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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THURSDAY
NOVEMBER 15, 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 8:43 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 OFFICIAL

DOUG FITZGERALD

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

8:43 a.m.

MR. FITZGERALD: Good morning. My name is Doug Fitzgerald, and I'd like to welcome you to today's meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health. I'm the Board's Designated Federal Officer, or DFO. And as DFO, I serve as the liaison between the Board and the Department.

Before we begin today, I'd like to go over some abbreviated housekeeping items to make sure everyone is safe and comfortable today. First, restrooms are located immediately outside the room to your right and left, and the restrooms to your right are handicap accessible. And next to each set of restrooms is a water fountain.

In the unlikely event of an emergency, you'll hear an announcement over the PA system and will be instructed to use the stairs located both to the right and left of the conference room and will be guided down to the exit through the

building's entrance on the first level where you came in until we receive an all-clear announcement.

Copies of all meeting materials and public comments are or will be available on the Board's website under the meeting headings. The Board's website can be found at URL dol.gov/owcp/energy/regs/compliance/advisoryboard.htm or you can simply Google Advisory Board of Toxic Substances and Worker Health.

If you're joining by WebEx today, please note that this session is for viewing only and will not be interactive and there is no public comment period scheduled for today's meeting.

During discussions, I would request that the people in the room remain as quiet as possible since we're recording this meeting to produce transcripts. I would also ask that those in the room put their phones on mute at this time.

The FACA requires that minutes of this

meeting be prepared. 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, we'll have them up on the website before then. We'll also be publishing the full transcripts, verbatim transcripts of these meetings, and they will also be put on the website.

And with that, Dr. Markowitz, I turn the meeting over to you.

CHAIR MARKOWITZ: Good morning. We're going to skip introductions, I think, because everybody was here yesterday. So we're going to just skip that if that's all right. Dr. Friedman-Jimenez, are you on the phone?

MEMBER FRIEDMAN-JIMENEZ: Yes, I am. Thanks.

CHAIR MARKOWITZ: Okay. Welcome. So all the Board members are here, so, unless there are comments or questions about today, we'll just start with the presentation. Mr. Vance.

MR. VANCE: Great. Well, good morning, everybody. This is John Vance again. I have the distinction of getting to show you guys the Site Exposure Matrices for those folks that aren't familiar with it. I'm not expecting everybody, I see some folks with laptops and that sort of thing. I'm not expecting everybody to follow along. I'm going to move fairly quickly just jumping around and showing some of the features of the database.

Let me give you a little bit of background of the Site Exposure Matrices. So the Site Exposure Matrices is one of the resources that the Department of Labor sponsors in order to obtain information regarding toxic substance exposures that exist at the facilities covered under our statute. So this is a very large database of information that is basically filterable by lots of different kinds of topics by facility. And it's a huge database. We're talking about thousands, tens of thousands of toxic substances that are out there that were

used in the production of atomic weapons that we maintain inventory information about by facility and also associate those toxins with different types of work processes and labor categories, incidents, and lots of different filtering capabilities. So think of it just as a database with lots of different relational connections between toxic substances and different types of work that was being done at the site.

It is also a database that also has a functional search capability for what we, as the program, accept as known health effects, which is just that we know that certain medical conditions are out there that are known to be associated with exposure to particular types of toxins, and I'll show you that a list in a little bit.

So what I'm going to do just as sort of an introduction is just sort of show you the basic features of how you can get to the site exposure matrices. I'm also going to talk a little bit about the public versus the internal version.

There are two versions of the Site Exposure Matrices. The one I'm going to be working in today is the publicly-accessible version. There are two versions because of a very simple reason is that we have an ongoing research project with regard to the site exposure matrices. It is never a static system. It is always being modified and updated with additional information as our contractor does research. So the Department of Energy and our contractor work very cooperatively in sharing information with regard to site material, how it was used, or other types of information about hazards that exist at the sites. And as that information is collected by our contractor, it is organized in categories by sight and they make the assessment of that information for updating our database. There needs to be a periodic classification review, so what happens is the internal site exposure matrices is basically, as updates occur in real time, that is accessible and useable by the claims staff. However, once it converts to a

public version, it's got to go through a clearance process. So there's this lag time between the version that the staff are able to access, which is updated in real time, and then it is frozen periodically throughout the year and it goes through a classification review to catch that up for public dissemination.

So Site Exposure Matrices is one of multiple types of resources that the program has. I tried to enlarge this screen here so people can see it a little bit better. It is right here. Site Exposure Matrices is toward the end of our claimant resource list, and, again, it's just the length that goes right on to an introduction of our Site Exposure Matrices, plus a little, you know, fun little information about where you can submit comments or input, if you want to mail things.

And then once we click through to the actual site itself, you can see the last big update occurred in May 22nd. They're actually getting ready to do another one I just heard this

morning, so that's going to be happening in the next few weeks. They're going to be freezing the current version that the claims staff have access to for a validation and then upload for public use.

So I'm not going to go through this, but there's all kinds of information about the Site Exposure Matrices. But the really important thing is this link box right here that has lots of different options for folks if they want to submit information for use by Paragon Technical Services for evaluation of information for modifications to the database.

So we do work with a lot of stakeholders, authorized representatives, claimants who have information not directly affiliated with their case but they want the program to be aware of or evaluated for changes to facility information available about toxic substances. So there is a portal right here for that. We also allow for the submission of disease-related information, so, generally, we're

going to be looking for epidemiological information or other types of peer-reviewed or scientific literature that can be routed through the system for evaluation and for determination as to whether or not we should be making changes to our health effect disease list in the Site Exposure Matrices.

We also have the ability to take just about anything. I think people can upload, you know, lots of different kinds of documentation, and I know that we make changes quite frequently based on public submissions. It's always amazing to me what data people have in their basement. We find all kinds of information that was stored in all kinds of very interesting locations.

The Department of Energy, in effect, is constantly finding new information, as well. That actually gets passed on to Paragon. But records are out there. As we find them, they are submitted to Paragon for upload, for evaluation and upload to the site as it relates to toxic substances and their use at these sites.

Any other things that are kind of interesting on this? So here is the link for HAZMAP right here. This is the source for a lot of the health effect data. And I thought I saw a hand.

MEMBER BERENJI: Oh, yes. Sorry. Hi, this is Mani Berenji. So I'm actually going through the website, and, honestly, I think it's very user friendly, so that's good. In terms of submitting information, so if someone submits information with respect to site-related information, for instance, what's the processing time in terms of when someone clicks submit --

MR. VANCE: It depends on the complexity of the data.

MEMBER BERENJI: Okay.

MR. VANCE: So I know that one of the representatives that we work with quite frequently had a huge volume of information that was submitted for Santa Susana Field Laboratory, a whole lot of information. It took a lot of time to evaluate that information because what

the contractor is looking for, for adding information into the database is relational data about toxic substances. So they've got to scour through information looking at, okay, what information do we have, does it relate to toxic substance, what is the information relaying about that toxic substance, is the documentation reliable enough for them to be able to make an update to the database?

So if it's a few pages, easy. It usually doesn't take that long. I'm talking weeks. If it's much bigger of a data submission, it can take months.

MEMBER BERENJI: I have a follow-up question. So in terms of processing, do you guys get some sort of output from Paragon in terms of how many submissions they got for site-related requests and --

MR. VANCE: Yes, they maintain data on all public submissions, and you can actually get an update on the data status, what they're doing. And then we actually have a contract manager who

oversees the work of the contractor to work with assessing and determining data uploads and, you know, if there are issues or troubleshooting issues with data and what the contractor should be doing, whether that's the responsibility of our federal contract overseer.

CHAIR MARKOWITZ: The input on the disease-related information, is that reviewed only by the contractor or is that also reviewed by the scientists in the national office?

MR. VANCE: It's submitted through the portal. It then gets evaluated by both the Paragon folks and our staff. So we've got folks that meet regularly to discuss those types of submissions.

MEMBER CASSANO: You talked about the classification process between what is internally available and what is externally available and that there is a time gap between publishing the public view. How often is there information available internally that does not translate into the public view, and why would you do that?

MR. VANCE: Everything that is in the Site Exposure Matrices has to go through the classification for security issues. So we generally don't, I am not aware of any issues that we've ever had, other than there are some restrictions to some data. And it's the Department of Energy that has to vet this information and allow us to update it, and they generally are pretty cooperative with allowing information to be released, but there have been instances where they've refrained from allowing certain information. And we have some, I'll show you an example of one situation where they don't want any information out there so we have to go through a different kind of process, but it's basically a security process. And once it's uploaded out into the public sphere, it's out there. And, generally, you know, the Department of Energy has taken a very productive view of this process in making sure that they're as open and accommodating as possible with releasing information. But given the nature of this type

of information, there are security concerns we have to account for.

CHAIR MARKOWITZ: So can we, this is a request, can we get the information on the value of public submissions and the turnaround time?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: So let's go ahead and get into the Site Exposure Matrices. So I've already sort of pre-played around with it to get us where we need to be. So here is the introductory page. I'll scan through it. I tried to increase the size to see it, so I have to sort of scroll back and forth to show you the whole page.

But, again, a relational database. All of these different links here are connections that can be made between different kinds of information in the system. And I'll show you a little bit about the filtering capability in a moment, but what you do need to know about is that there was, somebody mentioned yesterday about RECA, Radiation Exposure Compensation Act,

mines, mills, ore-buying stations. So you can search by different kinds of general categorization of facility. The majority of our information is maintained on Department of Energy facilities, which is a classification of facility. These are the sites that are going to draw your interest for Part E adjudication. These mines, mills, and ore-buying stations are generally going to be part of the RECA process that we have, but we also can apply our compensation process to those mines, mills, and ore-buying stations through the Part E process, but there are different categorizations.

So if you're going to be working on a case or looking at cases that involve RECA, you're going to always want to be searching by the mines, mills, and ore-buying stations. I'm not going to spend a lot of time on that today because that's kind of complicated, but we can certainly take a look at it.

But I really want to focus on the Department of Energy sites. These are the ones

that a vast majority of our work sort of resolves around.

So I picked Hanford. Hanford is always a good one because it's the one that we have the most amount of information about and just a huge volume of information about Hanford.

Let me show you a little bit about the search features here. So when you are looking at these sites, you can go and take a look at all the different pieces of information that we have in here based on that categorization. So here are all the facilities. Each one of these facilities is covered in some capacity and we have created a toxic substance profile for. So you can see these are all kinds of sites that did work in conjunction with atomic weapons production. Some of them are very large. Pinellas is a large one. Some of them are very small, like the Peek Street facility. Nonetheless, our research team is out there trying to collect information about these sites and trying to identify toxic substances that were

present at those sites and linking those toxins to work processes, labor categories, or whatever information we can link to that would associate that with workers that were doing work at the sites.

So it is a lot. There are, you know, some huge facilities in here with just an amazing amount of information, Oak Ridge is another big site, and other sites that are just very small for which we just don't have any information about at all.

The thing that I always point out about the Site Exposure Matrices is that this is basically the best resource we have for documenting exposure. There is no such thing as detailed employee-level monitoring data for these cases. It's basically this or nothing for a lot of employees when it comes to chemical profiling.

The Department of Energy over the years was fairly good, and I know people would disagree with radiological exposure monitoring, but when it came to chemical monitoring there is

just nothing. So when the program started evaluating these cases based on the criteria that we have to evaluate in associating disease to toxic substance exposure, we needed to be able to present a reasonable understanding of what employees were encountering in their workplace that we could then evaluate for causation. And so this was the impetus for developing this database.

So this was a resource that the Department of Labor felt needed to exist in order to facilitate claims adjudication and create some sort of reasonable basis upon which to adjudicate cases based on our best possible understanding of the exposures that the employees were encountering. So, again, this is a Department of Labor-sponsored resource, and it is a very vital resource but it is not the only resource that we utilize in our exposure profiling for individual employees.

So I've picked Hanford, and, again, you can see all the different types of things

that you can research up on the site. You can look at the toxic substances that are known to be at Hanford, and there are going to be a lot, as you can see. I'll just sort of scare everybody a little bit by just running through the whole list. I mean, this is a huge volume of toxic substances. And this is basically in our database. This is the information we have about the toxic substances that were at Hanford.

MEMBER DOMINA: I had a question. When you're going through these, are they using what chemical A is today or what chemical A was in the 40s, 50s, 60s, 70s, 80s, 90s?

MR. VANCE: Great question. So --

MEMBER DOMINA: Because they have changed, and a lot of them that we use can be the same name today and we're not allowed to use them.

MR. VANCE: Right. And so as part of Paragon's research, what we are looking for is primary data from the site that describes or identifies a toxin. They will also look for

trade names of that material, and I don't have any examples I can think of off the top of my head. But, yes, and you would look for that through this alias search feature. So you can search and see if you can identify a particular toxin that maybe had a trade name and see if there is a known link between that alias for that material and a particular specific toxic substance.

Just for example, something I know, in my early days I used to do something with a lot of construction and I used to have fly ash. We used to do this construction work with fly ash, and the company that manufactured the stuff just called it flow ash, so it was fly ash but the trade name for it was flow ash. And so if we have documentation that links a trade name to a particular toxin, then you search through this alias feature.

Same thing that we were talking about yesterday with the health effect data. So, you know, if you have a particular name for a

disease, berylliosis, that was used a lot in the early days and now it's commonly referred to as chronic beryllium disease, you know you're basically talking about the same thing. So that's that alias search feature.

MEMBER DOMINA: Well, another question that comes up is over the last two or three years, about, like, Rocky Flats, there's been an issue with NIOSH on manganese or, no, thorium and something else, I can't remember, but, anyway, there's these, like, 5,000 boxes which they originally said was 400 and they're not going, nobody is going through them, so how much information is not being done, let's just say for that site, because of all these boxes of documents that people aren't going through? It's doing a disservice to the workers and, not to mention, I know Hanford has probably got a whole bunch more, too. But the issue with the chemicals, the job categories, the way that they're done is, I believe they need to talk to the on-site people a little more frequently on

how things are done because, like PUREX for instance, they just walked away from that building. And so when you get ready to D&D, just like with some of our other facilities, these pipes and everything, they're loaded with stuff and a lot of them are mixtures.

And so the people that are doing this, in my opinion, can't possibly know what people are being exposed to without being more communication with the working people. And while I'm still talking, one of the biggest concerns we have is the health physics techs, they're our largest job classification for HAMTC and you go into 100 N and do a search and it shows, like, 13 chemicals and you know that's not correct because they're the first in and they're the last out during all the production years, any other time, because rad was always the big concern. And so they're exposed just as much as any other maintenance group, operations, or anybody.

MR. VANCE: Yes. I mean, the information that is supplied to Paragon that is

the basis for this information in the database is going to be facility-derived data. So in other words, it's actual production information, production paperwork, production documentation relating to, you know, whatever it was: job descriptions, labor descriptions, work process descriptions. But they have to rely on the written material that they collect, and I do know that Paragon does work with the sites in collecting information. I know Hanford right now is going through an exercise of imaging. Virtually all of their exposure data IH information.

So, I mean, there are efforts underway to try to identify available records. But as I was saying, there's always records being found and being submitted to the subcontractor. So, again, this is an evolving system.

So as new information becomes available or new record stashes are found that become available to Paragon or are submitted to us for consideration, it's going to be assessed

and added into the site exposure matrices if it conveys information specific to particular toxins.

MEMBER DOMINA: Right. But the other part that comes in, when you just mentioned IH data, IH didn't exist.

MR. VANCE: I know that. But I'm saying that there is, you know, generally, we're going to get better IH data as the age weapons process matured. So we do get lots of IH data for recent periods of time, but when you go back into the history you got nothing or very limited. And, generally, what you'll see is virtually nothing and then you'll start seeing asbestos monitoring data and then you're going to see a much more significant level of IH monitoring data. But, again, that's not anywhere near a complete portrait of what every employee would have been assessed for, for any kind of exposure. That information just doesn't exist.

MEMBER DOMINA: I didn't say they had a better understanding of what went on during

production because you can't possibly know what went on unless you were there.

MR. VANCE: Right.

MEMBER DOMINA: And the type, on what the mindset is during those years on what you were doing.

MR. VANCE: Right. And we actually account for that, and I'll sort of, when we get into the example of how we would do a search, I'll sort of talk about the way that a claims examiner sits down and looks at the information that an employee and the case evidence is presented and what they do to sort of create a correlation between what we're getting in a case file versus what they're able to do in the site exposure matrices.

So moving on, I'm going to go just -- yes, Marek?

MEMBER MIKULSKI: You mentioned that there are two versions of the database: public and internal. The claims examiners can access the internal one or --

MR. VANCE: Yes.

MEMBER MIKULSKI: -- the public?

MR. VANCE: That's the one that they are required to visit because that has the most up-to-date information.

MEMBER MIKULSKI: And what prompts the updates to the public version?

MR. VANCE: It's basically a process where once we have enough information that we need to basically create an update for the public version. So there's no formal schedule, but they do do, I would say every six months or so, they're going to do a freeze and then an evaluation by the Department of Energy and then that version of the site exposure matrices will be uploaded into the public realm.

So yesterday we were having a conversation about health effect data, so I just wanted to show you a little feature here. So people were asking, well, what does the Department of Labor utilize for established health effect data and this is the list. So when

we were evaluating cases, this is basically the recognized list of diseases, occupational illnesses that the Department of Labor is accepting that there is a correlation or a relationship between these and some sort of toxic substance exposure. So it's a very large list. You can see some of them are very specific and relate to chemicals. Others are biological because the definition of a toxic substance is any material that has a hazard based on its chemical, biological, or radiological properties.

So you can see that there's a mix of different things, but this is basically the list that runs through Haz-Map that is basically the established diseases that are linked to toxic substances. And so Dr. Markowitz was asking about lung cancer, so let's go back to that. So here's the list of all the toxic substances that are linked to lung cancer. And, again, this is a very broad search outfit because all we're looking at is the toxic substances that are currently established to have some sort of

epidemiological link to the development of lung cancer. So you can see it's a pretty lengthy list.

The other big one that we see that came up yesterday was chronic obstructive pulmonary disease, and, of course, our pulmonary diseases are the ones that we generally see the most of as far as claims and are also generally the most compensable on types of exposures. So, again, for chronic pulmonary disease, here's the list, and I'm sure many of you will recognize a lot of these.

And then, Dr. Silver, you were asking about direct disease links yesterday. Here are the, these are work processes that are known to have a direct connection to the development of COPD. And when you link on arc weld aluminum, here are the toxic substances that are specifically linked to that.

So it's sort of an ability of the claims examiner to look at it and say, okay, I found some information and hear that this person

has identified either in their occupational history questionnaire or some other information that this specific activity was occurring that the employee was involved in or any one of these.

CHAIR MARKOWITZ: I got a question about this work process. Does that come from the HAZMAP program or is that specific for --

MR. VANCE: I'm pretty sure that's coming straight out of HAZMAP, but we can check to make sure. But I would say that I'm fairly certain the answer is yes because they're looking at epidemiological information specific to these work processes, not just the toxins.

CHAIR MARKOWITZ: And is the link to disease needed by the exposures for that work process? In other words, for a work process, that leads you to a set of exposures --

MR. VANCE: Right.

CHAIR MARKOWITZ: -- which leads you to a set of diseases.

MR. VANCE: Yes. So in other words, like, you know, for example, I'm a claims

examiner and I'm looking at somebody that says this is, I'm a concrete worker, I'm a brick layer, and this is what they're spending a lot of time their time doing. If I click on that, I can immediately know here are the toxic substances that are specifically linked to chronic obstructive pulmonary disease and silicosis. So as a claims examiner, these are the exposures that I'm going to want to focus on in the development of my case and this process right here directly associates these toxins to something that the employee did.

CHAIR MARKOWITZ: So I think feature is more recently than the basic --- (simultaneous speaking)

MR. VANCE: This has been around for a while. Our disease link has been there for at least several years.

CHAIR MARKOWITZ: I'm just trying to understand how it helps the claims examiner above and beyond knowing the job title, the facility.

MR. VANCE: Okay. Well, then let's

talk a little bit about what a claims examiner does, and I'll walk you through it because I do case research on these things all the time. So you have to put yourself in the seat of a claims examiner. A claims examiner, as we mentioned yesterday, is not an industrial hygienist. They are not a medical specialist. They are an evidence analyst. They're evaluating information, and they're trying to obtain information in order to process a claim through a set of criteria to determine compensability.

And so they are looking at a case file and they are looking at information that's been presented in a case. And we have lots of different ways that we collect information through our case adjudication process. When somebody files a claim, they're going to provide information about where they worked and their employment history, they're going to provide years of employment. They're going to generally describe in general terms what they did, and that will generally be on the employment history form.

So that's one source of information, and that sets the ball rolling as to what the claims examiner will ultimately do when they get to the Site Exposure Matrices.

We also will collect information from the employee's work history. So when we go and begin our process, we will say, you know, John Smith has filed a claim, they say they worked at Hanford for 20 years in the 60s into the 70s. Maybe that employee is deceased, and it's a spouse filing a claim on behalf of their deceased, you know, husband. And so the spouse is saying, well, I don't know what he actually did in any great detail, but I know he was a welder and I know that he did welding at the site and he was there for years and he worked in probably one of the maintenance sheds or maintenance facilities.

We then will take that information and we'll go to the Department of Energy and we'll say what information do you have about this employee, and that's called a document

acquisition request. We will then get a submission back from the Department of Energy that basically gives us everything that they have available about that employee. We will get medical records. If this person was injured on a job, we'll have medical records. Or if there was some sort of screening that was being done at the site, which is oftentimes the case, we'll have information about that.

We will get any kind of exposure monitoring data if it was toxic or radiological because, generally, we'll do both. But we do get, if it's a cancer claim we'll do both. But we'll get any radiological monitoring data. We will get any kind of security information, such as, you know, clearances to enter different locations of the site. But just about any kind of information that the site has we will get, and that's a treasure trove of information because what the claims examiner is ultimately going to be try to do is link that kind of information to something in the Site Exposure Matrices.

So just based on a spouse filing a claim for somebody that worked at Hanford for 20 years, we know that they were a welder and we know that they could have probably worked in a maintenance service location or something like that. We have a lot to go on now.

You know, we would look then to say, okay, what disease are we talking about? Well, the spouse files a claim saying, well, you know, he had lots of different medical problems, but the thing that he had the most amount of issues with prior to his death was severe breathing problems. We know based on medical evidence that he had a host of pulmonary diseases, including chronic obstructive pulmonary disease. And so that's what we're going to focus on in assessing that particular employee.

So the claims examiner using whatever information they're getting in the case file then has to start building the claim. They have to start saying, okay, what do we know this employee could have been potentially exposed to that's

linked to COPD. Site Exposure Matrices is the tool that does that. This is what the claims examiner has to build off of, given the fact that we generally do not have any employee-specific monitoring data. So they would start looking at information that they can filter on based on Hanford. They'd select Hanford. They'd maybe look at work process information. We know that it was a welder. What do welders do? They weld. So most claims examiners will ideally like to start with the labor category information, so let's go in and take a look.

So we know a welder welds. You can look at the list of toxins that we know a welder is going to be doing, but it's a fairly long list. Here are all the different processes that we know welders did. So this is just about everything that we know, and several of these are direct link, disease-linked processes.

Here's the locations we establish as where a lot of this type of work occurred. Now, these areas, when we see area 100, these could be

huge areas comprised of multiple buildings, multiple locations. And here is the listing of all of the locations that we know that welding occurred.

Now, again, you're a claims examiner. Your job is to try to identify the highest probable exposures that are going to get you to a compensable outcome, so you're going to always wanting to be filtering and identifying a list of toxins with the highest probability of getting it through a process with a positive outcome.

So, generally, we encourage staff to go down and get to at least seven toxic exposures. We need to have something, if you're thinking about a process where you have thousands of claims going through a process, you know, there needs to be prioritizations. So the way that we prioritize this, we try to restrict our exposures to seven.

So the claims examiner is then going to start looking at ways that they can identify a set of prioritized toxins. So we know that he

was a welder, and we know that the spouse is saying that day he was doing some sort of work in a maintenance facility. So you can look in here and you can see that there are two different locations. And so the claims examiner is going to be looking for information that the spouse has provided. So she said something about the maintenance shops, so we've got two locations. Well, you know, that's not really clear. We've got, like, three almost. We've got this one, we have this one, and we have this facility.

So what I want to do as a claims examiner, I got to figure out which one do I want to select. So now I'm going to go start looking through the DAR records. I'm going to start looking for any kind of employment information.

One of the most common places that we see linkages between specific buildings and workers is medical incident reports. So let's say we go through and we look, he cut his finger in 1962 and had to report to the health unit because they needed to put a band-aid on it.

They generally will complete a little medical report statement saying, you know, the employee was injured in the maintenance shop in building 272. If I can identify that information, I immediately have the ability to search by this facility.

So I'm trying to link things to this employee so they can filter this employee's work history down to something that is workable for me. We also know that the employee was diagnosed with chronic obstructive pulmonary disease. Maybe that's listed on the death certificate as the basis for his death, so that's something that we can use to accept as far as his, you know, the filtering capability for this. So then we look at the principle toxins that we're going to probably use in this case based on just some rudimentary information.

So this is what the claims examiners do. They take shreds of information in these case files and then they try to build a profile based on this primary source of information in

the site exposure matrices.

So now I'm a claims examiner. I've done my due diligence. I've identified two very prominent types of substances that this employee most likely encountered during this employment. This is the function of the Site Exposure Matrices, trying to identify linkages between an employee and a set of toxic substances linked to the filter capabilities of the site exposure matrices.

There are lots of different ways that a claims examiner can approach this, all right. So if I know nothing about an employee other than a description of a work process, maybe we don't know what the labor category is but maybe we know what he work process is and somebody describes their function as I did a lot of welding. I can search just on welding fumes and see information about the type of folks, work process, where this type of work activity occurred. I'm trying to create relational connections based on information in a case file to what I can identify

and search on through the Site Exposure Matrices.

Sometimes you can be very successful in these cases, sometimes not. It depends on the degree of information that you have. So in other words, if I get-- so for Kirk, on his tank farm individual, so if I'm getting information from somebody who is a person that worked at the tank farm, so let's say they were doing a job that required them to go to lots of different locations around the site. I'm a claims examiner, I'm trying to build the case. The more information that I have about where and what type of work was occurring, the better my search results are going to be here. I mean, it can be anything. When I do these searches, I'm going back and forth looking for connections. I'm looking for anything that I can relate that employee based on information that the employee or a family member has provided. I will be looking at employment history documentation. I will be looking at DAR information. I will be looking for any kind of information that I can

relate to that employee and then apply through a search through the Site Exposure Matrices. Okay?

And sometimes it can be shreds of information. Sometimes, in the occupational history questionnaire, we will get passing references to building locations or different kinds of things that I can then focus my search on. So I can go to a particular location or a building and look at, well, what did they do at that building. And then I can look at the context of what the employee or their spouse or family member was saying with the type of work they were doing and then link it through that process. There's lots of different search functionalities, and it's really hard to show you without actually applying it in a real life case.

Yes?

MEMBER REDLICH: So going back to Dr. Markowitz's question, I mean, this is all I do is, you know, have a page in front of me with a disease and the question is, is it related to their work.

MR. VANCE: Right.

MEMBER REDLICH: So if you start, there's a zillion exposures on all these different sites. If you start with the disease process, you have someone who has COPD and is a welder.

MR. VANCE: Right.

MEMBER REDLICH: I mean, if you look at the list of COPD, I think there's welding fumes as a cost, so you don't need every site, every exposure. Do you start with the list of exposure or the list of the diseases that the person -- and on the other side, there are a number of diseases just at looking at a number of these claims, that the entire category of disease, the evidence that work exposures contribute, is not very substantial. But it seems that there are a much smaller number where we realize there is a contribution.

And so it seems like the same energy is spent on -- so I'm just wondering do you start with the disease or the exposure?

MR. VANCE: You always need to think in the realm of this process, what we're talking about in the site exposure matrices is merely the toxic substance exposure profile for the employee. We're not talking about causation. This does nothing for causation. This merely does the work for the claims examiner of trying to identify the toxic substance that that employee potentially had an encounter with that we then will pass through the process through then the medical side, which is the causation side. Being able to establish that that exposure to that toxin is related to the disease that was claimed and that's done through that -- (simultaneous speaking)

MEMBER REDLICH: So you are looking here because you have, you know, a lot of very useful information where you had, if you go under diseases or health effect, you are listing what links. So it seems that what the claimant comes to you with is a list of diseases that they are concerned were related --

MR. VANCE: Right. It's always going to be driven by what the claimant is providing in their claim. They file a claim on behalf of themselves or a family member. We've got to evaluate, okay, given that we have nothing, we have no real good exposure monitoring records, we need to know, okay, what were the --

MEMBER REDLICH: You have a job title.

MR. VANCE: We may have a job title, we may not. We may not have any information. But our role is to first establish the linkages between that employee's work and an exposure to a toxic substance. So what this effort is being done is to try to identify those toxins that are known to be linked to the disease being claimed. This does nothing to establish causation.

This is just the first stage. This is just basically saying we know that asbestos is linked to the development of COPD. Now, we know that this employee was exposed to asbestos. We have not answered the question of whether this profile for this individual employee is enough to

establish that it's at least as likely as not that their exposure to asbestos was a significant factor and causing contributor in aggravating their disease in their unique circumstances. And that's the next stage in this process is that once the claims examiner has identified a set of toxic substances that are linked to whatever the disease is that's being claimed and links to the employee's work in some capacity based through this filtering methodology, the next step is actually having an industrial hygienist look at that and say, okay, this employee who worked as a welder would have been significantly exposed to asbestos throughout the course of their employment, they would have been significantly exposed to welding fumes. Maybe there was a moderate level of exposure to one of these other types of toxins and maybe a very incidental level of exposure to something else. So the characterization of the exposure is what the industrial hygienist then does. Then it moves on to a medical review unless we have a presumptive

standard that the claims examiner can establish in the case.

CHAIR MARKOWITZ: So you mentioned before that the claims examiner limits the inquiries to seven of the most promising agents and also that they try to select based on most likely exposures that would establish a link to the disease in question. So why is it limited to seven? I understand there are a lot of --

MR. VANCE: Just a programmatic determination of that was what was reasonable for the administration of the clients.

CHAIR MARKOWITZ: I'm sorry. That was a, that's a question of just resources? Because it couldn't go through a hundred --

MR. VANCE: Yes. I mean, it was a decision that the program made that seven was a reasonable presentation of what we could administratively process through this, and it's not to suggest that we won't look at additional ones and, in fact, we do. We actually do look at that, but from a claim adjudicatory process it's

seven. We established that in our procedures as what we ideally want to see in these cases.

CHAIR MARKOWITZ: And which seven do they choose?

MR. VANCE: They're going to always, what they're always going to be working is to try to filter these search criteria down to seven or fewer, depending on the circumstances. So in other words, if I look at, let's go back to the welder category. Let's say I go to a welder and I'm looking for COPD, and let's just see what we get for that. We get these two. So the claims examiners basically stop here, you know. There's not any need to go beyond this because these are the primary ones that you're going to see because these criteria right here, welder and chronic pulmonary disease, is getting you a pretty good presentation of the primary ones that that person was exposed to.

Now, if I just go, and here's the problem, you can go out there and you can search for -- let me see if I can find one. If you

would just search by health effect, you're going to get potentially, you know, you can filter some of these things down and you can find, you know, a huge number of them. You can't, you can't do an exposure profile for somebody that's working at Hanford.

Let's say you just show up and you say I worked at Hanford and I've got lung cancer. You know, are we going to do an exposure profile for every single one of these toxins? There has to be some prioritization and effort to try to restrict this down to something that is going to be workable. You know, we're not going to be able to, you know, just from an administrative and an adjudicatory standpoint, we can't do a profile for every single one of these. It's just, you know, it's a matter of how do you prioritize your workload.

CHAIR MARKOWITZ: Sure. So how do they prioritize? I mean, I see probably 15 different exposures and --

MR. VANCE: And that's what the

function of the filtering is so that you're trying to take this list, if you got somebody who shows up with lung cancer, you know, based on the unique features of the information in the case file, you're filtering down to try to identify out of this list for that employee what is a reasonable presentation of toxins that we can then profile that are likely going to produce as a positive outcome in the case?

And don't forget, you know. The claimant can submit information, as well, as we go through this process. We have lots of folks that submit all kinds of information in challenging the assessments of these cases, and then we have to make a judgment as to whether or not that's a reasonable presentation of information.

So, you know, for lung cancer, we would look, okay, what were you doing? What were your work processes? And sometimes we will get down to, like, just asbestos or we will get down to cement dust, depending on the circumstances of

the case. But the effort is to try to prioritize and get to a workable listing of toxins.

CHAIR MARKOWITZ: Sure. Thank you.

MR. VANCE: Okay. So let's go back now.

CHAIR MARKOWITZ: Oh, yes, I'm sorry. Ms. Pope?

MEMBER POPE: That's all right. I just wanted to echo what Kirk was saying in terms of talking with the workers. They're primarily the ones that would know what the processes were, especially in terms of Rocky Flats. The research team, would they be open to talking to workers or past workers?

MR. VANCE: Well, all I --

MEMBER POPE: To develop more information.

MR. VANCE: What I can say to that is just that, you know, we do collect information from lots of different sources, and I would say that my recommendation, whenever I'm talking with

folks, claimants or their families, is that as much information as people can provide in the submission of their case file. That's why the occupational history questionnaire, when we talked about that as being one of the things that we really need help with, is that the better information that we can collect from an employee or their family at the onset of their claim the more information that we have, if we're in a buildout or exposure profile for an employee, so in other words, that kind of information, when we ask somebody, well, what did you do at this site? What type of work did you do? Where did you do it? What type of incidents were you maybe involved in the site? Can you describe them? Do you have any recollection of the description of the material you were working with? Do you remember what the process was that you were engaged with? Was there any kind of trade name of the material you were working with? That's the kind of information that's very helpful because, again, your claims examiner, trying to

create relational connections between that information and what information is in the site exposure matrix to try to build out this reasonable presentation of exposures that can then go on to that causation analysis.

MEMBER DOMINA: And when we were just talking about Rocky Flats earlier where those 5,000 boxes that people know have been hanging out there for at least two years. So could those boxes be sent to Paragon to go through to look for chemicals and stuff? Because obviously NIOSH isn't going to do it. And to me, that stuff is doing the claimants a disservice when we know that there's potential information in there that could help them on their claim, you know. It could be the same thing at Hanford because when I look at this I see all kinds of shortcomings.

MR. VANCE: Right.

MEMBER DOMINA: Because that IH can't possibly know what kind of a place, the ceiling heights, the ventilation, all those things that come into play, and then they push something back

like it's infrequent, and they don't know because they're not there.

MR. VANCE: And that's the challenge of all of this is, again, we are operating in the absence of information. So I think that that's a question that Carrie can add as the question about, you know, if you're aware of a specific record source that is a potential source of exposure data, how does the Department respond or collect that information for assessment?

MEMBER DOMINA: Well, we talked about the maintenance shops or whatever, the secretaries sitting where you are, no offense. But it's just they're in the same, you got to know how many building zones of air and different stuff, just like we toured Los Alamos. That building had been there since '54 where all this machining and stuff is going on, and the only, it vents to the atmosphere, just like a lot of our buildings do. There is one zone. It's just whatever happens to come in through the doorway when you come in.

MR. VANCE: Right. And that's, and so in working with my industrial hygienist, the important thing that they would need to know is what do we know about that employee, what do we know about that work process, what do we know about what toxins they could have potentially had an encounter with. And then it's up to them to decide based on the best available information. We're not going to have the type of level of detail that you're talking about with regard to air monitoring data and all of that stuff. What they would then do is try to look at what is a reasonable presentation or characterization of an exposure based on their expertise, their knowledge as industrial hygienists, and if they have any specialized information about that particular site and an understanding about what is the reasonable presentation of exposure for somebody based on the characterization that they've given in their claim. And if we don't have that information, we are then left then to try to characterize it based on the best possible

information and that could just be an industrial hygienist looking at it and saying I've got nothing but here's what I can apply based on my knowledge, experience, and education, and whatever their background.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Yes, I have a question. You said that you wanted to get it down to a reasonable number of different toxins. So they go through this and they do the filter, and let's say there's five different things or seven different things that you think is where the money is, the claims examiner thinks where the money is on this exposure on this particular disease, and so that goes to the industrial hygienist, let's say, to see if there was, based on his time in the job, how much, whether there was enough exposure to cause the disease, does he then analyze each one of those seven separately or does he look at the possible synergy between all seven?

MR. VANCE: Now, the industrial

hygienists are going to look at each one of the toxins that have been identified by the claims examiner and create a characterization for each one.

MEMBER CASSANO: So if he was exposed to seven carcinogens, all of which can cause lung cancer, but, in exception of all the other six, neither one of them, according to the industrial hygienist, was enough of an exposure to cause lung disease, lung cancer, and he was exposed to seven of them, the guy's claim is denied?

MR. VANCE: No. What we are talking about right now is still just the exposure character profiling and characterization. The claims examiner is doing their job to try to, you know, to create connections between particular toxic substances and the facts that are laid out in the case evidence. Once we have done that, once the claims examiner is able to identify that through the use of the site exposure matrices or other information that's in the case file that may not be present in the site exposure matrices,

the industrial hygienist is then characterizing the extent and nature of duration of that exposure. That then completes the exposure profile for that employee.

That then is packaged and then submitted to a medical expert who is going to look at the characterization of the toxins that have been identified for analysis, and the physician has to then make a determination as to whether or not the characterization of that exposure is enough to convince them that that exposure, however it's characterized, is a significant factor in causing, contributing, or aggravating that claim to disease.

So the question that you're talking about is the collective reporting of that exposure and however it's characterized. That's not a judgment that's made by an exposure expert. That's actually assessed, and the doctor has to decide, based on the information they're presented, in whatever collective way that it is, is it convincing them that it's enough to

establish that causation threshold.

MEMBER CASSANO: So the doctor then can look at the combined effect of all of them.

MR. VANCE: That's correct.

MEMBER CASSANO: Okay. Thank you.

MEMBER DEMENT: I think you picked well. I think it's a good one to illustrate sort of the pervasive nature of those exposures, and I wonder, you know, one of the things we see in the building trades program is when we ask about welding, we have a few people who are classified as welders, not many, but welding is pervasive not only as an exposure, because of individual duress if they don't do it, they're around it a lot, even with a pipefitter, you know. They may do welding themselves but certainly around it constantly.

One of the things when I look at the site exposure matrix is the job category. We've heard it discussed at board meetings many, many times. Job categories are in many ways a process where you go through a large list to try to get

them grouped in a way that sort of makes sense by the work that they do. And the site exposure matrix has a fairly long list but certainly not comprehensive in terms of how they will present themselves. And I know there's some search alias in there.

MR. VANCE: Right.

MEMBER DEMENT: Is there anywhere a mapping where you sit with a map that says this is a job title and these are the 18 different jobs that we've mapped into this job title?

MR. VANCE: Yes. I mean, when you look at --

MEMBER DEMENT: I mean, I could search for it, but is there actually a table? Somewhere in your database, there actually is a table.

MR. VANCE: Yes, so let's take Rocky Flats and let's just see if it works for Rocky Flats. Let's go to Rocky Flats and see if we have a welder labor category. So we have a welder at Rocky Flats now. So this is everything that we, this is the unfiltered data right here

about what we know welders were doing at Rocky Flats.

So when I'm doing research on a case, sometimes I'll start at this level and I'll just get a familiarity about, okay, what do we know about welders at Rocky Flats. We know that there's a lot of toxins linked to welding at Rocky Flats. And don't forget: for these facilities, these profiles are based on the work that was being done by that labor category at that site. A welder profile at one site may actually be different based on the type of work they were doing at another site, all right? So a lot of people get confused in thinking that the machinist at Hanford is going to have the same exact exposures as the machinist at Rocky Flats, Savannah River, or somewhere else, and that's not accurate. Each one of these sites had different labor categories that may be associated with totally different kinds of work. So you can see this is a huge list.

And, again, getting back to what we

were talking about before, somehow I've got to get this into a workable list. I've got to get this into a workable construct. So what I'd be doing as a person looking at this case is, okay, I got to get this down, I got to get this to --

CHAIR MARKOWITZ: I think you're misunderstanding the question.

MR. VANCE: What I'm getting to is that, once you look at this overarching list, you can then look at here are all of the processes and activities performed by that labor --

CHAIR MARKOWITZ: It's a different question, it's a different question.

MEMBER DEMENT: You know, If I'm presenting my case and I'm in a labor category, I have a job title, I present it, is there any way that, before I submit this thing, I know where it's going to end up in some of these labor categories? I mean, I know in this database, there's a table in there somewhere, and I'm sure there are probably multiple linked tables, but there's no way I can actually look at that list

and say does it make sense. In other words, we don't have access to that mapping that's going on.

MR. VANCE: No, no. Are you talking about the process that Paragon takes to identify the documentation?

MEMBER DEMENT: Yes, there's a table somewhere that exists in here that says this is the labor category and these are all of the jobs. This is the site --

MR. VANCE: Yes, and that's the function. Yes, so that's the function of the contractor and their experts in looking at this information. And the people that do this work are generally familiar with these sites. They have industrial hygienists and epidemiologists that are looking at this and making these kinds of judgments. So everything that you're looking at in the Site Exposure Matrices for a welder at Rocky Flats is going to be connected to some sort of document somewhere that is identifying this information linked to welders. So whatever we

have here, so it's identifying toxic substances or work --

MEMBER DEMENT: I agree with that. But in many cases, there is not a document that's professional judgment.

MR. VANCE: Right.

MEMBER DEMENT: And that's fine. But I think that has to be open in terms of how that was done. We've heard many times, and I think the people or the site people here who can answer better than I, but, having been to many sites, I know that there may be subtle differences in the welder at site A versus site B, but, generally, a welder is going to have pretty close to the same sort of gamut of exposures.

MEMBER REDLICH: And, you know, let's say COPD, welding and COPD, so you really need to know more than the fact that he was a welder and maybe how long he welded for.

MR. VANCE: Well, where you're talking about welders, that's an easy one because you can just welders weld and so you're going to be

exposed to welding fumes and that's an easy one. You've got to think about other type of labor categories where you've got --

MEMBER DEMENT: Yes, that's not the problem. It's the other labor categories that do a lot of welding.

MR. VANCE: Right. And so when I would be searching for that, what I'd be looking for and, again, I'm a claims examiner sitting down and looking at information. Let's say I'm a laborer. That's my official labor category. But in my occupational history questionnaire, hey, I was doing demolition of buildings. As part of my demolition responsibility, I was cutting lots of girders and breaking things down and we used arc welders and welding tools to break down and chop these pieces of metal up. Well, as a claims examiner, maybe I search for the labor category of laborer and it's got nothing in there about welding.

Well, maybe I go and say what about decommissioning activities? Because that's the

labor process that's being described. It has nothing to do necessarily maybe with the laborer or laborer category itself, but it's a work process that the employee is describing. So then I can go and look and see do I have any work process information that links that activity to a particular toxin? And then that's how you get to your welding. You establish your exposure to welding fumes.

So, again, you're looking for ways to connect information that you've gotten from the employee to the filtering capabilities in the site exposure matrices. That's what makes this system so good to use is because there's lots of mechanisms that I can take to evaluate exposure. There's lots of ways to get to the information.

CHAIR MARKOWITZ: So I need to interrupt because we want to save some time for Ms. Hearthway's presentation. Can we interrupt this and then come back to it in a bit? Because there's tremendous interest and we need to understand it, and you're the person to explain

it to us.

MEMBER DEMENT: Just a point of reference, when I do a search for welder in particular, I mean, on the laborer in the example we just gave, I just look at the exposures for laborer and welding is not in there.

MR. VANCE: It doesn't have to be because I can go into the Site Exposure Matrices at Rocky Flats and do a search just for welding as a work activity, and then maybe I can look at, okay, what's linked to welding at Rocky Flats? And it may not be something that's associated with that labor category because we have no documentation about it. But the way that the employee is describing that, in my judgment as a claims examiner, I'm saying, well, is it reasonable that somebody that is in a decommissioning position who is talking about breaking down buildings, would they have reasonably been associated with welding because they were chopping up metal components of that building? Is that a reasonable presentation of

information based on what you're being told? The answer in my opinion is going to be yes. So you've got to make that judgment.

MEMBER DEMENT: I've spent a lot of time with this site exposure matrix, and I would expect that maybe claims examiners don't have that level of expertise.

MR. VANCE: Well, what they do have experience in doing is looking at information that's reported in a case file and try to make these linkages. If that information doesn't exist, then the claims examiner, let alone anybody else, is not going to be able to make that happen. The key component here is what information do I have that I can use to build my exposure profile? So if all I know is that I was a laborer, like a spouse filing on behalf of their husband saying he was a laborer and did all kinds of stuff and I have no idea what it was he was doing, that doesn't give a claims examiner much to go on other than the labor category, potentially. But if you have somebody that comes

in and says, you know, my spouse worked at this site and these are the specific things that he or she did, the claims examiner has a lot more to go on to build out a toxic substance profile that the industrial hygienist then can characterize.

MEMBER DEMENT: Yes, but that makes the occupational history questionnaire extremely important.

MR. VANCE: I would say it's one of the most important resources that we use in trying to make these kinds of connections, and I use it quite frequently. But I find, oftentimes, it is buried in there and you really got to dig for it.

CHAIR MARKOWITZ: Okay. We're going to come back to this. This is interesting. But we're going to just turn it over to Ms. Hearthway to speak a little bit about, I think, the recommendations. Thank you.

MS. HEARTHWAY: Thank you. I will gladly accommodate your schedule, so if you --

CHAIR MARKOWITZ: No, no, you can, why

don't we --

MS. HEARTHWAY: So thank you for allowing me just a few minutes here. It occurred to me talking with you yesterday and listening to some of the questions that it might be helpful if you understood how we approached the recommendations. It might be helpful for me to just sort of define our role a little bit and what we do.

I understand you want to review the prior Board's recommendations and our responses. There's a lot of them. I know that will take you some bit of time, particularly the new individuals on the Board. But just to take a few minutes to explain how we approached that and how we approach all the recommendations and how that interacts with your role I think might be beneficial.

So I signed off on all of the responses. I spent a significant amount of time, as did the entire Energy program, in looking and carefully studying and deliberating on your

recommendations. It's our job to carefully and thoughtfully examine each of the recommendations.

In doing that, we do seek other medical and scientific experts' advice. We also seek the help of program experts and legal experts, so we look at your recommendations. We really examine the support you've given for those recommendations, and we go out and look to see if there's additional support. It is not a question of one expert against a different expert. It is just gathering of, not unlike a claims examiner, as much information as we can that talks to this recommendation, that supports or doesn't support the recommendation.

We carefully look at resource materials. Everything you cite, I've required someone to go and look at as support for it and whether it's sufficient medical and scientific support or not.

So I wanted you to know the sort of detail that we go into. We take this very seriously. We're very deliberative. What is

extremely important and helpful to us is the support and the amount of support that you provide for each of these recommendations. The more that you can get, the easier and better it is for us to understand that kind of body of support.

And then we make a decision, and we provide to you what we believe to be well-rationalized responses. So we've looked at your recommendation. We've looked at all the material that you've given us and more that support or don't support those recommendations. And then it's our role to make a decision on that.

What I've just described, that deliberative process and the two different roles between the Board and us is, in my view, extremely healthy and productive. That's how you get to the right answer. It is also the way it is done in almost every situation I have ever encountered. It's what FACA requires. It is part of our job. Your job is to make the recommendations and provide support for those

recommendations. It is our job to very carefully look at that and make a judgment call whether to accept the recommendation or not.

I did want a moment to just impress about how seriously we take that role and how carefully we take that role. I know, of course, we don't always agree, but I hope you respect that process and respect that we are being very careful when we look at each of these. We're spending a great deal of time in trying to have the support for the recommendations.

When you review the recommendations already made, I think we've given our written responses. I think they provide, in some cases, of where it's perhaps not quite clear enough that we need some clarification and others as to why we didn't accept the recommendation and others as to why we did. You, of course, are an independent body, so any of those recommendations you want to resubmit, that is your prerogative. If you do, we will very carefully and deliberately look at them again. I just ask that

you add support behind those recommendations when you do that. Provide whatever studies, medical, scientific, you have backing those recommendations up so we can look at those, as well.

I do, again, want to ask that you look at what we are looking for and seeking assistance on. And I think John is going to be available later to answer any questions, clarify, because we gave an outline of those items that we're looking for your advice and help on.

But with that, I, again, just wanted to sort of reiterate we're in this dual role where you very carefully provide us with recommendations but then we have a responsibility to carefully go through those recommendations and particularly the underlying support and background of those recommendations. And we pull in a great deal of body of knowledge to make that.

So I just thank you for the opportunity to reiterate that. And the more that

kind of support and background that you can provide, it then gives us the ability to accept those recommendations.

So with that, I know you have more that you want to accept. I just wanted to kind of clarify that and maybe impress upon you that this team really does look at these extremely carefully. Every site we look at and we read, and we do pull in information with the hope that we can accept as many recommendations as possible.

All right. Thank you.

CHAIR MARKOWITZ: Thank you. Any comments or questions while Ms. Hearthway is still here? Thank you very much.

MS. HEARTHWAY: Thank you.

CHAIR MARKOWITZ: So let's return to SEM. Well, I want to make a comment. So we did the former worker screening program at Paducah and Portsmouth and numerous other sites, and all the sites, actually, we get many, many job titles. We ask people to write down their job

titles. In fact, at any given site, probably hundreds. They change over time. The same job changes over time.

In SEM, the job categories are numerous but smaller than the total number of job titles, which is a good way to go. I take it Paragon is the one that is sifting through those job titles and assigning them job categories.

MR. VANCE: Right, yes. And it's always going to be derived, as I said, from site information.

CHAIR MARKOWITZ: Right, right. I did notice that in Paducah there are about 85 job categories and, in Portsmouth, there are about 125 job categories, and those are very similar facilities, which was interesting, that kind of variation. I'm asking about this or commenting on this because when we get to one of the COPD recommendation or another one of the recommendations where there's a list of job titles, job categories that are specified for presumption, and we're interested in expanding it

to include all maintenance and construction job titles. There's a challenge in figuring out because of site-to-site variation which job categories encompass the maintenance and construction.

Anyway, Dr. Redlich, did you have a comment or a question before --

MEMBER REDLICH: No, I don't know if this is the time, but I thought -- sorry. I don't know if this is the time, but I thought it might be helpful, we're reviewed a number of the cases, and I think maybe if we just went over one as an example, obviously, to identify just very briefly so that I think it might just be illustrative of how we sometimes feel that all of the effort to create greater specificity with the SEM maybe then ends up with an answer that doesn't seem basic common sense. So I don't know if this would be the time or later.

CHAIR MARKOWITZ: Probably this is a good time because this is a chance for Mr. Vance to participate in that.

MEMBER REDLICH: Okay. While I'm just pulling it up --

MEMBER DOMINA: Well, I was just thinking back to what Carrie just said because when we were here about, I don't know, two and a half years ago I think it was, the amount of time that the claims examiner spent on a case was minimal in our opinion. I believe I heard 30 to 45 minutes. We can pull it up in the old -- so that was one of the things that drew the ire of the Board on the limited amount of time that they spent on it. Because, you know, we deal with people's lives every day, and it's not easy. And, you know, we see the personal side of it face to face and not on a piece of paper, and I just feel that it's a disservice to our workers who are, a lot of them who are military vets but they're also cold war vets, and, you know, for me, it's my age bracket now, you know. And we're cleaning up these sites, and it's not getting any better.

And so I just think that I agree with

Carrie, we should look at this for some of the members that weren't here the first meeting that we had. You know, I understand time constraints and stuff like that, but, you know, there's always plenty of us out here and I just think that sometimes that they need to dig a little deeper.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: Okay. So this is someone who was a uranium miner, and, in this case, the disease is not in question. He has clear pneumoconiosis, pleural plaques, fibrosis. He's on oxygen, and his lung function is like 30 percent. He's been diagnosed with pneumoconiosis, and he worked as a miner. The question about his work, you know, lists basically various mining jobs, but he was clearly an underground miner, whatever that was. Laborer, rock crusher or some -- he had worked as an underground miner and has pneumoconiosis. So I would say right there you could stop and say that he has, assuming the other criteria are met

in terms of there's a covered facility and dose criteria.

So then assembly stuff, and so his job, we have job categories, slusher operator, loader, rock bolter, laborer, helper. So then the SEM concludes that he had exposure to aluminum, and then this went to a CMC. And the question that the CMC was asked was not was this person's lung disease caused by his mining work or whatever, the DOE approved work time -- the question was is it at least as likely as not that the employee's exposure to aluminum during his employment was a significant factor in causing, contributing, or aggravating his pneumoconiosis?

The particular CMC, and we had read a number of his, I would say didn't go out of his way to try and, you know, in fact, he actually seemed to go out of his way to sometimes try and deny some claims. So his response was the main cause of pneumoconiosis secondary to aluminum exposure is from chronic exposure to high concentrations of fumes during aluminum arc

welding.

So presumably the person did not engage in this activity while employed, and so basically he denied it. And so then the claim is denied. So we go from what seems like should have been straightforward and obvious, you know, causation to something that sort of defies reasonable logic. I don't know if this is, there were a number of mining ones where the exposure had come up with aluminum. If that's been corrected, that's great. But reading cases like this makes one leery then of the process.

CHAIR MARKOWITZ: Thank you. Any comment or do you want to continue or --

MR. VANCE: Well, let me just make an overarching comment about the process, you know. I'm not going to comment on any particular case because I just don't know the details, but, you know, this is a process. We have to go through a process to evaluate each claim, okay. There are always going to be unique features to each case as to how it's presented and how the evidence is

establishing X, Y, or Z factual finding.

When we talk about factual findings, it's the judgment of the claims examiner to look at whatever information that they are being presented with and make a reasoned judgment as to whether or not that evidence establishes a factual presentation of information.

Our claim adjudication process is such that we will provide as much information as we can when we make our determination of compensability. So in other words, we will go back to the claimant and say here is our proposal as to whether or not we're going to accept or deny your case. At that point, the claimant has every opportunity to provide whatever feedback or information that they want us to consider before we finalize that proposal. So in any situation where a person is looking at something and say I disagree or I don't think that you guys have done your due diligence in assessing the exposures that I encountered as a miner that are associated with this disease and I do not feel that the

medical opinion of your specialist is well rationalized for whatever X, Y, or Z reason, and here is my person or expert that has looked at that and is challenging that presentation of evidence. Then we have to look at that and make a judgment. Did we do something improper? Is it not a correct outcome for the case?

That is the process. It is a collaborative process. It's not meant to be, we're not looking to get to no, we're looking to get to yes. And so information in the site exposure matrices is constantly evolving and updating, and I would look at that and, just based on the description, I would say, yes, that sounds problematic to me, but I don't know what the details of that particular case are.

So there is an adjudication process for us to consider information. The key thing is more information and one particular case outcome, you know, it's hard for me to be able to generalize it and say that it's a common problem across the program.

CHAIR MARKOWITZ: Claims examiners, like everybody else, make mistakes. So how do you check, do you have a system for randomly checking their use of this animal to make sure that it meets the quality that you expect?

MR. VANCE: Right. So yesterday we were talking about or the director had mentioned the calendar review process. So one of the functions of our calendar review, and I think all of the programs in OWCP undertakes this internal self-auditing. One of the categories that we do look at is causation analysis, which is wherever we're looking at the quality of the development of the case, the appropriate utilization of resources in the adjudication of the process, the decision quality both at the recommended and final decision stage. So we do do internal audits where we're looking at that. We're having people that are not associated with that particular case or that district office come in and independently look at that and say did they do an adequate job in assessing the outcome of

that case? Did they do a proper assessment of the exposure profile? Did they use the industrial hygienist appropriately to characterize that exposure, and did they evaluate the sufficiency of the medical opinion making a judgment as to the compensability of the case?

So we do that as part of our calendar review process, and those outcomes are on our website if anyone is interested.

CHAIR MARKOWITZ: So, Carrie, if you can just point out the link to us. No, I'm sorry, Dr. Redlich.

MEMBER REDLICH: Just very briefly, there were two things that could have avoided this problem or solved it moving forward. One is I'm not sure why a SEM was needed, given that you had the job questionnaire. It seemed why didn't you just stop there? And then the second is if the question that the, if you got to the point of asking the CMC that question, if he had been asked, maybe this sometimes spits out the wrong thing, but did aluminum or his work as a miner,

you know, uranium miner contribute, then he could have come up with an answer that would make sense.

So I think, you know, just trying to have a problem solved moving forward, you know --

MR. VANCE: Yes. And my answer to that would be that, you know, the statute in the provision when we're assessing a compensable case, the whole standard when we're talking about it requires the identification of a toxic substance. A toxic substance, you know, is at least as like, you know --

MEMBER REDLICH: But we don't know what miners were exposed to toxic substances so that is --

MR. VANCE: But the question would be which ones. And, you know, you do, but you have to remember these are claims examiners that are doing evidentiary reviews. This is the resource, so this is what they would be looking to. So they would look at this and say, and, yes, this is a very obvious example, so, yes, in my

opinion, a miner is going to be exposed to more than aluminum, but I don't know what the specific characterizations of this case are. So in other words, I'm a claims examiner. I've got to make a judgment as that the toxic substances are that I can associate with this miner based on what factual presentation of information. If all this person does is says I was a miner at mine X, Y, or Z, can you make a presumption that, no matter what, these are the potential exposures?

MEMBER REDLICH: So I realize you have a really difficult job with, you know, so many different diseases and so many different exposures. In the pulmonary realm, it's only a limited number of diseases. This is making it way more complicated than -- I can't imagine, you know, so I think there are other job categories similarly, like welding, where I think that someone who had subject matter expertise could sort of look at this. There could be some simplification. This is a compensation system. It is not necessarily, you know, it seems that

the amount of time and effort that's being spent for certain decisions is just, I'm having trouble.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: I just kind of want to piggyback on what Dr. Redlich said because I went through these with her about two years ago, and so maybe we can pull up uranium miners and stuff in here because several of them are just like she said, and every one of them, I believe there were 17 of them because they stumbled onto this looking through the claims because they're supposed to do, like, four or five. And they went to the same doctor, and every one of them said this can't be caused by aluminum. And when you bleed it down, and it's been a while since I looked at this, it shows uranium miners being exposed, some of them were less than 12 substances. And I just, you know, I ain't a uranium miner, never been a uranium miner. That just seems a little odd to me. And then when aluminum was always the top one that they said

couldn't have caused his respiratory type illnesses.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Yes. I'm going to loop back a little bit. The whole problem with this process stems from the fact that you were looking for a, quote, unquote, toxic substance. And as we discussed yesterday, the statute does not define what a toxic substance is. The statute is interpreted by your legal department as to what a toxic substance is. So I don't understand their rationale for saying it has to be an individual chemical or element or whatever. And I'm wondering if maybe, at some future meeting or maybe somehow, that the legal department explain to us how they came down to that interpretation, as well as there's another issue where it's the interpretation of the statute. And I really think it would help us really understand why this gets narrowed to this point if they could explain how they came to that decision. Thank you.

CHAIR MARKOWITZ: So, Mr. Vance, do you have much more on the SEM or --

MR. VANCE: No, I mean, I can answer any other questions, but I will say that the definition of a toxic substance does exist in our regulations. It's a regulatory provision, so that definition does exist.

MEMBER CASSANO: Which is something you can change. You just have to do the hard work to do it. Thank you.

CHAIR MARKOWITZ: I had a question. Sometimes the CE refers a question of exposure disease link to the toxicologist who does a formal review, writes a well-rationalized report, makes a decision that may have implication for other claims. Is that, is that decision folded into the SEM? Is it added to the SEM?

MR. VANCE: No, it's usually a case-specific evaluation. It can, depending on the ability of the program to generalize that information. But, generally, what Dr. Stokes is doing is evaluating case-specific submissions on

conditions that don't have any known health effects that we were able to identify. And so someone submitting epidemiological or other types of information that they're basically petitioning our program to say here's something that I think is a disease that is linked to whatever toxin and here is the body of information that I'd like you to consider. And then her role is looking at that and saying, you know, yes or no, is there some scientific validity to the information that's being submitted and then making a judgment of that.

So it's more so looking at case-specific information, but she is part of the team that's evaluating health effect updates to the HAZMAP and our site exposure matrices.

And I just have a couple of other quick things on SEM, and we can move on real quick. So I just wanted --

MEMBER FRIEDMAN-JIMENEZ: Could I make a comment?

CHAIR MARKOWITZ: Sure.

MEMBER FRIEDMAN-JIMENEZ: I think that there's a problem with how the question is framed. If you frame the question as did aluminum cause the pneumoconiosis, of course you're going to get a wrong answer. I think the person who framed the question is probably not the right person, and the question should probably be framed by an occupational physician who is trained to basically to frame these questions and not by someone who is not trained in occupational medicine. And then once the question is framed, then you can go through all of the evidence procedures that you have, which are mostly reasonable. But I think having someone framing the question who is not trained in occupational medicine can lead to problems, such as what Dr. Redlich's case presentation illustrates.

The other comment that I have is there is a disconnect between the interpretation of the statutory definition of a toxic substance, which includes infectious organisms like hepatitis A or

pneumoconiosis, I mean pneumococcus and the NIH definition of a toxic substance which is on the National Library of Medicine website that specifically excludes infectious organisms but does include mixtures of toxic agents. And I think that we need to have a serious reconsideration of the interpretation of the phrase toxic substance.

CHAIR MARKOWITZ: Thank you. Dr. Silver?

MEMBER SILVER: The occupational health questionnaire asks about use of personal protective equipment, and a recurring issue at all of our meetings has been how the claims examiners and the industrial hygienists interpret the answers that workers give. Dr. Sokas, who is not on the Board anymore but is an editor of a leading textbook, informed all of us that the way occupational physicians interpreted an affirmative answer to respirators being issued is simply that air contaminants were present in the workplace at high levels. She and the other

occupational physicians don't draw any inferences about whether the respirators were used or how frequently, etcetera.

But I think I've seen screens in the SEM that takes the opposite interpretation. Respirators issued and used for a certain period of time in a certain work location, and I've certainly heard from claimant advocates about the IHs and CMCs assuming that respirators were used; therefore, people got lower levels of exposure. So what's the state of play of respirator information when it comes to evaluating claims?

MR. VANCE: All right. So all I can tell you is what I know to be the case. When our industrial hygienists are reviewing cases, they are generally not going to be commenting on the use of personally protective equipment. They're going to be only responding to the characterization of the toxins that have been identified for evaluation.

Now, when a physician gets the case file or his or her evaluation, they're going to

be presented with all the information that we have, including the industrial hygienist's characterization, any exposure data, any medical information, and the doctor is free to weigh and consider any of the information that is contained in that referral to make a judgment.

Now, we're not going to, you know, disqualify physicians that consider how information is presented on personally protective equipment or what have you, but, from our standpoint, we don't characterize the use of personally protective equipment for our exposure profiling. So that information may be contained in there and, hopefully, those physicians who are generally occupational medicine physicians are understanding of that. But, again, they're the experts at assessing that information and making an informed judgment on the application of whatever information they're presented with.

MEMBER SILVER: So is my memory hazy? There are not screens in the SEM for particular work locations and eras that claim PPE was used?

MR. VANCE: I am not familiar with it, no. I mean, it may be in here, but I wouldn't know how it's presented. But we generally don't profile the use of personally protective equipment in the site exposure matrices. If it's going to be anywhere, it could be in this incident reporting where there were incidents, but I'd have to look further or take a look at what it is that you're specifically referencing and get an understanding of what it is you're referring to.

MEMBER SILVER: Yes, I'll check my files.

MR. VANCE: All right. Just a couple of quick comments, and then I think I've got to wrap this up. First of all, the Site Exposure Matrices is an evolving database, like I mentioned. I just want to reiterate we are constantly updating that information. That means information is going in and it may be coming out. So as we are able to refine information, there are instances where we will change and remove

information because it is no longer relevant or it's been updated by some additional information.

The second big thing that I want to reiterate is the fact that the Site Exposure Matrices, while it is an important resource, it is not the sole resource that is at the disposal of the claims examiner making judgments of exposure profile, all right? Kirk, I was working on a case last week or a few weeks ago that took me an entire day to go through, so don't think that they're all easy. And in that particular case, what was interesting was, and this came to my desk because, and I'll just use it as an example, there was nothing in the Site Exposure Matrices, nothing that could relate any kind of toxic substance profile to this employee. And they were an engineer of some sort, and I can't remember the exact labor category.

But there were 1400 pages of documentation relating to his work at the site, and I don't remember what site it was. And so what I did was systematically go through that

1400-page submission looking for any references to industrial hygiene or monitoring records or anything that related a toxic substance to what he was claiming as the diagnosed condition. And I want to say on, like, page 495 or something like that, there was actually an industrial hygiene profile based on complaints that he was presenting to the Department of Energy about his work location and they went through and profiled his employment exposures, and we were able to identify, like, four or five toxins linked to his disease. We proceeded with the characterization of those exposures based solely on how the Department of Energy was characterizing this, and that was done absent the Site Exposure Matrices.

So the other big component here is to keep in mind that when we do get good primary source information in the documentation, we may circumnavigate the site exposure matrices and accept information that's in a case file based on employment records. Oftentimes, we'll find medical incident reports where people were having

issues with asbestos exposure. They did do asbestos monitoring on some of these sites, and we were able to get that kind of information. And we'll accept that as factual bases for exposure findings that the CE can make. So do not think that the Site Exposure Matrices is the only tool that we use. We have lots of other sources of information that we utilize in this process.

But, again, in the absence of any information that we have in the case file, the Site Exposure Matrices is generally going to be our only real resource to try to profile exposures.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Speaking of that case, how did that end up at your desk?

MR. VANCE: That was, I'll be honest and say I have my fingers on lots of different things. And when I run across things or hear about issues, I'll actually take a personal interest in. I don't know what the source of it

was. Most of the things that come to me are complicated cases that claims examiners are struggling with, questions from management saying we're having a challenge understanding what to do in this particular situation or can you give us some input on how to best construct a SEM search? And in that one, I think they were asking about the appropriate use of the Site Exposure Matrices because they weren't able to find anything and they were basically asking, well, what do we do, and then I said, well, let's go back through all the documentation in the case file and see if SEM is even applicable in the case.

And so when we went back and looked at it, I was like you don't need SEM in this case. You've got the information. All the information you need is right there. And then we can go ahead and proceed with the finding on those toxins that were identified in the actual Department of Energy records.

So it's a collaborative effort. We have a lot of very complicated cases that require

a lot of effort. Some do take a lot of time. Other times, given the lack of information, there's just not much to do with the case, so those don't require as much time. Simply, there's nowhere to go with the information that you've got.

So I see a lot of cases. I'm looking at cases constantly because we also deal with appellate level challenges to our final decisions at the director's level, so we also get those kinds of case referrals.

MEMBER DOMINA: I had a follow-up. So when you found four or five different things that, say, weren't in the SEM, so did you pursue, like, getting those added or how does it --

MR. VANCE: No, because those industrial hygiene records were specific to that particular employee.

MEMBER DOMINA: Right. But his work area or just with his job --

MR. VANCE: With a classification by the Department of Energy as far as it was a

listing of, if I recall correctly, it was a listing of toxins and then they profiled them out by saying incidental or moderate or what have you. And it was specific to that employee, so that would not be something we would generalize out for the entire facility.

MEMBER DOMINA: So Hanford specific, we have stuff that are so exotic that there is no known link, so how would something like that get used or not used or somebody saying it couldn't cause them when you don't know?

MR. VANCE: We don't know, there's not going to be a link to it. We might have information about it, but if there's no health effect associated with that toxin, there's not much that we're going to be able to do with it as far as profiling it for an ultimate assessment of causation.

CHAIR MARKOWITZ: We need to finish this. Dr. Redlich?

MEMBER REDLICH: Can I just give one other quick example just sort of as a way to

maybe improve things moving forward? This was someone who worked for 25 years at Savannah River site, and I've not been there, but the occupational questionnaire, she did work at a secretary, telephone type job, but it didn't mention that she went to different, all different locations at the site. So basically in the diagnosis of sarcoidosis of the lung is not in question, and it's a pre-1993 diagnosis. But the SEM came up with, at least with her job title, that she had no beryllium exposure, you know, having spent 25 years at that site. And I'm not familiar with the site, but, given also just what we know about beryllium and that secretaries can easily get chronic beryllium disease, to me, that should have maybe, you know, again, I would have said forget the job exposure matrix, someone spent 25 years in multiple buildings at a site that, assuming it's true that there was beryllium being used, that that's chronic beryllium disease. You know, sarcoid is a rare disease.

MR. VANCE: Well, the only comment I

would say is that it's our program and policy to recognize that beryllium was present at any of the DOE sites, so I'm not sure the specifics of that case. But we generally presume that if you're looking at a chronic beryllium disease case that's being claimed and they worked at a DOE facility, we pretty much presume that beryllium was present. So I'm not sure what --

MEMBER REDLICH: I think the job title was not a production type of job title.

MR. VANCE: It wouldn't matter.

MEMBER REDLICH: So that's why I'm just bringing it to your attention because it seems somehow -- I think our other concern is even when all the right things are in the manual and we agree with the manual, how that's actually getting implemented and carried out.

MR. VANCE: Well, and don't forget, and I don't want to continue this, but don't forget it's always going to be based on the unique features of that case. Maybe the claims examiner did evaluate that based on CBD and it

wasn't established as such, and then they started looking for other options for adjudicating that case and maybe they were looking for, absent the affirmative findings on chronic beryllium disease, they were then shifting over to look at is there anything else that we know about sarcoidosis of the lung that can be associated with another toxin? So it gets very complicated.

CHAIR MARKOWITZ: I think we should end here with points made. Thank you very much, Mr. Vance.

MR. VANCE: Thank you.

CHAIR MARKOWITZ: So we're going to take a break now, just for ten minutes, though. We've got a lot of work to do. So we'll be back at 10:30.

(Whereupon, the above-entitled matter went off the record at 10:27 a.m. and resumed at 10:38 a.m.)

CHAIR MARKOWITZ: Okay. We're going to continue. Mr. Fitzgerald has a brief announcement, and then we will continue.

MR. FITZGERALD: It was just brought to my attention that some of the public that's listening on the WebEx can't hear the conversation from the Board, so please use your microphones whenever you're making comments. And it would be helpful if you identified yourself, as well.

CHAIR MARKOWITZ: Okay. So we're going to review our recommendations from the first Board, and we're going to talk about DOL's responses. We're going to talk about our comments on those responses. We're going to try to identify which recommendations are settled one way or the other so that they're not for revisiting in the future and which recommendations are live and require continued attention.

The process of generating recommendations, getting DOL responses, having meetings so that we can have a discussion and make our comments on those responses, in the first Board it was kind of prolonged and a little

awkward because there were big time gaps between back and forth, including the fact that the previous Board ended in February earlier this year and we received the response for some of the recommendations from DOL in August of this year. So we're going to resume some of those conversations.

I had discussion with DOL about this, in the future, if we can shorten the time between when we make recommendations and when we get responses and figuring out how we can then shorten the time between our look at those responses and further comments so that the process is more concentrated and that we should try to do better in this Board's function.

I'm going to go through these recommendations and DOL's responses. In the binder, you will see Sections 6 and on are DOL responses to the recommendations. And I guess what I want to focus in on is for the recommendations that are still in contention or are still being discussed, if we can form an

opinion about the next steps for those recommendations.

So our first recommendation, this was October 2016, was we recommended that a certain circular policy of the program called "Post-1995 Occupational Toxic Exposure Guidance," that that be rescinded. And just to describe, for those of you who don't know this, this was the policy that the Department had where all exposures after 1995, it would be assumed that they were within the regulatory standards and it would be assumed that they were unlikely to represent a significant exposure and we thought that really was a false assumption and argued against that policy. And they agreed with us, and they rescinded the policy. If only they had continued that policy on our recommendations for the rest of the recommendations, this would be a short session.

The second recommendation from that time was that the program look more closely at sources of information in an Institute of

Medicine report from 2013, including those sources of information in the site exposure matrix. So just a little bit of background about that. So the Institute of Medicine, 2013, did a study, a look at SEM and had a number of criticisms, suggestions, and we reviewed that as the Board and we tried to identify some feasible way forward on some of the IOM recommendations because, frankly, not many of them had been adopted and some of them were very ambitious.

And so our view was the program should, at a minimum, make sure that the HAZMAP and the SEM included these recognized authoritative sources that the IOM had listed in a certain table. And the response to that was from the Department of Labor. I'm going to do my best to portray the Department of Labor response. I may not get it entirely correct, but I will do my best.

The Department of Labor actually asked for assistance from us in that task, and the challenge was that these diverse sources looked

at many different outcomes, were overlapping, contained a mix of human and animal data, and they didn't have the capacity to actually look at all those sources and do what we had recommended.

So our response to that was twofold. One is there was a separate recommendation which we'll get to and which we'll come back to, so I don't want to belabor it, but it was enhance your scientific and technical capacity because this is an important function, but, specifically about this recommendation, we said, fine, just do a few. We'd start with an abbreviated list, in particular the IARC, the International Agency for Research on Cancers Designations; secondly, the National Toxicology Program, which, within our country, their reviews of hazardous materials; and third is a system from California, I think, the EPA, it was the EPA system that we recommended because the EPA does thorough reviews, not many but some thorough reviews on particular agents and comes up with conclusions about causation.

So in the August 2018 set of DOL responses, and I think this is in your binder. Let me just point it out to you so you have the text in front of you. I think this might be, and I apologize to the people in the audience. Yes, Section 8. Okay. So if you want to look, but I'm going to summarize this so that people can follow along.

And, basically, it's a page long, the comment. Basically, the program states that it does keep up with the updated IARC Group 1 designations in the HAZMAP or, rather, that HAZMAP does that so when they update HAZMAP they acquire the up-to-date IARC designations, at least for Group 1. And with respect to the NTP and the IARC databases, basically, my read on this is that they don't have the capacity really to examine these databases and add this to the SEM.

If you look at the second full paragraph, those of you who are looking at it -- let me read it for people, "With regard to the

application of the IARC and NTP databases, the Board has suggested a process for evaluating health effect information maintained in each database. However, the Board does not offer its own analyses of either credibility or scientific reliability of the materials underlying the findings presented within each database. Each database communicates voluminous and complex data on a range of toxic substance and health effect topics. DEEOIC does not believe it would be appropriate to add these health effect findings to the SEM in the absence of any rigorous and comprehensive investigation of those findings by the Board."

And then it goes on, the next paragraph, "The Board is also recommending that DEEOIC identify a team that includes individuals with competence in toxicology, occupational medicine, epidemiology, to undertake a rigorous process for reviewing sources of information to be imputed into the SEM. However, the EEOICPA Act established an administrative program for the

review and adjudication of individual claims rather than scientific research. As a result, our primary mandate is to adjudicate those claims utilizing trained claims examiners."

And so just to close this out, this is the last paragraph is, "While the program has been able to supplement claims adjudication staff with policy analysts, communication specialists, IT professionals, and some scientists, DEEOIC is not a research-centric organization. Should the Board be in a position to offer more specific guidance regarding the content of data sources that are applicable and appropriate for administration of EEOICPA, the program would consider such input."

So any comments on this? Dr. Silver?

MEMBER SILVER: A couple of things. There's a long tradition of regulatory agencies incorporating the work of others, quote, unquote, by reference. We're in the same building as OSHA, and they've done it for several decades, okay? And if it's good enough for the national

toxicology program, IARC, and EPA, it's probably good enough for the Department of Labor.

Second point is the characterization of a rigorous look at those data sources being scientific research. Scientific research almost always involves a component of hypothesis testing, right? A request we made for rigorous use of the best products of research for the purposes of regulatory science. So I think we need to educate our colleagues in the program about what is and is not scientific research. It almost, you know, invites ridicule of a bunch of people with academic affiliations endlessly noodling around in interesting data for no purpose, and I don't think that's where we're coming from.

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

MEMBER DEMENT: One of, I guess, the comments just to offer an opinion in speaking of the Board, our own analysis of the credibility or scientific reliability of the materials, I think

we've offered that by making the recommendation it be incorporated in the SEM. And the recommendation, basically, from my perspective, is these are peer reviewed, reliable, and appropriate materials to be considered.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: And just to add on to that, there's no reason for any additional scientific analysis of these. You know, you can't get better minds than the people that are on these committees to assess, and these are consensus documents which means there's a pretty high bar as to what they consider 1A or 2, at least as far as I know, and also the NGP.

So the idea that somebody actually has to research through these things to see which ones are valid or not is really not even appropriate. Thank you.

MEMBER BERENJI: I have a comment. This is Mani Berenji. So not to play devil's advocate, but I'm trying to put myself in the seat of the claims examiner. So I'm not sure if

it has to do with an educational issue, which I do feel it's a major issue. If these folks are not trained in how to interpret scientific studies, then they're going to be given all this information and they're not going to know what to do with it.

So if they're looking for best practices, I mean, we can definitely provide at least some sort of way to kind of condense it to the nuts and bolts to be able to say, hey, you know, this is a distillation of all these respective scientific bodies with respect to exposure X and this is essentially the consensus in one paragraph. I mean, if that's what they're looking for, I don't think that's a hard ask. But if we've given them that, then that's the issue.

So I'm really trying to see what we can do to better help these folks. But if the issue is that they're not able to interpret the information based on an educational kind of divide and they're not able to interpret the

information that, you know, we recommended, I mean, I'm not sure if that's something that we need to hone in on.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I don't think we were asking the claims examiners to look at them. We were saying that that information should be incorporated into the set in some way so that it was readily available for the claims examiner. I don't think anybody expects a claims examiner to look at an IARC report because it's voluminous and, you know, sometimes hard even for trained people to figure out what section of it is really important.

So that was not the intent of the recommendation. It was to get that stuff incorporated into the set.

MEMBER BERENJI: Thank you for that insight, Dr. Cassano. This is Mani Berenji again. So that actually brings me to my next point in terms of how these folks identified Paragon as the contractor to be able to kind of

distill all this information. I still am not completely clear as to how these folks get this information, how do they sift through the information, and how they actually put it into the SEM. I mean, do we actually have any ability to contact the Paragon team? I mean, has there been any effort to really see what their process is? That I'm not sure.

CHAIR MARKOWITZ: Other comments?

MEMBER REDLICH: Where does this recommendation stand? Because a response was we're going to review this. I'm sorry. So I just wanted to clarify where this recommendation stands.

CHAIR MARKOWITZ: Well, we recommend that they develop a mechanism to ensure that IRIS and NTP-based information was included in the SEM and the exposure to these links. And their final response to that was if the Board can do that, great. But if the Board can't do that, it's not our role. And my view is the Board doesn't have the resources to do that. You know, this is the

workers' compensation system, so the question is how much can we reasonably expect the workers, very sophisticated and developed workers' comp system, how much can we expect the workers' comp system, which is focused on claims and claims development and adjudication, to actually ensure that it's based on good science?

I'm trying to picture, for instance, what a state, a state workers' comp system would never have a research branch to do that. But I do think it's reasonable that the SEM and Haz-Map include a finite number of authoritative resources to make sure that, given all the effort that is made in claims development and adjudication, that they have up-to-date information on what is really the weak link of the system, which is the exposure disease link, you know. The SEM is very developed. I don't think exposure really is the weak link in judgment of the claim. I understand there are challenges, but still there's a lot to go on. And identifying the disease is not really so much

the link because they probably get it mostly from the docs. The question is linking the two. And I think it's reasonable to expect that the program can identify a contractor who can assist them with the bare minimum of authoritative resources, a much scaled-back version of what the IOM recommended five or six years ago.

MEMBER CASSANO: Since Paragon is the company that does this, I'm wondering if we can't actually modify this recommendation again and say subject to contract restrictions or the next time a contract is renewed or amended that a statement be put in there that says that they should incorporate, at least somebody there should incorporate or look at these three references and incorporate them into their deliberations of updating the SEM.

CHAIR MARKOWITZ: Personally, I don't think we should tell them how to do it. I mean, which contractor to use or which contract to amend, they can figure that out. But I agree with the spirit of what you said.

MEMBER BERENJI: Actually, I have a comment to make on that. I think I agree with Dr. Cassano. I think they do need some guidance in terms of being able to find a contractor that has the subject matter expertise to be able to distill all these various data sources, and, honestly, I'm still not convinced that, I'm not sure who Paragon has designated to do these particular tasks. So I do feel that it's within our mandate to be able to ask how do you folks identify which personnel at Paragon is to do these respective tasks because I am not convinced of that. And I think giving them some sort of guidance in terms of what they should be seeking in terms of specific criteria, I definitely think that's also going to --

CHAIR MARKOWITZ: Well, sure. I mean, it's reasonable to say that whatever entity does this work should have the appropriate expertise in X, Y, and Z to ensure that it's a high quality --

MEMBER BERENJI: I think we have to be

more specific because, at least based on how I'm interpreting all these comments, we can give general statements, but unless we actually give specifics in terms of do this, this, and this, I have a feeling that this is going to continue.

MEMBER REDLICH: Well, I think it was that should be asking the Board to offer more specific guidance regarding the content of data sources that are applicable and appropriate. So I am not as familiar as probably some of the others with exactly which sources you would pick for this recommendation. But it seems that it makes sense to go back and decide, prioritize what outside databases would be of most use and relevance.

CHAIR MARKOWITZ: Well, we've kind of done that in the sense we, I don't have Table 3.1 in front of me, but it's a list of about eight or ten sources and we shrunk that to three, IARC, NTP, and IRIS, to make the task feasible.

MEMBER CASSANO: So if, I mean, if there are a couple of other people that want to

work on this and they want more specific guidance, then I could work on a recommendation between now and whenever with a couple of other people --

MEMBER BERENJI: I'm happy to work with you, Dr. Cassano.

MEMBER CASSANO: -- and we can bring it back and see if we can modify it because I think this is important. I mean, if you don't have the best resources available to modify the SEM, then you're already working at a disadvantage. And I think these are one of the things that we can have an impact on. It's going to take a little work on our part and probably a little more work on their part to find out who would incorporate it, but I think we can go a little bit further in helping.

CHAIR MARKOWITZ: Yes, Dr. Silver?

MEMBER SILVER: In the spirit of reasonableness and limiting the scope of the task, when it comes to IRIS, we should be aware that the community of our peers who rely on it

most heavily are people in the state health departments with environmental contamination and state environmental departments. And it has a lot of quantitative information, like no observed effect levels from animal studies.

So if we could say up-front we want you to lop off or not include the oral exposure pathway, effects limited to certain sub-populations not found in the work environment, nitrates in infants for example. We don't want you to go down the rabbit hole of quantitative risk assessment for each substance in the SEM. We're looking for qualitative information from these sources.

MEMBER REDLICH: I mean, really the question is, is the SEM accurate and reasonable, and, you know, for a couple of the diseases we looked at, it looks like it is for the latest version. But it seems like another approach is being time-efficient, if you know which of the 20 most common, you know, whatever number of most commonly-claimed diseases and ones that you think

there are associations and you look at the SEM and seeing if it appears to be reasonable and accurate. And if not, you know, one of these other databases improve upon it.

CHAIR MARKOWITZ: Yes, but I think that approaching it that way would actually require research, for instance what we're asking to do for Parkinson's disease, which is, you know, literature review and research. And I think that's probably an unreal, yes, that's unrealistic, I think.

Any other comments? Yes, Dr. Dement?

MEMBER DEMENT: When I last looked at IRIS, and I just logged back in to see how many substances there were in IRIS. Actually, there are only 510 substances in IRIS. Looking at the list, most of them are already in the SEM. Same with NTP. So a look at our homework here might indicate that this is not as a big task as expected. It's just comparing what's in IRIS, what's in SEM, where the gaps exist that could be pulled in. I don't think that's a big task.

CHAIR MARKOWITZ: So any proposed -- we can either draft a revised recommendation here and vote on it in a couple of hours or we could take a little bit more time to develop a revised recommendation and consider voting on it, maybe not waiting three or four months until the next meeting but on a telephone meeting of the Board, you know, eight weeks from now.

Okay. So I don't think we need to vote on this, this piece we don't have a proposal. But let me express the sense of the group, which is develop a recommendation which asserts that we believe it would be useful and relevant to include selected data sources to make sure what's available from those data sources is incorporated into the SEM on human relevant and worker relevant issues and that we will try to figure out how much work that would be involved with that. Is that appropriate? Any changes or suggestions? Okay.

So, Dr. Cassano and Dr. Berenji, you will draft that?

MEMBER CASSANO: I was not on the SEM committee, but it seems that one of the biggest differences that IARC, in addition to specific substances, does also give certain job, like painters or welders, you know, associations with cancer, in addition to specific substances.

CHAIR MARKOWITZ: Right. Okay. Shall we move on? Recommendation three was that we recommended that the former workers from DOE facilities be hired to administer the occupational health questionnaire, and the Department's response was that former workers within the complex were, in fact, hired by organizations that administer the occupational health questionnaire, which I think is the Resource Centers or the district offices. Okay.

Anyway, I can't remember the percent, but somewhere in the range of 20 percent of people employed at the resource centers were formally in the complex, worked in the complex. And that some of them were involved with administering the occupational health

questionnaires. So we said, well, that's nice, thanks for the data, try to quantify it further to how many of the interviews are actually done by former workers and what can be done to increase it from 20 percent to higher?

So the response, the latest response was in August of this year, and, basically, to summarize it, and it's on the last section of your binder, but I'll summarize it. It says basically that in the contract it states that preference should be given to people who were employed at DOE facilities but that they couldn't --- but that contracting laws prohibited them from requiring that a contractor only hire former workers.

So we understand that, and I don't think it was our suggestion, actually, that they only hire former workers but that emphasis be given. And they say, in fact, preference is given to former workers.

So my view is where at the end of this recommendation they responded that it is their

policy to prefer former workers and we're at the limit of what can be done. Comments? Okay, great.

Moving along here at lightning speed. Recommendation number four was we recommended that the compensation program establish a process whereby industrial hygienists may interview the claimant directly. This was part of our attempt to supplement the SEM and perhaps overcome some of its limitations by developing alternative sources of exposure information. And so we hear about all the questionnaire, we hear about the SEM, we hear about the records from Department of Energy, we hear about the industrial hygienist review, but the industrial hygienists ought to have the ability to actually interview the worker if they need to clarify certain things.

The response to that was favorable, I would say. They understood the need. The only wrinkle that they introduced, which was completely understandable and acceptable, is that the claims examiner be part of that process

because it's the claims examiner who is going to be acting on the information from the industrial hygienist and should be part of that conversation. And we thought that was fine. We didn't see any problem with that. We only need an update of where they're at with that.

And so my take on this is that we should just request a status report on they basically agreed to do this and if I can find the language, maybe we have it on the screen here --

MEMBER BERENJI: I actually have a comment. So in terms of requested tasks, I mean, do we have some sort of dashboard or some sort of spreadsheet that we're able to kind of tabulate, you know, what was advised, whether it was accomplished or not? I mean, I'm not sure if that's something that we can ask them to do from here on out so that way we could actually have that at future meetings to be able to see what progress has been made?

CHAIR MARKOWITZ: Right, yes. That's a good idea. So the request, Carrie, is

development of a system for a progress on specific recommendations. Specifically, on this recommendation, we would ask what the status of their agreement to this is. It says, I'm reading from the screen here, wherever that document came from, "DEEOIC has begun to develop procedures for claims examiners to use when such discussions are appropriate." So we need a status report.

MEMBER BERENJI: I actually have another comment. I mean, when we actually make these recommendations and they choose to accept that, does that get put into the procedure manual? I mean, is there a process by which the new information is added in real time to the procedure manual?

CHAIR MARKOWITZ: Presumably.

MEMBER BERENJI: Oh, we don't know?

CHAIR MARKOWITZ: Well, we don't know. We only know for the recommendations we've made so far the extent to which they've changed the procedure manual. But if there is a new procedure whereby the IH can call the claimant

and discuss that, presumably that will be described in the procedure manual because it's a new procedure. And when it's added, we'd like to know about it.

MEMBER BERENJI: But that should be in the progress report, like in terms of was procedure manual updated, yes/no, dates, so at least that way we got one sheet that has everything that we need so we can kind of keep accountability.

CHAIR MARKOWITZ: Agreed. Other comments on this? Okay. Yes, Mr. Domina?

MEMBER DOMINA: To me, it almost sounds like what needs to happen, too, is the claimant get a copy of what they're basically going to ask them before they call them because it's no different on the Part B when they have the CATI interview, the computer-assisted telephone interview, so the individual is able to look at the same document as it's being asked and are having a little bit of time to review it because it's different than somebody asking you

over the phone and you don't have that stuff in front of you when you're looking at it to digest it, especially when you're dealing with something that could have happened a long time ago or it could be current or somebody just lost a loved one.

And I believe it needs to be given to also the individual they may have developed in a case because they also talk about the claims examiner doing a statement of the accepted facts on the SOAF and that also, when Dr. Redlich was talking earlier about the uranium miner, the way the question were framed and that caused some issues with ones that we looked at two years ago big time. Just my opinion, you can ask a question a certain way to get the answer you want, and that's what we saw with a lot of those issues back then. So I believe the individual needs to have this probably at least a week or two before the telephone interview takes place.

CHAIR MARKOWITZ: No, that's a good point. And I think in our request for the status

of this new procedure, if we could also ask for the details about how it's going to be implemented so we can take a look at that.

Other comments on this issue? Okay. So recommendation number five is so we recommend that DOL review policy teleconference notes, redact confidential information and posting information on publicly-available database searchable by topic area. Basically, DOL did not agree with this. I think their rationale, and you guys can supplement this, was that these telephone conversations are works in progress. It's a space where they can explore and develop ideas on an approach to a particular problem. They don't represent final policy or procedure and that there wasn't an interest in sharing that kind of thought and discussion with the general public.

I think we reviewed this response before and we decided that that's their prerogative. Any comments on that? Okay.

Recommendation number six was that

Department of Labor explore the feasibility of prospectively having new case files made accessible to the claimant through a password-protected electronic portal. DOL accepted this recommendation and actually Ms. Leiton gave us an update yesterday, which is it's in progress, it will take a couple more years, it's not just an EEOICP but they're looking at it for the other compensation programs within the Office of Workers' Compensation Programs and that there are challenges in terms of privacy protection but that this is the direction they're moving in. And so we're happy that our recommendation was accepted.

Any comments or questions on that? Okay. The final recommendation -- no, maybe not final. Number seven was that we recommend that the Department of Labor reorganize its occupational physicians into an office comparable organizational structure to the Office of the Solicitor of the Department of Labor with physicians organized in groups to support OSHA,

MSHA, OWCP, and other units, as well as to provide overall support to the Department of Labor.

I don't think I need to go into the rationale for this, but we thought that it might make the occupational medicine job function more interesting, more diverse, and perhaps -- well, in any event, the Department of Labor advised us that this was a big issue beyond, not really so much beyond our scope but kind of beyond their planning for this program and this department. So it was a big idea we floated, which didn't really coincide with their own planning. And my personal thought is we don't have any further comment about that, but does anybody?

Recommendation eight is that the entire case file should be made available to the IH and the CMCs when a referral is made to either and not be restricted to information that the claims examiner believes is relevant. The claims examiner should map the file to indicate where relevant information is believed to be. The

Department disagreed with this recommendation for a number of reasons. They thought that giving the entire case file would be excessive and overwhelming to the CMC and the IH and it would also undermine the position of the claims examiner as the finder of fact because what might happen is that if the full file went to these consultants that they might begin to question what the statement of accepted facts was by the CE and you get into this iterative loop where decisions, it would be challenging to make decisions.

So any comments on this? I think we basically don't agree with them, but it is what it is.

MEMBER CASSANO: Just a comment. I think this is a critical issue, and I think all of the physicians on this board and those that are no longer here have been very vehement about the fact that none of them would do a medical opinion without having all of the case file in front of them. I think we all believe that. We

think this is a critical -- I don't want to say failure, that's the wrong word -- a critical defect in how the program is operated and I think we've all been on the record about that. I don't think there's anything more we can do at this point to change their mind, but I still want it put on the record that we do still support this and think that their position is not particularly justified. Thank you.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER FRIEDMAN-JIMENEZ: I think that, again, the question is who frames the question, and to have the claims examiner assigned to framing the question rather than finding the facts I don't think is appropriate. I think this is really an important issue that potentially could lead to some incorrect decisions often not in favor of the claimant, so I think this needs to really be revisited. I don't agree with the rejection of this recommendation.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: Well, you know, I think frequently, I mean, sometimes you have a question where you would like additional information, but many times what you do have is sufficient. So I was asking the question if let's say even one out of ten where you feel like you would like more information, can the person just request that?

CHAIR MARKOWITZ: The person meaning the consulting, the contract medical --

MEMBER REDLICH: Yes, because it is, you know, the volume of records is huge and I felt in the cases that we reviewed we actually had only the, you know, summary final decision recommendations, and in the great majority of them the information I had was enough to decide if that was a reasonable decision. There were a few that I felt additional information would be helpful, but many of them there was sufficient information. And, you know, it is a phenomenal amount of records now that one could get. So it seems that if it was just a mechanism for the few

cases that you felt you had, you know, and usually it's a specific piece of information that would be helpful and it may or may not be available.

MEMBER CASSANO: You know, there may be something that we --

MEMBER REDLICH: Is that in the system where if you --

MEMBER CASSANO: That's what I was going to say. I think it depends upon the determination of the CMC or the industrial hygienist that, with your case, that says, well, does aluminum cause his pneumoconiosis, that a CMC go huh and ask for more information and say, well, under what circumstances was this gentleman exposed to aluminum? But then again, it depends upon the curiosity and really the efforts of the CMC to go back to that, and I don't know how many of them are --

MEMBER REDLICH: I mean, if we're either talking about more exposure information or more disease information, and I guess the

situation where you have the occupational questionnaire filled out and whatever was done was done, how often would additional exposure information be needed? And on the medical side, I think frequently there is either no more information out there or it doesn't add any further clarity.

MEMBER CASSANO: One thing we might ask is that at least the exposure history questionnaire go to the industrial hygienist and --

CHAIR MARKOWITZ: Excuse me. Yesterday, I specifically heard them say that all exposure information goes to the IH. So the EE3, which is the initial work history, the occupational health questionnaire, the SEM results, whatever they get from DOE and the DAR, it all goes to the industrial hygienist, so it wouldn't be that voluminous. Yes, Mr. Tebay?

MEMBER TEBAY: It's Calin Tebay. This kind of goes back to the IH having the ability to call the claimant a little bit where even in this

situation the claimant doesn't have any input, and what happens is, is this information from the claimant's side, you turn in your original claim forms, your occupational history questionnaire, the claims examiner gets the information, passes on what they feel is necessary or pertinent to the claim to the IH or the CMC, and then you've got the claims examiner and the IH or the CMC lobbying questions back and forth that, like you said, who frames the question when the claimant doesn't have any input through this whole thing? Then when the final determination or the opinions are made at that point by these IHs or CMCs, it may be skewed at the end because the questions that were asked weren't clarified or the claimant didn't have time in this process to provide additional information or the missing pieces of the puzzle, if that makes any sense to anybody.

But then you've got this opinion or these recommendations on the claim, and the claim is moving on when really the outcome would have been different if somebody was stopped in there

and asked the claimant do you have this information? We're missing these pieces. Do you have this information? A lot of times, where I work at the HWEC, Hanford Workforce Engagement Center -- we're back to those -- we know where to get that information from the claimant in that process. We have access to folks that can provide that, so if we can get a hold of it and get it in the middle there, we can clarify some of these things so the recommendations are, you know, complete at that point.

So I think we need to think about the claimant involvement during this whole conversation between claims examiners, CMCs, and IHs.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Calin is right, because some of the claims that Dr. Redlich had us go through is that we had individual names, we had names, no job title, and no job site, and this was what was passed on to a CMC or an IH to help adjudicate the claim. Well, that's kind of

hard to do when, out of 300 and some odd sites, where did this guy work and what did he do? I mean, there was more than a few that we went through that were missing a lot, and it comes down to them spending maybe 30 to 45 minutes, like they admitted two and a half years ago --- that's all each claim is spent on.

And so if it's just an individual problem or has it improved? It's important because I don't know how you could possibly adjudicate that when you don't have the rest of the story.

CHAIR MARKOWITZ: Well, I do think an IH interview would give an additional opportunity and, frankly, it would be far better than what we normally do in occupational medicine in which, you know, there is no industrial hygienist who interviews the patient. The occupational medicine doctor does that. So if they were to move on that, then that would certainly add another dimension.

I think we should move on. So we're

now to April 2017 recommendations, the first one being on asbestos.

MEMBER REDLICH: I don't mean to --

CHAIR MARKOWITZ: Yes.

MEMBER REDLICH: So is there just simply a process of, let's say, the CMC would like additional information? I don't know. I mean --

CHAIR MARKOWITZ: I believe so, I believe so, but if, Carrie, if we could just jot that down as a question. If the CMC requests additional information from the CE, can they obtain it?

MEMBER MIKULSKI: I kind of have a general comment, suggestion maybe, and it ties in to Dr. Berenji's suggestion about progress reports. I wonder if it is within the Advisory Board's mandate to actually set up the deadlines for those responses, so we know, actually, that this is being worked on and this is being addressed on time.

CHAIR MARKOWITZ: I'm sorry. A

deadline for the DOL responses?

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: To us?

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: Well, you know, one problem we ran into, frankly, the first Board, was a change in administrations, a change in personnel. And so the director of OWCP turned over, and that created some delay. We have been promised that there will be quicker turnaround, so I don't think we -- let's see how that works out before we impose deadlines.

MEMBER MIKULSKI: I know this is a little bit idealistic but, might help.

CHAIR MARKOWITZ: Yes. Okay. So let's move on to asbestos. In the next few presumptions, the recommendations are presumptions.

I'm not going to read the recommendation. It's long. I'm not going to read the responses, but I want to summarize this. We set out for the cardinal asbestos-related

diseases certain parameters in terms of how much exposure there needed to be, what the time period of that exposure was, how much it needed to occur before the onset of the illness, latency, and what overall job titles should be subject to a presumption.

And our idea was, basically, if you were a pipefitter, if you were a maintenance mechanic, and you had a year's worth of work as one of those, in one of those jobs or any maintenance construction job prior to, we initially said 2005 but we later modified it to 1995, prior to 1995 that that meant that you had sufficient exposure if you developed an asbestos-related disease to say that there was causation. So one year of exposure in those job titles prior to '95.

And there was also some contradictory language within the procedure manual about asbestos because things had been added at different times. DOL, in essence, accepted much of this recommendation. I think probably the

biggest addition was they added lung cancer because they hadn't actually had the single most common asbestos-related outcome in the procedure manual acknowledging it specifically as due to asbestos.

They agree with the 250-day or one year of exposure, except for mesothelioma, which they have a shorter time period, 30 days. And we agreed pretty much on the latency, 15 years, although in one case it was reduced to ten years. So we're in agreement about that.

The sticking points are twofold. One is they have a list of, I think, 19 job categories that fall into this presumption on asbestos, and they are the familiar ones from building trades and maintenance. So pipefitters there and welders there and sheet metal worker and carpenter and the like.

We suggested that actually a broader approach should be taken, that all maintenance and construction job titles should be included, job categories should be included in this

presumption. And they said, they came back and said, well, if you want to add job categories, okay, but, you know, show us the time to get support for those additional job categories. And that's where it stands, actually.

When I re-looked at the job categories on their list, their list of 19, they didn't really include most or the vast majority of the construction and maintenance job titles or rather job categories. There's a little bit of devil in the detail in the sense of there are a lot of specific job titles at these plants that vary. The question is which category do they get put into, and that's why we discuss this a little bit around the SEM. But I think it is possible we could identify the complete list of job categories as used in the SEM that we think should be eligible for this presumption. That is to say take a list of 19 and expand it by whatever number that is, probably not a huge number, and then that would, that would, I think, satisfy their concern.

We provided a lot of scientific literature on our support for maintenance and construction workers, so I don't think scientific support is the issue.

The other issue that isn't resolved is they retain in the procedure manual, they continue to use 1986 as some sort of key date, and you may not remember this but they have this way in which, a formula for looking at significance of asbestos exposure. That is, before 1986, people on this list of 19 would be presumed to have a high exposure to asbestos. Between '86 and 1995, the same group, it would be assumed that they would have low but significant exposure to asbestos. I'm not sure what that is, low but significant. And then everybody outside the list would be looked at in terms of their own whatever evidence was accumulated for them.

And our approach was far simpler, which is prior to 1995. If you are on this list and you worked there for a year, then we assume you had significant, that is to say sufficient

exposure to asbestos to cause an asbestos-related disease. That's a formula you can work with in a presumption and resolve claims pretty quickly. So I don't know whether their retention of this 1986 was kind of an oversight or whether it was intentional, but, frankly, it perpetuates a scheme that makes no sense. And so I personally would like to see that language eliminated from the procedure manual or at least this specific issue of dates being resolved.

Any comments? I think there may be one other issue on asbestos, but, while I find it, Dr. Dement?

MEMBER DEMENT: As I recall the last Board's discussion of the 1995 date, I think we all pretty much said, agreed across the board that there had been a reduction in asbestos, sort of generally after 1995. However, a lot of asbestos was already in place and it continued to be certain job categories and many on this list that we've discussed that would have more than just an inconsequential exposure to asbestos and,

therefore, we pushed it to 2005. I think that was the rationale.

CHAIR MARKOWITZ: Right. We originally wanted 2005 as the cutoff date, meaning prior to 2005 we would assume exposure was significant. And then when they got back to us, we modified our date back to '95. It had to do with their procedures. They needed our rationale for use of a date, they needed a specific rationale, 1995 DOE issued an important health and safety order and so they used '95 as a cutoff date. We couldn't come up with a policy rationale underlying a 2005 date. They also felt that most of the workers who they included a 2005 date would also be included in the 1995 date, so it wasn't, we weren't losing a whole lot. So we compromised on that point and changed the date to 1995.

MEMBER BERENJI: I'm sorry. I just wanted to clarify the dates, but I think you just did that. Thank you.

CHAIR MARKOWITZ: Yes, go ahead, Mr.

Domina.

MEMBER DOMINA: The issue I think, too, why, in my opinion, it needs to go to 1995 is that you've got to look at all these facilities were in production mode. So the asbestos just isn't where it initially got laid. It's everywhere from startup, shutdown processes because of pipes vibrating, machinery vibrating, whatever, so it's all over the place.

And then I'll also comment on, I know we decided to use the maintenance and construction job titles, but it does leave people out.

CHAIR MARKOWITZ: What does leave people out? The use of maintenance in construction?

MEMBER DOMINA: Right. It does not include health physics technicians. It does not include that job category because the building trades does not have that job category, and that's, for us, like I said, once again, for Hanford, that's our largest seniority group. And

so it's a shortcut because it's not, I would think it would affect all the other sites, too, because the fact is when you're doing this work, you're first in and last out on all these job processes, you know, for health and safety reasons because you're looking for rad first and the chemicals and hazardous substances didn't come in until later. But, you know, that's why we're here to sort that stuff out, but it's a shortcoming but I realize we had to use that as something, but they need to be added. They can't be excluded. We're not doing our job if we do, if we leave them out.

CHAIR MARKOWITZ: Mr. Mahs?

MEMBER MAHS: Actually, there are quite a few others, like rad workers, safety officials, there's quite a few others that were left out.

CHAIR MARKOWITZ: I can tell you what, if we propose additional job categories, DOL is going to ask us for what scientific medical information we have that demonstrates that those

job categories are at risk for asbestos-related disease. That's what they're going to ask. And unless we have that, there's no sense in us proposing it, I think.

MEMBER BERENJI: Actually, I'm sorry, I just wanted to add a comment to that. Is there a way where we can stratify risk? I mean, obviously, the maintenance and construction workers are considered at a higher risk, but if there's a way we could come up with some sort of stratification system, and I'm happy to look into literature to see if other folks, like the health physicists or other individuals who may have had lower risk of exposure but it was still a risk nevertheless, is there a way we can come up with a stratification scheme?

CHAIR MARKOWITZ: I think we should look at the literature, actually, to see if we have the support. And if it shows excess risk, then we have what we need, however stratified. Dr. Cassano?

MEMBER CASSANO: Yes. I think, and

I'm a little fuzzy on this, but I think in the studies of shipyard workers, there is ample evidence that incidental exposure during that period of time of workers that were not in production also had asbestos-related disease and I think that would be, I'm always open to that anyway. But I think there are parallels that can be brought between the two cohorts, but I'm sure that's been identified in shipyard workers.

CHAIR MARKOWITZ: Yes, Dr. Dement?

MEMBER DEMENT: We go way back to Ruth Lewis's (phonetic) early work in the chemical industry where certainly people that were maintenance and trades were exposed, but it went across nearly all of the trades in terms of asbestos-related disease risk. And it goes back to what Kirk was talking about.

I, frankly, I don't know which job classification are mapped into these categories, so it's a little hard to propose others. They may already have been considered, unless I have them at the table before me. You know, what's

mapped into a laborer, for example? There's lots of categories that do labor.

CHAIR MARKOWITZ: So you brought this up twice now. Do you want to make a request to look at some of those data or --

MEMBER DEMENT: I don't know how best to provide it. It certainly exists in the electronic file somewhere, and so it would be interesting to take a look at how these were mapped.

CHAIR MARKOWITZ: Do you want to pick a couple of sites in particular or do you want to, I mean, how should we move on this issue?

MEMBER DEMENT: Well, electronic file can be provided across the sites. I don't see the, you know, it's just a matter of a few gigabytes a day.

CHAIR MARKOWITZ: So if you could note this request, and then we'll refine it, yes. And this issue of bystander exposure, my guess is that's what a health physicist is, bystander exposure, no?

MEMBER DOMINA: You know, that kind of depends because, like we spoke before in other meetings, when you do a reactor startup, let's just a hundred in, you've got hot water and cold water, you've got three-foot diameter pipes moving like it's a piece of spaghetti. So in that, in 109, you get the pipe gallery. It's foggy. You'd be lucky to see from here to the end of the room because there's so much in the air because there was over 10,000 valves in there, there's miles of piping, you know, and that's where it becomes with being able to frame it where if you're not there you can't frame it. And then you're going to come, it's going to come back and say that your exposure was incidental or low, which is not the case. It's not measured -- and then over the time of the, over 20 years, all that stuff just lays there. Each start up, there's more blows, and it's all through the whole facility at a hundred in.

CHAIR MARKOWITZ: Okay. So --

MEMBER CASSANO: The other part of

that is I think the health physicists in particular were the ones that would go in and sample if they were going to do something. Because in the shipyard they did.

MEMBER DOMINA: Right. It just didn't get sampled because it's one of those things that you don't want to know because you're in a weapons production. It's entirely different mindset. You get the job done.

CHAIR MARKOWITZ: Yes, Ms. Pope?

MEMBER POPE: And at Rocky Flats, it was just the opposite. You got the radtechs that were there, as well as the operator, as well as the health physics, as well as the lab person that was doing the sampling. So you have all those groups of people that were working in the same area, so it's hard to determine the level of exposure.

CHAIR MARKOWITZ: So let me propose that we're going to work on a response to DOL. Let me propose that I work on it, that Kirk work on it, that John work on it. Anybody else want

to work on it? Marek, okay, okay. Then we've got five.

Okay. You got that, Carrie? Domina, Dement, Mahs, Mikulski, and Markowitz.

Okay. We're going to move on to asthma and I'm happy to turn this over to Dr. Redlich.

MEMBER REDLICH: Okay. So the original recommendation from the first part was simply the terminology of work-related asthma occupational asthma work is updated and the OWCP agreed and implemented that recommendation, which was appreciated.

MEMBER FRIEDMAN-JIMENEZ: Excuse me, Dr. Redlich. Could you please --

MEMBER REDLICH: Oh, I'm sorry. Is this better? So I was just saying that the first recommendation related to just the terminology used to describe work-related asthma and OWCP agreed and implemented that recommendation.

The second related to the medical criteria used to diagnose asthma, and initially a

lot of, well, just to be brief, basically the OWCP also agreed with our recommendation and did implement this and it is in the most recent version of the manual. So that's number one and number two.

Number three was, in hindsight this probably wasn't the best-worded recommendation. It was simply referring to the temporal relationship and how important that is in diagnosing work-related asthma. The response, I think, actually, the -- I think we should just move on that because I think we decided it was okay as-is. So there's nothing else that we are requesting as far as that recommendation.

And then the fourth recommendation was, there was slightly different criteria for diagnosing work-related asthma when it was contemporaneous with the period of employment or if it was after the fact. And so we had recommended using the same criteria and that the current wording had referred to a specific triggering event, and we felt that that happens

sometime but that there might not be one single triggering event but many months or years exposure. And so we made that recommendation.

So the response is there on -- so, basically, the OWCP modified some of the wording, and I'd have to quote the manual. I think the major area where -- you know, it may just be best, I think we had done this last night, to pull up the wording in the manual.

CHAIR MARKOWITZ: Yes. So if we can locate the manual. It's in Chapter 15. Are you talking about the trigger incident language?

MEMBER REDLICH: Yes, or whether it was there or in 18. I'd have to --

CHAIR MARKOWITZ: No, it's in 15-4.

MEMBER REDLICH: Okay. We can find it --

CHAIR MARKOWITZ: Page 3 of 12.

MEMBER REDLICH: And we had agreed to make -- -

CHAIR MARKOWITZ: Go to Chapter 15. It's actually in the exhibit, the appendix to

this, so you have to scroll down. There are a bunch of exhibits. Keep going. The page numbering stops at the exhibits. Chapter 15.

MEMBER REDLICH: Yes, so where it says C. So after, the part above C is just the revised wording for making a diagnosis of asthma, and, you know, they noted a negative bronchodilator test does not rule out a diagnosis of asthma, especially if the patient is on medical treatment for asthma. So they incorporated the recommendation we made.

And then having established, then C, the covered contractor employment and a diagnosis of asthma, the following criteria are available to demonstrate the employee has work-related asthma. So the contemporaneous is I, the first one, that a qualified physician during a period contemporaneous with a period of covered party employment diagnose the employee with work-related asthma or does then afterwards the qualified physician conducts an exam and reviews the records and supports that the employee had

asthma and that an occupational exposure to a toxic substance was at least as likely as not in --- a significant factor in causing or contributing.

So I think we felt that this partially incorporated our recommendation. We felt that it would better do so if it removed the next sentence that the qualified physician must provide a well-rationalized explanation for the mechanism for causing, contributing, or aggravating the conditions. And the rationale, as someone who probably sees more work-related asthma than any pulmonologist in the United States, I barely know what the mechanism is. And so I think that that would scare away a physician from making the diagnosis. So maybe I'm not understanding the terminology or the wording that OWCP is interested in, but I think that would be just very confusing to include that in the manual.

And then the second sentence after that, the strongest justification is when the

physician can identify the asthmatic incident that occurred. And so I think it's, again, rare that you have one specific incidence. There's one type of work-related asthma called RADS where there's a single acute, you know, you got stuck in a chlorine tank type of event, but that's a very small part of work-related asthma. So I think this would be a much more effective, you know, guidance if those two sentences were removed.

CHAIR MARKOWITZ: Is that the only point, sort of, disagreement?

MEMBER REDLICH: I think. And then, I mean, I think we felt that it's reasonable to ask the physician to provide justification for deciding it was work related. It's just that it's not the mechanism.

CHAIR MARKOWITZ: Right.

MEMBER REDLICH: Because then, you know, I will say that I think the wording, as was noted yesterday, it is very important in the manual because the recommended decisions and the

final decisions refer to the wording in the manual as has that been accomplished. So I think one could just modify this, you know, just in terms of the type of justification needed.

CHAIR MARKOWITZ: So I guess the question is whether we want to vote on a modification, a recommended modification today or we want to re-look at it when we look at the other ones in a couple of months and vote on it then.

MEMBER REDLICH: Well, I think what they requested was for us to just provide very specific, so I think what we could do is give them some very specific alternate suggested wording and just make sure that, like, the appendix tables are consistent.

CHAIR MARKOWITZ: Okay. So then we should postpone, I mean, we should do that after the meeting and then come back to it, I think.

MEMBER REDLICH: Depending on others, but I think --

CHAIR MARKOWITZ: That makes sense.

Anybody want to work with Dr. Redlich on this?

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. Yes, I would like to.

CHAIR MARKOWITZ: Okay. So the asthma revision, Dr. Berenji, Dr. Redlich, Dr. Friedman-Jimenez. Okay. Is that it? Let's move on. COPD. Let me summarize COPD. The only reference in the procedure manual at present that I can find that was specific at all related COPD to asbestos. It may also be mentioned, it is also mentioned in what's called the matrix, and the matrix is an appendix of Chapter 18. I just want to check here to see if, in fact, they do mention -- yes, they do mention COPD. But it's mostly about the diagnosis and very little information about the exposures.

So the approach, as far as we can tell, the current approach of the program is identified 10 or 12 specific substances or mixtures that are known to cause COPD. They're in the SEM, and when a worker is identified, who has COPD is identified as having one of those

exposures, then the issue is examined whether that exposure caused a COPD. That was scientifically accurate circa 1995, agent-by-agent approach to COPD. And in the last 20 years or so, there's been a lot of work, a lot of studies published all over the medical literature establishing a kind of different approach, which was that workers in industrial environment who had exposure to vapors, gas, dust, and fumes on a regular basis were clearly at risk for COPD.

And so our recommendation was that the program accommodate that scientific basis. And we made an initial recommendation. We modified it, and then we have the DOL's latest response to it.

So the challenge is the toxic substance standard statute requires that there be exposure to a toxic substance in order to link an exposure with disease. And in just identifying that workers have exposures to vapors, gas, dust, and fumes doesn't specify one or more toxic substances or mixtures. And so our

recommendation, our revised recommendation was to try to address this, it's really attempting to try to triangulate a job title with, because all of these relevant job titles, particularly maintenance, construction, but some others, have, if you look at the SEM, they all have exposure to multiple toxic substances. There's no question they're exposed to toxic substances. And it's among those toxic substances where the exposure to VGDF comes from.

So the question was how to inject --- what's required by the program, which is reference to one or more toxic substances, into this formulation about COPD and exposure. And so our recommendation was that, in terms of exposure, that a presumption could be based on five years of work at DOE, five years or more of work at DOE, if they reported exposure to one of the 12 clearly-identified COPD agents, or if five years or more of work at maintenance construction if the job title is linked to one or more toxic substances in the SEM. So it's above and beyond

the list of 12 exposures. It could be to any number of toxic substances. Or if the worker reported five or more years of exposure to vapor, gas, dust, or fumes, and either their job title or their tasks linked them to classes of toxic substances, including solvents, acids, caustics, metals, and the like.

So this was multiple roots to try to link the job title with toxic substances with the exposure to vapors, gas, dust, and fumes. I think I got that right.

But, in any case, the response in August, three months ago, from the program was that the use of the phrase VGDF is overly broad and not legally permissible. Quote, however, the program would welcome input on additional specific toxic substances encompassing VGDF that it should add to the COPD health effect listed in the SEM, end of quote. And then it says the five years of exposure is not enough. It should be greater.

So we're back to this challenge of

matching up the VGDF approach with the need for identification of toxic substances. Comments? We need some creativity here.

MEMBER CASSANO: It's been said over and over and over again the definition of toxic substances does not relate to anything scientifically determined and needs to be changed.

CHAIR MARKOWITZ: Yes, I don't personally think that's the problem, but go ahead, Dr. Dement.

MEMBER DEMENT: Well, I think the question of complex mixtures goes across a number of different issues and calls for determination. I don't know how to resolve the issue here. Personally, I'd like to, we could talk about further work with the Board, I'd like to gather more cases of COPD and really take a hard look at how those have been handled; ones that have been awarded and ones that have been denied and see if, you know, what are the criteria being applied.

For example, we have other materials in the SEM besides asbestos, but are they actually being used at all in terms of awarding or not awarding cases? So I guess my recommendation is we sort of hold this in abeyance and take another hard look at the COPD cases and revisit it later. Just my recommendation.

CHAIR MARKOWITZ: Okay. I'd just like to make one further comment. With reference to asthma, I want to just quote from the procedure manual. The claims examiner does not apply a toxic substance exposure assessment to a claim for work-related asthma, including the application of SEM or IH referral process because any dust, vapor, gas, or fume has the potential to affect asthma.

So we have episodic obstructive lung disease, that's called asthma. We have chronic obstructive lung disease, that's called COPD. Under those 12 chemicals that are associated with COPD are causes. They're causal agents. But

under a standard of contributing to, it is true that any dust, gas, vapor, or fume would contribute to or aggravate the COPD.

So I tried to get at this a little bit yesterday. I don't understand why if they can apply in the assessment of asthma this general approach and not apply toxic substance exposures, why they can't do that for COPD? Mr. Domina?

MEMBER DOMINA: Just a comment. I mean, I think we have to keep pursuing this because, you know, for Hanford and probably Savannah River because we both have the same kind of tank farms so vapors, gas, dust, fumes apply because where the dust come in is all the years they had spills and stuff out there in the sand. Anybody that's been out there knows the wind blows and it blows a lot. And so no matter which one of these that you do, this causes breathing issues for our workers and I'm sure it's at other sites that I'm not as well versed in, but we got to keep after it. Something has got to change with this and especially, too, when somebody has

an acute exposure where immediately their nose is bleeding but, yet, they can't find anything that caused it, and when people come from all walks of life. I mean, we've got to pursue it, and I don't know what the best way is to do it but I'm more than happy to help.

CHAIR MARKOWITZ: Great. Yes, Dr. Berenji?

MEMBER BERENJI: I appreciate your comment, Kirk. I do understand that. I think the main issue, at least with these guys, is, for whatever reason, the vapors, gases, dust, and fumes, if we use that continuous terminology, we're going to get an automatic no. So I feel that we kind of need to take a step back, figure out what specifically is causing this response, and maybe we might have to kind of break this up into four respective categories, vapors, gases, dust, and fumes, and not just use that specific phrasing because, for whatever reason, that is just not registering with these folks.

So I feel that, if we can come around

it from a different angle, perhaps, and again, I'm happy to do some research on this just to be able to identify at least a general category of vapors that we're most concerned about, especially when it comes to COPD or a specific subset of gases when it comes to COPD. And I do agree with John's comment that we do need to get the case files so at least we're able to kind of tease that out because that way we can actually get some specifics because I feel that we're just going to run into the same issue if we keep bringing up this specific terminology.

CHAIR MARKOWITZ: So I suggest we -- go ahead.

MEMBER REDLICH: Yes. So it wasn't the subcommittee I was on, but one of the others did receive, I think it was about 20 cases of COPD, and I think what would be most time efficient would be to review those cases and John's suggestion. I think that would sort of shed light on the issues because there are already, if you look at in the SEM, COPD, they

have things like welding fumes, metal dust, I think. So there are some group exposures in there.

MEMBER BERENJI: Yes, I did see metal fume fever in that subset earlier, so I do feel that we have to use their terminology, and I know that those specific terms are in the SEM. So I think we just have to speak their language and, for whatever reason, this specific terminology is just not registering, which I don't agree with either but it is what it is.

CHAIR MARKOWITZ: Dr. Silver and Dr. Dement.

MEMBER SILVER: I agree with the review of case files. I wonder if on a parallel trek we might have more persuasive power if we compiled the evidence from existing workers' comp programs, state, federal, wherever, where mixtures are dealt with in a more contemporary, rational way. And, you know, statutory construction is sort of flexible, particularly when a law was written in a hurry.

I know there is legislative history around making claimant-friendly decisions and not burdening people filing claims with a lot of hairsplitting. Right off the top of my head, I think of the state of New York and their firefighters' presumptions for exposure to smoke, and I think if this group sat around in five minutes we'd have a list of 12 examples from workers' comp law that, over time, we could use in a dialogue with the attorney, too.

MEMBER BERENJI: Actually, you bring up a really good point because we could actually develop not only best practices for COPD but we could potentially apply that to other diseases. And I feel that, at least in this claims examiner community, if they're seeing that there's been similar paradigms followed by other agencies, I think that they can connect with those agencies. I mean, they're all part of the same collective. So I do agree with that.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: There's some

interrelated issues here that I think, as we review these cases, again, I would suggest the Board not divide itself, that we review the same cases, we come and we discuss them in a lot of detail -- is how this SEM is actually being used and specifically in the COPD cases but in general. So it's sort of the evidence comes from the history, occupational history, what comes from the SEM and how it's being used to decide these cases. I mean, we could spend a lot of time reviewing the literature and make a list of materials that have been associated with COPD, but, in the end, that list is very limited and we know from the literature that it's the collective vapors, gas, dust, and fumes that has the strongest signal. It is in our study. Now, we looked at specific substances, about a dozen of them, but the greatest signal was when we put those together collectively and looked at the risk.

So I think we ought to frame the questions how is the SEM being used for COPD, you

know, what's being used with regard to the CMCs.

CHAIR MARKOWITZ: So when we get to new issues, which we will get to, we're going to, we'll fold this into the new issue discussion because there may be an interest in examining the claims for a broader set of reasons.

We need to close out this discussion. We're going to take a break for lunch. We're going to start again promptly at quarter of one. That's in 40 minutes, so please be prompt because we have a lot of work to do.

(Whereupon, the above-entitled matter went off the record at 12:11 p.m. and went back on the record at 1:03 p.m.)

CHAIR MARKOWITZ: So taking up where we left off, I think we were pretty much finished with COPD. I think we were going to just draft a response and then also examine some COPD denied claims.

So the next is science and technical capacity of the program. We recommended that the program enhance its capacity. And I'm not going

to give you the rationale. We went back and forth and the final word from the program in August of this year was that they have the capacity that they need through the contractor and also the program itself, "evaluates peer-reviewed literature regarding toxic substance and health effects on a regular basis through research by the toxicologist updates by IARC and claimant or advocate submitted information." So we made our recommendation, and it wasn't really accepted. Any further discussion on that? Okay.

We made a recommendation on the interpretation of the BeLPT, the beryllium lymphocyte proliferation test. And that was a brief recommendation that two borderline BeLPTs be considered the equivalent of one positive or abnormal for the sake of considering claims. And this was not accepted because the program reported that the statutory language requires an abnormal for recognition of sensitivity or disease depending on pre- or post-1993.

So we've raised this repeatedly; we've

received the same answer repeatedly. Is there anything else? We discussed this a little bit. Is there anything else to say about this at this point? Okay. We're on the record as recommending something other than what the program does.

The recommendation on number seven from whenever, and this was about the quality assessment of the contract medical consultants. So we requested that the Board -- excuse me -- that the program provide the Board with resources to conduct a quality assessment of a sample of 50 contract medical consultants' evaluations. And we said we would assess the nature of the medical information reviewed by the CMC, the use of the standards of causation or reasoning of the CMC, the scientific basis, et cetera.

And the program's response was that they already do that essentially, and they're satisfied with the current process. This is from the August of this year response to us. Paraphrasing, they agreed that the quality

assessment of a CMC is important, and they currently conduct these quarterly quality control assessments.

So I referred to this yesterday. These are the audits that Dr. Armstrong does. There are three available on the website, the first three quarters, or at least three from 2017. He has certain forms. He looks at 50 CMC reports per year. There seemed to be 20 causation reports, 20 impairment reports, and 10 other reports.

And during those nine months, those three assessments looked at close to 150. I found somewhere about 15 percent of the impairment evaluations were faulty and that information then is reviewed within the program and action is taken about the validity of Dr. Armstrong's assessment. And action with the contractor -- QVC?

PARTICIPANT: QTC.

CHAIR MARKOWITZ: QTC -- thank you -- regarding correction of those erroneous CMC

reports. There are only one or two out of close to 150 reports and from the summaries in which there was a problem with the causation analysis. So that was infrequently found to be a problem.

MEMBER REDLICH: Whose assessment was this?

CHAIR MARKOWITZ: This was from Dr. Armstrong. So this actually in my view relates to new issues, and we can postpone this discussion for an hour and then resume it when we talk about looking at claims, or I think we should do that. Although I would make a comment. I don't think that an internal review by the medical director is the same as an external review by a Board.

I don't think we would be properly fulfilling our obligation under task 4 of the Charter to evaluate the quality objectivity and consistency of CMC and IH reports by relying on the current assessment that we would need to do that ourselves. Not so much to check the medical director's performance. That's not really the

issue. The issue is the claims files themselves and in particular the CMC and the industrial hygiene reports. If there's any comment on that line of reasoning, let's do it. Otherwise, we're going to discuss looking at claims in just a little bit and include this in that discussion.

Dr. Silver?

MEMBER SILVER: Tori was first.

MEMBER CASSANO: Oh, okay. Rosie worked on this quite a bit when you were working with her and then when we combined committees, and she has a lot of notes on these audits. And again, it's very limited because all he's looking at is the stuff that the CMC got and not looking at the whole process. So again, it's not telling -- these audits are not really telling us the whole picture of what's going on. So again, I think we need to look at them based on the entire claims file, not just what he sees.

CHAIR MARKOWITZ: Well, in fairness, his goal in those assessments is specifically the CMC report and not any large -- just for

clarification, not any larger pictures which I think is what you're referring to.

Dr. Silver?

MEMBER SILVER: Yes, to fulfill our mandate of objectivity and the other criteria we quoted, Dr. Markowitz, I think going outside of the agency is desirable. This program is a little different from other workers comp programs that DOL administers, black lung in particular, in that there's no claims review board. There's a Final Adjudication Branch, and I don't think they compile a case file like the black lung program does for people on the outside to look for patterns in the way the claims are finally adjudicated. So outside eyes are warranted.

CHAIR MARKOWITZ: Other comments? Okay. So we're going to come back to this.

So the final recommendation is from June of 2017, one related to solvent-related hearing loss. And the current procedure is that if the claimant has bilateral sensorineural hearing loss and is on a list of roughly 19 job

categories and has work exposure to one of now eight solvents for ten consecutive years prior to 1990, then they would be eligible for compensation.

And our set of recommendations related to reducing the time period from ten years to I think it was seven years to making it non-consecutive so that it wouldn't have to be seven or ten years in a row to moving the 1990 date as an important date in terms of likely exposure, expanding the number of job titles that are eligible for this beyond the list of 19 or so to include maintenance and construction.

And I think also we increased the number of solvents or solvent mixtures. So most of our recommendation actually was questioned or turned down by the program. One issue easily resolved is that our recommendation didn't specify that it'd be bilateral sensorineural hearing loss. They just said sensorineural hearing loss. So obviously that's an important correction in our recommendation.

And then they didn't agree with the seven-year time frame. They didn't think the science supported that. And they wanted, I think, additional information about a number of different aspects to this. They have a very long response. It's, I think, four-plus pages which we're not going to summarize.

We're at a little bit of a disadvantage frankly because the primary author of this recommendation was Laurie Welch, who no longer serves on the Board. And so she was really the one who best ensconced in the literature.

So we should take some comments. But my feeling is that if we want to pursue this further, we should put it back into sort of a subset of us to look at it and look specifically at the areas of disagreement or agreement and decide whether to what extent a response is warranted. But any comments at this point?

Dr. Silver, do you? This is kind of a complicated issue. Dr. Cassano?

MEMBER CASSANO: I think the major problem in skimming through this is the last part of their response where again we have to go -- we recommended that it'd be done based on the OHC and if they show that they were exposed to any one of a number of chemicals. But they're now saying that, yes, we still have to go back and put this in and all that sort of stuff. So that becomes -- it's the same problem in a different venue.

CHAIR MARKOWITZ: So the Board gave a very thoughtful, detailed response to our recommendation. And I think we would need to -- a subset of us would need to look at that response carefully and consider things in how we might if we want to modify the recommendation.

Anybody interested in doing that? Okay. We'll call for volunteers later.

(Laughter.)

MEMBER DEMENT: I'd be glad to work on it with one of the physicians if you would like.

CHAIR MARKOWITZ: Okay. I will work

on it. Thank you, Laurie. Okay. Next is a definition of chronic respiratory disorder. This is a really easy one, we thought.

So basically in consideration of beryllium disease, there is referenced one of the criteria for either a diagnosis or causation is a history of chronic respiratory disorder. And I don't know, Carrie, whether you want to do this or you want me to just summarize it?

MEMBER REDLICH: You can summarize it.

CHAIR MARKOWITZ: Yes.

MEMBER REDLICH: I'm going to pull it up while you're doing that.

CHAIR MARKOWITZ: Okay. So we basically said that a person who has significant breathing respiratory symptoms for three months or more that that would constitute a history of a chronic respiratory disorder. And I'm trying to think whether it was any more complicated than that. I just need to look, unless you know, Carrie.

MEMBER REDLICH: So I think they

agreed. The response was agreement, but the actual wording in the most recent manual doesn't appear to have changed. Where is it? Because I'm just looking, sorry. So I think that my guess is the history over the years what constitutes a chronic respiratory disorder has been revised and it was sort of a complicated description. And we had, after substantial thought, tried to come up with a more reasonable, simpler definition that also would not include anybody with any cough or symptom. So I think the manual is the same as it's been.

CHAIR MARKOWITZ: So let me -- I found the section, I think at least one section. And this is -- I can just -- we don't have to look at it. It's Chapter 18, page 169. And this is under the section talking about CBD prior to 1993. And it says, "Evidence of a chronic respiratory disorder includes records communicating existence of a long-term prolonged pulmonary disease process." So I think that's still the --

MEMBER REDLICH: No, I think it's page 186 of the procedure manual, Chapter 18, clinical course and system in chronic respiratory disorder may include the following disorders. And it has a list of hypoxemia, air flow obstruction, pulmonary hypertension, sarcoidosis.

CHAIR MARKOWITZ: Is that in the matrix?

MEMBER REDLICH: No, it's on page -- it's showing up -- it's page 186 of the old manual, Chapter 18.

CHAIR MARKOWITZ: Under what section?

MEMBER REDLICH: Under -- let's see. I think it's under the beryllium -- I mean, it's --

CHAIR MARKOWITZ: They're numbered, like 8, 9, 10, et cetera.

MEMBER REDLICH: Yes. It's under 6, establish CBD before 1993.

CHAIR MARKOWITZ: Oh, I see. Okay.

MEMBER REDLICH: In response to our recommendation -- so if you could just -- I'm

sorry. Could you just read what the response to our recommendation was? It's agreed, correct?

MEMBER CASSANO: They agreed. OWCP procedure guides now requires evidence communicating the existence of long-term prolonged pulmonary disease process. Version 1.1, Chapter 18, and it's on page 200 and 201. It's useful in establishing uniform guidance for physicians to consider when assessing a claim. However, OWCP considers an important goal pertaining to the reviewing physician allowing to determine whether the available medical evidence constitutes establishing chronic respiratory disorder such they agreed at the Board's recommendation to procedural guidance in order to assess the chronic respiratory disorder.

So they agreed with it, but it will not apply it as a dispositive standard. In other words, if it fits, they'll agree. But it's not exclusive of any evidence.

MEMBER REDLICH: Well I think that's okay.

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Okay. I didn't see any reference to a three-month course.

MEMBER REDLICH: So why don't --- I think I will simply review the wording and length throughout the document. But in adding it in addition to what they have is okay because it's creating more opportunity to fit a criteria for chronic respiratory disease. That's what actually happened.

CHAIR MARKOWITZ: My only concern was that the phrase "long-term prolonged pulmonary disease process" suggested to me much longer than a three-month time period. But if that's just my idiosyncratic interpretation, then let's move on.

MEMBER REDLICH: No, I think what I'd like to do is, since there are a couple references to it, just to see how the wording was.

CHAIR MARKOWITZ: Okay. So we'll table this then?

MEMBER REDLICH: Correct.

CHAIR MARKOWITZ: Okay. We'll revisit it. I think that's all for the prior recommendations.

MEMBER CASSANO: So the ones in Section 8, we just revisit the whole thing?

CHAIR MARKOWITZ: I'm sorry?

MEMBER CASSANO: Section 8 which was proposed August 23rd, 2018, that was just a revisit of earlier ones?

CHAIR MARKOWITZ: Section 8?

MEMBER CASSANO: Section 8 is the response that's August 23rd, 2018.

CHAIR MARKOWITZ: Oh, yes, yes, yes, right. Those are the old ones.

MEMBER CASSANO: The old rehashes.

CHAIR MARKOWITZ: Right. Well, in some cases, they're further responses to our comments, et cetera. Okay. So we can move on to new issues for the Board. I think we have two ways we can just walk down the four tasks that were given and then do it by task, or we can just entertain miscellaneous ideas for new things that

we should address.

Maybe we should start by talking about the requests from DOL for the Board. The first one relates to Parkinson's disease, yes. So this is a comprehensive -- wouldn't it be a comprehensive look at the disease, how the disease is medically defined, what exposures have been related to it and how to draw exposure-disease connections.

This has been an issue I think we've heard about through public comments. It's an issue that actually I think DOL asked that we might look at this -- the first Board look at this actually. We were busy with other things. So the question is: should we do this, and who wants to do it?

MEMBER CASSANO: I wouldn't mind taking the lead on this. I was instrumental in developing the presumption for VA on Parkinson's disease. And just recently -- well, not so recently any more -- but 2014 Institute of Medicine, now the National Academy of Medicine

report, clarified Parkinson's disease and Parkinson-like syndromes, Parkinsonism, and Parkinson's-plus syndromes and such.

Basically most of the literature does not separate them when they're discussing the epidemiology, and therefore they concluded that they need to include all of those diseases within the umbrella of Parkinson's disease.

So I've worked on this, and it would be less of a huge task for me I think than anybody else, but I will appreciate some help on it.

MEMBER MIKULSKI: I can help you.

MEMBER CASSANO: Thanks you. Anybody else?

CHAIR MARKOWITZ: So Carrie gets that. We have Mr. Mahs, Ms. Pope. We've got Dr. Mikulski and Dr. Cassano. So by the way, which task -- just so we stay within our mandate -- which our four tasks do we think this request falls under?

MEMBER CASSANO: This would probably

be weighing medical evidence. So my --

CHAIR MARKOWITZ: Number two.

MEMBER CASSANO: Well, we combined those two, the CMC and IH and the --

CHAIR MARKOWITZ: No, no, no. I'm not talking about committee; I'm talking about task now. Yes, sure, we combined committees at the end. I'm talking about the four tasks. I want to make sure the work that we do stays within our mandate.

MEMBER CASSANO: Medical guidance for claims examiners for claims would be appropriate.

CHAIR MARKOWITZ: Okay. So it's medical guidance and issues of causation, which Ms. Leiton clarified yesterday. Okay.

The second request has to do with looking at the draft occupational health questionnaire and giving detailed input into that questionnaire. Just for the new members, we actually discussed this and had some interaction looking at a new draft and offering some comments on the new draft. So this is really a

continuation of that process. Which of our four tasks do we think this fits under?

MEMBER CASSANO: Well, it's not Part B.

CHAIR MARKOWITZ: Four because the industrial hygienists work -- use the occupational health questionnaire as an input.

MEMBER CASSANO: I put the claims examiners used it, but the IH does get the output.

CHAIR MARKOWITZ: Well, task two, the claims examiner addresses use of causation which uses the exposure information. We're proving that everything is connected to everything else, the first law of ecology.

MEMBER CASSANO: It fits into all four.

CHAIR MARKOWITZ: Right. Okay. So what do people think?

MEMBER CASSANO: I thought somebody --

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I think it's very

important. I'm not sure how the interaction should take place. And I think the Board can take a look at the new history and make some recommendations again. My sense is, though, it's going to be a little more interaction with our staff that are actually developing the history. So I'm not sure how best to implement that.

CHAIR MARKOWITZ: By the way, I think we may have paper copies of the current draft.

MEMBER REDLICH: We had it on one of the disks. It was sent out that way.

CHAIR MARKOWITZ: Okay. That's fine.

MEMBER CASSANO: Didn't we come up with a draft in this committee somewhere. I don't know who had it, but was it Rosie that did that?

MEMBER DEMENT: No, it's a committee that Laura had. We made some recommendations and sort of pulled back on a lot of the tasks. Some of the tasks came from the BTMed team, of course, since that's when we had the most task information. It also expanded it in some areas

where we ask for agents and tasks. But we specifically ask for a description of how that was done.

Hopefully in some of the things that we saw in some of the occupational histories is that some individuals would check everything on there, just check that they did it, and we know that's not true. It's just not taking the time to do it. And there's a counter side of that is a lot of the individuals didn't check anything, and we know that's not true either.

So we're trying to use all the tools that we have had some experience with programs over the last 20 years is at least show a list of tasks and materials that would stimulate hopefully some recall and then require some comments by the worker to substantiate the fact that he actually did that task, work with that material. So that's where we were. The new drafted occupational history I think leaves a lot of room for the individual to write in things.

But it's almost like a blank slate, at

least my review of it. So a blank sheet that you sort of write your material in and fill it in. And I guess, this is my personal view, that it needed some stimulation of -- some information to stimulate your recall. So probably the best history is probably between the two somewhere along the way.

CHAIR MARKOWITZ: So I think did I hear, Dr. Dement, you agree to take a look?

(Laughter.)

CHAIR MARKOWITZ: No, no, no. That's just a factual question.

MEMBER DEMENT: I'm happy to work on the issue, whomever would like to work with me. I think you worked on it some, Kirk.

CHAIR MARKOWITZ: Kirk? Okay. And I will help. Okay, great. So we've got Dement, Tebay, Domina, and myself.

MEMBER DEMENT: So I think if we could have the current redraft, I don't know the changes the last time we've seen it. We can take another hard look at it and see what we've got.

CHAIR MARKOWITZ: So let's move on to non-cancer outcomes of associated -- health outcomes associated with radiological materials. The task is to look at the existing human literature and make some suggestions about how it might fit into the current SEM, quote, in terms of links within the SEM but also how it might impact procedural manual policy modifications. So the floor is open for discussion.

I guess while you all are thinking about this, thinking through which task it fits into, I suppose again weighing medical evidence and SEM. Okay, yes. Dr. Silver?

MEMBER SILVER: I hope I'm not imposing my own interests before this meeting onto this question. But I always felt there was an untapped body of literature on the non-cancerous effects of ionizing radiation exposure that maybe would be the basis for some Part B claims, simplest being severe radiation dermatitis, right? It turned out to be disabling for a person for a period of their career. There

are also benign thyroid conditions. I can't remember exactly how NIOSH deals with those under Part -- did I say "B"? I meant "E" for these.

So yesterday when Ms. Leiton presented this, I asked if that fell within the scope and she seemed to think it did. So that little bit of it would interest me if it's really within the scope.

CHAIR MARKOWITZ: So I actually propose that we table this request, and the next request was to look at how it affects aliases, and move on to items that we want to address as a new board. And then come back and revisit those two. Because I think we're running into a resource issue here which is how much collective effort do we have on various important topics.

So this is not to communicate that this issue is not very important because it is. The question is do we have the person power to do that. So I suggest we table that and then come back to it before 4:30 and see where we're at.

Okay. So the floor is open for

discussion of new issues that the Board think is relevant, falls within our four tasks that we need to get to or should look at. Dr. Redlich?

MEMBER REDLICH: Well, I think this was already mentioned, but review of the cases. So we could decide what particular cases in the setting of the -- I think the Part B from when we had looked at it before, it looked like the total number of cases and new claims has gone down. But I think it would be helpful to see since we have last reviewed to basically review whatever CBD claims there have been depending on a number. But it seemed like it wouldn't be an outrageous number.

CHAIR MARKOWITZ: So to review some CBD claims?

MEMBER REDLICH: And I would say -- I mean, we could specify specifically. But I think the Part B would be --

CHAIR MARKOWITZ: Okay. Part B claims? Okay. Dr. Cassano?

MEMBER CASSANO: Well, I think the

agency was sort of mixed as far as some of the presumptions that they did accept and didn't accept. And they gave us various reasons for that. But all of our presumptions are in the lung disease category. And I think we need to move beyond that. And I would propose that there's some really low hanging fruit in organic solvent disease. Benzene and AML were sort of a no-brainer, trichloride and kidney disease, et cetera.

So I would like to -- I think we should consider looking at presumptions for some of the organic solvents, well-known associations.

CHAIR MARKOWITZ: So just to clarify, there are some -- in the procedural manual, they do address TCE, kidney cancer, and leukemia and radiation maybe. Maybe not leukemia and benzene, I'm not sure.

MR. VANCE: I think it does do benzene.

CHAIR MARKOWITZ: Yes, it does. Okay. Right. So there are existing schema to look at

this. So you're talking about looking at claims and seeing how well those schema are applied?

MEMBER CASSANO: Or you look at the procedure manual and see what's actually in the procedure manual and see if there's some that are still obviously missing that we could add those or make a recommendation to add those.

CHAIR MARKOWITZ: Add what? I'm sorry. Add what?

MEMBER CASSANO: Add those additional presumptions that are very obvious now and replete in the literature and in IARC and NTP and all that that are not listed in the procedure manual for organic solvents and then make recommendations on whether to make presumptions on that.

MEMBER DEMENT: And just a comment on it. It may be worthwhile just taking a look at some existing presumption in those areas. For example, leukemia and benzene, and it goes into 250 days of exposure to benzene. But it has a latency requirement that I'm not sure I would

support. It says the leukemia diagnosis has to be made within 365 days or one year from initial exposure to benzene. I don't think the literature supports that.

MEMBER CASSANO: No, it's a much longer latency.

MEMBER DEMENT: It's certainly shorter than most solid tumors. It's certainly not this short.

MEMBER CASSANO: You might see aplastic anemia in that short of interval but probably not leukemia.

CHAIR MARKOWITZ: Okay. So you're discussing --

MEMBER REDLICH: I guess in any of these also whether it's an issue would be to see what claims have either been accepted or denied under that diagnosis.

CHAIR MARKOWITZ: Okay. So one idea is to look critically at some current presumptions in the procedure manual that we haven't looked at and weigh them and provide

input. Related to that, we could, in parallel with that, request claims involving those conditions, those exposures, and looking at the outcomes from those claims and how they're treated. So is it preferred that those two things be done in parallel, or do you want to begin to take a critical look at the presumptions even before any claims review?

MEMBER CASSANO: Doesn't matter to me. I think parallel is fine. I bet it doesn't take much to look at the procedure manual and see what's there, but I think we also need to look at claims.

CHAIR MARKOWITZ: Any other comment on that?

MEMBER SILVER: Yes, Ken Silver. Are we taking this on because we're interested as people who work in the field or does it come up repeatedly at our public comment period?

CHAIR MARKOWITZ: I think TCE has come up actually as an important issue. I don't recall leukemia and benzene per se, but I think

TCE and kidney cancer has come up.

MEMBER CASSANO: Does that mean we can come up with a list of the chemicals that we want to look at claims for?

CHAIR MARKOWITZ: Okay. So then talking about one proposal is to look at some Part B claims. Another proposal is to look at some claims that involve current presumptions that we haven't so far looked at. I'd like to get back to the recommendation that we made that resources be provided to involve an outside organization to look at 50 claims for the -- to look at the quality, objectivity, and consistency of a CMC report. That request was, I think, denied.

But I think we should do it actually. I think we should look at those CMC reports and those IH reports because for twofold. One is that we'll get a better understanding. But two is this is true for the first Board, too. We only looked at a limited number of claims. So we spent most of our time addressing policy and

procedures and our ideas about how to improve those, in some cases, how to make them more scientifically sound.

But the money is in the claims, to quote Dr. Cassano. And if we want to understand the program better, both new and returning board members, we should look at some claims and see how the program actually works. Does it correspond to how it's portrayed, and what are the opportunities for improvement?

MEMBER REDLICH: I agree. I mean, I think from our review, we had looked at probably about 60 Part B claims. And I mean, some of them were very reasonably reviewed and we agreed with. I think one of the areas that was noticeable that probably about a third of them was one particular CMC that we had concerns about.

MEMBER MAHS: I don't know about the other new members. But I think for myself going through some claims would help me understand the program a little better.

MEMBER BERENJI: Agreed.

MEMBER REDLICH: I will say that I think that the information that we were given which was the questionnaire, the preliminary decision, the final decision, if it was assumed that that was -- and if it was the -- so for the summary of --

CHAIR MARKOWITZ: Accepted facts, statement of accepted facts.

MEMBER REDLICH: Yes, that entity that I think the majority of the cases that that was sufficient because I think all the medical records becomes quite wieldy. And I would think that it would be reasonable to start there and that if people felt that they really couldn't get a feel for the process with that information could then discuss whether further information would be helpful.

CHAIR MARKOWITZ: But if the interest is, in part, looking at that formulation of accepted facts but also of the CMC and IH reports, then we ought to look at claims that get information on all aspects of those comments.

MEMBER REDLICH: Okay. I guess you're right.

CHAIR MARKOWITZ: For the sake of efficiency, actually. Yes, Mr. Tebay?

MEMBER TEBAY: I think you just answered it; my question was: are we going to be able to review the IH recommendations and the whole entire claim?

CHAIR MARKOWITZ: Well, we certainly need all the exposure. If we look at the IH report, we've got to look at the exposure information. And if we look at the CMC, we've got to look at whatever the CE sends to the CMC and the basis for their opinion. Right. And the only question is do we also want to request the medical information that the CE uses to develop the medical evidence and decide on what the health conditions of -- verified health conditions are. Do we also want to do that?

MEMBER REDLICH: I mean, my guess is that -- and I've seen some that there can be many hundreds of pages of medical records. And at

least the ones that we reviewed, the medical component seemed not to be the major issue, some of them. But I think some of them where there was -- it was someone's deceased historic records. And I'm not sure there was probably that much more that would be helpful.

MEMBER DEMENT: So this is John. I think we ought to sort of target outcomes or claim types as opposed to just getting the broad spectrum. Because the last time we reviewed these claims, when we got the first batch as I recall, there's a whole bunch of things in there that were denied. And frankly, if we reviewed them and said, we agree and there was just not enough there to support a relationship.

MEMBER REDLICH: And the same on accepted. I mean, beryllium sensitization, it was beryllium sensitization.

MEMBER DEMENT: Yes, and it's pretty straightforward.

MEMBER REDLICH: Exactly.

MEMBER DEMENT: And so I think we

ought to try to target harder issues as opposed to those and not get a whole bunch of claims that are straightforward. So I would certainly say COPD is one, and maybe some of the other outcomes that we haven't really looked at.

MEMBER REDLICH: And I don't know if you, Dr. Dement, last time that actually been given some of the data on the "B" claims and very nicely sort of organized it and showed yearly the number that were approved/denied across the different disease categories. And having that information but I have the summary in front of me. And by looking at that, you clearly see what areas you would be interested in looking at.

For example, in 2016, there were a total of eight sarcoidosis claims, all of which were denied. For COPD, there was a total -- this is the most recent year we had. There were a total of 244, 98 were approved and 146 denied. And for asthma, there were a total of about 111 and 55 approved and 56 denied.

So I think looking at that, an updated

version of the data, I think would be helpful just in terms of seeing the trends. There were some clear trends which to me would make sense in that, like, the number of CBD claims has gone down over time substantially, same also with beryllium sensitization.

The other category by just looking at this, that would -- and something like chronic silicosis, 77 percent of those were approved. The other area that struck me that I'd be interested in looking at is interstitial lung disease. I think it was ILD pneumoconiosis. Only one was approved, and 20 were denied.

So I think at least for the COPD and the lung conditions and asthma, if we could look at an updated version of the data. And then after we saw that, we could, as John suggested, more sort of efficiently target what condition we're looking at. At least 75 percent of what we had looked at or maybe two-thirds of COPD were reasonable. So it's not that we disagreed. I think to give credit, it's not -- plenty that are

appropriately decided.

CHAIR MARKOWITZ: So let's formulate that as a request now so that we can get it --

MEMBER REDLICH: Sure.

CHAIR MARKOWITZ: -- on the books. So the request is to look at numbers of accepted versus denied, and reasons for denial. Right?

MEMBER REDLICH: We did get that also.

CHAIR MARKOWITZ: We did get that, reasons for denial.

MEMBER REDLICH: That's right.

CHAIR MARKOWITZ: We're talking about all pulmonary conditions, not just Part B.

MEMBER REDLICH: I think what we can do is have a similar request to we had before. But it would be probably two more years now.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: And then I also have a sense -- I think from this we do have a reasonable sense of the pulmonary claims. I don't have a very good feel for what all the other stuff is. And it seems that in terms of

targeting issues that might just -- cancer, neurologic, what the major --

CHAIR MARKOWITZ: Okay. So --

MEMBER REDLICH: -- entities are. But just so we get a feel for it.

CHAIR MARKOWITZ: Right. So let's talk about cancer for a moment. All the cancers are compensated under Part B through the radiation. And then they're accepted under Part E for impairment or supplemental kind of benefits. I'm sure I didn't get the word right, but I think that's --

But can I just ask you, Mr. Vance? I don't want to put you on the spot. But within Part E, is it possible to identify the cancer claims that were not accepted within Part B? In other words, Part B are accepted and then they're accepted under "E". And those are radiation related we're not interested in. We're interested in the toxic substance-related cancers.

MR. VANCE: The answer to your

question is I'm not sure. We would have to go back and look. I think we can generally do pretty good data extractions from the information we have available. And I know that we've done similar type of requests like that in the past. So I would say that we would have to go back and take a look, but it should be something that we probably can put together a fairly decent and accurate report on.

CHAIR MARKOWITZ: Okay. I mean, we're talking about all cancers for claims under "E" minus those that were successful under "B".

MR. VANCE: Yes, because we would have to do a relational pull. We'd basically extract out any case that was -- you'd have to do basically what we accepted under "B" that is an ICD-10 coded case for cancer that was not translated into an approval under Part E. But that's going to be kind of rare. Because if we've accepted it under Part B, then we'll have accepted it generally under Part E.

CHAIR MARKOWITZ: Right. So it's the

ones from -- the refugees from "B" we're interested in, and the ones that weren't accepted under "B".

MR. VANCE: Yes.

CHAIR MARKOWITZ: But now will come in under "E" for consideration.

MR. VANCE: Yes, because then you're going to be looking at those strictly for the chemical component.

CHAIR MARKOWITZ: Right, right, right, right.

MR. VANCE: So yes, I think that's possibly doable. The thing I would caution is just remember our data is derived for case management purposes. So the specificity in detail is very important. So whenever you're talking about looking for a particular population, be thinking about: how do you identify a specific population of cases that you want to look at?

So if it's by disease, it'll be by ICD-10. If it's by case category, you'll have to

really specify. And keep in mind, there can be lots of reasons why a case is denied. And you probably don't want to pick that up. So if it's being denied for -- if you say we want to see every Part E case that's been denied that has a cancer component to it, well, there could be in that category cases that were rejected because there were no eligible survivors. So you have to be very conscious of the categorization of the data request.

CHAIR MARKOWITZ: Yes, so the last time we got a reason for denial, so we were able to carve out the causation versus -- but the ICD nomenclature is perfect for us because it's very specific.

MR. VANCE: And that's what they would search on.

CHAIR MARKOWITZ: Okay. That's very useful. So yes, so we could look at the cancers that were not compensated under "B" that came into "E" directly or they came after a failure under "B" and the same kind of information, how

many accepted, how many denied, reasons for denial. And we can get the specific cancer type because that ICD code is available. So that would be good.

So what about neurologic conditions? So while you're here, so we're not talking about Part B. We're talking about exclusively Part E, and you have it by ICD code. So we could pick out selected -- whether it's Parkinson's disease or neuropathy or dementia, or you name it. We could pick out certain diagnoses and request the same kind of data. Sorry about that. Comments?

MEMBER CASSANO: I think we just go with some of those that we're pretty sure we're going to find some. And there's lots of cancers and there's lots of conditions. And I think dealing with things like kidney cancer, bladder cancer, obvious neurological disorders, that would be a start and hematopoietic cancers. I think that's probably what we're going to find the most of.

CHAIR MARKOWITZ: So while we're

considering outcomes, any other major classes of outcomes? We talked about lung disease. We talked about cancer, neurologic disease.

MEMBER SILVER: Not directly responsive to your question, but I see this ramifying to a wrong number of outcomes. I'm reminded about a COPD case that I got as part of our review last time around. It had 1,300 pages, and the man had been to over 20 doctors. And if the rationale of the medical people had been a detailed part of my review, I might still be working on it.

There's a principle in the public interest advocacy movement that you pursue information to leverage more information. And what we're doing here, I don't think we should give up on the idea of getting outside resources. I think maybe a smallish review of files here could lay the justification for requesting again outside resources and perhaps a bigger sample involving folks from the Association of Occupational and Environmental Clinics who have

some overlap with the Board. But that was Dr. Sokas' original proposal for an outside contractor.

But if we could do it in a stepwise procedure kind of like a pilot on all these different ideas and then provide a stronger rationale for our request for outside resources, that's how I think we should proceed.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Given what you just said about AOEC, would it be of any interest to ask Katherine Kirkland to address the Board on what kinds of things they could do?

MEMBER REDLICH: I'm currently on the Board. I think it would be helpful for us to first get a better feel for what these cases are. I mean, my guess is that there are a large number that are very appropriately decided, and it's more: where are the issues?

CHAIR MARKOWITZ: Well, sure. There's always the option depending on what we find to say, yes, we were able to learn so much, and we

need to learn more. That decision would be based on what we actually learn from the case review. So I would say we just keep the question open.

I mean, frankly, if we do 50 claims or whatever and we divide them up by COPD and cancer, we're not going to be looking at that many claims for any given condition. So we may not be able to draw any big conclusions, but we'll certainly get a better understanding.

MEMBER SILVER: At which point, we may, to quote a Board member, decide to go big or go home, right?

(Laughter.)

CHAIR MARKOWITZ: I think that was used in a different context. So fine, lung disease, cancer, neurologic disease. Let's leave it at that. If the Board is around for two years, if we succeed and we want to look at claims in other areas, then we can make that request. Does that make sense?

MEMBER REDLICH: Yes, I mean, I still think it would just be nice to know what the big

ticket areas are. If there are 2,000 claims in a year, those may be them. But I don't know, dermatologic. At least to know what the major categories are.

CHAIR MARKOWITZ: So what you're asking for, I think, is data on the overall claims, accepted versus denied, for the ten most frequently considered health conditions. Is that what you're --

MEMBER REDLICH: Or organs. You know what I mean? Like, I would lump all kidney stuff together and something like that. Or all hearing together just to get some idea.

MR. VANCE: We wouldn't have it by organ system. We'd have it by disease classification.

MEMBER REDLICH: Okay. Sure, that's fine.

MEMBER CASSANO: Because, I mean, to just say all cancers, there are a lot of very obscure cancers out there. I mean, how many osteosarcomas and rhabdomyosarcomas are you going

to find? And to have those included in the mix is going to really dilute your ability to determine a trend in any one cancer. So I think we need to stick with those cancers that we know up front are going to have a large number of responses.

CHAIR MARKOWITZ: No, I would actually argue that we should look at the ones that are most likely to be occupational. But regardless, let's get the data first. And so the request then is to look at the ten most common conditions, claims under whatever recent time period is reasonable is done I think is where the fourth quarter of 2018 including the most frequently denied claims by health condition. And we may need to refine that a little bit, but if you just get it --

MEMBER BERENJI: Is that two separate things?

MEMBER REDLICH: This is separate from the pulmonary because our pulmonary request we know because it's similar to what it was last

time.

CHAIR MARKOWITZ: So we would probably want to look at those data before we get more specific about which claims we want to review, right? What's the rough turnaround time for this, the request about the --

MR. VANCE: It depends on what you specifically ask for. I think the exercise that we went through before, and I'm looking at Carrie because there's a lot of refinement that has to go on. So once you have an idea as to what it is that you generally are going to want, you present that. The Department will evaluate that and say, okay, well, here's what we think you want. Let's go and look at different options. And I seem to recall there was a great deal of back and forth to make sure that we got to them.

MEMBER REDLICH: There were three conference calls I think on that.

MR. VANCE: So there is a lot of refining that goes into that.

CHAIR MARKOWITZ: So I'm glad that we

already did that work so we can just skip all that stuff. We can just skip over that step and get the answers we want.

MEMBER REDLICH: We will resurrect the files on pulmonary, and I think that will save time.

MEMBER CASSANO: That's easier if you knew them.

CHAIR MARKOWITZ: And particularly for the new Board members, once we formulate a request to look at claims, those claims have to be prepared. And I can't remember how long that takes, but that took some time also before they were sent around. Four to six weeks, does that seem reasonable?

MR. VANCE: Yes, I think --

CHAIR MARKOWITZ: We won't hold you to it. We just want approximate times.

MR. VANCE: -- it was not days. It was weeks or months or a month or so.

CHAIR MARKOWITZ: Yes, okay.

MEMBER BERENJI: And how is that

information disseminated? Is it via a secure portal or --

MEMBER CASSANO: They sent disks out, password protected, et cetera, and under penalty of death if you lose it.

MEMBER TEBAY: Is the claim information in the file? Can it be extracted by work history, medical causation, IH? Or does it have to be pulled all in one big --

MR. VANCE: Okay. Since 2013, we've been organizing it into an image file. And there are dozens of indexing categories and subjects. So if you're looking at a case file and you're saying, show me all the medical records that you have. If they're indexed properly, keeping your fingers crossed, then you will get all the medical records.

So there is categorization of documentation in the case file. But I always caution because for that to be accurate, that means it'd have to have been indexed correctly. So I generally will say that represents probably

the vast majority of the medical reports are in the OIS system as indexes medical records. But that doesn't mean there could be medical record mixed in with other documentation that may not get categorized properly.

So when I'm doing my reviews, yes, I'm going to look at the medical records. And then I'm going to have to go back and just make sure something else might not be mixed in with something else. So yes, there is a categorization of data in the system.

MEMBER TEBAY: I asked that because obviously other people have different interests. And like COPD, what we see in COPD at the HWEC is the diagnosis is not contended on as much as causation. And I mean, to me, for us and the people we represent, it's more important to find out why that disconnect is there. I mean, is thedisconnect between the SEM?

Often we see a claim that says -- the claims examiner states that there is significant exposure via the SEM. And the diagnosis is not

contended. The work history is there, and the SEM puts them in a building or an area with several different exposures.

In the end of that, we'll see that claim then get forwarded on to the IH, and the IH will then agree that there was significant exposure, but not significant enough or not beyond -- as Mr. Artzer said yesterday -- not beyond the OELs and PELs. Well, I'm kind of interested in that information of how that gets assessed and where the recommendation comes out of that.

So that was my question is: categorically, can you just view that information specifically?

MR. VANCE: Yes, that would be indexed into our OIS system as either if it is originating from our internal industrial hygienist or it's a referral to one of our contractors. That information could be extracted out of the case file as its own as just that material.

CHAIR MARKOWITZ: So I want to get back to what are our goals in looking at these claims, and make sure we come to some preliminary agreement about that. So we're interested in the -- as charged in task four -- with the quality, objectivity, and consistency of the CMC reports, of the IH reports. And we're interested in the CE's ability to generate an accurate statement of accepted facts. Is that correct?

Or this latter issue of whether the CE does a good job in identifying the medical conditions is not something we feel the need to look at. I'm not expressing an opinion. This is an open question.

MEMBER POPE: I think that's vital. That's the beginning of the process of the claim, and it begins to build a case. I believe looking at that CE and what they're looking at and how they submit it, I think that's really given us insight to how the process begins.

MEMBER REDLICH: If the goal is to try and help facilitate this complicated system for

workers, in the ones that we had reviewed, there were several where, yes, the specific disease requested was appropriately denied. But it would've been helpful to inform the worker that they had asbestosis or some other condition.

So I think it's usually at least from my experience looking over even the information we had on them. It became pretty clear what the potential issues were in terms of the quality of the decision making about the clinical piece, the exposure piece, and then the association. Did you think each of those was adequate in terms of the information -- adequate and accurate and both on the exposure side and the disease side and then the decision making.

CHAIR MARKOWITZ: Right. But we wouldn't necessarily look at all the medical records --

MEMBER REDLICH: Correct.

CHAIR MARKOWITZ: -- unless we were interested in taking some look at the CE's ability to generate appropriate subject. So it

does impact sort of how complete a claim we're asking for. Are we asking for the whole claim file, or are we asking for just parts of it? But I think what I hear is that so far is that, no, we shouldn't look at the CE's ability to accurately identify the medical conditions.

MEMBER CASSANO: I do have a question. Is there either a statutory or regulatory requirement that the CE only look at the particular contention that the claimant is presenting? Or in other words, I have lung disease due to asbestos exposure. Or if there is something else in the file that it's very obvious to the CE that there should be another disease association. Can they put that forward, or can they only work on the contention that's presented?

MR. VANCE: That's kind of an interesting question. But the frame of any claim is going to be derived from what the person has asked the Department of Labor to do. So if I filed my claim for COPD, that's the context of

the claim.

Now, you say it's very obvious that there might be something else going on. We certainly will reach out in some of those instances where when we have something that's really clear cut, and I've done that. But in other situations, it's not so clear cut. And there could actually be reasons why a claimant doesn't want to pursue a claim for a particular condition.

So we generally advise our staff not to be proactively searching for other types of claims that could be made. That is going to be -- this is a claims driven process. So it's up to the claimant or their authorized representative to seek out what benefits that they want for whatever condition or benefit they're seeking.

MEMBER CASSANO: I was not trying to figure out right or wrong; I was just trying to see what the policy is.

MR. VANCE: It's a claim adjudication process. You file the claim. We have to give

you an answer on what you're asking for.

CHAIR MARKOWITZ: Yes, sure. John?

MEMBER DEMENT: Having been on the Board before, we sort of divide up into various groups and we went off and we looked at pieces of the process, lots of different pieces, let's say on the IHC, OHQ, and it was helpful. But I think at this point the most helpful was to find the difficult cases. How will we define those cases, and look at the process in totality, and how was the OHQ used in making those statement of facts.

I think Carrie pointed out sometimes in the medical records, there's something buried in there. They're voluminous, and we will all probably use a small portion of the time looking at those in great detail. But I think they're helpful and certainly the IH and the CMC. So I would rather look at a smaller number of cases, but look at them in great detail.

CHAIR MARKOWITZ: So what do you mean by most difficult cases?

MEMBER DEMENT: The ones that -- some

of the cases are -- I would say the ones that -- some of the cases that have presumptions but were denied. To me, that list is something that most likely would be more useful.

MEMBER REDLICH: I mean, I think from the work that you did, I think that -- and sorry I couldn't pull it up for everyone. But we had seen before in terms of what number of cases and how many accepted or denied under different pulmonary conditions, I think it's obvious where one would want to review cases.

MEMBER DEMENT: Yes. But I think collectively we can do a better job in dividing up and reviewing a piece and coming back. So I don't know. We have a lot of different views and expertise on the Board. And I'd just like to see us review a smaller number or in greater detail look at the whole process. I mean, how you would define that is a challenge, of course.

MEMBER REDLICH: I think I agree. I think that there is benefit with people, even just the ones that we had reviewed. Like, Kirk

picked up on pieces that I didn't, John also. And because we were sort of each keying in on a different piece and had different expertise. And it's probably where if we reviewed five to ten cases, we would then have a better idea of where that, in and of itself, would I think help target our efforts.

MEMBER DEMENT: Yes, we beat up on the SEM a lot. And it's a useful tool in lots of cases. In the cases we reviewed, the SEM was very useful and it came to a conclusion that were in the case. So I'd just like to see how it's used or maybe some of the areas that could be enhanced. That's all.

MEMBER REDLICH: And so we have been picking on the issues. There are plenty of areas where there aren't issues, and we agree.

CHAIR MARKOWITZ: I don't think we beat up on SEM. People may have beaten up on the SEM. But no, in all seriousness, if the industrial hygienists are now looking at over half of the cases, at least the cases with

questions in the last two years, that is a huge evolution in the program. Correct me if I'm wrong. Because if prior to that you didn't have IH review, you had the SEM. You had a couple other --- maybe DAR from DOE. That doesn't really give you a whole lot of detail about exposure.

So the SEM was central, but it strikes me that there are multiple sources now for information about exposure. So that's a big change. But that argues for two people, or members of the board from different backgrounds looking at each claim that we look at, because they're going to have different perspectives and see different things. That means we'll probably review fewer claims, right, because there are only so many of us, but it's probably worthwhile doing.

MEMBER REDLICH: And we did put up like a standardized form that everybody sort of took, and I sort of synthesized everybody's input together.

CHAIR MARKOWITZ: Right, right. Could you share that form?

MEMBER REDLICH: Sure. Yes, we could modify it.

CHAIR MARKOWITZ: So Dr. Redlich is going to provide a claims review form.

MEMBER REDLICH: It was focused on the pulmonary side.

MEMBER CASSANO: And I have another one that I can order that we use for the --

CHAIR MARKOWITZ: Dr. Cassano is going to provide a claims review form.

MEMBER CASSANO: We'll combine them.

MEMBER DEMENT: I would suggested even if we divide into the actual worker reviewing in detail, that we all get the files. In some cases, it was useful to be able to reference back some of those comments. So I think we should all get the same cases to take a look at.

CHAIR MARKOWITZ: So the sequence is going to be that we're going to get information about -- data about denied claims, accepted

claims, the most common denied conditions. Then within certain categories, chronic respiratory disease, cancer, neurologic disease, the same kind of data. And then when we look at those data and then decide on which kind of claims we were going to request. Is that right? Which and how many. Yes, Dr. Dement?

MEMBER DEMENT: Just one clarification. I think last time I was given a file that basically a claim I went through and summarized for this. But I think you can generate the same thing for your system. I don't think there's anything that I generated that can't generate. So it's sort of an unnecessary process for me to get this huge file and have to deal with it when I think the program can provide those summaries quite straightforwardly.

MR. VANCE: Yes, I mean, we can -- right now, with everything being imaged, it's much easier to collect and try to divide up information based on its categorization in OIS. So it just depends on what you're asking for and

then what can the program do to accommodate that request.

MEMBER REDLICH: The way we had it before was well organized. The questionnaires labeled what they were all in a folder for that person. The one area that we did not have necessarily a lot was on medical records.

MEMBER DEMENT: No, I'm speaking of just the file that was used to generate those summary tables that we'd generate by case. So I think an unnecessary intermediate step and a lot of work on my part.

MEMBER REDLICH: Sorry. I misunderstood. Okay.

CHAIR MARKOWITZ: With our request when we formulate would be for them to do that for the respiratory disease, for cancer, and for neurologic disease. Is that right, John?

MEMBER DEMENT: Yes, that's the case.

CHAIR MARKOWITZ: So John and Carrie and I and anybody else who wants to volunteer will work on formulating that request. Anybody

else? Okay. I got you. Okay, good.

So is there anything else about claims review that we want to discuss? Dr. Friedman-Jimenez, do you have any comments or do you want to provide any input? Okay. George knows where to find us. We're going to take a break in 15 minutes. Yes, George?

MEMBER FRIEDMAN-JIMENEZ: Yes. No, I think we're going the right direction. I just have a question. Will there be an opportunity for continued dialogue on some of these recommendations that have been declined and will come back with a revision? Will we do that at the next meeting? Is that the planned process?

CHAIR MARKOWITZ: Well, I think the answer is yes. There will be continued dialogue. The question is whether we need to -- if we revise a recommendation, we're going to need to agree on it as a group and then submit it to DOL. So it's really just a timing issue. Whether there are certain revisions we could handle over the phone as a Board or whether we need to wait

for the in-person meeting.

My preference is to move things along. So if we can get there and do an internal full board telephone meeting and consider some of those and vote on them, then we should do that. Does that answer your question, George?

MEMBER FRIEDMAN-JIMENEZ: Yes, I'm little concerned about the restrictions on our communicating outside of a Board meeting because I think it will require some degree of collaboration to revise the few recommendations that we want to revise.

CHAIR MARKOWITZ: So you're talking about communication with DOL?

MEMBER FRIEDMAN-JIMENEZ: Among ourselves.

CHAIR MARKOWITZ: Among ourselves.

MEMBER FRIEDMAN-JIMENEZ: Are we able to do that? Can we email a draft of language back and forth without restraint?

CHAIR MARKOWITZ: Well, so far, we have no subcommittees. So short of including the

entire board, maybe we are allowed to do that. We're not trying to skirt our commitment to open this. We're just trying to figure out how to work. Well, we're going to think about that for a few minutes and get back to you.

MEMBER FRIEDMAN-JIMENEZ: Okay.

MEMBER REDLICH: I have one question that you may know the answer or not. It just seems that for some of these claims sort of every disease the person has gets listed. And so from my perspective, there's whole categories. It's just like cardiac disease, it's unlikely that that's going to be work related. So how much is all that other stuff taking up people's time and effort?

MR. VANCE: It actually does because don't forget the program, as Dr. Markowitz noted yesterday, was we can actually have consequential effects. So in other words, let's say you have a severe pulmonary problem. That can directly aggravate or worsen a cardiovascular disease process.

So that relationship can be established. So people can file a claim saying that while I was accepted for COPD, now I've developed a much more worse form of arteriosclerosis or whatever cardiovascular problem. And then as long as they have a physician offering a rationalized basis for saying, yes, there is a connection, then they can file the claim and we have to go through the exercise of looking at that other consequential illness.

But again, under the nature of Part E, you can file a claim for anything. And so we get claims for all sorts of things. And we have to go through this process for every single one of those claims.

MEMBER REDLICH: Because that might be one other area that we could provide guidance on where --

MEMBER CASSANO: I don't think there's -- I mean, I see this a lot. I mean, I see people have 45 contentions on a claim including

their hangnails. And you have to go through the process with every single one. I don't think there's anything we can do avoid that.

As much as I think we'd like to help, say, no, you cannot file a claim for such and such. But it creates a certain amount of -- I don't want to say animosity. But when you see 45 contentions, most of which you know are probably not related to anything work-wise, it sours you to the claimant a little bit.

MR. VANCE: Well, and my only comment to that would be so you have to be thinking about this from a medical health science perspective versus that claim adjudication process. When people are talking about prioritizing and figuring out ways to refine these cases in a way that gets them through the process, we do get cases that are -- I've seen them come through my office that are six or seven boxes of material, and that's just on the hybrid material that existed prior to when we started imaging records.

So there could be an equal proportion

of those records in our image system. So you have to think and balance the reality of medical health science research that's required in some of these cases against the adjudicatory process, the administrative process of evaluating and making decisions on each one of these disparate types of claims.

MEMBER REDLICH: I mean, I would say for -- I mean, you may be doing a whole exposure and association for something like their lung disease. But for their cardiac disease, yes, it might be secondary to their pulmonary. But are you also addressing causation?

MR. VANCE: Oh, absolutely.

MEMBER REDLICH: So --

MR. VANCE: So it depends on the nature of the case. So if I am a claimant filing on -- if I have cardiovascular disease that I'm arguing that's associated with low levels of long-term exposure to radiation, that's the nature of the case. That's what we're going to take in our evaluation.

If I get a claim for someone who is filing Alzheimer's who believes hard metals are contributing to that disease, that's what we're going to have to look for. What is the information that's being presented to us by the person seeking those benefits under the law?

MEMBER REDLICH: So I understand that. I just think that there's certain diseases where there's just really no -- there's no literature supporting occupational causes except in an extremely rare case.

MR. VANCE: I will give you a quick history lesson that we actually attempted to do that years ago and decided that that was not a wise maneuver.

MEMBER REDLICH: Okay. And I understand.

MR. VANCE: Yes.

MEMBER CASSANO: It is sad but true.

CHAIR MARKOWITZ: So we're talking about consequential conditions, right?

MEMBER CASSANO: No. We're just

talking about basically -- I don't want to use the term frivolous but claims that have no basis.

MEMBER REDLICH: From the perspective of the person, we immediately prioritize what would be more likely to be work related. But you could imagine from the perspective of a claimant that they're just going to write down every condition they have.

MR. VANCE: And the other thing --

MEMBER REDLICH: And it just seems to be unfortunate that that is probably -- that's what I was sort of asking is if that's eating up a lot of time and resources --

MR. VANCE: And --

MEMBER REDLICH: -- that is an issue in terms of the operation of a --

MR. VANCE: And I've been working on claims for a long time. My other comment to that is that it's always amazing what you ultimately can find in some of these cases. And there have been instances where I've looked at a case just like that and said, that's ludicrous. How can

you possibly make that argument? And yet when we've gone back and looked at it, we're like, wait a second. There's actually some substance to what's going on in this particular case.

So you have to be very cautious just because when you first look at it, you don't think there's something obviously there. But when you actually going through the process of evaluating the case and looking at it or looking at the arguments that are being presented by the physician or the epidemiological information or whatever the circumstances are, you may actually have a compensable claim on your hands.

So it's a challenge. And when you have a claim with dozens on these things, you've got to look at each one and give them all due diligence and whether or not they are compensable illnesses.

MEMBER SILVER: Pretty early on, I was alarmed to see the resource centers casting a very broad net and kind of recruiting claims whatever they might say. They may have had or

perhaps still have some contractual incentive to rack up a large number of claims filed through their resource centers.

So that's kind of where it's coming from. I don't think it's claimants trying to be greedy or blaming the Man for all of their diseases of old age. And I think the program is taking really the only compassionate approach to work through them.

CHAIR MARKOWITZ: It seems we're taking a break.

MR. VANCE: Sorry about that.

CHAIR MARKOWITZ: No problem. But we'll back 20 of.

(Whereupon, the above-entitled matter went off the record at 2:29 p.m. and resumed at 2:51 p.m.)

CHAIR MARKOWITZ: Okay. We're going to get started. So the way we're going to work after this meeting is on the various tasks that we've agreed upon. We're going to form a sort of provisional working group on those tasks. They

won't be official subcommittees because they're not really specific to an individual task. And we also want to be able to get to work on those in a timely fashion.

So we're going to send around via email a list of the tasks and the people who have signed up. You have the right to add your name. You don't have the right to subtract your name. I'm only kidding. You decide what you want to do. But we'll make sure that there's enough person power to get the task done. So that's the way we're going to proceed.

MR. FITZGERALD: And this will be communicated in the email. But as work groups do their work, they should communicate with the DFO through the Board's email address so that the DFO is informed about the progress on that work. Like all work groups, the work is a work in progress until the Board actually meets and has a discussion and on votes on this.

CHAIR MARKOWITZ: So I asked actually Malcolm Nelson and Greg Lewis to just give us

five-minute overviews of the work that they do that is relevant to the Board. In the first Board -- you can come on up, Mr. Nelson. In the first Board, they actually had formal presentations from the ombudsman office and the DOE. And we decided there wasn't really enough time in these two days to do that. But I think we have a few minutes now, and I think it would be useful just to get a relatively brief overview.

Mr. Nelson, welcome.

MR. NELSON: Welcome. First of all, my name again is Malcolm Nelson, and I'm the current Ombudsman for the Energy Employees Occupational Illness Compensation Program.

I usually would start out by saying, welcome to Washington but the weather today. It's a little bit unusual. But it's often like this. They often predict snow. And either we don't get any or we get more than we expect. And I understand that today the weather is a little bit worse than they actually had predicted. But

nevertheless --

CHAIR MARKOWITZ: We're going to South Carolina for our next meeting, so --

MR. NELSON: Yes, good move. Very quickly, this program, as you know, was created in the year 2000. And four years later in 2004, Congress amended the act and at that time in those amendments they created my office, the Office of the Ombudsman.

We have really three duties. One, we are to recommend the placement of Resource Centers. And currently, there are 11 Resource Centers around the country that will assist claimants in the filing of their claims.

Our second job is to provide information to claimants and on the benefits available under this program and on the procedures for this program.

The third duty is that we submit an annual report to Congress. And in that annual report, we are to set forth the number and types of complaints, grievances, and request for

assistance that we receive during the calendar year. And we are to provide an assessment of the most common difficulties encountered by claimants.

In order to do that, we rely on our interaction with claimants. A large number of the claimants will call us, email us, or write letters. But what we have found is that in this population, there is a hesitancy to really complain. These workers often feel that they did a very important job for the government. They're very proud of that, and they don't want to be viewed as complainers.

And thus, we find that a lot of people really won't call us. But they will if we go out and go to town hall meetings or attend their luncheons. They will come up to us and begin to talk. And in those conversations with us, they will often start to outline many of the problems they have. So one of the more important aspects of the job that I really impress is for our office to try to get out as much as we can to

talk to claimants, to be at the various events to interact with them.

The bottom line if you would ask me what the biggest problem is and it's something that's been said over and over the last day or two that this is a complicated program. And as such, most claimants simply are overwhelmed with the procedures and just the mere concept of this program. We find that most claimants do not have an attorney representing them. And if they do have an authorized rep, that authorized rep is usually a family member or somebody else who themselves may not be familiar with the program. And thus, probably the biggest thing we do is really just trying to explain this program to people.

This program, and I'm sure most of you know, is somewhat different from most other worker compensation programs. And so many of the claimants try to apply the rules they've seen on TV to court or the rules that they've experienced with maybe their state workers compensation

program to this program and simply become confused and overwhelmed. So a lot of our job is simply trying to explain the rules, point them in the right direction, and explain how to proceed.

In that sense, I want to just commend this Board. The recommendations, the findings that you've made over the last year have really in my mind supported many of the grievances and complaints that we hear about this program. I'm not going to go into any detail on them. But just in a sense over the years if you read my report, you will see that claimants have outlined a number of concerns.

Many times, they are unable, and as an attorney, I'm unable to put those concerns in a very scientific or medical terminology. And I commend the Board because you have been able to help me and assist me in understanding the medical and scientific aspects of those problems. And like I said, in that sense, supporting the concerns of the claimants.

Like I said, I'm going to make this

very short. But I do want to throw out -- I wanted to come up anyhow because I think John made reference to it and I just want to support it. We were talking earlier and we kind of talked about frivolous claims that maybe did not have merit. And just two things that I've encountered with this program and just want to outline.

In this program, if a worker files a claim and that claim is accepted, that worker is generally entitled to medical as of the date of the filing of the claim. And therefore many claimants are encouraged or realize that they need to file those claims even before they have a diagnosis that is work related because that's the only way they will get all of their medicals paid for.

The situation we see most often is with skin cancer. If a worker waits until after the skin cancer has been removed and they're told they have cancer to file their claim, when that claim is accepted, they will not be paid for all

the surgery that was done before the filing. So we often find that many people will rush to file their claim even before they have a diagnosis just because they know that's the best way to be entitled to medicals.

The second is that many claimants thinking that this program is similar to RECA ask for a list of covered illnesses. And especially -- well, under Part E, there is no list of covered illnesses. So we often find that when people go to the Resource Center or come to my office to say, is my illness covered? The answer is, we cannot tell you now, file a claim and it will be determined, so that very often, people will file claims just because they know they have an illness.

They don't know whether it's going to be covered or not. But filing the claim is the only way for them to find out if that illness will be covered. So a lot of these claims will turn up to be un-meritorious in the end. But filing the claim was the only way for the

claimant to find that out.

If you have any questions.

CHAIR MARKOWITZ: Any questions or comments?

MR. NELSON: Well, thank you very much for this opportunity.

MEMBER REDLICH: I guess just from your perspective, are there problem areas that you think that we have not touched on that we should be addressing?

MR. NELSON: I think for the most part you've touched on the main issues. One issue that I've kind of talked to some people about and just one I just like to hear -- I mean, I don't know if the Board as a whole but just somebody who has expertise in this area.

An issue we see is with firefighters and other first responders and the types of illness -- the types of toxins they may be exposed to in the course of their employment. That very often I'm encountering cases where firefighters will say, SEM does not show that

they were exposed to any particular toxin or doesn't show all of the buildings and all of the accidents that they went to.

And I think what has really pushed this issue forward is the work that was done with 9/11 where you do have these programs now where they are covering first responders for specific illnesses. And in this conversation today, I'm understanding that certain states have begun to start presumptions for first responders. And I think that the first responders in this program, hearing about those programs, are starting to ask why something like that is not done for them.

MEMBER POPE: I just wanted to thank you, Malcolm, and your office for the work that you do. I know there's a lot of folks out there sick and dying or have already passed away. And it must be an extreme burden on them to try to navigate through that process. And having folks like you -- people like you and your office to provide that support and help is certainly appreciated.

MR. NELSON: Thank you very much.

MEMBER POPE: Thank you.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: Yes, I want to second that and particularly commend the report that you put out annually. I think it's a greatly underused resource for this Board. The new board members might really want to look at a few of the recent ombudsman reports. And it'll be like deja vu for this meeting.

MR. NELSON: Thank you very much. One other thing I will say it happened last year, some of the meetings, especially during the public comment that some of the people will come. And as opposed to having issues that the Board can directly address, they may have more complaints or grievances. And I just want to let you know that my office is always here and more than happy to assist those people. So feel free to refer them to us either at that time or later. But we will always be more than happy to assist any of the people who come to the Board with

complaints or grievances. Thank you very much.

CHAIR MARKOWITZ: Thank you. So I'd just like to make an editorial comment that we accidentally used the word "frivolous" in relation to claims. And I think it's unwise for the Board to refer, accidentally or otherwise, to claims as frivolous.

People do the best they can in submitting their claims in the former work program. We realize that we've seen a lot of people at a lot of sites where there are also construction and certainly people from the community now. People don't really have any access and still don't have access to occupational health, occupational medicine, doctors. You talk about well rationalized reports. They can't get them because those doctors don't even exist. And frankly, the primary care doctors aren't knowledgeable enough to provide that kind of input.

So people make the best decisions they can based on what they know. And what they've

known for decades is a relative vacuum because that information, they haven't been told about what they were exposed to. And the health care system didn't really help them in understanding that.

So people do the best they can based on what they're able to do. So some claims may or may not end up being meritorious or being accepted, but so be it. It certainly doesn't mean that those claims were frivolous. So I'll leave it at that and introduce Greg Lewis from the Department of Energy.

MR. LEWIS: All right. Good afternoon, everyone. I guess I'll just go through our role fairly quickly. I could talk for an extended period of time. Usually, I do --

CHAIR MARKOWITZ: No, do it quickly.

MR. LEWIS: -- this about 30 or 45 minutes. But I can go quick.

(Laughter.)

MR. LEWIS: And you all can stop me and ask questions or ask questions at the end if

you like. So again, I'm Greg Lewis. I'm with the Office of Workers Screening and Compensation Support at DOE which is a part of the Office of Health and Safety.

So in addition to the compensation program, I provide records for EEOICPA. We also do the former worker medical screening program, support that. And then the larger Office of Health and Safety does policy and some oversight and some international health programs for DOE. So they do a number of things within health and safety.

So for the compensation program, what we do essentially is provide records. We do that in a few different ways, but we provide records. That is our role mostly for individual claims. So when someone files a claim, Department of Labor or if they refer it over to NIOSH, both of those agencies are going to take a look at that claim, figure out where the person says they worked, and send a request over to DOE for that person's record.

We also work with both DOL and NIOSH on a large scale site characterization projects. So that's the big one for DOL, of course, back in the '07, '08, '09 time frame. We worked with them and put together the initial work with DOL, I should say, and put together the initial site exposure matrix. And then since then, input they've gotten or when they're trying to fill in gaps, they come to us for assistance or for verification of what they're hearing. So we've helped add to the SEM over the years.

So we do this. We're set up -- each site -- each DOE site has a site point of contact for EEOICPA to basically manage the program. And in fact, directly behind me is Gail Splett is our site point contact for the Hanford site -- Hanford and PNNL.

These folks are really what makes this program run. They're the ones who have contacts within their site. They're the ones who have developed the search procedure when NIOSH and DOL come in to do research. They're the ones who

facilitate that, bring in site experts to interview, sometimes help arrange for site retirees to come back on site and provide information. They set up the site tours that I know you were discussing. And I know we'll be looking for Savannah River, so we'll be working on that. So the site POCs is really kind of run things out in the field.

Now how we respond to records, for the individual request, we initially respond to the employment verification. So it's all for the same person, but we'll kind of break it up into three different types of request. So first we'll get an employment verification. That's just kind of for the basic HR. And so did the person work there, for how long, what job titles, that kind of thing. So those are kind of shorter and faster.

We'll also, if it's a Part B case, refer it over to NIOSH. NIOSH will ask us for the radiation monitoring information. And then we'll get what we call the DAR. So you guys are

probably -- most of the ones who've been on the board before certainly are familiar with that. And those that aren't, I'm sure you'll see that.

The DAR stands for document acquisition request. So it's kind of just a generic acronym that we came up with back in the early days of the program. But what it is, that's basically everything that has that employee's name on it on site that we can find. Any type of exposure record, first we'll have the full HR file, medical records, industrial hygiene if we have it, radiological monitoring records, incident and accident reports, and anything else we have basically linked to that individual.

And for each individual, I mean, typically we will have to go to a number of different locations, but sources I guess I should say for that record. Particularly if it's a long-term career employee, been there many, many years. The contractor could've changed on site. The records management practices could've changed on site.

So for one employee, even for -- let's say for radiological monitoring. For the early years, we might have to go to a collection of microfilm or microfiche. Then it might be -- or actually I should say the early, early years, it might be paper, then it might be microfilm-microfiche, then it might be some early forms of electronic records, a database. They might've updated their database, move to a different platform.

So we might have to go to four or five different sources just for one individual's dosimetry records or radiological monitoring records. So it's a little bit complex how we have to put this together. But with our POCs, we're typically able to do that even though we have to go to a number of sources.

We handle -- just to give you some basic numbers, we do about 17,000 records request a year. And again, that's between the three types, so that's not 17,000 people. You can kind of roughly divide that by three, although it's a

little more because not everyone gets all three types so to get the number of people.

Our DARs average, somewhere between 150 and 200 pages. I mean, we have exact numbers of the page counts. But some of the information in there is duplicative because we might have an employment verification plus the HR file or the NIOSH dosimetry records in there. So it's hard. But we may be double counting a little bit. So the actual number is something like 230 pages per DAR. But some of that stuff is duplicative. So I would say it's about 150 to 200 pages is average for the DARs that we provide.

But again, it's just that. For a 30-year employee, we've seen files over 3,000 pages for one individual. But for subcontractors, particularly building trades are very tough. They may have been on site off and on for years and we may be able to find very little unfortunately. So it really does vary, but that's just an average to give you an idea.

And then in terms of timeliness, we've

made a deal with NIOSH to get to these requests within 60 days. On average, we do that in 34 days. That's for all of the different requests. The EVs are a little quicker. The DARs may take a little longer.

And then certainly sites have a variation between them. Some are faster, some are slower depending on how the records are organized and how many are digitized, that kind of thing. But I think last year, we were able to get, I think, 97 percent of all responses to DOL and NIOSH in the under 60-day time frame.

So I think in a nutshell that's the quick version. But I'd be happy to answer any questions.

CHAIR MARKOWITZ: So when the CE makes a request, on average, how long does it take before they get the records from DOE?

MR. LEWIS: The average is 34 days. And again, that's done through -- and I probably should've mentioned this. But we've set up we call our SERT system, Secure Electronic Records

Transfer system. So it's an online platform accessible by NIOSH, DOL, and DOE. But it's encrypted per all of the government requirements because of the high volume of PII for some information, medical information in there.

So all three agencies can access this system. And so when a CE goes into that system, uploads a request, and they could be sending it to five different DOE sites, one different DOE site, or ten different sites. It doesn't really matter. They kind of select wherever they want. As soon as they hit send, if they send it to Hanford, Gail or one of Gail's staff members on their computer email pops up, it says, you have a claim waiting in SERT. And that clock starts going.

So this is 34 days, not business days, not work days, not whatever. So in terms of how many work days, it's a little bit different. But again, a claimant doesn't really care about work days. They care about the time. So it's 34 days is the average.

CHAIR MARKOWITZ: Thank you. Any other -- Dr. Redlich?

MEMBER REDLICH: No, just the same question. Are there any issues that we could address that you think would be helpful? Or what do you see as some potential problems or areas to improve?

MR. LEWIS: From DOE's perspective, this program is run by DOL. So we make it our business to make sure that we are getting the right records to DOL and NIOSH as fast as possible. And they're our client I guess you could say for this program. In terms of how they adjudicate claims and things like that, that's definitely not our charge.

CHAIR MARKOWITZ: Other questions or comments? Dr. Silver?

MEMBER SILVER: So when you hear about several hundred boxes or several thousand boxes at particular sites that the advocates feel would be useful and they're not being systematically accessed and reviewed, does that fit within your

gambit?

MR. LEWIS: Absolutely. I will also -- we've had many occasions where collections were, quote-unquote, "discovered". For whatever reason a collection was labeled something, and when either DOE was in there looking for something or oftentimes NIOSH actually because of their Special Exposure Cohort research, they're probably the biggest user I would say at many sites of their older project files.

If they get in there and find that it's not what the label said it was or, oh, well, this is useful stuff even though you wouldn't think so. We have, many times, gone in there and tried to index the records or get them into a fashion that we can access and respond to claims. And then, of course, if we find such a collection, we will go back to DOL and NIOSH for past names and say, hey, we may need to work with you, DOL, on past denied claims to see if this particular records collection is valuable.

Sometimes it's records from the '70s.

So we'd say, okay, denied claims with employment during the '70s. Resend us a list and we'll get you these records, without knowing the specifics and having talked to you about any particular case.

MEMBER SILVER: I remember that Los Alamos County had a Quonset hut with records from the old hospital which was sort of under the lab's administration. Was it highly unusual to have this solution come partly from the congressman's office? Are you able to solve most of these problems without congressional intervention?

MR. LEWIS: That was a real unique case I will tell you. Because again most of the records that we find are DOE records in DOE possession. Those records, because Los Alamos was a closed city to beginning with, the hospital in Los Alamos was actually a part of the lab for many years. And then they kind of -- they separated at some point. But the medical records for the lab workers just stayed at the lab. They

probably should have gone to DOE back in I think it was mid-60s if I'm remembering correctly. It's been a while since we -- it's been about ten years since we did that project.

But in the mid-60s, I think the records should have just gone back to DOE. But for whatever reason, the stayed at the hospital and somehow ended up in a Quonset hut that was owned by the hospital and used for kind of auxiliary record storage.

So because they weren't DOE records, it was fairly complicated. I think we ended up having to enter into some kind of contract with the hospital to -- they had to go in and decontaminate these records because there was concerns about Hantavirus, mold. I guess this Quonset hut was leaking and just a holy mess.

So we ended up having to enter into the contract with the medical center to do this. And it was I think somewhere around a million dollars I want to say, I don't know the exact number, to clean these records up, get them in

the right condition, and transfer them over to DOE. So yes, most of the time we do not have interaction with any congressional office on projects like this. But that was a project, very different.

But we were able to -- that is one example. We were able to get those records, clean them up, organize them. And when claims come in for Los Alamos, that's one of the collections that's checked for records.

CHAIR MARKOWITZ: Any other questions then? Well, thank you very much especially on the spur of the moment.

MR. LEWIS: At any time. I'd be happy to answer questions anytime.

CHAIR MARKOWITZ: Okay. Thank you. So let's get back to our discussion about new issues for the Board. We could just walk through our tasks and see if any of those tasks raise issues. The first is the Site Exposure Matrices. Any questions or issues that we haven't so far discussed? I'm curious about the whole issue of

aggravation and contribution because we were told that the SEM doesn't address that. The SEM has causation, right, disease exposure links.

And so the claims examiner is thinking about aggravation contribution in addition to causation. So how do they do that? What resource do they rely on? Their job is to develop a statement of accepted facts. And how do they make their judgment about aggravation and contribution? And it's not easy issue because most compensation systems don't really deal with this to a generous standard in a law. And I'm wondering if anybody had any thoughts on how we might see whether it's being done.

So I think that what we can do is ask DOL actually how they address issues of aggravation and contribution. I mean, it's in the asthma presumption, the recognition of that. Perhaps not in the COPD presumption, but I don't know that it's in any other presumptions because they usually focus on causation, but --

MEMBER REDLICH: It looks when someone

is asked a question, like a contract physician, if they're asked, could this cause -- sort of they're all lumped together.

CHAIR MARKOWITZ: Right, right, right. Yes, it's not in any point in process whether actually a condition is identified as an issue of aggravation contribution as opposed to causation.

MEMBER REDLICH: And for something like asthma, there is a much larger list of exposures that can trigger preexisting asthma. Or I'd say there's a larger literature on substances can trigger preexisting than cause new asthma. And so one does think about those as somewhat different processes. But I suspect that for most of these conditions, it's just being considered the same.

CHAIR MARKOWITZ: I mean, we come up with -- the thing about chronic kidney disease, this may well be initiated or largely caused by diabetes or hypertension. But there could easily be workplace contribution or aggravation to kidney disease, less so with cancer. And I'm not

sure about neurologic conditions actually.

MEMBER REDLICH: Look for pulmonary then.

CHAIR MARKOWITZ: Right, right.

MEMBER DEMENT: But indirectly, they are considering contribution when you start talking about things like lung cancer and COPD. Because we know one of the major causes of smoking, it's not into the mix here. And we know that smoking will contribute to those risks. So they are considering, at least in my view, the occupational contribution of the disease.

CHAIR MARKOWITZ: Right.

MEMBER DEMENT: And not necessarily a single causation.

CHAIR MARKOWITZ: Right, right. And that's where contribution and causation have merged, right? Something multifactorial has multiple causes. And so for the new members, we've been told previously that actually smoking is not -- the CEs and the CMCs are not really permitted to factor the issue of smoking in terms

of their determination about the work relatedness of the exposures which is interesting.

But I think I will formulate a question. And Carrie, if you could write this down, a query for a written response to the issue of how the program addresses issues of aggravation and contribution which actually goes to the task of medical guidance for claims examiners. Were there any other issues on that topic actually that we want to think about?

The third task is evidentiary requirements for claims under Subtitle D, lung disease. The first board spent a lot of time on this, and we're not discussing COPD or looking at claims for COPD. That's not a Part D condition. It's just silicosis and chronic beryllium disease. But were there any other issues? Is there any issues that we wanted to think about or revisit in terms of Part D?

MEMBER REDLICH: I think one is we did go through -- we had been given a number of specific documents that we had gone through and

addressed. And I think it would just be helpful to know what the DOL has decided, if they agree or disagree just so we know where we stand on those. And if they had decided to modify. So I think it would just be helpful if they go through and respond eventually. It was just a more general statement that they were considering for responses.

CHAIR MARKOWITZ: So Carrie, if we could set that as an action item. Do you know what we're talking about, Carrie?

MEMBER REDLICH: I can. It's the long response that we gave. Because at the very first meeting, there were maybe 20 specific questions that were addressed related to Part D conditions.

CHAIR MARKOWITZ: Right. So we just want the Department's reaction to that.

MEMBER REDLICH: Yes, I just think if it's -- and the reason.

CHAIR MARKOWITZ: And task four is we discussed the work of the industrial hygienist. Actually, it says any staff positions or any

consulting positions. But the staff positions, really, I think that's Dr. Armstrong. And if you want to look at his work, all we need to do I think is to look at the audits that he conducts. I don't know that he has any other work product for us to examine actually. Do you know? Okay.

MEMBER SILVER: On Dr. Armstrong if I may, I've heard of a recurring symptom that some of the physicians would like to have more interaction just to get a physician's perspective on how the program is running from the inside. Am I misreading that? I thought I heard it at the last few meetings.

CHAIR MARKOWITZ: No, no. And in fact, it's an action item that we're going to request that he participate in our next face-to-face meeting. He may not be available to appear wherever we are. But at least he could be there by phone and present his work and entertain questions.

MEMBER REDLICH: Has he been in the same position the whole time?

CHAIR MARKOWITZ: The last year-plus.

MEMBER CASSANO: They didn't have a position for a while, and then he's been here for a year. We had a phone call. I don't know if it was a subcommittee. There was a phone call with him last year. I can't remember if it was a subcommittee.

MR. FITZGERALD: Yes, it was a subcommittee. I'm not sure which one.

MEMBER CASSANO: And I remember I was on the phone call. And I don't even remember what the subject was at this point. So he has, but I think he has to be requested.

CHAIR MARKOWITZ: I would also like to request the toxicology reports. It was mentioned in the procedure manual that questions are addressed to an in-house toxicologist who reviews the relevant literature and comes up with a decision. And if -- whatever recent time period, say over the last 12 months, if we can just take a look at those reports.

If they contain personal information,

obviously we want them redacted. But there's the reference to this. It's in the procedure manual, and I think we should take a look at what they look like. And the same thing with looking at the work of industrial hygienist at the contract positions.

MEMBER REDLICH: Is there a sort of head industrial hygienist to oversee the others or --

CHAIR MARKOWITZ: So it discussed two IHs in house. And I think Dr. Stokes is the in-house toxicologist. Is that right as far as you know?

MR. FITZGERALD: I think that they mentioned that there would be contract status.

CHAIR MARKOWITZ: Okay. I'm interested in the in-house tox reports.

MEMBER REDLICH: Do they then supervise the external industrial hygienists or --

CHAIR MARKOWITZ: Yes, and I don't know if 'supervise' is the right word.

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: They probably monitor the work --

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: -- on the outside. We'll get a better sense when we look at the projects. Okay. And maybe all I have -- so we're going to go back to the two requests from DOL. But are there any other issues or questions?

MEMBER REDLICH: The one that had come up before is if we have identified cases that we've had questions about how it was communicated, whether there was any process for those to be reviewed or what.

CHAIR MARKOWITZ: And I think we got a verbal answer, but I don't recall what it was. So let's re-ask the question.

MEMBER REDLICH: Well, I think at one point we were requesting to provide a list of those cases. But I wasn't really clear as I understand it. So maybe we should get some

clarification.

CHAIR MARKOWITZ: Okay. So let's go back to two additional requests from Department of Labor. One has to do with addressing radiologic outcomes of radioactive materials. And it's essentially the doctor reviews on these and characterized the appropriate health outcomes, the status of knowledge in relation to I think we've got five or six different agents.

I suppose this is an appropriate request. I think we decided to do number two, medical evidence. But in any case, there's a fair amount of work. I know this kind of work that the Department program should have the in-house capability of doing which is not to say that the Board wouldn't assist. But it's part of the reason why we recommend that enhanced capacity.

And so the question is whether we have the resources in doing the work. So the floor is open. Dr. Silver?

MEMBER SILVER: I think we could be of

service to them if we gently rewrote this. Substances are not radiogenic. Diseases are radiogenic. That's one point. Okay. And this would imply there is such a thing as cold non-radioactive plutonium that has toxic effects separate from its radioactive -- and it would imply the same for americium. And I'm not sure that's true. Are there cold plutonium and americium isotopes? Those may be decaying to something pretty quickly.

I think what they were driving at is my interest and I don't want to impose on this. But does radiation cause noncancerous conditions that might be covered by it? So those are two interrelated issues, and Ms. Leiton acknowledged that the latter one was within the scope. But just the way this first one is written I think would confuse their in-house toxicologist. Bring it on if I'm wrong.

MEMBER CASSANO: I thought the question was about chemical effects of radioactive materials such as what does uranium

as a chemical do rather than just the noncancerous effects of radiation which actually I think belongs more at the radiation board than this board. The second part, the chemical part probably does belong.

MEMBER SILVER: Sure. There's depleted uranium and its chemical toxicity is a big issue. But anyone heard of depleted americium or depleted plutonium? I don't really think that's where the money is. I think the money is on the non-cancer effects of the radionuclides. So my view is this needs to be re-conceptualized but maybe not.

CHAIR MARKOWITZ: So after it's re-conceptualized, what's the level of interest in providing some concern? And by the way, I would say that if you don't feel capable of doing it now, it doesn't mean six months from now we couldn't entertain a request. In the first board, there was a considerable -- a greater number of requests. And we got to many of them but not all of them right away. And we didn't

get to all of them actually. Does anybody want to work on this? Okay.

MEMBER SILVER: I'd be interested in 2.0 perhaps. Let's see how it comes out. I'd be happy to redirect this and see if that's what they really want.

CHAIR MARKOWITZ: Okay. So yes, that'd be good. If you could actually send out the questions, what the actual request is and clarification of the request.

MEMBER SILVER: And is there anyone remotely interested who would look at my redirect before it goes to the whole board?

MEMBER CASSANO: I'll look at it.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: I'll look at it. I'll look at it after Tori looks at it. Okay, okay. And I think realistically it looks like we're not going to take on this issue at the moment. We don't want to hold off DOL in case they want to otherwise pursue it. But we'll keep it somewhere on the burner for further

consideration again.

Now as a fourth issue they asked us to consider which is looking at health effect aliases. And actually, when they raised this with me last week on the phone, I asked the question either on the phone or email, I can't remember, but how many are we talking about? I mean, how much work would we be signing up for?

MEMBER CASSANO: It's a pretty extensive list. I mean, it's behemoth I think. And more I think medical lexicographer would be a better person to do that than us. I mean, there's no way. I just went and I did a google search. I said, what are synonyms for chronic renal failure, and I got nothing. So I wouldn't even know how to start.

CHAIR MARKOWITZ: So what I'll do is frame a clarifying question so we understand the burden of the work. And then we can reconsider it.

MEMBER BERENJI: I mean, that would have to come with some additional support because

that's a pretty extensive task to do.

CHAIR MARKOWITZ: Yes. Well, let's see what the ask is on that one.

MEMBER BERENJI: I mean, we know what the ask is. It's just that what kind of supports do we want to look at. If we can identify medical librarian or someone who is well versed in doing searches to have someone like that as part of the offer, I think that would be reasonable. To do this without any sort of support is just --

CHAIR MARKOWITZ: Okay. So we can ask at the same time whether support might be available.

MEMBER MIKULSKI: Another idea might to be ask if it's possible actually to merit aliases. I'm sure that there are some aliases, that there is a certainty, no question. But there are some that might be worth looking into and maybe that's a more manageable task.

MEMBER BERENJI: That was my original impression that they wanted us to focus on NEMA.

Then I looked at the actual questions and, like, oh, my God. They want us to look at everything.

MEMBER CASSANO: This is another area we're seeing what the more common claims are might also direct efforts. I think what scares me -- it may be helpful. What scares me is if we do somehow come up with a list of aliases, I'm afraid that if it doesn't show up on the list, then it gets tossed somehow. And really if somebody is concerned about whether chronic renal insufficiency or end stage renal disease is the same as chronic kidney disease, then you look it up and see what the disease is.

MEMBER BERENJI: But see, they don't want to look it up. That requires more work.

MEMBER CASSANO: I mean, I don't know every disease out there in the book. I mean, I see diseases that are sent to me all the time that I'm like I don't know anything about this. And you find out what it is.

CHAIR MARKOWITZ: That's why you should ask Google.

(Laughter.)

MEMBER CASSANO: That's been very helpful.

CHAIR MARKOWITZ: Okay. Dr. Silver?

MEMBER SILVER: It's really a medical history project too because some of the medical records may have been generated in the late '40s. What were they calling these conditions then?

CHAIR MARKOWITZ: Okay. So any another other items? I guess we still need to discuss a little bit about the next board meeting.

MEMBER POPE: Dr. Markowitz, do you want to talk about the public comments?

CHAIR MARKOWITZ: Right. So was that the public comments from last night or just sort of, in general, how do we approach it?

MEMBER POPE: Right.

CHAIR MARKOWITZ: So the question is how do we hear other people say but it's a segregated session, right? It's not at the time we're discussing that issue. So it's hard to

remember to come back to that issue or to integrate it into our discussion. So the question is how can we do that? The comments that we think, oh, we should be talking about that, considering that, asking questions about that. How do we remember to inject that into our discussions?

MEMBER DEMENT: I thought Carrie had a spreadsheet that she put together.

MEMBER REDLICH: I had one. I have it updated for what we had last night. I'll give it to you.

MEMBER DEMENT: Which I thought was very useful.

CHAIR MARKOWITZ: So you read it?

MEMBER DEMENT: No, the ones prior.

MEMBER POPE: I think I recall that we had a meeting in Washington. It was after we had visited the Hanford site. And the public comment session after that, there was a conversation about one of the claimants had expressed some type of disease that they had. And there was

some discussion about that and I hadn't heard it before. And it was quite interesting to see.

CHAIR MARKOWITZ: So the question is I mean it's yet another thing to read with the spreadsheet. I know it's very useful, but it's another thing to read in preparation with the other documents we read for any given meeting. To me, it's useful. The question still is how to integrate the relevant concerns into our conversation. And I'm starting to think of a mechanism that we can -- kind of a reminder mechanism that we can use to do that. Dr. Silver?

MEMBER SILVER: We tend to have a mid-meeting break. In person, it's our lunch break. I just wonder if we could have a brief segment where we put up the spreadsheet of public comments and ask at that moment whether there anything we discussed in the morning bears on public comment and look ahead to see if anything on the agenda in the afternoon bears on the public comments just as a little reminder to

ourselves.

CHAIR MARKOWITZ: So we could actually use that spreadsheet as a summary, project it and just have a brief review?

MEMBER SILVER: Yes.

CHAIR MARKOWITZ: That's a good idea. So should we try that next time? And that can include comments from, say, the session yesterday. Also if any letters or comments come in between now and the next meeting, we could include those as well. So there's an action item for you. Okay.

So in terms of the next meeting. So normally we have two in-person meetings a year which would put the next one within probably March or April. I actually haven't looked through the number of claims yet by site to see where. What I looked at whatever a year ago, I think it was Savannah River. But we're just walking down the list and hopefully someday we'll get to Portsmouth which I'm sure we will, but --

MEMBER REDLICH: Are there any sites

in Hawaii?

(Laughter.)

CHAIR MARKOWITZ: Greg, any DOE sites in Hawaii?

MR. LEWIS: Yes, but it will take you awhile if you're going by size.

CHAIR MARKOWITZ: Oh, we could add other criteria. I think some of the early DOE research was done in Manhattan. How about that?

(Simultaneous speaking.)

CHAIR MARKOWITZ: And normally these meetings are two days, although sometimes we try to cut them a little short to accommodate people's travel so as to not take up too many days of people's time. And here before we've been able to offer an optional one-day tour usually the day before the -- always the day before the meeting.

So we'll try to replicate that. The tradeoff in shortening the full two-day meeting is we may or may not get to all the items. It hasn't really been a problem I think. Maybe

Hanford may have been a little time rush, but otherwise we were okay.

But we will descend around times for meetings in the not distant future actually and the location so that you can get them on your calendars to see if there are any conflicts. Are there any other issues around scheduling meetings?

MR. FITZGERALD: Just have to look at holidays. I don't think much will be an issue this year. Sometimes it's an issue.

CHAIR MARKOWITZ: So we're going send around a list after this meeting of the things that we agreed to work on with people's names attached to it. And we're going to try to send out time frames around that.

If we decide we need a full board meeting by telephone between now and April, that would be a two or three or four-hour meeting at most. But the advantage of that is it allows us to move on some items that otherwise would have to wait an additional couple of months. But

remember that takes six weeks at least to schedule, so we're talking January. We'll have it at the second half of January at the earliest.

MEMBER BERENJI: To schedule a board meeting, like a teleconference?

CHAIR MARKOWITZ: Yes. It requires six weeks lead time in the Federal Register to announce the meeting. Okay. Well, if there are not other comments and questions, then I think we're at the close of business. Any parting words, Doug?

MR. FITZGERALD: I just want to thank everybody for their time and dedication to the mission of the Board. And we covered a lot of territory today.

CHAIR MARKOWITZ: And I thank Kevin and Carrie and everybody else who helped us produce this meeting and for all their work.

(Applause.)

CHAIR MARKOWITZ: Mr. Nelson and Ms. Leiton and Mr. Lewis for coming.

(Applause.)

CHAIR MARKOWITZ: And thanks to Mr. Vance in being very flexible and fully loquacious in all of his responses. And then for the public who came here as well. I know you came from some considerable distance, so thank you very much for coming.

MR. FITZGERALD: The meeting is adjourned.

(Whereupon, the above-entitled matter went off the record at 3:48 p.m.)