposed to uranium other than --

MS. LEITON: Yes, that's what Dr. Andrews --

MEMBER SILVER: All right, so, let's get clear about this. It's not just the chemical

toxicity of radionuclides; it's non-cancer health effects of radiation exposure.

So, it's been a while since I've read the NIOSH regs, but I imagine non-malignant thyroid disease?

MS. LEITON: There are a lot of things that radiation caused, but that's -- I'm sorry.

Yes, it is non-cancer. Because the cancer ones, we know what we have to do with those. We're required to do those.

We have to go to NIOSH for cancer or radiation exposure.

It's the ones where we don't have cancer and we don't go through the NIOSH process. But, it is radiation. And so, it's how we handle those particular types of conditions.

MR. VANCE: Radiogenic sources.

MS. LEITON: Yes.

MEMBER CASSANO: So, you want us looking at both then? Both the chemical consequences and the non-carcinogenic effects of radiation?

MS. LEITON: Yes.

MR. VANCE: Yes, thank you.

CHAIR MARKOWITZ: Any other comments, questions on this issue?

(No response)

CHAIR MARKOWITZ: Okay.

MR. VANCE: The fourth one is a recommendation that came from the SEM team again.

So, and I'll demonstrate this a little further tomorrow, but when searching site exposure matrices, we have health effect data relating to specific conditions that basically there is no science associating that particular type of condition with an exposure to a particular toxin.

Our site exposure matrices has categorizations of these diseases and one of those things is an alias field.

So, in other words, if you are looking at the history of a case and you see that a physician has referenced a particular condition in such a way, we can accept that that is

synonymous with this definition of that particular condition.

So, the example in the write-up that we did was for chronic renal failure and some of the aliases are CRF, chronic renal insufficiency, chronic kidney disease unspecified.

So this is just an effort to identify in the history of these cases that we see, different terminology that basically is communicating a particular type of diagnosis.

So, another example that's pretty familiar for some folks is chronic beryllium disease. A lot of folks refer to that as berylliosis and that's, you know, it's interchangeable. Physicians use those interchangeably, so when our staff are looking at the cases and they see a claim for -- that's referencing either one of those, they know they're dealing with chronic beryllium disease.

So, it's just basically a categorization and identification of aliases in the site exposure matrices.

MS. LEITON: Now, I mentioned earlier that that's one of the projects that we have our SEM team working on is looking for aliases.

But, it's important in the claims process because, you know, our claims examiners, they have a disease, they go look it up and they see just that disease and nothing, you know, they don't see anything for it.

But, if we have an alias for it that says this could also mean this other condition, they might find it there and then they can actually make the links for the exposures that they need to find.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Do you see on some of these I guess lack of a better term that from one site to another there might be a cluster of Disease A that you've gone through on a, you know, say, on one of these that you see renal failure, a lot of them coming out of, say, Savannah River, for instance compared to Hanford?

So that, do we need to look at maybe

the chemicals or whatever sources or something there? Have you guys broke it down to try and narrow any of those that are just pretty general globally?

MS. LEITON: Yes, we don't have -- we haven't been able to do cluster studies or that sort of thing in terms of our current claimant population and where these specifically are coming from.

It would require a significant amount of data pull to see where these conditions pop up and what different sites.

I mean, it's a project that could be undertaken, but it would just require us to pull a lot of reports and then I don't know that we have the resources, but it's something that we could pull and if you guys wanted to help us look at that, it's something we could think about.

MR. VANCE: It's a great research project.

MS. LEITON: Yes.

MEMBER DOMINA: I guess we won't see

it tomorrow then?

(Laughter)

MS. LEITON: Not tomorrow.

CHAIR MARKOWITZ: So the request on the aliases, synonyms, is only about health effects and you -- the SEM has a lot of these and the request is for us to look -- to review the current aliases and make sure that they're accurate?

MR. VANCE: That's correct and then looking as seeing if there are other aliases that we should be applying in some way based on the collective knowledge of the board.

MS. LEITON: Yes, I mean, I imagine -- I mean, you can look at the various -- obviously, you're not going to look at every single condition that has a health effect in SEM, but, you know, we could tailor it down somehow and look at certain ones. I don't know how you would want to start that project, but we can help you with whatever we can provide.

MR. VANCE: And, you know, and then

we, you know, you can always start with the ones that we see the most claims from and that's certainly going to be our pulmonary diseases.

So, we have aliases for COPD, and include, like, chronic bronchitis, emphysema and other types of aliases that we use.

And so, that's what we're looking for are those appropriate aliases? Are there other aliases that you would apply to that particular classification of disease or that particular disease?

CHAIR MARKOWITZ: And, for any given health effect, let's say there's a primary name for it and then you have these aliases, are all of them searchable?

MR. VANCE: Yes. And, I'll show everyone tomorrow. You can do an alias search, you can do keyword searches in the site exposure matrices, and that's what you have to put your mind into the head of the examiner when they're sitting down and dealing with this. They're going to be seeing all kinds of things in these

cases starting in as early as 1942.

And so, physicians over time are using different terminology in how they evaluate, you know, medical evidence and using different terms and terminology throughout the history of these cases.

So, these claims examiners are trying to figure out is this diagnosis the same as this which we have information in the site exposure matrices about. So, they're always trying to get back to that health effect linkage.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I do have -- and it pertains both to the Parkinson's and to this alias because, in some ways, there are similar questions.

A lot of these diseases that you mentioned come under an umbrella of broader disease but may have very, almost minuscule differences in either the pathology or in the symptom complex.

So, and most of the time, epidemiology

a lot of times doesn't break all of them out. Some epidemiologists will lump them together, some of them will break some of them out.

So, would you be looking for the -- basically, I'm saying, are you going to be -- do you want us to be lumpers or splitters?

Or in other words, are you looking for the umbrella and then which ones would fit under that umbrella, or do you want us to really tease out differences between diseases? Because that makes a difference in how we approach this.

MS. LEITON: So, what we're going to be looking for is, in the context of the health effect that we're looking at, and so, if you're looking at health effect, you see chronic renal failure, you're going to see certain toxic substances, right?

And so, if you look at that in the SEM and say, okay, they're saying the chronic renal failure and these are linked, if you're going to give us another condition that could be used and linked the same way, that's what we're looking

for.

MR. VANCE: So, you have to think of the -- and I'll show you tomorrow -- the site exposure matrices are predicated or the health effect data in the site exposure matrices is predicated on a listing of established, you know, human epidemiological linked conditions.

Those are listed out. And, what we're talking about are aliases of those conditions. Okay?

CHAIR MARKOWITZ: So, you have a team working on making some corrections in the SEM including working on this task. So, how would our effort --

MS. LEITON: Well, they've got a lot of other tasks that they're working on. So, we would definitely pay attention to many other projects that they're trying to -- like gaps in facilities and things like that.

CHAIR MARKOWITZ: Okay, any other questions or comments?

Oh, yes, Dr. Silver?

MEMBER SILVER: This morning, Dr. Markowitz asked where the program gets its epidemiologic expertise and, Ms. Leiton, I think you mapped it to the epi trending in the toxicologist and the epi trending in the occupational physicians.

But, I thought I heard you, John Vance, you referred to the epidemiologist an hour and half ago, and epidemiology is getting mentioned with increasing frequency.

So, can we just clear up who that is?

MR. VANCE: Okay, so let me just back up a little bit and make sure I -- make sure everybody is clear.

So, we had a conversation about health effect data that's reported through HAZMAP that gets translated into the site exposure matrices.

That's generally done under the auspices of HAZMAP and Jay Brown. That information is then listed out in the site exposure matrices.

Then, when Lynette Stokes, who is our

epidemiologist or toxicologist within the program is looking at an evaluating claim level submissions for new health effects or evaluating case-specific submissions in conjunction with, you know, epidemiology or toxicology.

MS. LEITON: I believe we also have epidemiologists on staff on our SEM project at the Paragon that help with these that work on some of these items.

They don't go into HAZMAP, but we do have epidemiologists.

MEMBER SILVER: All right, so, Dr. Stokes is both the toxicologist and an epidemiologist?

MS. LEITON: Yes.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: Okay, thank you.

So, there are some issues about Board functioning that we should begin to discuss. Then we'll take a brief break before the public comment period.

As we heard this morning in the FACA

presentation, we have the option in our subcommittee meetings of making them open or not. Open means that the subcommittee meetings usually take place over the phone. It means that non-Board members could call in to those discussions and participate.

The previous Board elected to do that and the -- both because we thought it was a good thing to make the whole Board work as transparent as possible and also because the Radiation Advisory Board which has been in existence since the early 2000s, also follows that method.

The feature of those -- of that process is that you have to schedule such a meeting by Federal Register at least six weeks prior to the meeting.

So, let's say there is a subcommittee or a work group that would like to meet and discuss an issue, this is a subset of the Board and, you know, this being mid-November, you could schedule that for some time the first half of January if we decided, you know, by Friday to

start scheduling that because it has to be published in the Federal Register.

Actually, it's more the notice goes in six weeks before the meeting but then, the notice actually has to go through the process within DOL. So, we're really talking seven, eight weeks.

So, we did that and it wasn't really that much of an obstacle. It kind of diminishes spontaneity a little bit.

But, there wasn't -- we don't have that much need for spontaneity in this Board function.

So, now, I have to be reminded, when we take a vote, it's a simple majority.

MR. FITZGERALD: It should be a, what's the term?

MS. LEITON: Consensus.

MR. FITZGERALD: Consensus, and that's not well defined but it's certainly more than 50 percent plus one.

CHAIR MARKOWITZ: Okay, okay.

So, Dr. Friedman-Jimenez, are you on the phone? Can you hear us?

MEMBER FRIEDMAN-JIMENEZ: Hello?

CHAIR MARKOWITZ: Yes, we're -- yes, we hear you, yes, okay, good.

So, I take it you're on mute, so there's a little bit of delay, that's fine.

So, let's -- we should --

MR. FITZGERALD: One second, excuse me, Mr. Chairman.

Just add a couple of other points here, one is with regard to subcommittee meetings. We normally, and the public listens to those; they do not provide public comment at the subcommittee meetings.

And, I would just kind of go back to what Joe Plick, our FACA counsel told us today about the spirit of open meetings with regard to the FACA as well.

And, kind of the current mood is to move toward more openness rather than less openness.

CHAIR MARKOWITZ: Now, we have, you know, these subcommittees in the past have had four or five members. There have been discussions among one or two or three members short of a full subcommittee which has not been part of the open process. They are --

Well, didn't necessarily -- we have a work group, but that work group really functioned more as like a subcommittee in which we scheduled the meeting and there was a significant number.

The reason it was called a work group was because it cut across the committees basically.

I'm not -- I don't know whether we'll retain that designation for any activity, we'll figure that out.

But, just saying that short of a full subcommittee, there can be quote-unquote, closed discussions among smaller numbers of members. It didn't happen much, but just so you know that discussion among one or two people isn't entirely inhibited by the need to schedule such a

discussion six weeks in advance.

MR. FITZGERALD: Right, the subcommittee chair could assign some work to a group of people within the subcommittee to go out and some work. They would come back and present to the subcommittee. That would then be discussed in a public forum.

CHAIR MARKOWITZ: Right. And so, we did have a one work group on presumptions and it functioned just like the subcommittee, there was no real difference.

Yes?

MEMBER CASSANO: What about when we went to Seattle? That was a work group.

CHAIR MARKOWITZ: So, if you could turn on your mic and just describe what you're talking about.

MEMBER CASSANO: We had another work group that looked at cases. We went to the Seattle claims office and looked at cases and that was a subset of a subcommittee and that was not a public meeting because it would have been

logistically impossible.

CHAIR MARKOWITZ: So, we need a proposal about whether we want our subcommittee meetings to be open or closed and --

MEMBER CASSANO: Motion to make all subcommittee meetings open meetings to the public.

CHAIR MARKOWITZ: Is there a second?

MEMBER MAHS: Second.

CHAIR MARKOWITZ: Okay, open for discussion. Any comments?

So, the proposal is to make all the subcommittee meetings open and all those in favor, raise your hand?

And so, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

CHAIR MARKOWITZ: Okay. So, it's unanimous, all 12 members vote in favor open processes for subcommittee meetings.

Do subcommittees vote at all? And, if so, are -- is there any guidance about that?

MR. FITZGERALD: I don't think there's

any particular guidance on voting. Whatever the subcommittee decides to report will be before the full committee.

CHAIR MARKOWITZ: Right, okay. And, what I heard this morning from the FACA presentation was that the subcommittee brings whatever the results of their discussion to the full Board, that engenders a full Board discussion and not a simple vote on whatever the subcommittee proposed.

So, every meeting, we will have a public comment period. And, I think in some meetings it had been longer than this one. We've had two public comment periods.

They usually occur at the end of the day, although, if it's the last day of our meeting, we generally try not to make it at the end of the day.

The -- and the people who are present and request time on the public comment period get the time that people can participate by phone.

We generally divide the amount of time

by the number of people who make requests. And that, so far, has worked out pretty well.

We hear the public comments. We -- in the first Board, I struggled -- my view is we struggled a little bit on how to organize and not really respond to public comments but fully consider some of those comments in our discussions.

And, correct me if I have a misimpression about that.

And so, I think we did, Carrie, we developed a system where we tracked the public comments by spreadsheet and circulated that among the Board members to make it easier to figure out in summary what was said and then the public comments are available on the website so they can go to the website.

So, we need -- we should continue to do that.

Part of the problem is that the public comments may or may not pertain to exactly what we're talking about that day or they pertain to

something we talked about yesterday and we're not coming back to that by the next Board meeting, we don't remember what those public comments were.

So, if there are ideas beyond what we did last time and we'll replicate which is kind of a spreadsheet with web access to the public comments.

If there are ideas that either now or you think of as we go forward to try to accommodate and consider those comments more closely, then please raise those.

If anybody has any thoughts now, it would be a good time.

(No response)

CHAIR MARKOWITZ: Okay, I mentioned before we develop requests and action items from our meetings, not so much today, but we will.

And, Carrie keeps track of those. If you do make a request, just -- and if I don't alert Carrie to that, just try to make sure that it's brought to her attention.

She keeps -- she will provide us with

a running log of these things and then we get a spreadsheet on the responses or actions taken by DOL, either the information is provided or the decision about access to that information or whatever. Questions, comments about that?

(No response)

CHAIR MARKOWITZ: Now, locations of meetings, what we'll discuss in our next meeting were tomorrow, but I would say that previous board, we met once in Washington in this room.

And then, we went and -- to various sites. First, we went to Oak Ridge, then we went to Hanford, and we went to Los Alamos.

And then, we had a phone meeting. And, Greg Lewis and his group very nicely arranged for tours at those facilities which is extremely useful. We would show up a day early and we would see either legacy buildings or legacy processes or we'd see current things going on.

But, particularly for people unfamiliar with the complex, it was a very

useful, very informative exercise.

So, my preference would be to continue that, but I'd like the sense of people's experience. Yes, Mr. Domina?

MEMBER DOMINA: This question might be for John Vance. Because at every Part B board meeting, NIOSH always reports on the most new claims for a four month period prior to or six months, depending on how far apart the meetings are.

Because, I guess over the last 30 meetings they've had, Hanford's led the complex in new Part B cancer claims.

And so, what my question is, is do you guys track on where the most Part E claims come from or is there a way to do that?

MR. VANCE: Yes, well, we could definitely go back and look at the Resource Center intake for different regions of the country.

I think that we can probably do some sort of basic analysis, see where claims are

coming from and try to provide that information. So, that's going to be a request for Carrie.

MEMBER DOMINA: Okay, just because we followed the Part B board the last, you know, few times we went to Oak Ridge, Hanford and then Los Alamos and I just wondered if that might be an appropriate way to do that.

CHAIR MARKOWITZ: So, the way the locations were selected was by the number of claims, or cumulative number of claims from those sites. So, the most claimants were from Oak Ridge and secondly Hanford and third, New Mexico.

It was either claims where they were from or where the claimants resided, I can't remember.

And, I would propose we continue to go -- to do that which would probably Savannah River would be the next.

MEMBER REDLICH: I was wondering where Savannah River fell in this.

CHAIR MARKOWITZ: Yes, it's number four I think. But, I'm going to -- I check the

website and look at that.

MEMBER REDLICH: Okay, because I mean, this is anecdotal, but just from the few cases that we reviewed, it seemed that sort of the level of medical care and was probably not as optimal there as let's say, if Hanford, or Colorado.

CHAIR MARKOWITZ: Right.

MEMBER REDLICH: Or it just seemed like it would be --

CHAIR MARKOWITZ: Right.

So, does it make sense to people to just continue by the number of claimants and we only have to pick one ahead of time. We don't have to go to the next. But, I can't remember what number five was, in any case.

MEMBER REDLICH: I mean, I think it is important to the claimants in the area, too.

CHAIR MARKOWITZ: Yes.

MR. FITZGERALD: Steven, I'd like to -- one limiting factor we should consider is that our overall budget just from a fiduciary

standpoint, just managing the resources allocated to the board compared to tours.

We just need to weigh that particular opportunity against other things we do.

Last year, I know we had a lot of subcommittee meetings that were not necessarily financially -- so, we just have to keep that in mind.

CHAIR MARKOWITZ: Okay. And, the expense of the subcommittee wasn't travel but it was transcription and production and all that, right?

MR. FITZGERALD: Right. The tours themselves happen the day generally to the travel so, yes, that's the issue.

CHAIR MARKOWITZ: Okay.

Now, one -- there's an issue that I think we should discuss. I have a hard time finding relevant documents on our website. And I'm wondering other people's experience.

Right now, they seem to be organized by our meeting date. So, we had four in person

meetings and then you can go to those particular meeting dates and then I understand you can get the transcription, you can get the minutes, that makes sense because that's date specific.

But then, there are the documents that we review at that meeting, for instance, today, actually we just did a -- we kept the briefing book relatively small.

But, in our next meeting we'll have relevant documents which we'll put up, that will be useful in our discussions.

And, I'm looking for ideas on how to improve the organization of those materials so that -- and particularly the new members, it can be helpful here when you do get to look at them, which is how should we organize them so that they're easy to get to?

MEMBER REDLICH: Well, I have one suggestion just as far as our recommendations, I can't keep straight the date of the recommendations, the number.

You know, maybe we could just start a

new numbering system that was a continuous one, two, three and also we could have a simple table that would say, okay, this topic, you know, these recommendations address that topic so you could find, you know, whatever that might be, lung disease or --

Because, right now, you know, I'm open on both of the ways. Is that this state or that state? And, I think if we simply had a running list of numbers.

CHAIR MARKOWITZ: So, consecutive numbering across meetings?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Yes, that's --

MEMBER REDLICH: And --

CHAIR MARKOWITZ: We'll do that.

MEMBER REDLICH: And that will be easy to have a little table of the recommendation and the topic and then you could immediately find the one that you wanted.

CHAIR MARKOWITZ: You know, it's a little complicated as we make a recommendation,

DOL has a response, we have comments on their response. So, sometimes we're --

MEMBER REDLICH: But, it still --

CHAIR MARKOWITZ: And sometimes revised that recommendation.

MEMBER REDLICH: But, even still, still like number three, it was all was related to this --

CHAIR MARKOWITZ: Right.

MEMBER REDLICH: -- then you could just do that. I don't know, I'm open to any other Board members.

CHAIR MARKOWITZ: Right. Yes, we'll do that, that's a good idea.

Any other ideas?

MEMBER SILVER: Since we came into existence by an act of Congress, we should make our recommendations and DOL's responses and the next round of our responses to their responses available at the fingertips of anyone who goes to the website.

We don't need to unlink them from the

meetings where they were voted on, but if we could compile those links in a simpler table on the website, I think that would be of service, not just to people on The Hill, but to people in the claimant community.

CHAIR MARKOWITZ: So, for the new Board members, I just want to say that just so you know, the Board has no staff to do work.

Obviously, they're DOL staff designated liaison, Mr. Fitzgerald and Ms. Rhoads who help with the meetings, but in terms of either tasks or activities that are requested of us or activities that we take upon ourselves, we have no staff to do that research.

Just so you're aware of that. We've never requested it, but it wouldn't -- my take is that -- my understanding is it wouldn't be possible within the current budgeted amount for the board. So, it would require a different kind of budgeting process. So, we've never really made that request.

Any other issues on the board that we

need to discuss?

(No response)

CHAIR MARKOWITZ: Okay, why don't we -- we're not scheduled for public comments until 4:30, we can't begin public comments early, so that means we're just going to have to take a break.

But, let's come back at 4:25 so we're ready to begin.

(Whereupon, the above-entitled matter went off the record at 4:15 p.m. and resumed at 4:35 p.m.)

CHAIR MARKOWITZ: So, we're going to start in a minute, but 4:30, but I want to just say to the Board members, you know, this public comment is not really a discussion, it's not really a question and answer period.

People -- we can make the occasional comment, but in general, it's the opportunity for people to say what they want to say and we listen.

With that, I think we can get started

if -- we've got six people who had signed up to speak. I would ask that you speak no longer than ten minutes, of course, you're free to use less than ten minutes if you've exhausted what you want to say. But, it is up to you.

Is Michele Jacquez-Ortiz on the phone?

(Off-microphone comment)

CHAIR MARKOWITZ: Thank you, I'd like to welcome our first speaker which is Michelle Jacquez-Ortiz from Senator Udall's office.

(Off-microphone comment)

CHAIR MARKOWITZ: So, why don't we move to Terrie Barrie? Oh, she's back. So, Ms. Michelle Jacquez-Ortiz, are you there?

MS. JACQUEZ-ORTIZ: Okay, thank you.

I'm sorry, Chairman Markowitz and members of the board, can you hear me?

CHAIR MARKOWITZ: Yes, we can hear you. You can start, thank you.

MS. JACQUEZ-ORTIZ: Okay, thank you, Chairman Markowitz. My name is Michele Jacquez-Ortiz and I work for United States Senator Tom

Udall and have a prepared statement from the Senator to read into the record.

And, it starts here. U.S. Senator Tom Udall's statement to the Advisory Board on Toxic Substances and Worker Health, Washington, D.C. November 14th, 2018.

As some of you may know, I worked with a bipartisan coalition in Congress to establish the Advisory Board on Toxic Substances and Worker Health.

The work of this Board and the recommendations you provide are fundamental to the integrity of the energy employees occupational compensation program, or EEOICPA.

Earlier this year, I expressed my concerns to the United States Department of Labor about the long delay in Advisory Board reappointments.

I urged the Agency to take quick actions and also secured language in the fiscal year 2019 labor, health and human services appropriations bill formalizing congressional

concerns about board vacancies and directing the Department of Labor to ensure that the Board has sufficient funding and staffing to meeting its obligations.

I was pleased when DOL subsequently filled the vacancies. This Board is specifically designed to offer the Department of Labor a unique mix of scientific, medical and claimant expertise on important issues facing the program.

The Board thoroughly evaluates the natures for its recommendations and is judicious in the recommendations that are given.

As such, the Department of Labor has a responsibility to act on those recommendations in a timely manner.

Two and a half years ago, I teamed up with my Republican colleague, Senator Lamar Alexander to express concern that DOL's proposed rule changes for EEOICPA.

Claimant advocates have recently reached out to my office to share their request that DOL withdraw its proposed rules and engage

in a negotiated rulemaking process.

I encourage the Agency to carefully consider this request which has authority to do so under the Administrative Procedures Act.

A negotiated rulemaking will benefit the claimants and best serve the public interest.

When Congress enacted EEOICPA, it intended that the program would be science-based and would compensate legitimate claimants in a timely manner without imposing unnecessary bureaucratic requirements. That was the spirit of the law.

EEOICPA is complicated and requires expert analysis on many levels. The Advisory Board has a difficult task considering the complex issues associated with this program.

I appreciate the hard work and long hours each of you commit as members of this important board and I thank you for your valuable and generous service.

Thank you for allowing me time on the agenda for my statement this afternoon.

Tom Udall, United States Senator, end statement.

CHAIR MARKOWITZ: Thank you.

Ms. Terrie Barrie?

MS. BARRIE: Thank you, Dr. Markowitz and members of the Board. My name is Terrie Barrie and I'm the founding member of the Alliance of Nuclear Worker Advocacy Groups.

I welcome the new board members and look forward to the continued review of this important compensation program.

The previous Board made so many excellent recommendations to improve the program. I applaud the dedication of the previous board members for their outstanding work.

I am thankful that DOL accepted some of the recommendations the Board made. Specifically, the criteria to presume workplace exposure resulting in asbestos related diseases.

I am a bit concerned about statements made earlier today about why some of the other recommendations the Board made may not be

accepted.

It sounds more like a bureaucratic problem than based on the sound science.

Ms. Leiton explained earlier that when it comes to a claims examiner reviewing two different doctor's letters, that one may have more probative value because that doctor was an expert in the field, say a pulmonologist, as opposed to a personal physician who is just a GP.

And, that's understandable, the specialist letter might hold more weight than GPs.

However, the discussion today implied that despite this wonderful group of well-experienced experts, you have the top notch experts here. And, I would think that the opinions and recommendations made by this Board would outweigh the recommendations of the in house DOL experts or site, or whatever, site matter experts.

So, I would recommend that Department of Labor accepts all of your recommendations.

You review the problem and the issues from every aspect. You have long deliberations before coming to a consensus.

And, they honestly are lucky to have you.

I would like to -- it sounds like, you know, for the new Board members, you've seen all the recommendations the previous board made, it seems like that maybe all that there is to do. Well, there isn't, trust me.

There is still much work that needs to be done. I still hear complaints about the letters from the industrial hygienists and the CMCs and the toxicologists.

Part of your responsibilities is to review those letters and sample them for consistency and accuracy and using the most current science.

I recommend that you put this on your agenda for the next coming term. It's important to make sure that claims are decided equitably.

Let's see, the statute -- it was

explained that there was a new medical benefits adjudication board, now while the statute doesn't specifically call out and say that you can review that office, it is a new office and it does involve making decisions based on medical documentation.

And, I think that clearly falls within your responsibility.

The other issue I'd like to suggest is the Site Exposure Matrix, there's a lot more, if you would consider it, a lot more information or a lot more decisions that need to be reviewed for that. The last time I checked, there was processes that didn't have labor categories attached to it and vice versa.

So, for instance, there might be a painting process at Iowa, there was no painter listed as a job category. And, that's important because claims are denied, you know, or if they can't prove -- not denied initially, but ultimately, they will be denied if the SEM doesn't list something and the claimant can't

provide documentation that he did -- he was a painter and they did paint at Iowa.

The other part is about the RECA program and you did touch on this today with uranium. There's a lot of disease, well, not a lot of disease, but there are some diseases that are covered under RECA and are presumed to be due to the exposure to uranium.

The kidney failure, or kidney insufficiency is one of them, lung cancer, a host of other lung conditions.

I would see if you can develop a presumption for DOE workers who worked with uranium based on the exposure that is covered under RECA. I don't think it should take too long, but that would just make a lot of claims go right or be expedited a lot quicker.

Okay, so, the Secretary -- this is my closing -- the Secretary appointed this Board because of their vast expertise as well as of occupational medicine, epidemiology, pulmonary field as well as a number of the workforce who,

you know, some currently still work there.

The Board members are held to great esteem by their peers and by the claimant community.

I welcome you and look forward to your continued review and thank you.

CHAIR MARKOWITZ: Thank you.

Mr. Tee Lea Ong?

MR. ONG: Hi, Tea Lea Ong with Professional Case Management. We are a home care agency that works under this EEOICPA program.

First of all, thank you to the DOL for allowing me to -- this opportunity to comment and also, thank you to DOL again for the expressed eagerness to renew the collaborative effort to serve the claimants.

So, and for the Board, welcome or welcome back for some of you. Thank you so much, your work is very important for helping the special claimant community, sometimes the depth of the work is sometimes underappreciated, so I just want to thank you again for that.

I know a lot of you read the 700-page document, so clearly, that's a lot of work involved, so appreciate that.

I really only have one comment but there's probably some themes around the comment that would help add color commentary to it.

And, my comment was about the proposed rule changes that was proposed over three years ago.

The rules were proposed about three-plus years ago and with over a 100 changes. It is a very substantive proposal authored probably over quite few number of months.

So, one can safely infer that it was work that was done quite a bit before and prior to the establishment of this Board with the assembled experts representing different areas.

So, with that said, a lot of the comments I heard today, albeit, were directly specific to the procedure manual, a lot of the concept or the themes I think are equally applicable to the proposed rule changes.

For instance, Dr. Markowitz, you mentioned that a lot of things I believe your words, evolved over these past, you know, few years. And, clearly, the same can be said about the proposed rule changes, a lot of things since it was last proposed have evolved, especially as brought on by conversations in meetings like this.

And that proposed rule changes elicited over -- about 500 comments. And the question that Dr. Markowitz, you asked, which is that what are some of the most common questions or themes that were raised?

I would submit that, in that period of time, it warrants a complete re-think of what are some of the topics that most important to the proposed rule changes so that it can be appropriately addressed.

Likewise, in the course of these meetings, and which I've been lucky to participate in most of them, there were a lot of different discussions, themes that were surfaced,

some that accepted, some deliberated and perhaps partially accepted by the DOL and whatnot.

And there were rebuttals, as you mentioned, Dr. Markowitz, on some of these themes.

Well, those usually bring up new questions. So, to look back at something that were proposed that long ago, it makes a lot of prudent sense to take a step back and say, hey, should we not consider withdrawing that and using the expertise and guidance from the people in this room to rethink and say, what are some of the rules that should be changed to make it more claimant friendly as expressed by the DOL? And start from there.

Because I think sometimes what happens is that when you edit and you keep changing the edits that were made, I think Dr. Redlich just mentioned now, sometimes when you try to do that, it makes it even more convoluted than the original topic, if you will.

So, with that in mind, it seems to

make sense that in order to start with the expertise in this room and say what are some of the things that ought to be addressed and changed from a rule standpoint, it makes more sense to withdraw it and start from the advice that would be provided from this board as opposed to we keep editing on topics that may not be relevant anymore looking back.

So, that is really my comment which is that editing, at some point in terms of its value, probably diminishes as compared to advice from the board that wasn't even established at the time, when the rules came out, this board has been authorized but had not been seated.

And, since then, the first meeting which was in this room and Dr. Markowitz, you were sitting in the exact same spot, and we talked about the rule changes at that time.

A lot of good conversation took place. And since then, a lot has changed.

So, my recommendation for the DOL and I urge DOL to consider this, is to start with

what's relevant and withdraw it and then using the assembled experts to guide that conversation.

And then, perhaps, and just one more comment, too, with a third of this board being new and I know there's a lot to learn and obviously, you've spent a lot of time on it, a full third of the Board is new and I think it will take some time for this Board to really coalesce on focus on which are the topics that ought to be addressed in the next round of rule changes.

So, I would submit that this is the great time to take a step back and consider and looking forward what should be the rules as opposed to how do we edit what was proposed previously.

And, sorry, I said one comment, perhaps this is two, I heard a lot of conversations about the procedure manual today which all really are relevant ones. And I think Kirk, you mentioned, that hey, you know what, can we coordinate, you know, from the DOL folks so

that if you were working on changing the procedure manual, updating it, I think version 3.0 was mentioned as an example, let us know so that we don't kind of edit something that you're about to, you know, change anyway.

I would submit that with the team here, we heard some really good conversations about expertise, the few experts in the nation, for instance, on beryllium that, perhaps, this should be a more serious thought of not just, hey, let me know what you're changing, rather it should be really tapping into the experts that have volunteered their time to look into it.

So, accept the guidance and counsel from this Board rather than, let's coordinate you choose whether you should accept, you know, our help or not.

So, with that said, thank you very much for allowing me to speak and I appreciate your time.

CHAIR MARKOWITZ: Thank you.

I just want to remind the Board that

actually the first time we met, they had -- DOL had reopened the comment period and we did analyze and made comments on the proposed rules at that time. And since that time haven't been involved.

So, our next speaker is by phone, it's Ms. Donna Hand.

MS. HAND: Yes?

CHAIR MARKOWITZ: Hi, you can start now. Thank you.

MS. HAND: Well, first, thank you very much and thanks for the Board that you finally got seated and we're all together working on this issue for all the claimants.

I wanted to bring attention, you asked about the Radiation Exposure Compensation Act, that Act was used for specified answers in the statute Public Law 107-20 as the overview as well as an edit on a condition on that that the National Cancer Institute said that it's a medical condition or a nomenclature of any of those that are listed, of the 22 cancers and a

submitted as otherwise cancer.

So, that's where the Radiation Exposure Act illness got involved with the statute part of the DOL program.

The next issue is that first Hearthway on October the 24th and Deputy Solicitor, Tom Giblin today said the statute cannot be changed.

The regulations can only be changed through notice and comments. Well, the regulations say that the definition of beryllium sensitivity means that an individual has an, a-n, abnormal beryllium proliferation test performed on blood or lungs.

So, nobody knows what is an abnormal other than, yes, it's an abnormal test.

Back in 2010, to the beryllium congress with the beryllium compensation community, DOE had an abnormal test to have, too. But, it was brought up that this worker only has to have one.

So, if any of those deliberation figures are reacting to beryllium, then they have

an abnormal beryllium test when they seem reasonable.

So, really, you know, the Board underlined what has to be an abnormal as not normal. So, and it wasn't defined definitively in a statute or the regulations, you know, it can't be changed by policy.

The other issue is that Dr. Armstrong has informed the internist doctors that you can't use the asthma chart with chronic beryllium disease.

The issue is with chronic beryllium disease, it has asthma like symptoms. It has symptoms similar to other respiratory conditions.

And the beryllium bio today of the beryllium not only goes to the lungs, but into the bone and then it goes to the renal and bladder and large intestines and then it goes out through urine and the lower larger intestines.

So this is, you know, from the Washington State University, the medics say the bone and the liver it's well known that the

bones, the skeleton and the liver is all connected with chronic beryllium disease.

But, these are never addressed.

The other issue I'd like to find out is what is a lymphocyte process that's consistent with or characteristic of CBD?

There is a foreman case in the Knoxville, Tennessee federal court where they were saying that you have to have 10 percent. The person had 50 percent and they said that that wasn't enough.

The court ruled in favor of the claimant that all they had to show is only the process consistent with CBD.

So, there are numbers in this. So, what is a lymphocyte process that's consistent with CBD?

Basically, the -- also the medical -- the IOH report are reporting significant lows, significant highs, significant middle. Well, that's not what the statute says. It says significant factors. And that's back in 2006 so

the final registry for again the presumption, OWCP said significant factor is any factor.

So, the statute applies and the regulations also says, you're going to use any factor. This regulation also proof of exposure is that the employee came into contact with it.

And then, the process is in the material that has the potential. They don't have to definitively do it.

So, for the statute to say that a physician do a trigger chemical or a trigger exposure, it is an -- it's not even required by the statute or the regulation because that has a potential because of its radiological chemical or biological nature.

To be any factor, it's aggravating, contributing or causing and is that exposure regulated?

So, in order for me to find out how an expert can determine the level exposure without any data. So, I'd like for the Board to address how can an industrial hygienist go back and do

historical documentation of the levels that the worker was exposed to, to the toxic substance?

Thank you.

CHAIR MARKOWITZ: Thank you.

Next we have Ms. Vina Colley. Are you on the phone?

MS. COLLEY: Yes, can you hear me?

CHAIR MARKOWITZ: Sure, sure. Welcome.

MS. COLLEY: I'm Vina Colley and I'm a former worker at the Portsmouth Gaseous Diffusion Plant and I am the cofounder of the National Nuclear Workers for Justice and I want to thank you for allowing me to speak.

And, I'm requesting that the Board comes to Portsmouth and Paducah, Kentucky where all this happened back in 1999 to get the Board all these decisions in the process of getting workers compensated.

As a worker, I'm still wondering how does the claims which are being sent to the examiner, how do they know they are our claims? Because I'm getting workers reports on other

workers in my branch and I don't know if these consultants are getting our true records.

I have eight records saying that I worked at Paducah and I smoked a pack of cigarettes every day for 20 years and both of those was a lie because I've never worked at Paducah and I never smoked.

I listened to you a while ago say that you pick the site by the number of claims that are filed, that is where you hold these meetings. And Oak Ridge was mentioned.

I'm wondering if Oak Ridge is used for Paducah and Portsmouth of gaseous diffusion plant? Because, if so, that should be not done that way, because Portsmouth is the largest industry in the world. We do the highest assay of bomb grade material, 99 percent.

And not only did we do that, we've done Russian down and we had plutonium at the site since 1953.

This compensation bill started out because Portsmouth and Paducah had plutonium at

the gaseous diffusion plant.

I was involved in that the night it happened, the hexafluoride at Paducah, Mary Davis and myself who was notified by the media that this is what had happened.

Now, the other big chemical in the gaseous diffusion plant that we don't care anything about is the fluoride. Uranium hexafluoride, there is a needs assessment done by the Department of Energy at all of these sites who were scored for Superfund.Tyson submitted to the Superfund test and so did Paducah. Paducah was put on this list but Tyson never was.

So, I would like for you to come to Portsmouth. The few of us can take you on a tour and I listened all day long at all this red tape and it's a -- the procedures that they had to go by, who in the world is going to read 700 pages of procedures?

I commend the Board for trying to do the right thing and put them in the right direction. But, I'm looking at records from

other workers that work at say Rocky Flats and a lot of electricians at Portsmouth, we are -- our records look the same except for denied, have my name on mine and their name on theirs. But, these records that the Department of Labor are writing are copycats.

So, I don't know how to solve this problem. At one time, this was started up and it was a resolution of $150,000 for each worker and a medical card.

That medical card is worth more than any money. And, I don't know what happened to this in 18 years, but we're still fighting. We shouldn't have to be doing that.

You know, I really thank the Board for taking on a big project, but I'm scared this is going to be another 18 years down the road and more and more workers are going to have the same suffering. It's time to do the right thing.

The other thing is Oak Ridge, there we're getting, when I started the national group, they were getting grant money to go to Washington

state to represent workers that they didn't represent.

And, I know that Oak Ridge is not the same site and somehow or another in all of this, Portsmouth and Paducah got lost in the sewer somewhere.

I'm asking you to come back to Portsmouth and Paducah to where this all started.

And, you had another site there by Paducah which Honeywell in Indianapolis which is starting to have a lot of sick workers that are coming forward.

So, we've got to find out how all this fraud is going on in these claims. I mean, it's -- I should be here 18 years later fighting -- I have not ever gotten one consequential illness.

Every time the case worker approves my case, they get moved or switched or get fired. But this is happening to me. It's happening nationally and it's a criminal act. It's got to stop.

CHAIR MARKOWITZ: Ms. --

MS. COLLEY: And I wanted to mention about the local office. We have these offices, they are great. They go in, we go in and they make our allowances for our travel expenses and do all that, but here's the process right here where workers are getting turned down.

The people in those offices are not advocates, they don't know the rules and regulations. They don't put our records together before they're sent into the Department of Labor.

And so, when the worker goes in there thinking they've got all they need, they don't have all they need and they're turned down.

And, once they're turned down, it's hard to make that decision retroactive.

So, you may have somebody in those offices, maybe someone from the union or whatever that knows their exposures before these records are sent in to Washington, D.C. to the Department of Labor and then turned down and finally just turned down and denied and denied and denied.

And I'd still like to know the answer

about the Oak Ridge site, did those claims get approved or denied or how do you characterize these claims that are going to certain sites?

And, I would think that you would want to come when that whole thing started back in '99 at Portsmouth. Thank you.

CHAIR MARKOWITZ: Thank you, Ms. Colley. And thank you for the invitation to Portsmouth.

Our next -- last speaker will be Mr. Josh Artzer.

MR. ARTZER: Good afternoon, my name is Josh Artzer and I'm currently the chairman of the Beryllium Awareness Group at Hanford and also appointed by HAMTAC as a workforce specialist at the newly opened up Hanford Workforce Engagement Center.

Our office was opened up to help current and former workers and their families kind of navigate these claims processes, whether it's state O&I or the Department of Labor and it's also to provide them with information

regarding to beryllium and also the medical screening programs that are available to them.

One of the concerns I have is I know that the board made a recommendation on the borderline BLTPs and I also know that additional information regarding the use and value of the borderline results has been submitted to the Department of Labor by Dr. Maier from National Jewish Health.

From the earlier discussions today, it's my understanding that the Department of Labor evaluated this and that their legal team made an interpretation.

One question I have is was that interpretation, did it have medical reasoning and was that provided the board and also back to National Jewish?

We have quite a few workers affected at -- excuse me -- affected workers that kind of fall into this realm where they're being, you know, medically restricted. Their job classification have been changed based on these

borderline. They're being treated as affected workers, but they can't apply for the Department of Labor programs.

As far as what we see at the Hanford Workforce Engagement Center regarding occupational illnesses or diseases related to toxic substance exposure and causal link is that the majority of the time these claims are forwarded on to the CMCs and to IHs for recommendations for claim acceptance or denial.

The one question I have is where do the IHs get the data when they're providing these recommendations and opinions?

Often we see that the -- excuse me -- often we see it's determined that the claimant hasn't been exposed above OELs or PELs.

The problem with that is, you know, at Hanford specifically, we're not always being monitored at times.

We, as claimants, can't even provide that information. So, when the CMCs and the IHs are making this determination, where are they

getting their information, you know, when they're making that recommendation?

Also, to put the burden back on the worker to do that when they know for a fact that this information is not available.

So, that's one of the other issues that we have down there.

Third thing that I had was, I was glad to hear that Mr. Vance brought up the recommendation to the Board about Parkinson's disease. We see a lot of that down at our centers, especially within the last few months.

Again, that, you know, when that's being evaluated through the Department of Labor's process, it does go back to the doctor's diagnosis, documentation providing that causal link.

Also, you know, to a known chemical potentially. So, I was glad to see Mr. Vance bring that up and hopefully you guys can come up with some sort of recommendation to help with, you know, that process for these claimants.

So, thank you for your time.

CHAIR MARKOWITZ: Thank you.

Any other people wish to make public comment?

(No response)

CHAIR MARKOWITZ: Yes, if anybody's on the phone and they want to make a public comment, you should press star-zero.

(No response)

CHAIR MARKOWITZ: Okay, so public comment period is closed. Tomorrow we begin at 8:30. So, what time shall we meet upon arrival at DOL? 8:15, that's good.

So we'll meet downstairs at 8:15 and come in together. So, do I adjourn the meeting or do you?

MR. FITZGERALD: I will be happy to do that. So, the meeting is adjourned.

(Whereupon, the above-entitled matter went off the record at 5:15 p.m.)