U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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WEDNESDAY
NOVEMBER 15, 2023

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The Advisory Board met at the Eldorado Hotel & Spa, Zia Boardrooms, 309 W San Francisco Street, Santa Fe, New Mexico, at 9:00 a.m., Steven Markowitz, Chair, presiding.

SCIENTIFIC COMMUNITY

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

MEDICAL COMMUNITY

MARIANNE CLOEREN
STEVEN MARKOWITZ, Chair
MAREK MIKULSKI
KEVIN VLAHOVICH

CLAIMANT COMMUNITY

JIM H. KEY
GAIL SPLETT
KIRK DOMINA

DESIGNATED FEDERAL OFFICIAL

RYAN JANSEN

ALSO PRESENT

KEVIN BIRD, SIDEM
D'LANIE BLAZE, CORE Advocacy for Nuclear & Aerospace Workers
SOPHIA CALBAZA, DOL
AMANDA FALLON, DOL
TYLER GREEN, DOL
DEB JERISON, Energy Employees Claimant Assistance Project
REGINA GRIEGO-KELLEHER, DOE
GREG LEWIS, DOE
MATT MILLER, Field Representative, Congresswoman Teresa Leger Fernandez
RACHEL POND, DOL
CARRIE RHOADS, DOL
TONYA TAYLOR, DOL
PETER TURCIC, Paragon*
JOHN VANCE, DOL*

*Present via video-teleconference

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

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

(9:01 a.m.)

MR. JANSEN: Good morning, everyone. My name is Ryan Jansen, and I'm the Designated Federal Officer for the Department of Labor's Advisory Board on Toxic Substances and Worker Health. I would like to welcome you to today's meeting of the Advisory Board here in Santa Fe, New Mexico. Today is Wednesday, November 15th, 2023, and we are scheduled to meet from 9:00 a.m. to 5:00 p.m. Mountain Time.

At the outset, I'd like to express my appreciation for the hard work of the Board members in preparing for this meeting, and their forthcoming deliberations. I'd also like to thank Carrie Rhoads, from the Department of Labor, and Kevin Bird, our logistics contractor, who are both with me here today, for their work organizing this meeting.

The Board's website, which can be found at dol.gov/owcp/energy/regs/compliance/advisoryboard.htm, has a page

dedicated to this meeting. The page contains materials submitted to us in advance of the meeting, and will include any materials that are provided by our presenters throughout the next day and a half. There, you can also find today's agenda, as well as instructions for participating remotely in both the meeting and the public comment period later today.

If any of the virtual participants have technical difficulties during this meeting, please email us at energyadvisoryboard@dol.gov. If you are joining by Webex, please note that outside of the public comment period this afternoon, this session is for viewing only, and microphones will be muted for non-advisory Board members. So the public may listen in, but not participate in the Board's discussion during the meeting.

If you are participating remotely and wish to provide a public comment, please email energyadvisoryboard@dol.gov and request

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

The public comment period opens at 4:15 p.m. Mountain Time this afternoon. Please note that the public comment period isn't a question and answer session, but rather an opportunity for the public to provide comments about the topics being discussed and considered by the Board. If for any reason the Board members require clarification on an issue that requires participation from the public, the Board may request such information through the Chair or myself.

A transcript in meetings will be prepared from today's meeting. As the Designated Federal Officer, I see that the minutes are prepared and ensure that they are

certified by the Chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, but if they're available sooner, they'll be posted sooner. Although formal minutes will be prepared according to the regulations, we also prepare verbatim transcripts, and they should be available on the Board's website within 30 days.

During the discussions today, please speak clearly enough for the transcriber to understand. When you begin speaking, especially at the start of the meeting, make sure that you state your name so that it's clear who is saying what. I would also like to ask that our transcriber please let us know if you have trouble hearing anyone or any of the information that is being provided.

As always, I would like to remind Advisory Board members that there are some materials that have been provided to you in your capacity as special government employees

and members of the Board which are not suitable for public disclosure and cannot be shared or discussed publicly, including during this meeting. Please be aware of this throughout the discussions today and tomorrow. The materials can be discussed in a general way which does not include any personally identifiable information, or PII, such as names, addresses, or a doctor's name if we are discussing a case.

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

CHAIR MARKOWITZ: Good morning. Welcome, members of the Board, members of the public, people from the Department of Labor, people from the Department of Energy, and members of the public who are online as well.

And see Dr. Friedman-Jimenez, as you -- we can see you loud and clear. So that's excellent.

I want to thank Kevin Bird and his crew for putting this together, and of course to Ryan Jansen and Carrie Rhoads for all the preparation for this -- for today's meeting. I also want to thank -- I don't see Greg Lewis here yet, from the Department of Energy, but he arranged for us to have a tour yesterday, which was a very good tour of Los Alamos. We were lucky enough to get an excellent historian who had a lot to say, I would -- you know, and about the history, that -- particularly the early history of Los Alamos and the Manhattan Project.

And also, we had an excellent visit with the occupational medicine department at Los Alamos, which is something, actually, the Board hasn't done on previous tours. I thought that was useful. So thank you, Greg.

Let's do introductions, and then we'll quickly review the agenda. So my name is

Steven Markowitz. I'm an occupational medicine physician, epidemiologist, from City University of New York, and since 1997 have been running the former worker program, medical screening program for Department of Energy workers, now at 12 sites throughout the complex. Mark.

MEMBER CATLIN: Hi, my name is Mark Catlin. I'm a retired industrial hygienist. I spent many years working with different organizations at different DOE sites, and happy to be on the Board.

MEMBER VAN DYKE: Is that -- oh, there we go. It was already on. Good morning. My name is Mike Van Dyke. I'm an associate professor and industrial hygienist at the Colorado School of Public Health. I've spent many years doing research and working on several sites, mostly around beryllium exposure.

MEMBER CLOEREN: I'm -- I'm going to go through the same thing. You're hearing me? I'm Marianne Cloeren. I'm an occupational

medicine physician and associate professor at the University of Maryland School of Medicine. I have some background with federal compensation programs, and I guess this is my second year on the Board. Happy to be here.

MEMBER DOMINA: Good morning. My name is Kirk Domina. I'm a retired Hanford worker. I was reactor operations, nuclear chemical operator, and the employee health advocate for the bargaining agent. I was at Hanford for 38 years.

MEMBER MIKULSKI: I'm an occupational epidemiologist with the University of Iowa, Occupational and Environmental Health. I direct the former worker program for the former DOE workers from the State of Iowa.

MEMBER SPLETT: I'm Gail Splett. I've retired from the Department of Energy at the Hanford Site after 45 years. In that time, I served as a Freedom of Information Privacy Act Officer, technical information officer, litigation manager, senior records official,

and the EEOICPA program manager.

MEMBER BOWMAN: Hello, my name is Aaron Bowman. I'm a professor of toxicology at Purdue University. I'm in my second term on the Board.

MEMBER VLAHOVICH: Good morning, my name is Kevin Vlahovich. I'm an occupational medicine physician at the University of New Mexico.

MEMBER KEY: Good morning. I'm Jim Key, a 49 year plus employee at the Paducah, Kentucky Gaseous Diffusion Uranium Enrichment Facility. Having been on ground zero at the start and inception of this program, providing congressional testimony, and lobbying those in congress at the time for its passage, I look forward to the interactions of the Board members today, their insight, and how we can continue to streamline this convoluted program, correct the inaccuracies within it, and supply those claimants with the intent of Congress at its passage.

I would also like to point out to you today, or inform you, this is the anniversary of Bill -- former Department of Energy Secretary Bill Richardson's birthday. As you may know, he passed away a couple of weeks -- months ago and was very instrumental in providing the FOIA documents that created this program. The help of him, along with Dr. David Michaels and others, we wouldn't be here today if it wasn't for him. So I just wanted to bring that to your attention.

CHAIR MARKOWITZ: Thank you. Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Good morning. I'm George Friedman-Jimenez. I'm an occupational medicine physician and epidemiologist at Bellevue Hospital, New York University School of Medicine Occupational Medicine Clinic, and this is my third cycle on the Board.

CHAIR MARKOWITZ: Okay, thank you. Could we -- we have a mic for members of the

audience. If you could introduce yourselves, that'd be great.

MS. CALABAZA: Hello. Sophia Calabaza. I'm from the EEOICPA program at the Los Alamos Field Office.

MS. TAYLOR: Hi, good morning. My name is Tonya Taylor. I am a policy analyst with the ombudsman's office for the EEOICPA.

MS. FALLON: Good morning. My name is Amanda Fallon. I'm the ombudsman for the Energy Employees Occupational Illness Compensation Program.

MS. GRIEGO-KELLEHER: Good morning. I am Regina Griego-Kelleher, and I am the EEOICPA program manager for the U.S. Department of Energy.

MS. JERISON: I'm Deb Jerison with the Energy Employees Claimant Assistance Project.

MR. GREEN: Hello. I'm Tyler Green, chief of staff for OWCP.

MR. MILLER: Good morning. I'm Matt

Miller, field representative with Congresswoman Teresa Leger Fernandez.

MS. POND: Good morning. I'm Rachel Pond. I'm the director of the Energy Program of the Department of Labor.

CHAIR MARKOWITZ: Carrie, did you introduce yourself, Carrie?

MS. RHOADS: I'm Carrie Rhoads. I'm the liaison to the Board for DOL and OWCP.

CHAIR MARKOWITZ: Okay. And then we have Kevin Bird and his group that -- who largely prefer to remain anonymous. So okay. Thank you. Let's discuss the agenda. Of course, we remind ourselves, our role is to provide advice to the secretary of labor regarding the EEOICP program, in particular, their five areas in our charter, which we all know very well.

This is going to be an interesting meeting, I think, because we're going to have a lot of discussion about important topics. We're going to -- uh -- Chris Godfrey

unfortunately couldn't be here. He's the director of OWCP. Or he was here, but had to leave for a family emergency. So we're not going to receive a welcome from him, but we hope that everything works out well for him.

And we're going to hear from Ms. Rachel Pond, an update on the program. And then we're going to get into the site exposure matrices, which is, I think, actually, probably the number one task assigned to the Board if you look at our charter. And over the -- since 2016, the formation of the Board, we have recurrently discussed the site exposure matrices, but we come back in the -- to that topic in the hope of providing additional advice.

And then we're going to talk about our responses to some recommendations the Board made; two recommendations at our meeting six months ago to the Department, which we received responses to those recommendations, and we're going to discuss our responses to those

responses.

Later today, we're going to discuss -- begin the discussion about the term significance and what that means in terms of how it's described in the procedure manual and how it's used, both in the industrial hygiene analyses of claims, and presumably in the medical consultant reports as well.

The timing on all of these topics, a little bit uncertain, because it's not clear how long discussions will last. But we'll be flexible about that. And then tomorrow, we've received a request from Department to look at some new probable human carcinogens identified by the International Agency for Research on Cancer that have been worked up by Paragon, and we've been asked to weigh in on whether those should be added to the site exposure matrices. So we'll begin a discussion of that tomorrow.

And then I'll get into miscellaneous topics regarding any changes in program policies and procedures, touch on new issues.

We would like to, if there are public comments, we'd like to discuss them here, to the extent that they relate to our charter, and then develop a plan for work over the next six months before our next meeting.

So are any -- any additions or corrections or suggestions about the agenda from Board members? Okay. Great. So let me welcome Ms. Pond to the speaker's table.

MS. POND: Can everyone hear me okay? Welcome, everyone. Welcome, Board Members. Thank you again for all of the work that you do to help us with our program. There -- this is not a simple program, as you all know. There are a lot of nuances and interpretations that are required, and a lot of science that's still yet to be developed. So we really do appreciate the time and effort that you all put into the work of the Board and the assistance that you provide us.

Today I'm going to walk through just some of our updates, kind of an overview of

what we've been doing, a little bit about our policies and procedures, updates to that. And I think John Vance is on the line. He may or may not jump in. But after I talk, I will be happy to take questions before our program manager for the site exposure matrices comes on the line.

He was actually on his way here to be here in person with you, but the flights just did not cooperate all day long. He waited for flights, and they kept getting cancelled, and at the end of the day, he couldn't make it. So he will be here virtually.

So just a little update about new claims that we've had this -- it seems like we've had a little bit of an uptick in new claims in this last year, ranging about -- especially over the last couple of weeks, we've ranged about 300 new claims per week, a lot of those coming out of our New Mexico resource facility. I'm not sure what that is attributed to, but we have been able to do a lot more

outreach this year, to make people known about the program. And so that might be part of it.

We have -- cumulative total we've paid in the last -- in 2023 was $2.3 billion. Over half of that is -- goes to medical benefits. You know, with our elderly population and the rising cost -- and the costs of their care, a lot of it is home healthcare and medical, you know, other medical benefits, ancillary medical benefits. Home healthcare benefits continued to rise over the last several years. We've gone from about 9,000 unique home healthcare payments in 2021 to 12,000, over 12,000 in 2023.

And we -- as a result of these rising costs, and also just the rising benefits, we've really ramped up, in 2023, our medical benefits branch. We doubled the staff in that branch to handle all of the ancillary medical equipment and home healthcare requests that have been coming in. We've adjudicated over 54,000 claims for ancillary medical

benefits and home healthcare.

We have a new unit manager in that branch. We have a -- like, a total of six supervisory medical benefits examiners, and 52 medical benefits examiners now, which is a significant increase to what we had in the past.

And something that -- the way that the medical benefits branch works is that the claims examiners' units, which are located in the district offices, they handle all the claims that are incoming, the development steps, all the steps before adjudication. The also will handle impairment and wage loss claims for benefits that come in after.

But there's a -- kind of a maintenance period after a claim is accepted, where the medical benefits need to be managed, and we need to make sure we're approving benefits as they come in. So that's why we created this other branch, so they could focus on that piece of it and our claims staff could

focus on the incoming, making sure we're getting decisions out the door.

And then we of course have our final adjudication branch, which is made up of our hearing representatives who handle the claims for after the recommended decision before a final decision.

We actually, you know, we have a very robust operational plan, meaning we have very tight timeframes for our claim staff to follow. It's in our operational plan, it's in the Department of Labor's agency management plan to make sure that we are moving these cases as quickly as possible while still maintaining the quality. And so one of our goals is to complete initial adjudication within 145 days 92 -- 90 percent of the time -- 92 percent of the time, and we met that goal last year.

Final decisions on certain types of cases within 30 days, 99 percent. Within 75 days, again, we are at 99 percent. A lot of

our final decision processing went a lot more quickly this year, partly due to the fact that we were able to hire up a little bit more, and we were able to redistribute the claims in certain ways. Our lump sum awards have been awarded within -- 99 percent within 14 days as well.

So that's just some of our statistics. I'll talk -- I'm going to talk just a little bit about the site exposure matrices before we bring on the project manager. But there have been 33 sent data sets updated for 33 sites in 2023. Department of Labor assumes sponsorship for Paragon's -- that's the contractor's name -- security clearances from DOE.

The appearance of silicosis diseases, some were updated to better support DOL procedures. So it now is silicosis acute, silicosis complicated, and silicosis simple. And their alias is combined under the same disease name, silicosis. The public internet

accessible site was updated on June 13th, 2023, and the next update is scheduled to occur on November 16th, 2023, which is today, I believe.

Fourteen sites changed since the last update on November 16th, 2022, including significant additions to Canoga Avenue Facility, Chupadera Mesa, Climax Uranium Mill, Connecticut aircraft Nuclear Engine Laboratory, Portsmouth Gaseous Diffusion Plant, S-50 Oak Ridge Thermal Diffusion Plant, Sacandaga Facility, Savannah River Site, and Uranium Mill and Disposal South.

I also just want to talk a minute about some changes that were made to our beryllium vendor coverage. We published a Federal Register notice on September 14th, 2023, and we added a beryllium mill in Delta, Utah as a covered beryllium vendor facility. We extended coverage at beryllium mill in Delta, Utah, beryllium mine at Topaz-Spor Mountain in Utah, and Shoemaker's plant, Pennsylvania.

This was -- basically has to do with the definition of Brush-Wellman, which in the site -- in the statute itself, it just says Brush-Wellman Incorporated, and including predecessors of such entities. So we had some questions arise as to what that actually means in the last year.

And so we've clarified that by adding these particular facilities. Brush beryllium -- and we've identified these as Brush Beryllium Company, 1969 to 1971; Brush-Wellman Incorporated, 1971 to January 23rd, 2001; Brush Resources Incorporated, January 23rd, 2001, to March 8, 2011; and Materion Natural Resources Incorporated, March 8, 2011, to the present.

And was the biggest, I think, one that kind of impacted these other beryllium vendors that we've accepted, and will impact future ones if we determine that they're part of this Materion Natural Resources.

We've also made some updates with

regard to our IT, our forms initiatives. There is a medical form called the 957 medical travel refund. This is basically for individuals who travel for medical appointments and that sort of thing. And they've been able to file this form manually for years, that's now electronic.

And this'll be followed by the addition of the EN-10 and EN-11B forms for impairment and wage loss, meaning people will be able to file those now electronically, and not just through the mail.

We are also this year in the process of developing a new consequential illness form. This is something that had been suggested by the ombudsman office for DOL. It's also some -- from surveys we've received, public outcry about differentiating between an initial condition that has been filed and a new condition that is a result of that condition. And so that, I think, will be a welcome addition to our forms process, and will be coming out this year.

We are also working to add more single sign on functionality for our systems, which really doesn't impact the public or you guys, but it just means it'll be a little bit easier for our staff to sign into various systems, ECS, SEM, OIS, that sort of thing.

And we're also looking to -- we're working for the Office of Worker's Compensation Programs and their administrative officer to change the provider enrollment form, just because we've found that a lot of the providers say that it's complicated, it's over -- it's excessive.

So we're trying to -- this is not our form for energy, you know, like, ourselves. But it is an OWCP form, so based on the feedback we've received from various surveys and from providers, we are going to try and simplify that form, make it a little bit easier to understand. Again, that's something that we're working on this year.

We're also going to continue to do

more outreach to the providers to help them understand the process, and to make sure that, you know, they're aware of the benefits that we do provide, and make it as simple as possible for them to understand so that we can get people to enroll in our program, doctors. As you know, there's a difficulty for claimants sometimes to find doctors who are willing to work with us. So we're going to continue to try to reach out to them.

As -- in terms of outreach, we were fortunate enough in 2023 to be able to go out and talk to people in person, and that was something that, you know, the pandemic had prevented us from being able to do. So in 2023, we held nine joint outreach task force group town hall events, which is the events that we have with DOE, Department of Justice, and NIOSH. And that brought in about -- over 1,300 stakeholders.

In 2024, we plan to hold four joint events with the joint outreach task force

group. Those will include presentations from the various agencies, followed by Q&A, which is the way it typically is.

And then as a part of a broader strategy of targeted outreach, we're going to continue to reach out to underserved communities, locations identified through research we've done with the census bureau as having high populations of underserved communities. And we're going to prioritize those.

We also did, in fiscal year 2023, added two remote Navajo speaking caseworker positions to our resource centers as a part of our targeted outreach plan. They've -- they went to some of the -- they're going to continue to do outreach, and they can help us do translations when we do go out to the Navajo regions. And I think it's going to be a really good, big benefit to us in terms of reaching out to that community.

We're also -- in this fiscal year,

we're going to be hosting smaller in-person outreach events throughout '24. This'll include our staff, research center staff, who'll present information to provide assistance to stakeholders. We're going to work with the JOTG on some of those events, but then we're all going to kind of try to find areas where we haven't been, which is always a challenge, continue to work with Department of Energy, with their lists that they have of former workers, to reach out to these areas. And we're going to come up with a calendar in the coming months to determine exactly where we're going to be.

We're also going to continue to sponsor webinars. We -- during the pandemic, we started to do webinars, since we couldn't do outreach to the public. And these webinars are basically people who've -- can subscribe online to get emails from us about policy or various other topics. We also publicize them.

But they're to count -- they're to

provide information to anybody who's interested on medical benefits, survivorship, covered employment, impairment, wage loss, our FAB operations, various tools and resources we have available, and that sort of thing.

We also continue to do -- in the last couple of years, we've started a very robust customer experience program. We have a series of staff dedicated to this, and we do surveys throughout the year, which we'll send out to our claimant population. Sometimes we'll send out after a certain type of development was set out, or we'll send it out after they've received a certain type of medical care, or an impairment, or wage loss, to ask them how it went, what we can do better.

And we've really been able to get a lot of information out of these in terms of what we can do to improve, how we can -- you know, where we can target our resources to make the lives of the claimants and other stakeholders better. We're going to continue

to do that in fiscal year '24.

We're also going to be updating our website to be more customer friendly. You know, some people say that it's hard to navigate our website, they don't know where to find things. So we're going to continue to try to make that better. And we're continuing to do what we call journey maps, which kind of gives you an idea of where -- how the claim process goes throughout the system. We're going to do another one of those on consequential illness claims in '24.

We also have a very robust quality control plan. We have an entire unit devoted to quality control. They review various types of decisions throughout the year, meaning they will look at the FAB decisions, our final adjudication branch decisions, medical benefits decisions, and claims examiners decisions, to determine accuracy, the quality of the case, the decisions that are being written and the development letters that are being written.

And in addition to that, our -- all of our supervisors throughout the country do a very robust sampling, meaning every month, they review at least three cases a month, per CE, to see the quality of the work. It will, at the end of the day, impact their performance evaluations.

And we've continued our contract medical consultants and IH reviews. Those reviews encompass whether or not the contractor is adhering to the standards in the contract, but also whether or not our claims staff are referring claims in such a manner that it's understandable to the IH's or the CMC's who are receiving the request for information.

I'll go into a little bit of the federal procedure manual updates that we have made. In 2023, in March, we included guidance about references and links to all relevant former worker program websites. The part B silicosis, employment, and exposure criteria update for Nevada Test Site, industrial hygiene

exposure reporting language modification.

New chronic silicosis causal presumptions under part E, employment development requirements, to include cross-reference of DOE, covered facility -- they're -- I'm sorry. It's basically the -- how to cross-reference the covered facility database with this employee pathways overview document, which is a document we have for our claims staff that kind of goes into some detail about the various facilities and helps them to adjudicate their claims.

And then we are releasing, probably the end of this week, the latest procedure manual update. And that covers organ transplants as an accepted consequential condition. Claimant's eligibility for an impairment award not extinguished awaiting transplant. So it has to do with the transplants and their impairment awards.

The procedure for handling claimant delays and scheduling impairment ratings, so

we've found that for impairment ratings, claimants often times can't get a doctor very quickly who are willing to do these. So instead of just holding that case open, we're going to provide them with some options and tell them if they want to delay or defer that impairment instead of us denying it, they'll be allowed to do that for up to a period of a year. So that's in there.

There's some information about directed medical examinations, and we're also, you know, making sure that any impacted providers are provided copies of all decisions related to medical benefits that are relevant for that physician to have.

And then there's some guidance about the necessary -- where it's necessary to have a raised stamp for certain legal documents, and some follow-up actions for EN-20 forms, which is our payment forms, and how to make sure that those are getting returned. We've found that there have been a number of EN-20 forms, people

who have not returned their payment forms over periods of time.

And we've -- you know, want to make sure we're following through with those people to see -- make sure they understood that it's a payment form, that they -- if they return it, they will get money. I mean, in some cases, people don't necessarily want to complete that form because they have other conflicts like state worker's comp or tort.

But for the most part, you know, we've been seeing -- we've found that there are people that maybe just haven't been aware. So we're going to make sure that they're aware that that form we sent out is their payment form, to return it and they will get their payment.

We are also still working on the -- the Board has asked for access to our case files electronically, and we'll -- we are still, I think, in conversations with you guys about how to do that, how to make that happen,

and what it would look like. It would -- there is a ECOMP system that can get you through into our system in a way that would make it maybe easier to do overall. So we're still looking at that issue.

John, did you want to elaborate on anything that I said on the procedure manual updates?

MR. VANCE: The only thing that I would add is just on the comment on the beryllium vendor register notice, that was actually a Department of Energy publication. And that was something that we had worked with cooperatively with the Department of Energy to ensure that we had resolved a question of coverage for those beryllium vendor sites.

And I'd also like to add that for those affected cases, we have gone back to reevaluate cases that are now going to be getting coverage because of the changes, those beryllium vendor changes to the sites.

This is also something that we are

going, with regard to the presumptive standards that Rachel had mentioned, with the hearing loss and the silicosis, we're wrapping up our reevaluation of all of the potentially affected cases.

And we did that as a program to make sure that any change to those presumptions for the silicosis and the Nevada Test Site, and our hearing loss changes would also be reevaluated by the program. And I think we're wrapping that up. It's been a lot of cases looked at for the hearing loss we've reviewed. And that's all I had to add, Rachel.

MS. POND: Thank you. Questions?

CHAIR MARKOWITZ: Any Board members have questions? Go ahead, Dr. Cloeren.

MEMBER CLOEREN: Hi, Marianne Cloeren from the University of Maryland. I wanted to follow up on something you said. I wanted to make sure I understood it. The impairment ratings, the claimant is responsible for obtaining their own impairment rating exam?

Is there not an option to get a referral through the consultant network?

MS. POND: There -- yes. The claimants have a couple of options. Sometimes they want to go to their own doctor, and they know of a doctor they want to go to. And if they want -- if they choose that route, sometimes those doctors they want to go to are backed up for months. And so that's where sometimes that delay comes in.

We also will tell them, if you want to, at this point, have one of our contract medical consultants do this, you can. They would only have to go get a certain test, depending on the kind of, you know, impairment it is. But yeah, they do have the option, but often times they want to go with their own doctor.

MEMBER CLOEREN: Thanks.

MS. POND: Mm-hm.

CHAIR MARKOWITZ: Other questions? Actually, I have a few questions. So 500 -- or

excuse me, 300 new claims per week. That's 15,000 a year. So we're 23 years into EEOICPA, we're 18 years after 2005 amendment. So that's a lot of activity.

And I'm just wondering if you have a sense of what all these new claims are about. Are these previous claimants who are coming in with new conditions? Are they people whose impairment rating has changed, their health status has changed, new requests for various types of medical benefits? Any -- consequential conditions. Any sense of that?

MS. POND: Yes. I think that a lot of them are more new conditions that are being filed from the same claimants. I think there's -- that could either be consequential or another separate condition. A lot of it is from ongoing, current, existent claimants.

That said, it's hard to say, you know, where that trend's going to go. And we still are seeing new people, new claimants, just not as many. I think a lot of this is

from recurring claimants.

CHAIR MARKOWITZ: And since we're here in New Mexico, and it seems to be a lot of new claims coming out of New Mexico, do you have any sense of what that's about?

MS. POND: Maybe just the outreach that we've been doing in that area. I mean, we did come out this direction last year and did some robust outreach to the Navajo area, and we've been doing some targeted outreach that way. But that's the only thing I can really say that I would be aware of that is moving it forward or making these cases more robust. John, do you think -- can you think of anything?

MR. VANCE: Yeah, hello everyone. I should have introduced myself. My name is John Vance. I'm the policy branch chief, so I'm --

CHAIR MARKOWITZ: John --

MR. VANCE: -- actually, Rachel --

CHAIR MARKOWITZ: -- it's Steven. If you'd just speak a little bit more slowly,

because you're coming through at super speed.

MR. VANCE: Okay. Good afternoon -- well, good morning, everyone. My name is John Vance. I should have introduced myself before. I am the policy branch chief.

My research and my inquiries into this, I think, is that you have particular representatives that are serving clients, and they are driving a lot of the work, at least from my ad hoc understanding of what's going on in New Mexico.

You have a couple of, or a few representatives who are just very active in submitting new claims for their clients and actually reaching out to their previously accepted claimants to have them file for additional conditions.

CHAIR MARKOWITZ: So are these workers from Los Alamos and Sandia here in New Mexico, or are these in part from people who have retired to New Mexico, they're from other facilities and retired here? Any sense of

that?

MR. VANCE: No, no. It just is that the resource center is the one with the intake of the claim, and so that would suggest that you're dealing with individuals that have either worked in New Mexico in either mining or Los Alamos or one of the sites approximate to New Mexico.

But really don't have any clear details on the genesis of this, other than the commonality of generally this means particular authorized representatives are driving a lot of the claims.

CHAIR MARKOWITZ: So -- thanks. Ms. Pond, you mentioned quickly about accelerated silicosis, chronic silicosis, acute silicosis. I didn't quite get what you were saying there.

MS. POND: John, do you want to go into that a little bit more?

MR. VANCE: Yeah. I'll just keep coming back for it. So when you -- what we did was -- we used to have, in the site exposure

matrices, these different variants of silicosis listed out separately. What we did was we just consolidated them all under a health effect for chronic silicosis, and then used all of these other aliases to sort of define what chronic silicosis is.

So now when you go into the site exposure matrices, you should be able to see -- or you'll see that chronic silicosis is listed there, and all these subsets of it are listed as aliases. It's just a method for simplifying the research that's done for those claims.

CHAIR MARKOWITZ: And that applies to part B and part E, right?

MR. VANCE: Principally, it's --

MS. POND: It's E.

MR. VANCE: -- the change that applies to the site exposure matrices, so it's going to be part E primarily. It doesn't affect how we evaluate the part B claims, because those are really rigorously set by the statutory provisions for silicosis.

CHAIR MARKOWITZ: So the Board has never really focused much on consequential conditions. So these would be claims that come in for new ailments that are caused or somehow related, aggravated, contributed to by prior ailments that -- for which claims were submitted.

And I would imagine over time, in particular as claimants age, that consequential conditions would become more and more important. So I don't know whether this is something that the Board needs to take a closer look at or not. We've touched on it in the past.

The -- but if you could just explain why there was a need for a new consequential condition form, and who fills out that form, and what function it serves, that would be helpful.

MS. POND: Absolutely. The -- so in general, as you point out, we were getting just initial claims for new claims, new conditions,

and we were adjudicating those. And then we started seeing more claims being filed that had other conditions on there, and we couldn't always distinguish between whether that was a new condition that they're saying was related to their toxic substance exposure in the workplace, or that that was related to something we had already accepted, and they were saying it's related.

So that distinction was kind of difficult to navigate sometimes when we'd get these new claim forms in for -- under a same claimant name. And also, people were getting a little bit confused when filing these forms. They were just like well, I don't know. Do I file for a new condition? Do I just submit a letter from my doctor saying it's related and then it's accepted?

And we found we do need a new claim form, for certain legal reasons, to -- for them to file for any condition that they're going to file for. So they were being told okay, well

you still need to file a new claim form. And then the confusion into what are we developing for here, came into play.

For consequentials, it's a lot different. The process for accepting and developing a claim for consequentials is obviously a lot simpler, because we've already verified employment, we've already established causation for the other condition, that it's related to toxic substance exposure. And this is just a matter of having -- getting a report from a doctor linking that condition to the one that we've already accepted.

And so, you know, knowing right off the bat, when we get that claim in, that this is for consequential, it's going to take it down another path of review. And so making that distinction is important not only for claimants to understand, but also for our claims staff when they're getting these claims to know which direction to take it.

CHAIR MARKOWITZ: So I would assume

that a personal physician of the claimant is providing some documentation, some rationale for why this is -- the new ailment or whatever is a consequence of the prior. So are these -- do these often go the CMC for additional input, or are these usually settled at the level of the claims examiner, having had the input from the personal physician?

MS. POND: Typically, we don't -- a lot of these don't go to a CMC necessarily, unless there's some big question about the relationship between the condition and the one that we've already accepted. You know, if a doctor just says it's related and doesn't give us any other information about how or, you know, how it -- the nexus there, then we'll go back to the treating physician usually, and usually they can provide us more information. If they can't, then at some -- in some cases, we'll take it to a CMC to kind of help us determine that.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Rachel, you mentioned the outreach to the Native American. Good step forward with that -- with adding that translator, it's my understanding there's 20 other tribes and Pueblos who also need to be considered with appropriate outreach and translators of their own.

MS. POND: Yeah. We are, as I said, it's actually a focus not only of the energy program, but we have a community of practice -- we're working with other agencies across the government, we're working with other agencies within Department of Labor to determine the best way to reach out to the tribal nations across the country in various ways of -- not only for the EEOICPA, but for other ways to reach out to them and to provide them with government benefits. So thank you for that.

CHAIR MARKOWITZ: So I have another question. The reevaluation, going back and looking at prior claims from a change in policy, of the program, that's very

interesting. That sounds very challenging and extremely useful to the claimants. And you mentioned the change in the hearing loss criteria, and also the change in silicosis.

So I know you're in the midst of doing that, but I would request that the Board receive the results of the reevaluation, how many people were affected, what the outcome of the relook was for -- both for hearing loss and for silicosis, because that's very interesting.

MS. POND: We can do that. I think that, you know, it's something we do anytime that there might be a change from a denial to an acceptance. Any time the Board makes recommendations that creates new, you know, links for us, we'll go back and look at those cases. And we do the same thing with the special exposure cohorts. So we'll definitely give you the results of that.

CHAIR MARKOWITZ: Okay. Any other Board comments or questions? Mr. Catlin.

MEMBER CATLIN: Thank you, Ms.

Ponds, for the report. You mentioned a claims manager quality control program, that monthly they review a small number of claims from other claimants. Did I understand that right? If you could describe that in more detail for us.

MS. POND: Sure. We -- in the national office, we have a group of -- well, we have a branch called the performance -- it's the -- our performance management branch. And within that branch, there is a unit of quality assurance or quality review analysts. And in the last few years, three or four years, we've created this unit in order to do a second level of kind of review of individual claims.

So these reviewers are not claims examiners. They are not associated with a district office. And they will take -- every month, they take a sample of cases in each category, a sample of cases from the final adjudication branch, medical benefits units, and our claims staff. They'll look at recommended decisions, final decisions,

development letters, and letter decisions that are issued.

And they've got a list of questions that they actually use them in our quality -- we've got a database that kind of captures it all. And they'll go through a list of all the different things to look for in the development of the case, in the final decision itself. And they'll categorize each case and determine whether there were deficiencies.

And at the end of each -- actually, the claims staff is given an opportunity, the supervisors, to go back and look at those each month to say oh, I'm looking at this case to see if there's a problem, if we need to fix it, or if I disagree. At the end of each quarter, we get quarterly reports based on these analyses throughout the year to provide us with that kind of real time evaluation of the claims and the quality thereof.

We used to do what we called annual accountability reviews. So we'd get a group of

staff together once a year, we'd review a sample of cases from these various categories. But there was only, like, maybe a small amount that we were looking at each year, and it only gave us a snippet in time. So we changed the process so we could actually see what's happening within the last month, within the last quarter.

MEMBER CATLIN: Thank you. Is that -- Dr. Markowitz, is that something we've seen? I don't -- that doesn't seem like reports that we've -- that the --

MS. POND: I --

MEMBER CATLIN: -- Board has seen.

CHAIR MARKOWITZ: You know, I don't know. I don't know.

MS. POND: I'm not sure.

MEMBER CATLIN: If not, is that something -- are there summaries or reports of that that we could be reviewing?

MS. POND: I believe so. I will --

MEMBER CATLIN: Okay.

MS. POND: -- double check on that.

MEMBER CATLIN: Thank you very much.

CHAIR MARKOWITZ: Yeah, Dr. Cloeren.

MEMBER CLOEREN: I have another request, Ms. Pond. Would it be possible for us to review the questions that they're responding to? That'd --

MS. POND: Yes.

MEMBER CLOEREN: -- be helpful. Thank you.

CHAIR MARKOWITZ: Okay. Well thank you very much, Ms. Pond. Thank you, by the way, for coming here in person as well. And throughout our meeting, if you have additional comments or we have questions, feel free to participate. Thank you.

MS. POND: Absolutely. And I'll be here all day today. I am leaving tomorrow, but John will be online in the morning if you need --

CHAIR MARKOWITZ: Okay.

MS. POND: -- additional questions -

-

CHAIR MARKOWITZ: Okay.

MS. POND: -- answered. Before we go on to the project manager for the SEM, I -- no? Do you want me to move to that or --

CHAIR MARKOWITZ: No, no. I just have one comment. Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Yes, thank you. I want to raise an issue that has become clear to me over the last several years, which is sensorineural hearing loss. And I think this is a policy issue because we've had discussions on this in the past.

This is common, it's debilitating, it's preventable, it's treatable with hearing aids, which are not generally covered by medical insurance or Medicare. And it can be caused by chemical exposure to a variety of toxic substances in the SEM, as well as noise exposure, which is not in the SEM, and combined causal effect of chemicals and noise exposure, as well as other things like ototoxic drugs

that are not work-related.

But it doesn't fit easily into either the SEM, because the SEM is qualitative; it's not quantitative. And sensorineural hearing loss is really dose-dependent. It's probably related most closely to the frequency of exposure to extremely high noise levels, peak dose, in essence. It doesn't fit easily into part B because it's not ionizing radiation and it's not consistently measured. There's no individual dosimetry conducted.

So in reviewing the SEM for the chemical causes of hearing loss, which we did several years ago, it became clear to me that there were many people likely that had noise-induced hearing loss, or hearing loss due to the combined effects of noise and toxic substances.

So my question is, is there a way that this issue can be revisited? I understand that it's a legislative issue. It sort of falls between the cracks of part B and part E.

But I think that there are a lot of people that could be helped if noise-induced hearing loss combined with chemically induced hearing loss were incorporated into the program and people could at least get their hearing aids paid for.

It is debilitating, and hearing loss has been associated with cognitive loss. Whether it's causal or consequential isn't completely clear. But that's my question. Is there a way that we can revisit this, that the Board can suggest that this issue be raised to a level that it'd be discussed, and this be addressed by the occupational worker's comp program?

MS. POND: So I -- noise -- my understanding, in working with our lawyers, noise by itself is not something that's going to be covered under the statute the way it's written right now. But we do consider solvents and noise exposure together already in our policy and procedure.

And, you know, we've looked at this

over the years several times, and it's -- we do have a pretty specific way of evaluating it, based on numbers of years, based on the research we've done, based on, in fact, some of your input, the Board's input, we've changed that definition over the years.

But we are -- our hands are tied at a certain point when it comes to just noise, and we would have to have a combined with toxic substance exposure, solvents exposure with the noise. But, you know, we're always open to additional information or additional guidance that the Board may provide us on this issue.

MEMBER FRIEDMAN-JIMENEZ: So that raises the question, if someone did have purely noise-induced hearing loss, and they were a member of this program, what could they do? Could they file for worker's comp through their state where they were working, or is that precluded by their being in the OWCP? What would be their options to get some relief, and maybe get their hearing aids paid for, for

example, if it's not part of the EEOICPA program?

MS. POND: There are other options. I mean if -- just because they file for us, if we deny it, they can go to their state, they can go to their company, file for, you know, state worker's compensation, tort claims. If we do accept -- if we do end up accepting hearing loss, sensorineural hearing loss, and it is the combined, we will pay for their hearing aids.

But yeah, they're not precluded from filing in other areas. It's just there might be some offset if there's a dual benefit there.

CHAIR MARKOWITZ: This is Steven --

MEMBER FRIEDMAN-JIMENEZ: All right. So there's really no other additional action that can be taken because it's at the legislative level, and we're not prepared to go to that level. That's essentially the response?

MS. POND: I can't make those

suggestions at that level.

MEMBER FRIEDMAN-JIMENEZ: Okay. All right. I understand. Thank you.

MS. POND: Mm-hm.

CHAIR MARKOWITZ: This is Steven Markowitz. I just want to -- in 2017, the Board actually made a recommendation to the program regarding noise and solvent-related hearing loss. At that time, the requirement in the procedure manual was 10 consecutive years in a -- one or more particular list of occupations prior to 1990.

And we recommended that actually the number of years be reduced from 10 to 7, and also that the -- it not necessarily be consecutive, because it's cumulative without necessarily being consecutive. And I think we believed that the 1990 time -- date in particular seemed arbitrary.

I think -- I'm not -- I think our recommendation was largely not accepted, but there has been evolution in the program since

that time. So I think, for instance, the list of accepted occupations has been either broadened or there's been the provision that if the claimant could demonstrate that their job title was the equivalent of one or more of those on that list, in terms of noise and solvent exposure, that they would be eligible. And I think that the 1990 date has been also eliminated.

MS. POND: I believe so.

CHAIR MARKOWITZ: So I would say that the program's slowly coming our way. Having said that, I think we could revisit this. Because the issue of 10 consecutive years, again, still seems arbitrary to me. And then the question of what the minimum number of years should be. Should it be 10 or should it be less than 10?

So I would think this is fair game for the Board to relook at. Comments? Other Board members? Dr. Cloeren.

MEMBER CLOEREN: Yeah, I totally

agree. I mean, I gave a webinar on this topic about a week ago and was able to look at some of the just kind of changes in research. And I know our recommendations need to be evidence-based, and I think there may be different evidence at this point that's worth taking a look at that might help support changes in some things. Maybe the list of jobs, maybe the timing. Is that me?

MEMBER SPLETT: Gail Splett. The other concern that I had, I did enjoy Dr. Cloeren's webinar very much, was the term consecutive years. On -- at least on the Hanford Site, a lot of our electricians, for example, are subcontractors. They're onsite, they're offsite, they're onsite, they're offsite. And what did that mean, absolutely consecutive? Is it 10 years combined, or does it truly need to be consecutive?

CHAIR MARKOWITZ: Well -- Steve Markowitz. I interpret the word consecutive to mean consecutive. But that's something we

should look at again. Mr. Key.

MEMBER KEY: Yeah, I'm Jim Key. Although changes have been made based upon the Board's suggestion, we are still seeing inconsistent interpretation of the new hearing loss guidelines. The CE's are not following the new hearing loss 7.0.

CHAIR MARKOWITZ: Dr. Bowman.

MEMBER BOWMAN: Yeah. This is -- thank you, Steven. I just want to second what Marianne said, and think given the amount of time passed, it definitely would be worthwhile looking at new evidence in the literature, and looking at that, I'd be happy to be involved in something like that.

CHAIR MARKOWITZ: You know actually, sir, while we're volunteering for this, I know that Dr. Friedman-Jimenez has an abiding interest in this topic. So I'm sure he's -- would be willing to participate, Dr. Bowman. I would as well. I think I was part of that recommendation in 2017. Anyway, if other Board

members -- you don't have to now, but if you decide you want to volunteer, you would be welcome.

Other comments or questions? So let me again thank Ms. Pond. Actually, welcome, additional people who have come into the room since we started. In particular, Mr. Greg Lewis from the Department of Energy. He's head of the unit that deals with EEOICPA information issues, and also the former worker screening program.

And Greg, before I -- in your absence, I thanked you for the tour -- arranging for our tour yesterday. It was a very informative historian, and a great visit to the occupational medicine program, so thanks.

Okay. Should we move on?

MS. POND: Sorry, yes. Before we introduce the program manager for the site exposure matrices, I think Ryan was going to say a few words. And then I want to answer one

of the questions on this before we go to him, because it was really directed to us. So go ahead, Ryan.

MR. JANSEN: Yeah. Thanks, Rachel. I just wanted to briefly outline the structure for this session. So the program manager for Paragon is here to provide responses to the written questions previously submitted by the Board. And the Board can certainly ask follow-up questions of the program manger as necessary to clarify any of his responses.

However, if the Board has new questions on new topics, the Board will be able to submit those questions in writing after the meeting and receive those responses at a later date. Thank you.

MS. POND: Thank you, Ryan. I also just wanted to mention, and Dr. Markowitz, maybe we can discuss this, but he had suggested that maybe we could -- they could do a demo to small group of Board members, if you want to take that into consideration, of the SEM

itself, and kind of walk through some of that at a future date, maybe in one of your subcommittees or something like that, just to kind of give them a better understanding of the ins and outs of it.

I know you've got some demos, but it might be something you want to talk about and consider in -- just because in a smaller group and not a public meeting, if that's possible, that might be helpful to --

CHAIR MARKOWITZ: Sure. That'd be great. The offer is accepted.

MS. POND: Okay, great. The first -- before we move on, the first question just asked about the status of -- you guys had asked for certain documents, like the contract for Paragon. We are still awaiting information from our procurement people at Department of Labor.

We did follow up with them just before I got here. I will follow up with them again on Friday when I return to the -- to D.C.

to ask them about this and elevate it as necessary. I apologize for the length of time it's taken to get you an answer on that, and hope to get you something very shortly about what we can and cannot give you regarding that contract. Ms. Splett?

MEMBER SPLETT: Gail Splett. One of the things that we talked about this morning is one of the things we're not interested in in a contract are any financial arrangements --

MS. POND: Okay.

MEMBER SPLETT: -- how the contractor's paid, how they're paid, what they're paid is not really of interest to us.

MS. POND: Okay. So we can make a note of that. Okay. So without further ado, as I indicated, unfortunately he couldn't be here in person, but is on the -- online. Mr. Pete Turcic is the program manager for the site exposure matrices.

He has extensive experience with this program. As many of you may know, he used

to be the director of the energy program at Department of Labor before me. He also has extensive scientific experience over his long career at various agencies. And I will turn it over to him. Pete.

MR. TURCIC: Thank you, Rachel. Can you hear me?

MS. POND: Yes.

MR. TURCIC: Okay. Thank you. Like Rachel said, I really -- I'm sorry that I couldn't, you know, make it out there to be with you in person. It'd be a lot simpler. But United Airlines just wouldn't cooperate yesterday.

I guess I'll just go through these additional questions. The second one regarding the -- that SEM includes 132 substances with 152 disease links not in HAZMAT. And the Board is requesting that this -- for the list of those associations.

Our chemical manager put together a list for me. I just received it. Basically,

it gives you an idea of what those substances are and the links. A hundred eleven substances are tied to Parkinsonism in SEM, which is not in HAZMAT. HAZMAT does not recognize Parkinsonism, and so there were 111 substances that are tied to that disease.

The remaining of those 132 substances, there was 21 substances tied to 41 diseases that are not in HAZMAT, and those are all based on the Board's recommendation to include the IR2A links. So that's -- that is the genesis of those substances that -- and disease links that are in SEM.

And I just got that, as I said, I just got that list. I'll be submitting it to DOL, and then, you know, for response, you know, back to the Board. Any other questions on those differences?

CHAIR MARKOWITZ: Dr. Bowman.

MEMBER BOWMAN: Yes. This is Aaron Bowman. I just -- I obviously will wait until we get the actual list. But of the 111 that

are tied to Parkinsonism, which seems very reasonable, there are actually a large number of chemicals tied to Parkinsonism, could you talk to me about sort of the timing of when those got added and the rationale, just like you just did for the IR related --

MR. TURCIC: Yeah. The rationale for that was based on, as you know, HAZMAT does not recognize Parkinsonism. And at DOL's direction, Parkinsonism was going to be recognized and linked. And so we went through and tied 111 substances to Parkinsonism.

MS. POND: And this is Rachel. Just to clarify, our toxicologist did some research on that, and we had various -- and that was part of the reason.

MR. TURCIC: Yeah.

MEMBER BOWMAN: And just sort of the timing on that.

MS. POND: We'd have to go back and look at the exact time when those were added. I don't have that off the top of my head.

Pete, you don't either, I'm assuming.

MR. TURCIC: No, I don't know exactly. It was quite a while ago.

MS. POND: Yeah. It's been a while.

MEMBER BOWMAN: That's fine.

CHAIR MARKOWITZ: Steve Markowitz. Excuse me. Actually, I think I remember. The Board made a recommendation around Parkinson's disease --

MS. POND: Yes.

CHAIR MARKOWITZ: And also the second set that Mr. Turcic mentioned, the IR2A carcinogens. That was June 2020. Dr. Mikulski led the group that looked at Parkinson's disease within the Board, he made a certain recommendation, and that was accepted by the program.

And so thereafter it became operational, they had to determine which particular agents would be covered. And actually, I don't think we've ever seen that list. So we welcome seeing that list. So

that's the genesis. It would have occurred -- would have happened over the past three years.

MR. TURCIC: Okay. As I said, I'm -- I just got the list, and I'll be, you know, submitting that to DOL.

MS. POND: So the --

MR. TURCIC: Any other questions?

MS. POND: Sorry. This is Rachel. Before Pete goes on, the next -- number three question you guys had was that you indicated that the SEM links for the four closure sites didn't work. And, you know, we did go back in and basically tried to reenact getting to those links, and were able to successfully use the closure links for Rocky Flats and K-25.

Again, maybe that demonstration that we've talked about can help with that. And Pete, you can add to that if you have anything to add to that.

MR. TURCIC: Yes. I just wanted to add that if -- the way it is presented in the IAS, or the internet accessible SEM, is there's

a -- up on the right-hand side, when you pull up the site, it'll say, you know, search a specific to the selected site, and like, for example, it'll say Oak Ridge Gaseous Diffusion Plant, and then below, in a -- in blue lettering would be, you know, to see the closure profile, and you just click on it for the closure from 1988 and beyond.

And then when you click on that, that brings up -- that'll bring up, in IAS, that'll bring up the closure profile for K-25, for example. And then the blue below would be -- would give a warning -- not a -- I mean an indication to return to the main Oak Ridge Gaseous Diffusion Plant profile, all pre 1988 plant operations, and 1988 to 2020 basic site services. And then you click on that and it takes you back to the operational site profile.

That may be confusing, but it is explained in the -- if you go to the guidelines that are on the public SEM, it'll explain how you go back and forth on those.

CHAIR MARKOWITZ: Okay. Thank you.

MR. TURCIC: On question four, seeing the change logs was useful. And for nondisclosure sites, it was unclear how SEM captures the changing nature of toxic substance exposures by job category buildings over time.

Here again, a demonstration would probably be the most useful. But in responding and putting together, you know, the response for that, we -- I tried to look for some examples to use as a -- to demonstrate.

And a very good example to show you what -- how things, you know, stay in SEM throughout the life cycle of a particular element, a good example is the Hanford B reactor. You know, it is now a National Historic Landmark at the Hanford site. But it was the world's first plutonium producing reactor created in the Manhattan Project.

At that building, the construction for B reactor began in 1943. And it was initially shut down at the end of 1946, but

then restarted in '48 to continue to support the production of plutonium for the Cold War, and it operated until 1967.

As I said, the B reactor is now a museum. And in fact, the Department of Energy offers public tours at it. If you go into SEM and you look at B reactor, basically what it'll show you, that there are 44 toxic substances listed as potential exposures in building 105C, which is now listed as an alias of the B reactor museum.

If you look at some of those 44 contaminants, they include things like carpet cleaners, floor strippers, floor waxes, and other commercial cleaning products that you would expect, you know, to see in something like the museum. But then there's also present a whole host of contaminants that you would expect to see at a operating reactor or a, you know, during the decommissioning and decontamination of the reactor building.

And for -- like for example, there -

- the site, the work processes, activities that are listed in that include things like asbestos assessment and abatement, cleanup equipment with solvents, decontamination and deactivation commissioning, D&D activities, museum and visitor support activities, reactor operations, and bell pit operations.

And also, you know, some of the labor categories that are there span that whole life cycle also, asbestos worker, decontamination and decommissioning worker, D&D worker, D&D operator, laborer, operator of nuclear plant, operator of nuclear process, and health physics technician.

That was just one example of what is attempted, and any information that we get that we apply to a building or a work process, that stays in SEM and does not come out. And then it's just factored in in the, you know, during the adjudication process of, you know, what contaminants may be applicable to a given labor category or work process.

There's many other examples. And I think, again, I think some demonstration may be well worth it to, you know, to show how things that people have specific questions about specific sites, in that we could go through and demonstrate and see what is in SEM now.

If we had identified a document that -- and something was added to SEM, we don't take it out when, you know, when the nature of the building changes. Any other questions on that?

CHAIR MARKOWITZ: This is Steve Markowitz. So under what circumstances do you remove information from the SEM?

MR. TURCIC: The only time we remove information is if we find information that is an obvious error. To give you an example, we recently, in the spreadsheet in the SEM display, the SEM profile for ORISE included for the labor category for the security guards, included information, the generic profile information for, you know, weapons work.

Cleaning weapons, target practice, there -- a whole -- there was a whole profile or a generic profile for weapons work.

Well, in a SEM mailbox question, and in contact with the -- with DOE at the site, we came to find out that the guards at ORISE never carried weapons. So that was one example of, you know, substances that would be removed. We don't remove things, and anything that's taken out is, you know, is coordinated with DOL.

CHAIR MARKOWITZ: Other comments, questions from Board members? Mr. Key.

MEMBER KEY: So explain to me, if you will, how we have a SEM database for the Paducah Gaseous Diffusion Plant that had its own fluorine sale operation, and when you go to that building, fluorine is not a listed chemical under it. There's no chemical relation or chemical stated for that building at all. How is that possible?

MR. TURCIC: It would depend on how -- so you're saying fluorine don't show up at

all in the -- or for the building or that work process?

MEMBER KEY: I'm sorry. I didn't understand your statement.

MR. TURCIC: If you look under the work process, would fluorine show up for that labor category?

MEMBER KEY: No, it does not.

MR. TURCIC: I would have to look into that. And which building is that?

CHAIR MARKOWITZ: Are there more comments, questions?

MR. TURCIC: Which building was it in Paducah?

MEMBER KEY: It was the C410, K, and D building.

MR. TURCIC: C4 --

MEMBER KEY: C410 -- 4, 1, zero, D, and K building.

MR. TURCIC: We'll look into that and provide a response to, you know, to DOL that they can pass it on to the Board, then.

CHAIR MARKOWITZ: So this is Steve Markowitz. I have a question.

MR. TURCIC: Sure.

CHAIR MARKOWITZ: So I think I understand closure sites and how the SEM addresses them for -- et cetera, that --

MR. TURCIC: Yeah.

CHAIR MARKOWITZ: -- there's a description of -- there's inclusion of job titles, work processes, agents, buildings, et cetera, facilities that are applicable when the site was active, and then you can --

MR. TURCIC: Mm-hm.

CHAIR MARKOWITZ: -- delineate pretty clearly the period of time when the D&D occurred and it was closed, and what the potential exposures were during that time period with associated --

MR. TURCIC: Mm-hm.

CHAIR MARKOWITZ: -- job titles and the like. So I think I get that. I'm not sure I accessed every one, but I think I get the

approach.

But what I still don't understand is all these sites evolve over time in terms of what they do, what their function is. They take on special projects during certain periods. And the SEM by and large doesn't contain dates. It doesn't really date when certain activities occurred. There might be closure dates --

MR. TURCIC: Right.

CHAIR MARKOWITZ: -- but generally speaking, there aren't dates. And I understand why there are not dates, because probably the underlying information didn't allow you to put in dates accurately, with confidence. So I get that.

But as the mission of a site, the activities, what it does evolves over the decades, I don't quite get how the SEM contains the information about how potential exposures might evolve over that period. Again, I'm not talking about closure activities. I'm talking

about a site that was active, still active for decades, in a given building, and they did one thing in the '70s and something else in the '90s. Even the same job title could change in terms of the insulators work with asbestos in the '70s, and in the '90s it was fiberglass. So how does the SEM deal with that kind of evolution?

MR. TURCIC: It -- all of the substances, SEM is basically validating that there was some document identified that some toxic substance was potentially present. So if it was present, it stays in SEM. And SEM cannot identify -- you're absolutely right about dates. There's -- that's next to an impossibility, to identify dates.

As an example, you know, there are a lot of refrigerants and things like that that changed over time, and SEM contains them all. And then during the claims process is where it is worked out what is the likelihood, you know, of some contaminant.

But like I'm saying, we -- if we document and validate a substance was present, it stays there. The example that I was talking about is a perfect example, is that reactor B. There's information in SEM today that covers that reactor B through the whole life cycle, when it was a reactor being constructed, when it was operating as a reactor, when it was decommissioned, and now that it's a museum. And that's the general principle that is applied to SEM.

Dates are -- and as you know, dates can be very misleading. For example, when a building goes into operation, that's usually the date or, you know that is in documents that something became operational. But in the DOE process, those processes were tested prior to, you know, before there was readiness reviews, things like that.

And so there were potential exposures, and that's why we put -- when we identify a potential exposure for a process or

a building or a labor category, it goes into SEM and it remains there, again, unless we find out that there was some error.

CHAIR MARKOWITZ: So by the way, another example, just to probe a little here -- and Mr. Key, I may need some help. But in the '70s, in Paducah, there was a period of time when they were undergoing major renovation, or some major redo of some -- yeah, okay. And so that was time -- that was a time-limited project, right? That occurred over whatever number, three, four, five years -- eight years. Okay. And that was in the '70s right, roughly?

And so that special process entailed -- well this is a question, actually. Would it have entailed, perhaps, different exposures than occurred otherwise, either before or after that at Paducah?

MEMBER KEY: Well, certainly, any exposures that occurred during that time, because they were tearing down and rebuilding a cascading enrichment cell, one per week. You

had three basic labor categories. They're tearing it apart and putting it back together.

This is when the 40-foot converters were cut out and lifted up above the workers, taken down a crane rail, hitting lead air, thereby producing HF where you couldn't even see the crane operator operating a crane.

And after that Sitka Cascade Improvement Project, those exposures, you know, decreased significantly. There were still some. There was still some HF exposure and equipment leaks. But by and large, during that phase of the cascade improvement process is when you had the potential and the likelihood of the greatest exposure period, with exception to the plutonium exposure that the federal investigative DOE team came into Paducah and created EEOICPA.

CHAIR MARKOWITZ: Okay. So I take it then that certain exposures might have been more intense, but SEM doesn't deal with intensity of exposure.

MR. TURCIC: Right.

CHAIR MARKOWITZ: But if there were some chemicals that were used in the eight year period that weren't used previously or thereafter, so they would be unique to that operation, that period of time at Paducah, so the question really is, then, for Mr. Turcic is so how do you deal with that in the SEM? Because Paducah operated from '53 -- yeah, '52 to '20.

MR. TURCIC: The way we deal with that is that we're always updating and getting -- if we got documents, and I'm sure if it was a major project that they probably had documents identified -- that identified that as a process, and then that information would be in SEM.

And the way we deal with that on a continuing basis is when we are trying to update all these active -- the large active sites on a five to 10 year cycle, and the way we try to do that is we have a two-tier

process. The initial request for documents is we'll ask for very high level documents.

Like we're in some reviews now that the last major review was in 2015. So our first initial document request from DOE would be high level documents, like their -- asking for their capital projects back to 2015, and asking for their industrial hygiene surveys, and other 851 required, you know, documentation back to that time. We asked for information on maps, the most current map. And then our researchers look at that information and identify things that, you know, that we may not have in SEM currently.

And then our -- we go with our second document request, where we get more specific, you know, input. Well, we don't have this process, so can you give us the procedures related to that, the health and safety analysis reports related to that, and so forth?

So we're always trying to, you know, update things. And we try to keep track of

major projects that are going on in the DOE facility. And when things change, we try to, you know, to schedule an update in order to add the new facilities and things like that.

We've been doing that for quite a while now, and that seems to be the best way we know how of, you know, keeping up with changes at sites, because there's changes all the time.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Yeah. Mr. Turcic, back to my initial question to you regarding the C410 D --

MR. TURCIC: Yes.

MEMBER KEY: -- and C410 K buildings. Fluorine is listed --

MR. TURCIC: Yeah.

MEMBER KEY: -- but when you go down to the labor category involved, it has none. I have a group of workers who most recently, within the last year and a half, were running a special project, and we will be filing their claims as a group, not as individuals. They're

-- this was a specific project. They all received high exposure from fluorine, and one had to be treated in the hospital for four days.

So when we pull up the SEM, or when someone submits a claim and the CE pulls the SEM up and there's no labor category involved in this building location, then they're automatically denied.

MR. TURCIC: That's -- I would be surprised if that's the case. First of all, you've got to realize that SEM is basically a relational database. And if that -- those chemicals were tied to that labor category, it would show up as that labor category. And then if that labor category is shown working in that building, then that's how it gets tied in, you know, to tie it into that building.

MEMBER KEY: To my point exactly. There is no labor category listed.

MS. POND: Okay. This is Rachel --

MR. TURCIC: What do you mean

there's no labor --

MS. POND: This is Rachel. I just wanted to add here that, you know, the SEM isn't a decisional database. The claims examiners don't go to SEM and say this will determine whether or not a case is accepted or not. But we look at all the other evidence in the case file, any statements that are submitted, affidavits, we utilize our industrial hygienists.

You know, so yes, the SEM is built as a tool to assist our claim staff in adjudicating claims, in helping them guide their -- the direction of the claim. However, they look at everything that's submitted in the case file and take that a whole. So I just wanted to make sure we're keeping that in mind when we say, you know, oh, it's not in SEM, and therefore it's going to be denied.

Also, the SEM is always evolving. It's not going to be -- have everything in it from day one. That's why we're constantly

updating it. As we get more information, we can submit things through the SEM mailbox and they will review those incidents, accidents, things like that.

So all of that can be added if we don't already have information about it. And when we're looking at an individual case, we're looking at the whole. So I just wanted to clarify that.

MR. TURCIC: Rachel, can I add something there? I can give you a direct -- recent example that Rachel is mentioning, that in a case that was filed, a claims examiner had a question, and some of the -- a DAR request, the document access request that a claims examiner gets from DOE had information that was not in SEM.

So they sent a question to the SEM mailbox, and information from a medical record that was in that claim was then used to add that to SEM. And we add -- you know, you had a question -- the Board had a question about the

difference between minor and major updates. Most of the minor updates are things where we get documents through the SEM mailbox, or come through the IAS, that has information not in SEM that we then update that profile to add that information.

CHAIR MARKOWITZ: This is Steve Markowitz. So I know you're updating the SEM all the time, but how much new information do you really get about the old processes, you know, going back to the '60s, '70s, '80s. Are you really receiving new documents regarding those -- that era in terms of updating the SEM, or is most of the update really framed around the current or recent activity, say over the past 10 years?

MR. TURCIC: The -- more the current, recent, over the past 10 years. However, our library has thousands of records that were received initially, and then in subsequent, you know, updates from the DOE sites. You know, we're always receiving

documents from the DOE sites.

Again, you're right. Most of the records were -- from years back were received in the initial development of SEM, where the researchers went to the -- right to the sites and obtained records, and those are all in our -- in the library. But there's very few -- we very seldom get new records that are dealing with, you know, from years ago.

CHAIR MARKOWITZ: Are there comments, questions from the Board? Ms. Splett.

MEMBER SPLETT: Are we going to go to the original questions that we sent to Department of Labor, or just these supplemental ones?

CHAIR MARKOWITZ: We may go through whatever we want to go through. So if we're going to start on a series of questions, we might take our break for a few minutes and then start. Maybe that'd make some sense.

MS. POND: Doctor Markowitz, we have

this set of questions still, which there's only, I think, four more questions on here. We can go back through those other responses. I just -- there was a lot of them, so just keep that in mind.

CHAIR MARKOWITZ: Right, right.

MS. POND: That was like 10 pages worth of questions. I'm not sure you're going to be able to go through all 10 of them --

CHAIR MARKOWITZ: Right.

MS. POND: -- today. But --

CHAIR MARKOWITZ: We'll try to speak quickly.

MS. POND: All right, thanks.

CHAIR MARKOWITZ: Okay. So it's quarter of 11:00, so let's take a 15 minute break, reconvene at 11:00 a.m. Thanks.

(Whereupon, the above-entitled matter went off the record at 10:42 a.m. and resumed at 11:01 a.m.)

CHAIR MARKOWITZ: Okay, let's resume. I want to remind the Board members,

having not reminded you before, that when you have a comment or you want to speak, just if you could take your name board and put it vertical so I -- otherwise, I'm just looking around the room.

So Ms. Splett, you had some responses or questions you wanted to follow up on.

MEMBER SPLETT: I do. I have some questions of -- after I got those answered --

CHAIR MARKOWITZ: Is your mic on?

MEMBER SPLETT: -- whether the rest of the team wants to go through the Board --

CHAIR MARKOWITZ: Is your mic on?

MEMBER SPLETT: Yes, it is. Pardon? Okay. I do have some follow on questions, and then if the rest of the Board wants to go through the detailed questions, we certainly can.

But I have some kind of specific questions, one of which is, is the majority of the SEM in Excel spreadsheets or is there a

relational database, SQL or ACCESS that is being utilized, or is it mainly just in Excel?

MR. TURCIC: No, it's a combination. The spreadsheets are Excel spreadsheets, but that's just the raw data. Then there's a huge relational database, with a lot of coding that goes into it, that -- and that's done in, I believe it's ColdFusion.

MEMBER SPLETT: One of the things that I was concerned about reading some of this, it talked about Paragon owning some of the data, and that was some of the concerns about releasing the spreadsheets. Is that what the ownership of records clause says with DOL and their -- contract, or is that something that you're comfortable answering right now?

MR. TURCIC: Our concern with the spreadsheets themselves is -- really gets to proprietary information, and also an issue, a potential classification issue.

MEMBER SPLETT: Okay. So if we ask for the spreadsheets that have earlier been

released and published, they've been classified reviewed, so they were already released. They're not proprietary because they're already in the public domain. But I think many of us did not think to copy those at the time.

But if we ask for the spreadsheets for K-25 or PFP, excuse me, the Plutonium Finishing Plant, for those spreadsheets that have already been published, there should not be any classification review or concern or any proprietary concern. Is that correct?

MEMBER SPLETT: No, it's not, and here's why. Let me explain. What goes through classification review is the display, the SEM display. So it's a combination of the spreadsheet, plus the coding in -- the SEM hard coding.

One of the big concerns from a classification standpoint is the, you know, the presence of a mosaic effect. Now, what that means is that there can be several pieces of non-classified information that when put

together, becomes classified.

DOE office of classification does not -- has not reviewed the spreadsheets themselves. They review the changes that we make and the outcome. And the important difference is that there are some issues, and that's what I explained in my -- I have to be a little careful in my -- in the response that DOL sent through, I explained that how we handle that information is all provided in a secret document, and I really can't go into details on that. But --

MEMBER SPLETT: So --

MR. TURCIC: But what --

MEMBER SPLETT: -- I guess my question is --

MR. TURCIC: But --

MEMBER SPLETT: -- what has shown up for the SEM, the public view, and if we asked for that historically, the public view of that SEM for a particular facility --

MR. TURCIC: Oh.

MEMBER SPLETT: -- from when you first started it, can you share that with us?

MR. TURCIC: No, because we don't have them. When it changes -- that would mean making a complete copy of every SEM version and keeping it.

MEMBER SPLETT: You don't have a record copy of all of the changes and how you publish them?

MR. TURCIC: Oh, we have a copy of all the changes that we made in the spreadsheets. But what you're asking for is the SEM display.

MEMBER SPLETT: Correct.

MR. TURCIC: It -- the SEM -- we don't keep the complete SEM display. It's a whole database. That would be keeping a copy of, you know, the -- every SEM version every time there's a little change made. We just don't keep those.

MEMBER SPLETT: I -- okay. I guess I'm a little bit surprised that you have not

maintained that. But could we do a couple of examples of things we've -- questions we'd like to ask you on the SEM, Dr. Markowitz? Is that okay, or do you have other questions you want to ask?

CHAIR MARKOWITZ: No, no. I don't have any questions. Go ahead. Dr. Bowman, did you want to chime in here?

MEMBER BOWMAN: Sorry. This is just a quick follow-up to the keeping of past versions of the display of the SEM. What is the size of the database in question here that we would be talking about being kept? Are we talking about terabytes, gigabytes, more than gigabytes?

MR. TURCIC: You'd have to -- I'd have to get that -- the size from, you know, our IT people. But just as an example, just the spreadsheet alone for Hanford is something like 140 or 150,000 lines of data --

MEMBER BOWMAN: Okay.

MR. TURCIC: -- and, you know, every

version.

MEMBER BOWMAN: If you could ask the IT what the total size is, and then backup was a relatively -- you know, if it's less than a terabyte, that would not be very onerous, I wouldn't think. And that length you described would, I think, in my mind, be well less than a terabyte. Could -- would it be possible to keep those going forward?

MR. TURCIC: That's one spreadsheet.

MEMBER BOWMAN: Yeah.

MR. TURCIC: Multiply that by 140.

MEMBER BOWMAN: Sure.

MS. POND: I'm not sure what you're asking.

MR. TURCIC: I'll --

MS. POND: We -- this is Rachel. I'm sorry. I mean, we keep a -- we keep track of the changes. To say that every time we make a change, and we have to keep an entire new copy of the entire database, it's not really a feasible way to do it. We have all the

information about what changed in the documents, and we have a record of all of that. But we revise it every six months and republish it every six months.

So to say oh, we're just -- instead of continuing to publish based on the database that was there and increase it, you want us to keep a picture of all these databases for the last ten or plus years so that we can go back into 2000 and, you know, six and say oh, this is what it looked like then, it's just not a feasible way -- we haven't done it that way. We do have a record to show what changed.

MEMBER BOWMAN: Sure. I guess I was just asking because I was -- I got the impression that the record of what changed is not accessible, that the Board can't view that because it has the proprietary information. So therefore, the only way the Board could evaluate it is the public version.

MS. POND: I believe that it's something that is currently under review, how

we -- what we can provide to you. That's something that's currently with our procurement, as I indicated earlier.

MEMBER BOWMAN: Yeah. I think the Board is only interested in just trying to see the changes over time. And just if the -- if the way were talking about it is not possible, then an obvious possibility would be just to save a mirror image of the database. And data storage is really inexpensive.

So I don't understand the full details, but I would think data storage is super inexpensive and easy to do. So that would be another solution, should the first solution not work.

MS. POND: So it may just be the way we're wording what you want. I mean, I -- you know, the changes over time versus the spreadsheets from this many times -- all -- I think that we maybe should talk about how to word that request.

MEMBER BOWMAN: Okay.

CHAIR MARKOWITZ: Ms. Splett.

MEMBER SPLETT: I've got a couple of examples of something I got out of Oak Ridge that I'd like to ask a couple of specific questions, if that's allowable, from the SEM. Mr. Domina, do you want to help over on this --

MEMBER DOMINA: Yeah.

MS. POND: If they're going to be new, just keep in mind we may or may not be able to answer them off the cuff here today, and we might have to take them back.

MEMBER SPLETT: I will say that they are SEM printouts for a couple of specifics that show no entries or limited entries, and the year, the two years before that, there were multiple entries. And we're just trying to understand -- we've been told that things aren't being taken out. I think we have multiple examples of where that has happened.

We're just trying to understand why that is, and how that's logged, and who's made the decision. It's not intended to be a

"gotcha" moment. We just are really struggling with that.

CHAIR MARKOWITZ: Yeah. So we're -- I guess the Board members, we're going to raise an issue here. And whether we get a definitive answer or not at this moment is uncertain.

MS. POND: Okay.

CHAIR MARKOWITZ: But we'll raise the issue, try to clarify the issue. And then if we can get a response now, fine. If it's a little bit later, that's fine too.

MEMBER SPLETT: Why don't you put 105(c) up and why don't you talk to that one, okay? That's the K-25 labor category laborer. K-25. That would be in Oak Ridge.

MR. TURCIC: Okay.

MS. POND: Are you able to see the screen? Pete?

MR. TURCIC: Yeah. I -- what's the question?

MS. POND: Yeah. I just want to make sure you can see the screen as he's

scrolling to it.

MR. TURCIC: Oh, no. I can't see the screen at all. I haven't seen any screen.

MEMBER SPLETT: Okay. Let's put the labor category labor anyway.

CHAIR MARKOWITZ: Well, we're -- we're looking at the SEM. Which facility, K-25?

MEMBER SPLETT: K-25, labor category, laborer.

CHAIR MARKOWITZ: Yeah, okay. K-25, then you get labor category, laborer, then you'll be looking at what we're looking at. And I might add that the added benefit is that Kevin Bird is now getting proficient at using the SEM.

MEMBER SPLETT: It should show 21 matching criteria for toxic chemicals. Is that right?

MR. TURCIC: I can't see any of that.

MS. POND: Right. I think that Pete

isn't actually on the Webex. He's just on the phone.

MR. TURCIC: No, I'm on the Webex, but the -- the screen is just black. It's been black.

MEMBER SPLETT: Okay. The same search that somebody printed out 4/13 of '21 shows 63 criteria. So the question is between '21 and '23, what happened to 42 mentioned criteria? I mean I -- we're putting you on the spot, because you don't have the specifics.

So that -- we've got multiple examples. And just -- we just are really trying to understand it. With the change longs, that we took this chemical off for this reason, this chemical off for this reason, what would that change log look like?

MR. TURCIC: Well, first of all, I'd have to see -- I would have to see the labor -- so you're saying labor category, laborer --

MEMBER SPLETT: Correct.

MR. TURCIC: And when you say -- you

said that at some point there was 21?

MEMBER SPLETT: There are currently 21.

MR. TURCIC: Twenty-one what?

CHAIR MARKOWITZ: The hazardous chemicals.

MEMBER SPLETT: We're looking at the potentially encountered by labor category.

MR. TURCIC: Okay.

MEMBER SPLETT: And two years ago, that same number was 63.

MR. TURCIC: Oh, okay.

MEMBER SPLETT: Now, could you go to --

(Simultaneous speaking.)

MR. TURCIC: I -- go ahead, I'm sorry.

MEMBER SPLETT: Okay. Would you go to Y-12, Kevin?

MS. POND: Yeah, Pete, I think that we're just going to take their questions and then take them back and respond to them once we

have a chance to look into it.

MR. TURCIC: I think that's the best, Rachel, because, you know --

MEMBER SPLETT: Because I don't expect you to have that stuff at your --

MS. POND: Sure.

MEMBER SPLETT: -- fingertips.

MS. POND: Right, right.

MEMBER SPLETT: We understand that.

MR. TURCIC: Right.

MEMBER SPLETT: But these just came in. I just got these very recently. So are you at Y-12? Y-12, all the way down to the bottom. It's right above Yucca Mountain, and sheet metal worker.

MR. VANCE: Dr. Markowitz, can I chime in real quick and provide a clarification that might help slightly, and then maybe Pete can talk to it.

CHAIR MARKOWITZ: Sure.

MR. VANCE: So don't forget, there's also a separate category for construction sites

all, which is a generic profile.

MR. TURCIC: Right.

MR. VANCE: And I believe there are categories for both laborer and sheet metal workers that may have a substantially larger number of toxins associated with the labor category. So if you're looking at the Y-12 or the Oak Ridge, you may get a refined list. But if you go to that construction site's all list for subcontractors, you may get a substantially larger number of toxins.

Pete, do you want to talk about that construction sites all profile? That might actually help explain this.

MR. TURCIC: Yeah. If -- for anyone -- for workers who worked for a construction company, labor categories, you know, for all construction sites have the information that's supplied through that labor category in the construction process.

Now, for -- and that would be covered by, you know, a contractor, a

construction contractor, if they worked for a construction contractor. And so you would go to the all sites construction profile.

If they worked for a primary prime contractor doing construction work, you have a lot of the similar labor categories. And for people who may have worked for both, the list -- you know, the claims examiners would combine those lists.

MEMBER SPLETT: But I'm looking at exactly the same top of the spreadsheet where there's no indication go to construction, categories, or anything else. So as this shows, no hazardous chemicals. And in January 19th of '21, it showed 21 matching chemicals.

And there's no explanation. If somebody off the street is searching or an authorized representative is searching, this is not intuitively that perhaps there's another place that they need to search. There's no annotation on the form to do that. And again, probably not expecting an answer right now.

Mr. Domina, did you have something you wanted -- did you want to --

MR. TURCIC: What were those years? What were those years again?

MEMBER SPLETT: Obviously, the current one and the previous one. There was in January 19th of '21 and May 13th of '20 that showed 21 matching criteria. And then in '23, there's --

MR. TURCIC: And '23, this year?

MEMBER SPLETT: Yes. Yeah, of this year. Yes. October 19th of '23.

MS. POND: Dr. Markowitz, it's Rachel. I'm assuming we can get these in writing following this sub-lecture --

MR. TURCIC: Yeah.

MS. POND: -- we get it, correct?

CHAIR MARKOWITZ: Yeah. We --

(Simultaneous speaking.)

MR. TURCIC: Yeah.

CHAIR MARKOWITZ: -- will submit these examples with related questions in

writing. We're not expecting any real answers at the moment. It's really just helpful to have a little bit back and forth so that we can clarify and make sure we're asking questions that make sense to you. That's our goal at the moment.

For instance, this distinction between crafts trades, which are treated in two separate places, one is construction workers, and otherwise, at the main facility site. So sheet metal workers are going to appear on both places because --

MR. TURCIC: Right.

CHAIR MARKOWITZ: -- they might be employed full time at the site. They're going to be then by the site if it's by construction contractor, or there'll be elsewhere. So that clarification helps us with our questions.

MR. JANSEN: And I'll just add, it would be helpful to get a copy of the SEM printouts so we could potentially put them on the website.

MEMBER SPLETT: Dr. Markowitz, that's the majority of my comments. We have other examples that we can provide, but those are really my overriding questions. I don't know if the rest of the Board wants to go through the larger documents. Up to the remainder of the Board.

CHAIR MARKOWITZ: Well -- Dr. Bowman.

MEMBER BOWMAN: Sorry. Just on the additional examples, I think it could be helpful to go through some of the additional examples if you think the sort of initial ideas, like we just talked about, that there might be different types of related categories if that could help us revise them. If they're categorically identical, I would maybe not. But if there's some of your examples that are categorically different, we might get some insight to help.

(Off-microphone comments.)

MEMBER SPLETT: Excuse me. We were

just looking at some of the reactors from Hanford, and about some of the information is assuming to be inconsistent. And even the function of the reactors and the current titles seem to be inconsistent. But I think that we do need to provide that to DOL in writing. I, you know, want to catch people off base.

One of the things that I have to personally take some humor to it. Apparently we have rats and mice in one reactor, but five miles away, the other reactors, all through the Hanford site, that's apparently, they all just congregated at one reactor. That obviously was the only one that got identified.

(Off-microphone comments.)

MEMBER SPLETT: Yes.

(Simultaneous speaking.)

MR. TURCIC: Well, let me explain that. I'll tell you exactly how that happens. All we put in SEM is information that we can validate and verify. So --

MEMBER SPLETT: Well, to verify --

MR. TURCIC: -- there must be --

(Simultaneous speaking.)

MEMBER SPLETT: -- there's mice at the other reactors.

MR. TURCIC: Well, but we need a document. If you can -- if you have a document that shows us some way, then we would, you know, that would be put in.

MEMBER SPLETT: Mr. Turcic, I'm sorry, that was -- it was a joke. I apologize. But we can also -- I can also tell you having been in multiple facilities, we also have snakes in there, so. But I don't have any documents, but I have seen them and didn't enjoy that, so.

CHAIR MARKOWITZ: Yeah. Mr. Domina.

MEMBER DOMINA: I just have a comment on what Mr. Turcic said about having to have a document. I'll just give you an example for something, like when they're going to some of the reactors that we're decommissioning and they're digging up burial stuff, many, many

times over the years, they've stumbled across, quote, suspect fuel. And I'll clarify that because it's really fuel, it's just that it's not in the DOE inventory. And so then when it goes from whatever place and it -- most recently, it would get splashed at one of the K East or K West basins, then all of a sudden it's called fuel.

But when you have a worker digging it up, what they would do, they would have operations go over and identify it, and you would see a laborer or someone holding a white piece of paper with his bare hand behind this piece of fuel. And then all of a sudden, yeah, we got to handle it, get it stored. And then as soon as it goes in the basin and splashed into water, it's considered fuel. But in the meantime, the guy could put it in pocket, you know? And I think that the way some of this is done, you have to know more specifics on how things were done at each site.

And just like earlier, Mr. Turcic

brought up when he was talking about the last big review was in 2015, and then he talked about CFR 851. Well, 851 didn't come in till 1995. So it raises a lot of questions for me on what they did prior to 1995 because we know there's a lot of issues when 851 was actually implemented at different places on different sites.

Just like the problem with we have CFR 850 with beryllium, a lot of these sites still don't have a comprehensive beryllium program. We've been fighting in Hanford since 2008 with it when DOE sent the thing out to have a program where it's the same across site.

MR. TURCIC: But that's exactly why -- that's exactly the point I was making. That is why what SEM is intended to be is the validation of information. And, for example, the SEM would not add in that a site had a beryllium program or anything else unless we had a document that showed that it was implemented.

And as far as -- you're absolutely right, there's a lot of ways people were exposed to things that aren't in SEM, and that's why the processes, the claims process, is, you know, DOL has processes to handle that kind of information.

CHAIR MARKOWITZ: This is Steven Markowitz. Meaning the occupational health questionnaire in the interview, any affidavits or coworker affidavits would be where that information would be contained, right?

MS. POND: Yes. I believe so.

CHAIR MARKOWITZ: Right. Right. I think we'll probably get back to that a little bit later.

MR. TURCIC: And, Dr. Markowitz, I can point out that when we get -- when we get occupational health histories as part of the DAR request in a SEM mailbox, that information goes into the response in that mailbox, and that often ends up being an addition -- a revision to that profile.

CHAIR MARKOWITZ: So, Mr. Turcic, this is Steven Markowitz. So you're meaning an individual claimant's occupational health questionnaire might end up in your mailbox as --

MR. TURCIC: Yes. We get it every --

(Simultaneous speaking)

CHAIR MARKOWITZ: -- as submitted by the claimant I mean?

MR. TURCIC: No, no. It's submitted by the district. When the district office -- very often, it will be things like labor categories where labor categories, a claimant in the occupational history said that, you know, this is what labor category they had. A very recent one was a transportation certifying official, and the SEM did not have a transportation certifying official as a labor category.

Based on the information in the DAR, which included information that DOE in the

claims verification and the occupational history, we were able to combine that, and now that is currently being added so that the transportation certification official is being added as an alias to a base management specialist at that site because of the information that was, you know, provided in those documents. And that happens quite often. We get probably eight to ten SEM mailbox questions a month.

CHAIR MARKOWITZ: And the source of that information is -- are the claims examiners or their claimants?

MR. TURCIC: Claims examiners and information that are in the claimant's file they send to us, you know, to support when they're asking their question. But the exact same process is available and has happened a lot. I'll give you a perfect example where information we received through the IAS through the Internet Accessible SEM where the public submitted information relative to

trichloroethylene.

And what happened was the public submitted information that trichloroethylene was used as a degreaser by not only the electrical maintenance folks but also the instrument technicians and the electronics technicians. Based on that information, we looked at all the sites and identified that TCE was used at a lot of sites as a degreaser and primarily by the electrical maintenance people.

But based on the information that was submitted through the public, by the public, we put together a white paper and suggested that TCE be added also to the electronics technician and the instruction technicians. That went to DOL. DOL agreed based on the information we had. And so we went back through all the sites that did not have TCE in the electronics technician category, labor categories, and added that in. So that was about seven sites where that happened, and that was recently.

CHAIR MARKOWITZ: And just a quick follow up. Steve Markowitz. Just a quick follow up to that. The public information that you received, were those DOE documents, contractor documents? Or were those the observations or perceptions of, say, former workers?

MR. TURCIC: It started out as the observation, and then, in our research, we found information. We got information from DOE that, you know, helped for us to justify in that white paper to make that change.

CHAIR MARKOWITZ: Okay. Thank you. Other Board members have questions, comments? Ms. Splett.

MEMBER SPLETT: I would really like to take Rachel up -- or excuse me, Ms. Pond up on her recommendation to have an in-person demo because there's nothing I would like better to feel like the SEM was totally responsive and I just didn't know how to operate it properly. Again, back to the construction workers versus

--

CHAIR MARKOWITZ: Right.

MEMBER SPLETT: -- a specific facility. So I think there is a lot of us that would really like to do that. And I don't know whether that's something that could be done before our next six month meeting or not, but I do believe it needs to be done in person.

CHAIR MARKOWITZ: Well, we can do it before the next six month meeting. Yeah.

MEMBER SPLETT: But thank you for the offer.

MS. POND: Absolutely. I think it'll help with a lot of these questions to kind of understand that. There's a lot of nuances, and that's why we often have a lot of trainings. We try to have webinars for the public to understand how to search it and that sort of thing. But, yes, we'll set that up.

CHAIR MARKOWITZ: So are there other questions relating to the SEM while we have Mr. Turcic on the line?

Well, let me just -- first of all, Mr. Turcic, thank you, both for your effort to get here, which, unfortunately, wasn't successful. But also for being on the line today, and to be willing to --

MR. TURCIC: You're welcome.

CHAIR MARKOWITZ: -- engage in clarifying discussions. So thank you for that. Were there any other additional comments you wanted to make, Mr. Turcic?

MR. TURCIC: No. Not right now.

CHAIR MARKOWITZ: Okay. So then we should move on, I think. We're running a little bit ahead on the schedule. That's good. I think we can go to the industrial hygiene recommendation that we made previously, and Department of Labor did not fully accept that recommendation, so we wanted to discuss our views on that and whether there was some modification or some improvement we can make. I think there's a PowerPoint here. Dr. Cloeren.

(Off-microphone comments.)

CHAIR MARKOWITZ: So if -- just for clarification, this is the -- we're moving on to the topic that we had scheduled for 1:15, so.

MEMBER CLOEREN: I sent it to Kevin, but Kevin's out of the room.

CHAIR MARKOWITZ: Oh, great. So you should have -- Stefan, you have it.

MR. STEFAN: That's it, right? The one I'm showing.

CHAIR MARKOWITZ: No. No. It's the other one. It's the Cloeren one.

MR. STEFAN: Okay.

(Off-microphone comments.)

CHAIR MARKOWITZ: No, that's the medical one.

MR. STEFAN: Oh, okay. One second. The industrial hygiene report?

MEMBER CLOEREN: Right.

MR. STEFAN: Okay.

MEMBER CLOEREN: Okay. By way of

background, in May, we did recommend modifying the expectations around the industrial hygiene report to include more details about what data was reviewed, what was available to review, what it showed. We also recommended referring to the case file where there were data to support the conclusions.

We recommended that there be the expectation of an explicit statement about any, like, lack of case-relevant data beyond what's available in the site exposure matrix and to share that information in kind of an organized way, a new table format.

Just to remind everybody, the current procedural guidance is that the industrial hygienist will review all the information, and using a combination of the information and their experience, characterize the exposure to whichever, you know, maybe a variety of chemicals, and a variety of jobs, and a variety of different time periods, but to characterize each of those as significant,

between significant -- or between incidental and significant, or incidental, or no exposure, no evidence of any exposure. And then within significant, to then whether or not the exposure is high, moderate, or low. So those are kind of the categories that the industrial hygienist can use in the current procedural guidance to classify the exposure.

The rationale for our recommendation is that by synthesizing either a whole lot of data, which, I think is rare, but it's possible, along with the site exposure matrix, you know, findings, and then combining that with the industrial hygienist's knowledge into a conclusion, that misses the opportunity to share details with other experienced people, like the claims examiner and the contract medical consultant, that would provide more information about the type of exposure, the route of exposure, you know, inhalation, ingestion, skin absorption, intensity, frequency, duration.

All of these are used, you know, in industrial hygiene thinking, basically. Also, calendar timing, use of PPE if that's available, which, you know, may not be in some cases.

But, anyhow, we thought that the synthesis of pulling together all the information and spitting out a conclusion about significant high, significant moderate, and significant low, incidental, between significant and incidental, or no exposure missed the opportunity to share important information about the details. How is that conclusion reached? Next slide.

This, just to remind everybody, was kind of what we proposed in a table format, you know, providing information about each of the exposures. And so it would provide details about each of these things. And then we also -- - in the version that we actually submitted, this is an older version of it, we included the request that kind of page numbers from the file

be included. Like, where did you find this information? Next slide.

And so the response was an agreement that the new table format, or something along these lines, would be helpful if the industrial hygienist found an exposure to be significant, but not in other cases. Not if they did not find it to be significant. And there was also agreement to add a data field that explains the type of exposure, whether it was direct, bystander, or in the area when it was used.

But, basically, there was disagreement with other recommendations, including specifying where in the various sources of data that were reviewed, the data supporting the conclusions were found. And we also received an example of an IH report, a redacted industrial hygiene report that was a lot more detailed than the usual industrial hygiene report.

And I've reviewed, you know, several of them over the years, and I thought it was a

pretty good IH report that provided a lot more detail than we typically see. So I'm not sure it was a typical one, but even though it was more detailed than the typical one, I think there were still some problems that maybe demonstrate what we're trying to persuade the Department about. Next slide.

So this is an excerpt from the report, and one of the things that we wanted to point out is that the industrial hygienist had been asked about whether any of the pre-1990 jobs could be -- and this was related to a hearing loss claim, and so the question was about solvent exposure and whether the claimant was in one of the covered job categories. And so the question was whether any of the jobs that the person had been in would be synonymous with some of the covered job categories. And the industrial hygienist consultant said that it was beyond the scope of the referral and can't be addressed.

We felt that, yeah, there is an

opportunity to interview the worker. We don't see this done very often. Actually, I don't think I've ever seen any evidence of an interview. But an interview would be a really good way to try to clarify whether the, you know, the jobs that were listed are synonymous just by going through with the person, what it was they were doing. So just a comment. Next slide.

The industrial hygienist also used the language that we understood they were no longer supposed to be using about how, you know, the problems really existed before the mid-'90s, and after the mid-'90s things were safer. So we thought that was a problem, and we thought that that was not really supposed to be used in the reports anymore, especially when there's not data from a facility to support that, wow, you know, at this facility, everything got, you know, much better after the mid-'90s. Next slide.

The industrial hygiene report also

said -- and this is, I think for myself, at least, speaking for myself -- this is a problem area because in almost every industrial hygiene report I've read, they refer to many different sources of information, and then summarize, I reviewed all this stuff, and my finding is this. But they don't really say what they found, what each of the documents that they reviewed had, and I think that that is actually really relevant.

You know, I reviewed the occupational health questionnaire, well, okay, but what did it say? I reviewed the EE3. Okay. So that tells the job categories. I reviewed the site exposure matrix and the physician's letter. But the industrial hygienist in this report is not sharing anything from those sources with other people with expertise to maybe process some of that information. Next slide. And also the DAR wasn't listed for whatever reason.

And so I wanted to just throw out

this example to you. That paragraph -- or actually, that industrial hygiene report would apply to either of these situations. A situation where there may be a DAR that shows monitoring for the work area where the claimant was working with no problem exposures. I mean that would be -- that would be very important information if that information were available.

That the OHQ exposure information was explored with an interview. That the site exposure matrix indicated plausible exposure opportunities. And that the conclusion includes the site exposure matrix, but it's corroborated with other data sources.

And this is what the CMC's maybe believing when they get their industrial hygiene reports because there's implication that I reviewed all these sources of data, and all these sources of data helped me draw my conclusion. But the reality, honestly, is that, most of the time, it's the site exposure matrix information. But that's not explicit,

right, in the reports.

And speaking as an occupational medicine physician, I would always want to review an occupational health questionnaire myself. I wouldn't want someone else to review it and tell me, you know, what I need to know from it. And I think that's a disservice to the whole system to not share the OHQ. But in any event.

So the reality is there's usually no relevant DAR data. Who knows what the OHQ is saying. And this -- I'm sure the site exposure matrix is used, you know, very carefully and thoughtfully by the consultants. Next slide. But these are two different situations, right? And so if the end user of the report is making the assumptions on the left, they may draw much different conclusions than if they understood that all they're really going on is what's in the site exposure matrix. Next slide.

So this is important. And this is basically what I just said. And I think that,

if we had a transparent process, that would make clear what was found in each of the different sources, including there was no specific site information. There was no monitoring records, you know, from the site. And I think that's the last slide. So that's just for discussion.

CHAIR MARKOWITZ: Okay. Thank you. That was very clear. Board members have comments, questions? So -- Steve Markowitz -- so you're saying that in the IH report, that if there is specific information in these other sources aside from the SEM, that that information should not -- should be specifically noted in the report, and the source should be identified?

MEMBER CLOEREN: Correct.

CHAIR MARKOWITZ: And likewise, if those other sources don't have any useful information, that should also be specified?

MEMBER CLOEREN: Correct.

CHAIR MARKOWITZ: All right.

MEMBER CLOEREN: And I think that -- and that's more often the case, right?

CHAIR MARKOWITZ: Right, right. That seems like a pretty straight forward thing to do, actually. Could you go back to Excerpt 2 for slide? So I think you pointed this out that this is an excerpt that contains reference to the mid-1990s, that after the mid-1990s, programs were well developed fully implemented, and, later, it says that the likelihood of significant exposures was greatly reduced after the mid-1990s. And this statement is included as a general statement. It's not in this particular case substantiated by any monitoring data or any other data.

And this is a not-so distant cousin from previous language that centered on 1995, which the Department actually rescinded in 2017. The Board pointed this out that this was an arbitrary kind of cutoff date, and it was prejudicial. And the Department agreed and rescinded that. And this is a somewhat softer

version of the same language.

And I guess, in the absence of data to support that statement, the question is, what real value, real truth value, can you attribute to this general statement? And the problem is, of course, that there's rarely any real data from the worksite if you're just talking about industrial hygiene monitoring data one way or the other, that there was exposure, there wasn't exposure.

I don't think there should be a prejudice that in the absence of industrial hygiene data, there was over exposure. I don't think that should be the assumption because why would you make that assumption. And likewise, on the flip side, I don't think in absence of industrial hygiene data, you could assume that everything was fine.

But the reality is that those data don't exist for -- and they probably still don't exist, you know, at the various worksites. So then what do we do with this

observation, which we've seen repeatedly in industrial hygiene reports that the things got better throughout the '90s.

And the implication is that, to quote this excerpt, the second to the -- second line from the bottom, circumstances leading to a significant exposure would likely have been identified or documented in employment records, end of quote.

Is that true that it would have been identified in employment records? I'm skeptical about that. So I don't think the prejudice should go in either direction around a given timeframe.

And by the way, for people who worked at these facilities who are on the Board, I mean over the decades, conditions did get -- health and safety conditions did, generally speaking, get better. Is that right? That doesn't mean that every particular situation, every given task or job title, et cetera, you know, experienced no important

exposures. But, in general, conditions did get better. The question is can you really translate that into a determination for an individual claimant in an IH analysis? Personally, I'm skeptical. But I'd like other people's opinions. Dr. Van Dyke.

MEMBER VAN DYKE: This is Mike Van Dyke. I agree with what you're saying. I don't think that these things were very well documented, and they were definitely not well documented in employment records themselves. I think it's hard to get away from the bias as an IH that things did get better. And I think that, in their minds, in the minds of evaluators, they're going to use that in their minds.

However, I think that, you know, the lack of documentation cannot be interpreted as lack of exposure. And even if they said something like this and they ended it with the lack of documentation cannot be interpreted as lack of exposure, it would be much better. But

this does leave the CMC down the road of, oh, things were great, good record keeping, must be no exposure. And that's a very biased trial to lead someone down.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Yeah. I think we've lost our focus here. Some may have never had it because we go back to the original legislation and the intent of Congress, again, where there was no documentation at the site IH, health visits. Otherwise, there's specific language put in the statute that should direct all of us in our activities as an illness that was as least as likely as not that occupational exposure or a toxin created the causation, correlation, or illness.

And that specific language was put in there for a reason, so where there is absence of data. This is very vague, this IH report statement here. That provides no basis for approval or denial. I think you need to go back to the intent of the act and that specific

language.

CHAIR MARKOWITZ: The other thing -- Steve Markowitz -- is that it's one thing to think that conditions may have likely improved over time, but actually, that's not really the point of interest when examining an individual claim. Here's a person who has an illness, a particular person with a particular -- his job history who has an illness. And so the question is did this person have exposures that may have been significant or not? And for that, you need to know as much as you can about that particular person and their own history.

And so what was generally occurring in the facility is one thing, but it may be quite different what this individual person experienced. And, frankly, you know, the source of that really is going to be the occupational health questionnaire, the interview, the like, you know, what that particular person reports.

But let me ask Mr. Key something,

and I don't mean to ask you, but since there was very little objective industrial hygiene data showing one way or the other, over exposure or, you know, insignificant exposure. So to me, in the absence of information to lean in the favor of the claimant, does that mean -- which I appreciate, that was part of the original act. In fact, the whole establishment of the three gaseous diffusion plants as we didn't know what the radiation levels were, so therefore, we're going to compensate them for one of, whatever, 22 cancers or whatever. That was part of the act.

But what does that mean, in general, for toxic substances? Does that mean everybody gets compensated because we're going to lean in their direction? And this is not directed towards you, per say. I'm just saying in general, then how do you approach this if you say that, well, okay, we're going to be favorable to the claimant and we don't have any real data, and so, okay.

MEMBER KEY: I don't think you have to approach it that way. There is numerous incidents where workers were exposed, including myself, to asbestos. At the end of the day going to the shower room, completely covered white with asbestos dust, no industrial hygiene monitoring on the jobsite.

Our industrial hygiene department consisted of one person until the late 1980s, and then it had grew to three. There was no field monitoring, job-specific scope and monitoring going on. That did not even come into play, especially, and I can speak for the Paducah gaseous diffusion plant, until the mid-2000s where there was a robust build up an industrial hygienist and health visits technicians.

And also, just because a chemical had been outlawed and a contractor was aware of that, that did not mean that the contractor had the workers go out and secure all of those banned chemicals and bring them in and out of

the available inventory to use. Quite the opposite. They left them out there and used all of them in the meantime trying to find a replacement to bring on site.

So I think it has to be in favor of the claimant, especially up until, as I stated, the late 2000s where you had a more robust, on-job site health visits and industrial hygiene technicians.

CHAIR MARKOWITZ: So can we get other comments, questions? Oh, yeah, I'm sorry. Mr. Domina.

MEMBER DOMINA: I think you have to, you know, when you work at these sites and put stuff into perspective, a prime example is we would have more one of the national labs, Pacific Northwest National Lab, come out, like, in a building where we worked to try and replicate the way the air moves, ventilation because of issues with contamination, with uptakes of everything. It's never the same twice.

And it's no different than during these times when we're working. The reason they don't monitor -- because they don't want to know the answer. And, you know, I mean when you can -- when it's snowing asbestos on a reactor startup, and I know you may think I'm blowing smoke, but when you see it yourself, you think they're going to put a monitor in there? And then you're doing that every 28 days. It never goes away. You know, and then you're out there sweeping it on, you know, to clean it up. And like I said, we ventilated. In these old building, it ventilated to atmosphere.

But there's no filtered monitoring. We've had issues where people are standing shoulder-to-shoulder having lapel monitors and then an area monitor, and people end up with ingestion, inhalation, and the person next to them got nothing.

You know, this is, you know, we signed up for this, we got that, you know, but

the type of work that we do, there's certain things they didn't want a monitor like stuff at the tank farms, the industrial hygiene didn't get real decent until about 2016, '17 when the Labor, you know, HAMTC did a stop work for any work on the farms unless you're wearing supplied air, SCBA. But then that causes a host of other issues. People slipping and falling in the winter, hurting their back when they land on one. Or some people, you know, the SCBA weighing half their body weight.

And then when they started monitoring some of these things, I mean if you go out there now, there's stacks. They spent millions of dollars to ventilate some of this, they knew it was bad. But you can't measure that in these people except when their health is declining and then you're going to say that they didn't have any exposure.

I mean I understand both sides of this table. There's a scale for monitoring, not monitoring, and, yeah, you don't give it

all to the people and you also don't give it all to the other side. But it doesn't seem like the scale's very even.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Yes. Kirk jogged my memory a little bit. I'll give you an incident that just happened within the last two years which I related to earlier today of the exposure to fluorine to approximately 16 workers working a special project.

They had area monitors. They had lapel monitors. But they were instructed when the area monitor or lapel monitor went off, to turn on the industrial fans, to remove that as the engineering control away from them and to silence the monitors.

This group that we're going to file for, we have the documentation. It had to be reported to DOE either through their ORPS system, or their CARE system because one of the individuals suffered three days of blindness, had to be transported from the facility in a

hospital -- or in an ambulance and stayed in a hospital for three days until his sight came back, and then repeated just migraines for like four months.

So, you know, has it improved? Certainly it's improved to a degree since the '50s and '60s. But we still have instances where, as Kirk said, monitoring is sometimes not done because the contractor doesn't want to know. If it hits a threshold, then that's a reporting requirement.

CHAIR MARKOWITZ: Mr. Catlin and then Dr. Cloeren, she's -- oh, go ahead. Marianne.

MEMBER CLOEREN: Yep. Dr. Cloeren here. I want to go back to the OHQ. I don't understand why that is not shared with the CMC. And I wonder -- I don't wonder, can I propose that the OH questionnaire be included with the packet to the CMC? And also I don't know whether -- can the CMC request the industrial hygiene consultant to do an interview if

there's a conflict, for example, between the industrial hygiene conclusion on review of the SEM and what is being stated in the OHQ? Is there a mechanism for trying to resolve, you know, that difference and get some more information? Because like what you said about the SCBAs is really interesting, you're not going to get that from any place but the employee.

CHAIR MARKOWITZ: Steve Markowitz -- oh, go ahead.

MEMBER CATLIN: Go ahead.

CHAIR MARKOWITZ: No, just to follow up to what she said. Yeah, I think recommending that the OHQ be given by the CE to the CMC as part of their evaluation in addition to the industrial hygiene report, that's a perfectly valid recommendation for the Board to make.

MEMBER CATLIN: Thanks, Mark Catlin. Yeah. I actually view the occupational health questionnaire that the Department -- the

improved one the Department accepted a couple years ago from this Board really ought to be part of the IH report. I mean I think it should also go to the CMC. But in the IH report, they really ought to say -- they really ought to address what they saw in that report. And if they can refute it because they have data or if it doesn't make sense.

But I think a lot of times in the claims that I've looked at in my prior experience, the worker information in that good questionnaire will support the claim, and then there wouldn't be anything to refute it from the Department side. And then you would decide that there was some exposure. And I think that's a perfectly easy way to do it.

But in the IH reports I've reviewed, as you've described, they're usually very -- like we've reviewed everything, but it seems like there's no problem here. And they don't really say they reviewed the questionnaire, and I know I've looked at some of the claims where

you look at the IH report, and then you go through the questionnaire. And there's all sorts of potential exposures that are never addressed, and they just sort of get blanket kind of rejected.

So I think as the recommendation was to kind of make this more clear and make it more clean, I think the questionnaire ought to be -- ought to be something IHs have to address and not just sort of miss it. And I still think it should go to the docs, and the claims examiners should review it, too. But the IH has a way to look at those responses and weigh in on them, and maybe doing the interview also is, if there's any sort of questions. So thanks.

CHAIR MARKOWITZ: Dr. Bowman.

MEMBER BOWMAN: Yes. Thank you. I was just going to -- Mark, I think you make a very good point there with the IHQ being shared. I think the question that would easily come up in the mind of the CMC is what does the

IH think about this element of the IHQ? And so making sure that those elements are addressed in the IH report would help with the clarity. We don't want to cause even more confusion and more -- potentially even delays in the processing of a claim if there has to be a bunch of back and forth.

So I think maybe with a recommendation to share the IHQ, we should say that it should be -- that the contents of that should be specifically addressed by the IH.

CHAIR MARKOWITZ: Steve Markowitz. I mean I understand the perception that, you know, you give the exposure information to the exposure expert, that's the IH. They look at everything. They interpret it. They prepare a, more or less, concise report. And then that expert report is handed over to the medical expert who now has the exposure expert input, and then takes it, combines it with the medical. And then makes a decision about causation or whatever.

But actually, in reality -- that's, obviously, a useful thing. But in reality, the doc wants to see the primary information. And the OHQ is limited in amount, so it's not an overwhelming, certainly not a burden to the doctor.

And so, yeah, I mean they should see the OHQ in addition to the IH report because it's not one expert to the next. You know, the OM doc is an expert also in exposure. Not as much as the IH in measurement, but interpretation, probably. So that's why we need to see the OHQ. Okay. Having said all that, Dr. Van Dyke.

MEMBER VAN DYKE: No, there's always the physicians thinking they're industrial hygienists, right? No. I want to push back on that a little bit. I mean I think that that's true for many occupational medicine physicians, but I would like to know if you think that that's broadly true for the people that are doing these evaluations.

CHAIR MARKOWITZ: Yeah. That's hard to know. I mean I think if you give those CMCs both the industrial hygiene report and the OHQ, that, you know, they'll decide what they're going to look at, pay attention to, and I'm sure there's variation in that. I don't see any downside in giving them the OHQ. If they ignore it, they ignore it, right? But at least having the primary data in addition to the industrial hygiene report I think would be useful.

Let me just say something else about the, you know, we have an example report that was sent to us in response to this recommendation that was nine pages long, a little bit longer than most of the IH reports we've looked at. Speaking as a physician, I don't generally read line by line every nine pages of an evaluation. I'm going to focus in on the summary table. And I realize that, you know, the advantage of a text narrative is that you can put in, I think, nuance.

But it'll be very interesting to test what the CMCs actually use because -- and I know that was part of the DOL response is to look at what the CMCs, how they react to whatever. But I think that summary table is really key, and what's included and not included in that summary table because even if you read the whole nine page report, when you're sitting there making a decision, you're going to back to that summary table in terms of what your understanding is, unless someone disagrees with me about that. Dr. Van Dyke. Good. Disagreement.

MEMBER VAN DYKE: No. I'm circling back. I mean I think that, you know, what Dr. Bowman said around the IH should be required to respond to the reported exposures in the questionnaire I think is absolutely critical. And I think it's critical from the perspective of the claimant because the claimant, if they are not -- if those are not responded to, they feel like they're being ignored. And I also

think it's important because there is a piece that, you know, there's a misinterpretation or a misunderstanding about what people are exposed to sometimes.

So providing that list of they reported that they were exposed to X, Y, and Z, and saying whether that is substantiated or not in the SEM would be really helpful. And there might even be an opinion on whether this is possible given what we know about their work history. So I think that that disconnect where they're just feeling like they're not responded to at all is the big problem here.

CHAIR MARKOWITZ: Yeah. Steve Markowitz. I think that's a good point. I also think that, and I don't know, Dr. Cloeren where exactly you were heading here, but I think we could fine tune, modify the recommendation to hit on some of these specific points that would add some specificity to the prior recommendation and might help the Department.

So we don't have to do that right now in the four minutes before lunch, but we do have time -- would have time this afternoon and tomorrow morning to look at language and then discuss it and perhaps vote on it. Mr. Key.

MEMBER KEY: Yeah. Before we break for lunch, I guess this is a question to Rachel because I don't know the answer. Does the Department have access to the Department of Energy's ORPS reporting base and the other one where reports were filed at these locations on exposure, and if a claimant files a claim that occurred with an incident, let's arbitrarily say in the 1980s, do you have or do your CEs or someone within DOL have access that they can go into the DOE reporting systems and back to that timeframe to see the documentation that may possibly be there?

MS. POND: No. We don't have direct access to reports that DOE has. What we can do is ask for a DAR, which is a document acquisition request, which provides us with

more detail about their exposures and any records that Department of Energy has, they can come back and provide us with that information.

And so when we do have, you know, reports like that, we will do whatever investigation we can, go back to DOE with a DAR request for more information. But that's the extent of it, and I don't know if Gail wants to elaborate on that, but our access is limited to what we can get from DOE. We don't have direct access to their records.

MEMBER KEY: Okay. I guess a follow-up. Can the claimant then -- is there a DOE representative that the claimant can contact that knows a specific incident, that they can get that information, thereby, submit it also with their claim?

MS. POND: I don't have the answer to that, but maybe Gail can help.

MEMBER KEY: I mean there's -- it intrigued me yesterday on our tour that the site medical director listed the guards and the

fire department personnel as the top two labor categories on site for the EEOICPA program and going through their physicals. When we have these other sites across that firefighters and guards, you pull up their labor category, there's no exposures when we know that on site, not only did they fight fires that occurred on site, they went off site mutual aid agreement with the facility. And also they had the annual firefighting training that they intentionally set a specially built facility on fire to respond to that. So I mean there's exposures there, we know that. But yet, they're not included in the SEMs, being exposed to any chemicals whatsoever.

CHAIR MARKOWITZ: So -- oh, yeah. Ms. Splett. Go ahead.

MEMBER SPLETT: This is Gail Splett. I am not sure at Hanford when they do the DAR, if those CARES and ORPS reports are identified by individual names so that the staff could link to those, or how deep they would have to

dig. I will find that out. Do you know if the reports, or Mr. Domina, if they have specific names in them or they talk about like employee one, employee two? I don't know the answer to that. But it's --

MEMBER DOMINA: Well --

MEMBER SPLETT: -- a great question.

MEMBER DOMINA: -- the other part that would play into that is a PAAA violation because I've had them try to -- let's see, make sure to use the right wording here -- suspend some of my guys that I represented because of a AAA violation, and then you come to find out it's the contractor's fault once you get a copy of the report. And to me this can also prove that a certain event or something did actually take place.

MEMBER SPLETT: What kind of violation? Did you say triple --

MEMBER DOMINA: Price-Anderson Amendment Act. When the DOE fines a contractor for --

MEMBER SPLETT: Got you.

MEMBER DOMINA: -- a screw up.

MEMBER KEY: Yeah. I don't know the answer to your question, you know, if it lists the individual's name. But if we can get to a date and a location, and to me that's documented evidence that this person was, in fact, involved in that and submit that with their claim, absent of any monitoring data.

MEMBER SPLETT: I know that the Part B Board and NIOSH have requested from Hanford all the ORPS data, and we provided it all to them. But I don't know whether it was retrievable by individual's name or linked to a DAR when it was requested. But I will ask -- find that question because I think it is something if it was retrievable, that that could be something that could be added to the DARs for the various sites.

CHAIR MARKOWITZ: Any other last comment, question before lunch? Yeah. Dr. Bowman.

MEMBER BOWMAN: Yeah. I just wanted to link something that Jim and Marianne both said. At one point in time, Jim, you referenced the statutory setting of the criteria as being at least as likely as not. In my mind, that is highly similar to what Marianne was saying that in the absence of data, and also what Steven was saying, in the absence of data, we should not prejudice to either one way or the other.

I think there's a lot of similarities in at least as likely as not and to say there is an absence of data, so therefore, we cannot conclude an exposure or not an exposure. To me, those are very comparable. And so I think it's good to point that out that that links with that.

MEMBER CATLIN: But when you say absence of data, would you include the occupational health questionnaire as a piece of data, as data in the claim?

MEMBER BOWMAN: Yeah. I suppose it

would, and this is why it's very important for that data to be commented upon. Yeah.

CHAIR MARKOWITZ: Okay. So we're going to break for lunch. We'll resume at 1:15. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:17 p.m. and resumed at 1:17 p.m.)

CHAIR MARKOWITZ: We can get started again. Dr. Friedman-Jimenez, you can hear us?

MEMBER FRIEDMAN-JIMENEZ: Yes, I can.

CHAIR MARKOWITZ: Okay. Good. Okay. So we're going to actually for a few minutes go back to the same topic, try to identify some elements of the discussion that might be used to form a new recommendation for the Board. We're not actually going to write that recommendation in committee right this moment. We just need to identify what pieces we want to put in it, and then later a written version will magically appear that we can

modify and vote on. So, Dr. Cloeren, you want to start off this?

MEMBER CLOEREN: Sure. Okay. So there were several things in the letter back from the director. One of them had to do with agreeing with our proposal to use a summary table only if the industrial hygienist found -- only for the exposures that were found to be significant. And I think that we could agree that that makes sense. It doesn't make sense to have a table about duration, et cetera, et cetera, for things that were incidental or not found to be exposures. So I think that's the first point of discussion.

CHAIR MARKOWITZ: Sure.

MEMBER CLOEREN: Everybody -- okay. The second --

MEMBER FRIEDMAN-JIMENEZ: Do you want it now or wait to the --

MEMBER CLOEREN: I don't know. How do you want to do this?

CHAIR MARKOWITZ: No, no. What do

we have, what, maybe three or four points, right?

MEMBER CLOEREN: Three or four points. You want to go through them all? Okay.

CHAIR MARKOWITZ: Well, why don't you just briefly go down the three or four points.

MEMBER CLOEREN: Okay.

CHAIR MARKOWITZ: And then we'll --

MEMBER CLOEREN: Okay.

CHAIR MARKOWITZ: -- handle them one by one.

MEMBER CLOEREN: As we discussed earlier, we would like to recommend that the industrial hygienist should address all of the exposures that were claimed in the occupational health questionnaire, or otherwise by the claimant, whether that's in the doctor letter or claimant letter, or whatever. But that the industrial hygienist should specifically address what was purported, you know, by the

claimant, the former worker.

That the industrial hygienist should specify what data was found in each of the sources that were listed as reviewed. Right now, we sort of lump it all together, I reviewed all these things and my conclusion is this. And so I think we feel pretty strongly that there's an obligation out of transparency to state, you know, what was found in the DAR, if the DAR was there, you know, what was found in the OHQ, what was found in, you know, whatever other documents may have been listed.

And if there was no other information, no information found in specific documents, then that should be explicitly stated that there was no exposure information available because I think right now, lumping them all together and saying I reviewed all of these things, and my conclusions are blah, blah, blah, can imply that there was some information where there was none. Right? Did I capture your thoughts pretty well? Okay.

And then finally, the OHQ should be shared with the CMC, or whatever doctor the -- whatever doctor the claims examiner may be sending the industrial hygiene report to that the OHQ should be part of that transmittal because sometimes they'll send the industrial hygiene report back to the treating doctor, or, you know, the former worker program doctor, and the OHQ should be part of that. I think that's it.

CHAIR MARKOWITZ: Okay. So you want to just start with the first one, which was?

MEMBER CLOEREN: The table is only needed if exposures are found to have been significant. But even if they don't find -- well, so the second point was whether it was found to be significant or not, the IH report should be addressing what was claimed.

CHAIR MARKOWITZ: Okay.

MEMBER CLOEREN: But the table only needs to include the data for exposures that were in any of the three significant groups.

CHAIR MARKOWITZ: Low, medium, or high significant, right?

MEMBER CLOEREN: Yes.

CHAIR MARKOWITZ: Okay. Comments, discussion? Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Friedman-Jimenez, I'd like to respond to that. I think that part of the issue here that I think is important is transparency so that the claimant and their representatives all understand the rationale for a case being accepted or denied. And in particular, denied.

And so if the exposures that are classified as incidental are not included in the table, then that doesn't allow the claimant to understand the rationale for saying that the exposure was non-causal. And I would argue that there are some cases in which incidental exposures can cause disease.

For example, someone that has isocyanate exposure and occupational asthma, and become sensitized to isocyanates may be in

a facility where the air levels are extremely low, even not measurable, and still get asthma attacks from that isocyanate and wind up having to leave their job. And so it has a significant -- quote, "significant" impact on their life. But it could easily be classified as an incidental exposure by an industrial hygienist because it doesn't have a classic dose response curve.

So I think that it leaves the door open for some real misunderstandings if we agree that the negative exposures or the incidental exposures don't need to be justified in any detail. I agree that you can't say, you know, how long is the duration as easily, but sometimes something is called incidental because it's a very, very low level, but over a long duration. And depending on the pathophysiology, that could be medically significant, although, industrial hygiene-wise, may seem insignificant. So I think the problem is with the word incidental.

CHAIR MARKOWITZ: Actually -- this is Steve Markowitz -- I just want to follow up specifically on that, and there's also the category of more than incidental but less than significant, right? So it's not just the incidental ones that we're talking about.

I think the CMC should have access to that because it's a judgment as to whether an exposure was -- at what level it occurred. And the IH expresses their judgment. But for the CMC, we only have the universe of possibilities, and maybe I'm just repeating the comment that Dr. Friedman is making that they need to have that included in that universe. They may come -- they're likely to come to the same conclusion about its significance, but perhaps not. Dr. Bowman.

MEMBER BOWMAN: I was just going to comment further on this topic. I think that the table, of course, that the Board recommended use, you know, broke down various critical elements and are part of an overall

exposure assessment duration amount, and so forth. And I think part of the reason that I interpreted the Department did not accept the recommendation was one of practicality in terms of being able to answer that.

So you can imagine a situation in which -- and George, I 100 percent agree with you an incidental exposure can, in fact, be causative of illness. I completely agree with that statement. But it may not be possible or as possible to fill out all those details if the information is missing. And so to require -- to ask for a requirement of details in which it's because of an absence of information, the IH is trying to make their best guess, that might be difficult to do with all the level of detail we asked in the table because I wouldn't say that -- I mean could we not consider, you know, we don't want to say an IH should not use the table unless it's significant. Just it becomes harder when it's incidental depending on the nature of the incidental.

CHAIR MARKOWITZ: Dr. Vlahovich.

MEMBER VLAHOVICH: Kevin Vlahovich. I would just be concerned that if there was an exposure that was claimed to have happened, and then was not even mentioned at all in the summary table, that that would be an omission that would be fairly significant.

(Off-microphone comments.)

MEMBER VLAHOVICH: We're not going to go into that.

MEMBER BOWMAN: Right.

CHAIR MARKOWITZ: Seems to be some general agreement around this point, so I think we can probably move on to the next point unless there are further comments.

MEMBER CLOEREN: What do you think the agreement is?

CHAIR MARKOWITZ: Dr. Van Dyke.

MEMBER VAN DYKE: I really hesitate to say this because I'm actually coming around to the significant incidental, you know, classification because it is, you know, I think

that the way the statute's written, that's the only bar is significant or incidental. And while I still think the frequency and duration is important, maybe what we're heading towards is they have to address all the exposures. They have to cite where they got -- where they found the information, whether or not it's significant or incidental. Maybe we need a new table that's an easier table to address with just those things. See, I knew that was going to be difficult.

CHAIR MARKOWITZ: Just a comment on the. I don't think the act says significant exposure. I think it says that a significant exposure has to be a significant factor and contributing, aggravating, or causing. Correct me if I'm wrong, Ms. Pond. So that word significant is not attached to exposure, at least in the act. Just by way of clarification.

MS. POND: I know that it's used -- significant exposure -- I'm sorry, this is

Rachel. It is a significant factor in causing, contributing to, or aggravating. I don't know if it's used at all with the exposure, but I'll double check. I don't think it is. But let me check and get back to you.

CHAIR MARKOWITZ: So, Dr. Van Dyke, can you just repeat your thought here?

MEMBER VAN DYKE: Yes. This is Mike Van Dyke. So my thought was it's an agreement that we need to address all the exposures that are listed in the OHQ as well as what's identified in the SEM. We need to be able to say whether each one of those are incidental or significant. And I think we need to say where that information came from.

Now there will be incidents where you have something that's identified in the OHQ that there is no information to corroborate that or to, you know, provide additional information. And I think that that information in itself is probably important to the CMC as well is that, you know, we looked for this. We

couldn't corroborate this exposure. That says we looked, you know, there's no information out there.

So what I was proposing is that we put that into -- I mean a table would be helpful to be able to say all those things, and a table could be pretty simple. So that was my suggestion.

I want to add one more thing that in order to make this -- just tweak it a touch, it has to be a relevant exposure. So it has to be some exposure that has been associated with the disease. So I can foresee this OHQ having, you know, hundreds of chemicals on it and, you know, 89 of them are irrelevant to the particular disease. I don't think that the IH should have to go through those. So any relevant chemicals should be put in a table. And those relevant chemicals are identified through those relationships in the SEM.

CHAIR MARKOWITZ: That strikes me as complicated to actually do it. So the claims

examiner who is entering the SEM to identify the exposures, and that person may or may not be necessarily using the OHQ to do that. So then the statement of accepted facts, the claims examiner hands over the relevant exposures according to their way of looking, and the SEM to the IH. So it needs to be workable. So you're suggesting that the IH look at the OHQ and decide, above and beyond the statement of accepted facts, which additional exposures might be relevant? Yeah, Dr. Van Dyke.

MEMBER VAN DYKE: So Mike Van Dyke again. I'm all right with the claims examiner doing that. But we have to be very -- it has to be very clear that they're looking at the exposures on the questionnaire as well as what they're identifying on the SEM.

CHAIR MARKOWITZ: All right. But --

MEMBER VAN DYKE: I don't know -- I don't know if we could trust that.

CHAIR MARKOWITZ: Yeah. But the

problem is I, you know, is the claims examiner really qualified to decide, above and beyond the SEM from the OHQ, which are medically relevant or not? I'd be skeptical about that.

MEMBER VAN DYKE: Well, aren't all the exposure disease relationships -- I mean most of those are outlined in the SEM, right, from HAZMAT.

CHAIR MARKOWITZ: Right, presumably. But then you're saying the CE takes the exposures above and beyond what they found in the SEM in relation to job title, the exposures from the OHQ submits them through the SEM to determine whether they're medically -- whether they're in the ballpark. And then if they are, then move them on to the IH.

MEMBER VAN DYKE: Seems complicated.

CHAIR MARKOWITZ: Yeah. That's what I was thinking. Yeah.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. One comment to respond to this. I think the flow of events

went from determining what the disease is, and then from that disease what are the -- what's the short list of toxic substances that have been reported to cause that disease. And usually it's a short list, or none.

And so I think that's what Mike is referring to, and I would agree with that. That if you have someone with pulmonary fibrosis, you don't need to be looking at lead and, you know, a lot of organic solvents. You're looking at the three main causes of pneumoconiosis. And so those are the relevant exposures as defined by the disease and the disease exposure relationships that are listed in the SEM.

So then the question becomes is the SEM complete enough? Is it reliable enough to depend on it for an untrained person like a claims examiner to make that determination rather than it having to be made by a CMC or an occupational physician who is trained in that?

So I think it could be made into a

simple workflow where the disease is identified first, and then the exposure that's -- the exposures that are relevant to that disease are defined by what is known -- what's the science that's known about the causation of that particular disease and toxic substances. So then we get down to what is the -- how good is the SEM for that use so that -- I'd like to know what people think about that.

CHAIR MARKOWITZ: Dr. Cloeren.

MEMBER CLOEREN: This may not be -- this is an interesting example, I may be coming around to what George is saying. If you look -- if you look up beryllium, and I know that we have a test that lets you know there's somebody's sensitized to beryllium so that makes it kind of easier. But if you look up construction workers in relation to beryllium, you don't find that they're exposed to it. And we've got plenty of construction workers in the BTMed program that have beryllium sensitivity and, you know, several with chronic beryllium

disease as well.

So relying on the SEM to identify -- like they were exposed somehow, right? And there's increased risk at certain sites, you know, and that, you know, there's other evidence. You know, I don't think it's -- it's not a routine exposure for construction workers outside of DOE. But it's not reflected for that job in the SEM.

And so relying on the SEM to come up with potential associations for -- Beryllium is a pretty good example of something that where an incidental exposure, you know, could wind up causing disease down the road because it's not the classic dose response. So I'm not sure how to handle it, but I thought I'd share that example.

CHAIR MARKOWITZ: Yeah. Yeah. I don't see either the claims examiner or the industrial hygienist making a judgment about the medical relevance of potential exposures. I mean I think to keep it straight forward,

that we should recommend the industrial hygienist look at the OHQ, and if there are exposures they consider to be important, that they be included in the table. And that be passed along to the CMC, and the CMC decides the medical relevance.

Otherwise, we're in a circular situation where the SEM has undue importance in determining medical relevance. And the whole point of the OHQ is to get beyond the SEM to understand what the person was really exposed to. Dr. Cloeren.

MEMBER CLOEREN: So I think we're in agreement on kind of the principles of our response. What I think still needs to be worked out is kind of how the process might work, I mean the flow. I mean a lot of that is up to the Department to figure out. But we also don't want to be recommending something that is like totally impractical.

So the table may be hanging us up a little bit where I think that we are in

agreement about addressing the elements in the OHQ. We are in agreement with sharing the OHQ. I think we are in agreement about stating what data was found in each of the different sources that were reviewed or not found, you know, explicitly. So I think that, you know, we have overall agreement about that. It's mostly the table idea that I think is hanging us up.

CHAIR MARKOWITZ: Yeah. We definitely -- it's not our job to get into, you know, how this might be implemented, right? I mean we -- on the hand, we shouldn't recommend something that's totally unworkable, right? But we definitely don't have to get into the weeds about that because that's what the program does, so. But I would agree with you, what you say. Comments, questions?

MS. POND: I do have that definition if you want it. It's in 7385(s)(4) in the statute. It says, "Department of Energy contractor employees shall be determined for purposes of this part to have contracted a

coverage on this through exposure at a DOE facility if, A, it is as least as likely as not that exposure to a toxic substance at a Department of Energy facility was a significant factor in aggravating, contributing to, or causing the illness; and B, it is as least as likely as not that the exposure to such toxic substance was related to employment at a DOE facility."

CHAIR MARKOWITZ: Right. Yeah. And I think Ms. Hand, who is sometimes here in the audience, who's not here today. Maybe she's listening. But she has repeatedly pointed this out to the Board over the years, this distinction between significant exposure and significant factor. The act says significant factor, so. So what else do we have, Dr. Cloeren, on this? Yeah. Or we're ready to assemble? Okay.

MEMBER CLOEREN: All my cards are on the table.

CHAIR MARKOWITZ: Okay. So let's

move on, and there should be a PowerPoint that says Markowitz. So the Board made a recommendation last time, and I have an excerpt of that recommendation. I don't have the -- I didn't put the rationale on a slide, so if we need -- if we need to revisit the rationale, we can just discuss it.

But I highlighted the key phrase that we recommended that the program develop a mechanism to evaluate the validity and accuracy of the opinions and rationales expressed by the CMC in their reports. Then we went on to say that it should be done in a way that respects conflict of interest with, you know, the parties that are currently responsible for the CMC reports. And so this was not accepted by the program, and if we could go to the next slide.

So this is excerpts from the departmental response, and in order to fit it on a slide, I just really took kind of the key words or key elements of that. First, the

current adjudication procedures provide claims examiners with the necessary guidance to assist the weight of medical evidence in determining the validity and accuracy of medical opinions submitted by a CMC.

And then, above and beyond that, there are additional program safeguards. First the CEs are required to demand additional input from the CMC when the rationale or the foundation for their analysis is found to be insufficient by the CE.

Secondly, the program has clearly defined mechanisms to assure quality and accuracy. And third, that, actually, the program has staff who are dedicated solely to assessing quality assurance including, presumably, this issue of CMC. And the risk of another layer of review is that it would lead to duplication and delay. So if you can go to the next slide for a moment.

And then at the end, then, the Department requests that the Board provide

specific guidance or references. I want to -- I want you to pay attention to this text because I need some help here understanding this. To medical health science data that can be communicated to staff or CMCs about medical standards or epidemiologic data that could serve to eliminate or reduce instances of gross errors. That was the term that we had used in our rationale as mentioned by the Board.

So the request to us is that we identify guidance or references to medical health science data that they could use to communicate to staff, to CMCs concerning medical standards or epidemiologic data that can serve to eliminate or reduce instances.

So I don't want -- I want to get to this because -- not right away, I want to go back and look at the other elements of their response. But I do want to get to this because I don't -- yeah, I have my own opinion about this, which I'll express in a moment. But next slide.

Okay. So let's back up two slides if we could. Okay. So the first point is that there are procedures in place that provide CEs with the necessary guidance to assess weight of medical evidence in determining validity and accuracy. So I understand this to mean that we have in the procedure manual, and maybe otherwise, but in the procedure manual presumably, some specific directions to the claims examiner in order for them to determine whether the CMC is producing a valid and accurate opinion. And I want to discuss what these procedures are.

I think the question is whether they achieve what is purported to achieve here. But just to, again, review the one, two, three point, CEs are required to demand additional input when the CMC, the rationale, or foundation is insufficient. So that's a good thing, right, if a CMC produces a report and it's clearly inadequate, that they give the CMC another chance to actually beef up their

reports so that, you know, it's well rationalized.

And then the program has clearly defined mechanism, but I think actually this, in part, refers back to these adjudication procedures, and in part to the quality assurance program. And then the idea that they have staff dedicated to quality assurance, which is a good thing, but I don't think those staff -- and you can correct me if I'm wrong here, I don't think we're talking about healthcare providers who are doing that quality assurance exercise. I don't think it's being done by physicians or other healthcare providers. They're analysts in the policy branch who are doing the quality assurance, this part, and other parts of the quality assurance. So let's go ahead two slides.

And at some point, I realized in looking at this and trying to understand how the program views this and how we view this is that I think actually we have different ideas

about what accuracy and validity are. Like I'm basically wondering did the CMC get it right. Given the facts, did their interpretation, their opinion they expressed, is it correct? Or within a range of acceptable interpretations? It may not be exactly what I think for instance, but is it within the range of reasonable doctors would agree or disagree about it? Or is it outside that and they're just plain -- they're just wrong? I mean it happens, right?

And so that's what I think about. But I don't think that's the way the -- at least in the description I could find the way the program really zeros in on quality and validity. So from the procedure manual, Page 129, specifically, a well-rationalized causation opinion, and that's what the CMC is supposed to produce, you know, that's what the -- that's what the product is, from a qualified physician. By the way, it can be produced by the personal physicians, but we're really

talking here about the CMC report.

It communicates accurate understanding of the employee's toxic substance exposure, discusses in the employee's medical history pertinent diagnostic evidence, and then applies reasonable medical judgment informed by relevant, credible medical health science information.

So the CMC is required to apply reasonable medical judgment. So who's in the position of determining whether the CMC is applying reasonable medical judgment? And, frankly, can non-healthcare providers really make an accurate assessment of whether what the CMC is saying is a reasonable medical judgment?

And it's supposed to be backed up by references by medical health science information. Presumably, those are references in the report, right, and we've seen them. We seem the in the IH report. Frankly, the claims we've seen, a lot of the references that we've seen in these reports are extremely generic. I

mean we saw it again in the fictitious IH report that they sent us in relation to the I have. There are textbooks, there are a variety of sources that aren't specific to a particular case or exposure. Anyway, next. So that's what the procedure manual says.

And then to go on, this is -- now these are the instructions for the claims examiner, and I'm almost finished with my little monologue here, so. But instruction to the claims examiner, and I picked out I think the most relevant part. If anybody wants to see the context, we can just bring up the procedure manual, Page 137, and see the other elements.

So a well-rationalized opinion, well, the claims examiner is supposed to prefer the following: A well-rationalized opinion over one that is unsupported. Rationalized means supported by an explanation of how the conclusions are reached, including appropriate citations or studies. We just discussed that.

And the well-rationalized is a convincing argument that is reasonably justified -- represents a reasonably justified analysis of relevant evidence. And then it gives an example of where an opinion that is supported by interpretation of diagnostic evidence, relevant and scientific medical literature is well-rationalized. If it's not, then the conclusion that's reached is not well rationalized. And next slide. And this may be the last slide I have.

Okay. So we can back up. So my problem with all this is that the quality assurance procedures for CMC reports relate to timeliness of the report. These are the requirements of the contractor, the CMC contractor. The timeliness of the report, whether it has a well-rationalized argument in the report, whether it faithfully reflects the facts of the case, whether it appropriately addresses the statement of accepted facts, and some other elements of the report.

But unless I'm missing something, what I don't see is this head-on determination about whether the well-rationalized argument is actually correct or not. And the reason why it's important is when we did review claims over the years, that there were some, a small proportion I would say somewhere 10 and 20 percent, in which the CMC report was just plain off.

And it was striking because it was a shame. You know, the person was not going to get compensated because, you know, it was the CMC to do the report. And the procedures, the system had no way of catching that. They could catch it if the report was late, if it was absent of any argument, if it didn't have references, and other aspects of the appearance of the report. But the actual judgment itself that there wasn't a head on analysis of that.

Now I think there used to be because going back a few years, I think it's true that the physician associated with the program did

quarterly assessments of CMC reports, impairment, causation, and the like. And then would look at that issue of causation. But they rarely found any problems, and I think -- personally, I think the issue here -- and they frequently found problems with the impairment reports, about 20 percent of the time. Some of you may remember that when we looked at that because we've looked at that previously.

But I think they rarely found causation problems because OccMed people around the table understand this, but others should understand, too, within occupational medicine, there are various niches and, you know, I'm not an impairment evaluator so you wouldn't send me an impairment. You wouldn't have me go be a corporate medical doc for a company because I'm clueless about what they do. You wouldn't ask me to do supervised drug testing because I don't know anything about that. But if it comes to a question like epidemiology or causation, then, you know, we want Dr.

Friedman-Jimenez because that's what he does in life, right?

And there are these separate niches in occupational medicine that people specialize in or not. And so I think what's going on, in part, is there's some CMCs who this is not really their expertise, but they get -- they're placed in a position of doing causation reports. And that it seems like a problem that is detectable and addressable. End of my monologue. Dr. Cloeren.

MEMBER CLOEREN: This is all so kind of hypothetical. I want to give a case example that I think everybody could probably relate to. We saw a case of somebody that had asbestos exposure and had interstitial lung disease consistent with asbestosis ,and the CMC in the determination that there was not a causal relationship made the statement that you can't have asbestosis without pleural plaques.

And so that was kind of like a statement of -- an incorrect statement stated

as if it was a medical fact, and it's a common-enough condition that it might be one where the claims examiner might have thought to themselves, wow, you know, I've already adjudicated a bunch of claims of asbestosis without plaques, you know, were those wrong.

But I think if the requirement is that the CMC back up statements like that, that would at least maybe cause the CMC to look up, you know, what proportion of asbestosis cases show up without pleural plaque, and maybe that would be useful. Maybe requiring something to back them up because I think that's a really blatant one where I think we can all agree that's a problem.

CHAIR MARKOWITZ: But there is currently a requirement that the well-rationalized argument be supported by reference to the medical health science literature. That's in the current procedure.

MEMBER CLOEREN: I don't think this one has --

(Off-microphone comments.)

CHAIR MARKOWITZ: Well, I think -- you're probably a little bit more hopeful about the amount of time that you think that doctor will put into that question than I am. But --

MEMBER CLOEREN: I think that this CMC, this is a belief by this CMC that is probably used time after time after time in that CMC's report, and there ought to be a way to counter that kind of like misinformation that is shared, which I think is rare. I don't think it's not the norm by any means. But it's something that there ought to be some kind of way to address, and I don't know what that is, but.

CHAIR MARKOWITZ: Comments, ideas?

MEMBER CLOEREN: So actually did see that twice by the same CMC in two different claims, that's why I think it might --

CHAIR MARKOWITZ: Yeah.

MEMBER CLOEREN: -- a pattern.

CHAIR MARKOWITZ: And you didn't

review that many claims, right?

MEMBER CLOEREN: No.

CHAIR MARKOWITZ: Yeah. Yeah. Dr. Bowman, you look like you want to say something. Sorry. You just have that look on your face. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Well, you know, what's making this difficult is that there's no gold standard. It's not like, you know, a blood lead level that you can measure whether you're right or wrong. Now there's an element of judgment that is necessarily involved in these determinations. And so I think it's not a simple thing, and it has to be, I think, accompanied by some set of presumptions of exposure and of causation that claims examiners can apply who are not trained in making these judgments at a medical level.

But it also has to include detailed causation analyses by occupational physicians who are trained in that subset of cases for which there are complicating factors, or it's

not a clear cut exposure, it's not a clear cut diagnosis, et cetera.

So I think that we should really discuss this further. And, you know, I would propose that we have a working group to focus on the causation assessment. You know, certainly the exposure assessment is a major part of this. That's actually probably the weakest link. But I think there's a separate causation assessment that needs to be done that can be done in some cases by presumption in the extreme cases where it's a clear cut case, but which also needs to be done very analytically by trained occupational physicians, and hopefully then in the minority of cases where it's not so clear cut.

So I think that we do need to discuss this more. I think that we need to come up with a workable set of recommendations for streamlining this causation assessment in a way that's practical and that can be applied. And I don't think we're there yet, and I don't

think we have time at this meeting to make that recommendation. So I think a working group could address this.

CHAIR MARKOWITZ: I would say -- Steve Markowitz. I would say on the presumption front that the Board has provided advice to the program on presumptions in several areas over the years, and those have been largely accepted by the program. And if there are other issues that are ripe for presumptions that we should or the program wants us to look at, that we should address them because presumptions are very helpful to the program. But I haven't been able to think of any additional areas that we might help them develop presumptions for.

And so this really involves the non-presumption cases, right, the ones where you're looking at all the individual information and then trying to make a decision. You know, the -- so on this slide now, the Board is requesting that -- or excuse me, the Department

requests the Board provide specific guidance or references, medical health science data to be communicated to CEs or CMCs about medical standards or epidemiologic data.

I can't think of any way to do that. I can't think of any textbook, database, or a set of medical consensus documents, joint statements that would fulfill that purpose. I don't think it exists. And, you know, we can go into the reasons, but regardless. So I don't think there's any way really of complying with this request. But maybe other people have ideas. Dr. Bowman.

MEMBER BOWMAN: Steve, I agree with your assessment there. I used PubMed to look up if there's review articles on causation assessment with exposures to toxins and occupational health. And the only examples I could find are very specific to specific toxins directly with specific disease. And so the library of such articles that would be relevant would just be too vast to be something that we

could respond to.

But a second thing, going back to what you said earlier about you'd want to ask the right person for the opinion because of the nature of specialization in OccMed, and that's true for scientific fields as well. And I was thinking I don't know and maybe the Department can tell us, maybe someone on the Board knows, how is CMC expertise taken into account or not in selecting which CMC evaluates a case?

CHAIR MARKOWITZ: Well, I can just give an initial response, and if I'm wrong, the -- they try to pick the medical discipline that's most relevant to the questions of the claims examiner. So could be orthopedic, it could be pulmonary. It could be cancer, oncology. It could be occupational medicine or the like. And they try to match it up. I think the contractor's obligation is to try to match up what the questions are with the relevant discipline. Did I get that right?

MS. POND: Yes, that's correct.

CHAIR MARKOWITZ: Dr. Van Dyke.

MEMBER VAN DYKE: Mike Van Dyke. So I'm, you know, sitting here thinking about this with no gold standard, this is the art of medicine, right? I mean this is that undefined part that you have to put all those pieces of information together to get the right answer. And I'm skeptical that there's any way to do that given the breadth of the conditions and the breadth of the exposures because it's going to be a little bit different for many of them.

So I don't have a great answer for you. But I don't know if we have a good answer on the size of the problem either. So I think that if we could get some information around, you know, denial of claims and reasons they're denied in some sort of way that we could say, you know, 10 percent of claims are denied based on inability of the CMC to establish causation, you know, then at least we know it's 10 percent that we're looking at and it's not 50.

So I think that would be helpful as

a start. And then we might be able to dig into some of those because we might be able to identify specific diseases or specific exposures where you're consistently seeing more problems than others. But as a holistic problem, I'm a little skeptical that you can find a good answer.

CHAIR MARKOWITZ: The Department has provided for us, I think at two separate times, tables on the most common health conditions for which there are claims by organ system or sometimes by disease type, cancer. And then the number of claims in a given time period, how many were accepted, how many were denied, and then the reason for the denial, and it could be any number of things. Causation's one of them. But there are other reasons as well, ineligible and this and that.

And so it would be helpful to have an update on that table, actually, since the last one that was provided to us. Probably it's only a year's worth of data, but it would

be of interest. It may also be of interest relevant to the fluctuation in the number of claims.

I don't think that's going to answer the question because it tells you sort of the outer limit of the problem. But all you have is the percentage of claims that are denied by virtue of ineligibility or no employment verification or causation. And then within that, a lot of those causation opinions are going to correct, right? And then some portion are incorrect, and those are the ones we're worried about. But it'll give you some sense of magnitude of the problem. So I think we should request that and that might help the discussion.

But I mean to say about -- let me just respond to the art. I actually don't think this is a question of art. I think these are cases in which, you know, the doctor made the incorrect conclusion based on what we know about the medical science. And it wasn't a

question of art at all. It was a question of science, and they just got it wrong. And, you know, we can talk about the gold standard in a minute because it's not like I consider myself to be the gold standard. It sounds like it, but it's not. But, you know, there, you know, sometimes doctors are wrong, right? Dr. Cloeren.

MEMBER CLOEREN: What if in a few cases it's not about the art of science, but about bias of a particular CMC, or one or more? I wonder if the Department has ever looked or would think about looking at the kind of trends among CMCs in agreeing with, like, saying yes, caused and no, didn't to see if there's any bias in a particular direction.

MS. POND: This is Rachel. Yes, we have looked at that after some of the Board actually reviewed some cases and had brought some things to our attention. So we have looked at those trends to a certain extent. You know, we didn't find anything really

significant. I think there may have been one or two that we kind of had to look at more closely and talk to the contractor about.

But, in general, we didn't see anything specifically that would lead us to believe there was a particular bias other than there might be trends like you found in the one report about, well, this doctor consistently says this. And the trouble with claims examiners, they can weigh medical evidence, but they can't know if the medical veracity is wrong necessarily.

And that's where I think Dr. Markowitz is talking about that complication for us because we have to weigh the medical evidence, and we have to look at the quality of these reports. But different doctors at different times are going to say I don't agree or I do agree, and that's where we get into this kind of rub as to figuring out when it's the report that's just wrong and how we would know that as claims staff.

So our claims staff do the best they can in trying to look at the various opinions. Actually read through the references that are provided because we get these reports, not just from CMCs, but we're not getting a lot of them from treating physicians, authorized reps physicians that, you know, have been providing these reports.

So we have to shift through them in all those facets to review the references, are they relevant? Do they make sense to this actual situation? So it is a very complicated, as you all know, problem to have, and looking at the whether it's right or not in the face of it, the medical veracity of it, that's where we struggle and that's why we're where we are, I believe, with this topic.

CHAIR MARKOWITZ: Dr. Vlahovich.

CHAIR MARKOWITZ: Kevin Vlahovich. Similar to what Dr. Cloeren was just talking about, about whether a CMC is the appropriate person to review a study, or if there's bias

present. Even in the example that Dr. Cloeren gave about someone having no pleural plaques, but asbestosis. I'm sure that if you looked up PubMed, you could probably find some studies that will say that is true, you know, when the 99 percent of these might not.

Is there a way when reviewing evidence that has been cited to verify the accuracy or veracity of that? Like what impact study, the journal cited, or what types of studies have been cited, whether it's systematic review or case study? And I don't know if there's an answer to these questions, but --

MS. POND: Yeah. I don't know if that was necessarily a question for me. This is Rachel. I'm sorry. But in terms of when we do look at the citations that are provided, if we have -- if our claims staff have questions, or they say this seems kind of right but they're not sure, they'll go to the toxicologist oftentimes to provide us with some

more information about those articles of what they mean and try to give us some interpretation.

If there's a question that, you know, we can re-ask, go back to the doctor whether it's a CMC or the treating doctor, we'll do that and say we're not really sure what this means or where this comes from, we can do that. But that's where knowing when to ask those questions, when not to ask those questions becomes a challenge.

CHAIR MARKOWITZ: If we looked again at this slide about whether the Board can help find guidance, references, medical health science data, medical standards, or epidemiologic data, so, you know, I can think in the cancer field, if we're talking about oncology, how to do that, you know, you would go to the standard of care set out by the National Comprehensive Cancer Network, NCCN. They have treatment recommendations. And you can, if you were diagnosed with cancer,

whatever type of cancer, that's where the oncology community would agree, kind of a starting place for what treatments you give. And these are consensus treatment recommendations.

We don't have anything like that in occupational medicine. We don't have a textbook like that. We don't, you know, have a set of guidance documents or -- can anybody think of any response to this request from the Department that might be helpful?

MEMBER FRIEDMAN-JIMENEZ: Yeah. This is George Friedman-Jimenez. I've reviewed a small number of cases, and I would say I agreed with most of the causation analyses. But I saw several that I disagreed with, and that I think were in error. And in both directions, both denying causation when I thought that it was likely, and in one or two cases supporting causation when I thought it was not likely, which we didn't make an issue because we didn't want to overturn a settled

case. But I think those are in the minority, but it does occur in both ways.

And I think that there are some ways that we could identify implementable recommendations that would reduce the likelihood of these kinds of misinterpretations that lead to this likely errors. And I say likely errors because I'm not, you know, a gold standard either. These would be disagreements among physicians.

But I think we could improve on some of the literature reviews. They could be updated that are done to support some of the decisions. We could improve on understanding of multiple factors contributing to causation. There are a number of ways that we could improve on the accuracy of these causation determinations, and I think it would be worth looking at them.

And, you know, we're not going to solve the entire problem, and, in fact, we don't have a gold standard, as I said. And so

we're never going to be able to measure the sensitivity and specificity exactly of the causation determination compared to the actual truth.

But we can, you know, use the expertise of toxicologists, of industrial hygienists, of epidemiologists and clinical occupational physicians to come up with a best judgment in some cases that would differ from the judgment of a single CE or a CMC that made a determination that was based on either misinterpretation of data or not considering some of the available information on exposure or other disease-related factors.

So I think that there is some room for improving the accuracy of these determinations, and I think it would be worth reviewing that and seeing what we can suggest that would be practical and likely to make incremental improvements. Again, we're not going to completely eliminate errors in causation judgements, but I think we can make

some improvements based on the small number of cases I've seen.

Now many of you have seen a lot more -- reviewed a lot more cases than I have, and so I'd be interested to know what you think, if you've seen causation analyses that you think are incorrect or that there's some clear error that was made that could be avoided in future cases.

CHAIR MARKOWITZ: Well, one idea of approaching this would be kind of in parallel with the way that the program currently does quality assessment where they take a certain number of cases, a certain number of claims. Right now I think it's about 50 per quarter, and they're divided equally among different types of medical reports.

Some of them are CMC reports. Others are what are called file review reports and other types of reports. And those are reviewed by the dedicated policy analyst staff for various aspects of quality that we talked

about before, but not directly head on is this opinion correct or not.

And why not develop a small panel of causation physicians, that's what their expertise is, occupational medicine, but this is what they specialize in, who would participate in that quarterly assessment? And what their job would be would be to look at the causation claims, but the same could be applied to impairment, you know, impairment specialists, right, who look at the impairment claims. And look at whether, you know, look at whether it's valid, whether the opinion was valid or not.

And if there's a disagreement with the CMC, then you might hand it over to a second causation physician sort of as the referee, right, so that you're not wholly relying on a single person and their own set of knowledge, et cetera.

But to identify a small panel that could do this on a quarterly basis. It could

be, you know, I mean I don't know of the mechanism. Could be embedded I suppose within the current contract, CMC contract a separate panel of causation physicians within that contract, or the Department could do it itself, you know, that's a mechanism that's up to them.

And it would be an improvement on what there is now because it would be a direct assessment about whether the causation opinion was correct or not. And it would be a way of identifying certain CMCs who are repeat offenders because if you looked at a certain number of claims over time, you could see whether there are people who, you know, frankly, they shouldn't be doing the CMC evaluations. It's just not their -- it's not their strength.

So identify the rate of the problem, monitor that, and it could help identify some CMCs who, perhaps, shouldn't be part of the process. So that strikes me as maybe ambitious, but doable in terms of the way the

Department approaches quality assurance now. And having achieved unanimous consensus with this idea. No, seriously, people have any thoughts or reactions, or --

MEMBER BOWMAN: Steven. This is Aaron Bowman. I agree with what you just mentioned, and I think your use of the word consensus earlier is an important part of why I agree. Right? Like in the scientific community, we'll assess the quality of data being presented and whatever by a peer review process. So there is no, quote, "Gold Standard." Therefore, the standard is the consensus of the community.

So having other CMCs or relevantly trained experts to look at this, I would be -- I think, in fact, is the gold standard of how you assess right or wrong. And if something can be tied in with existing QA processes and procedures, that would be good as well.

CHAIR MARKOWITZ: So peer review is the --

MEMBER BOWMAN: Mm-hmm.

CHAIR MARKOWITZ: -- right, is the mechanism essentially? Right. Yeah. Other comments or -- okay. Well, Dr. Cloeren.

MEMBER CLOEREN: I think that sounds like a great idea. I suspect the problem is not as big as we may, you know, I think that, you know, when I used to federal worker's comp case management, you know, the cases that were going bad were the ones that I saw. And so like you get this skewed idea that everything's gone bad, and that's not the case. Almost, you know, almost everything is going well.

And so having a systematic peer review process would be helpful in documenting kind of the degree of the problem, and come up with some solutions, you know, to it if problems are identified. I think that's a good idea.

CHAIR MARKOWITZ: Yeah. It may not be, you know, we don't know, really, the magnitude. But the point is that the program

cares a lot about quality assurance. You know, it went through a redesign of quality assurance of many aspects of many actors in the whole process. And this is an omission, and it's an omission that can be rectified. So it's not a special effort, I think. It's just to fill out or complete the quality assurance process. And Ms. Pond is nodding her head yes, so I think we can move on.

MS. POND: I don't think I did that.

CHAIR MARKOWITZ: Oh, maybe she was thinking about something else. George, I was making a joke, just to be clear. Okay. Okay. So we've exhausted that for the moment. We can come back to it tomorrow morning if we want. But we've exhausted that for the moment. If there are any last comments or questions about this, otherwise we'll move on.

Okay. Okay. Speeding along here, are we ready to revisit the significance question, or should we take a little bit of a break at this point and -- okay. I hear two

nods in favor of breaks. So we're going to take -- it's 2:20, let's reconvene at 20 of 3:00, in 20 minutes.

(Whereupon, the above-entitled matter went off the record at 2:20 p.m. and resumed at 2:43 p.m.)

CHAIR MARKOWITZ: Okay, let's get started again. So the schedule for this afternoon, we've got one more topic, actually, to address by our agenda, and then we have the public comment period. So, as it stands now, we have no people requesting to make public comments, but the Board needs to be available at 4:15 in case anybody does come forth.

And let me just say for the public, to the extent the public is participating in this, you're welcome to make a public comment starting 4:15. The way in which you would communicate your desire to make a public comment would be, Ryan?

MR. JANSEN: Energyadvisoryboard@dol.gov. Just send a

message to that email address and we will put you on the list.

CHAIR MARKOWITZ: Okay, so now we're going to return to a topic that the Board discussed at a meeting or two ago about some language from the procedure manual relevant to what we were discussing before, which is basically different levels of exposure that industrial hygienists can estimate for use in claims evaluations. So what I've done is actually bring up from the procedure manual the part, page 127, procedure manual 7.1, which deals with this, but let me turn it over to Dr. Cloeren.

MEMBER CLOEREN: Okay, well I think everybody can see it. This is just kind of a quick review, I guess, that the levels -- so I'll just read parts of it. The IH will assign a level of exposure to each toxic substance as incidental, significant or more than incidental, but less than significant. I think there's kind of implied in there or none,

right?

So, if there's an exposure it's incidental, significant, or more than incidental but less than significant and then within -- well, I guess we could look at what incidental is. It's generally kind of in passing, intermittent, infrequent. Thank you, that's helpful. And, usually without a connection to their normal work.

Significant, then, is further broken down into three potential categories - high, moderate or low. So this would be for each exposure that's relevant. Then, in categorizing it, they take into account their job classification, their work tasks, the presence or absence of exposure monitoring data, and I think that's actually really important that that's in there. They take that into account and I'm sure that weighs into their decisions, but the reports don't tend to be explicit about what is available about exposure monitoring.

Frequency of activities, and I think a lot of what the industrial hygienist does, I believe, is makes a judgment call based on their own experience, rather than having any actually written evidence of how often, how long, etc., and without having interviewed the worker, which would be helpful. Then, any information that is known about what's going on at the site at the time, use of personal protective equipment, and use of personal protective equipment, I think, is assumed in most cases. If there's not documentation of it, the worker might have information about it, how reliable is the information, you know, I don't know, but that may be the best way to get that information in most cases.

Then, in thinking about all of this, the industrial hygienist uses their knowledge and judgment to assign a level of significance. The procedure manual goes down and defines each of the categories, so more than incidental but less than significant and I think this is part

of what Dr. Friedman-Jimenez is pointing out, that you can have incidental exposures that are still clinically significant and as written it doesn't take that into account too well.

All right, we can go down to the next page. So that was the only thing that's really described. It doesn't really describe the low, moderate, and high. The reason we keep on coming back to this is because the word significant is used in the statute in two different ways, and the conclusion of the industrial hygienist that an exposure is significant can easily be interpreted as that it was a significant contributor to the medical condition which is not something that is really within the industrial hygienist's purview.

CHAIR MARKOWITZ: Steve Markowitz, I have a question. You just said that the act uses the word significant in two different ways.

MEMBER CLOEREN: Well, I think from what Ms. Pond read earlier, it's both

significant exposure and significant contribution to the illness. I think it's in both parts right? No?

CHAIR MARKOWITZ: The act says it has to be a significant factor.

MEMBER CLOEREN: Okay, but isn't it also exposure? Maybe I misheard.

MS. POND: The act does use the term twice, but I think significant is only in there once and that's at the beginning of that phrase where it's a significant factor and the second part of exposure is that the exposure has to be related to DOE employment. So, first it says the exposure must be a significant factor in causing/contributing to or aggravating and then it says that the exposure has to be related to employment and that phrase in the act itself.

MEMBER CLOEREN: Okay, so in the act significant is connected with causation. The causation decision, whereas in the procedural manual, well I think it's both ways if we were to do a search for significant, it shows up in

a lot of different ways in the procedure manual, but most importantly for our purposes right now, it's used to describe the exposure, which can be -- it would not be surprising to I guess learn that people may interpret the significant exposure and kind of add that therefore it's causally related or not a significant exposure and therefore not causally related, right?

CHAIR MARKOWITZ: So my reaction, Steve Markowitz, is that as an occupational medicine physician, is you've got six categories of exposure, right? You have none, incidental, more than incidental, and then three levels of significant and based on either the report of the patient, the participant or usually no real industrial hygiene data, monitoring data. You might have the data of the occupational health questionnaire, right? Represents data. I'm hard pressed to divide the exposures into six different grades based on that kind of information.

MEMBER CLOEREN: Marianne Cloeren. Yeah, I agree. I mean I think that the kind of the fine parsing out of the different levels suggests that it's based on data and there's not a lot of data on which to base the determinations anyway. So, I agree.

CHAIR MARKOWITZ: But what do the industrial hygienists think of this? Dr. Industrial Hygienist?

(Laughter.)

MEMBER VAN DYKE: Mike Van Dyke. Since you asked, I mean, I think, to me, one of the problems is that they don't really define high, moderate and low very well, for one. So, it kind of leaves it up to the judgment of the industrial hygienist, and I'll tell you from experience that industrial hygienists think very differently about low, medium and high. I think that's a problem in itself.

I mean, I think it gives you a framework, it gives you a scale. You can work with a scale. I don't like the words

necessarily, but there is a scale there. Probably too fine of a scale, but sometimes industrial hygienists like precision, unjustified precision, I should say.

CHAIR MARKOWITZ: Preferably precision based on facts, right, yeah. Mr. Domina?

MEMBER DOMINA: I think different than you guys do, just because of my experience, but I also have problems with that in passing only with the low, medium and high in our world, let's just say 10 is low, 15 is medium, 20 high, well, now you can't get your work done. So, now all of a sudden 10 goes to 20 or 30 or 50 on some measurement that you're doing, if they're measuring it at all. That becomes problematic because, you know, like now everything's run to failure. Well, just because a light turns on, doesn't mean that whole thing hasn't failed.

You know, same thing, 100 percent used to be here, 100 percent's here now and you

have to look at it differently. Because that in passing only is problematic for me. Somebody could be beryllium sensitized in passing only, but there's a test to measure that. It's the same thing as I've had people go out on the tank farms, four people together in one instance. Two of them are 5 foot nothing, two of them are 6 foot 4. The two for 5 foot nothing end up on the ground based on atmosphere, different stuff pushing the vapors down, and that stuffs not measured. So, a lot of this where somebody who has no experience of being in the field, making a decision that it's in passing only, it's low but not significant is not correct. Without them talking to the people and understanding the type of work -- like I spoke earlier today, when we're talking about tank farm vapors where you got in respiratory protection, well they spent millions and millions of dollars to put stacks in to get it away from the people, but certain times of year, the spring and the fall, when

the air gets dense that stuff can get pushed to the ground. So, that's my two cents.

CHAIR MARKOWITZ: Mr. Key?

MEMBER KEY: Yeah, I echo Kirk's concern and summation on it. A low chronic over a period of time to an individual certainly could be the causation as opposed to a significant short burst effect.

CHAIR MARKOWITZ: Peak, peak exposure right?

MEMBER KEY: And so that presents a problem I don't know what the determining factor or person is thinking. If they see that it's low significant, but don't have that worker health questionnaire that that exposure being low was chronic over a period of 15 years.

CHAIR MARKOWITZ: Mr. Catlin.

MEMBER CATLIN: Mark Catlin. I have two thoughts that concern me and I'm not sure how to deal with them. One is I guess from my own experience, I've seen the hygiene

definition of significance where it's interpreted by medical people who aren't occupational medicine docs and they interpret that to mean there couldn't have been a disease, based on that exposure. So, it's giving industrial hygiene a little more credit than it should in terms of causation.

So I'm concerned if that is --

(Simultaneous speaking.)

MEMBER CATLIN: Oh, I'm sorry.

CHAIR MARKOWITZ: Could you repeat that?

MEMBER CATLIN: Yeah, and shorten it. So, I guess I have two concerns and one is the word significant, how the hygienists field uses it versus occupational medicine or medicine. I've just seen in my own experience where non-occupational medicine docs have sometimes interpreted industrial hygiene definition of like low exposure meaning the person couldn't have disease related to work and so the claims would be denied in a Workers'

Comp system. So, I don't know if that's something that's happening here with both the CMCs and/or the claims examiners and I would be concerned about that and figure out if we can address it.

The other one is before coming to the meeting, I was looking through this in different ways, and I saw some historical references to exposures, you know, problem events that were listed. They would have the short summary that exposure was very low or exposure was below legal limits, but you also look at the dates and so some of these are like 1964, some of them are like 1986, and we've seen this in some of the claims examining where it's not clear when the IH report will say the exposures were within legal limits, you're not sure what time frame, what limits they're talking about, so that could be incredibly confusing and misleading, too.

MEMBER CLOEREN: Can I just --

CHAIR MARKOWITZ: Sure, sure go

ahead.

MEMBER CLOEREN: I just want to embellish a little bit. For people that may not be aware, I think what Mr. Catlin's getting to is that the standards at the time may have not been exceeded, but today that would have been definitely exceeded because the standards have changed over time. We know that lower levels are more dangerous than it used to be thought. Is that what you were getting at? Yeah. Thanks.

CHAIR MARKOWITZ: I think there were some comments on this side.

MEMBER BOWMAN: Yes, thank you. Aaron Bowman. Actually, skip ahead, Mark, to your point, I think that on your first point that is, in fact, the concern that some of the claims that we examined had that exact thing where a CMC stated, IH says this is low, therefore, it cannot cause disease. So that's what we're trying to point out.

Then back to the point that Jim was

making earlier, you made a point about chronic versus acute basically. That's exactly why we made the new table because to just use one term to describe an exposure, ignores all of exposure science and that's why we had the table, right, which was now maybe not fully going to be used, but it's for those exact reasons, because the nature of the exposure makes a difference and it's not -- presumably, I guess maybe there's one term because we're leaving it up to the IH to determine an amalgam of all those things whether it was significant, which is why we had this working group of what significance means in the first place.

So, we are all the way back to square one, but we don't want to go around the same circle again, so it might be helpful to think about any recommendation we made in the context of learning what recommendations we have previously made were not effective and thinking more forward about them.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: Mike Van Dyke. Yes, I agree with you Dr. Bowman. We feel like we're running around the same exact circle again and I was kind of hesitant to jump on that track, but I agree with the duration, frequency and intensity of exposure are the important constructs of exposure. I think I've said this before, the industrial hygienists and physicians don't necessarily speak the same language, and trying to think what the other person is saying based on a term that's not defined, is difficult. I think that if we could get more defined terms, we might get to a better place because at least there's some common place people could go to look for that definition, but without defined terms, we're going to kind of miss each other in the night a lot of times.

CHAIR MARKOWITZ: Dr. Cloeren?

MEMBER CLOEREN: I wonder if -- I have no idea whether this is already done, but guidance to the CMCs kind of pointing out the

different ways the terminology is used and providing examples where low exposure might still mean clinically significant, whether that might be something that's considered unless something like that already takes place.

MS. POND: This is Rachel Pond. We don't necessarily send out guidance to the CMCs that say that exactly, but we also have to keep in mind that it's not just CMCs that are issuing these causation determinations, it's treating physicians. But yeah, we give them a certain amount of guidance. We have a manual for them in general terms, but I don't think that we've laid it out exactly as you've indicated.

CHAIR MARKOWITZ: I just have a question of clarification. Mr. Vance explained this to us previously, but I don't recall, there's something about the word significant here that's relevant in terms of other provisions of the procedure manual. If you are deemed to have a significant exposure of

whatever -- low, medium, high, it gets you eligible for something. I think it's a presumption and that's important because the presumption is a facilitated pathway towards a successful claim.

So, you want it to retain the use of the word significant because it makes you eligible for a prize and yet, I guess, the program decided that you needed something less than significant in which to characterize exposure. Did I get that right?

MS. POND: This is Rachel. Yes, that's correct. And some of these presumptions that are in Exhibit 15 of the procedure manual, you'll see where it says you had to have had a significant amount of exposure for this prolonged period of time or whatever it is depending on the condition and that is why we do look for the word significant in the IH reports when we're looking specifically for presumptions.

CHAIR MARKOWITZ: So that's why it

makes this hard for us to recommend somehow getting rid of the use of the word significant here because it ties into other parts of the procedure manual. My concern about the relatively new category of more than incidental but not quite significant is that it's a place to park a lot of exposures that you don't understand what they meant. You don't know what their levels were, and the CMC is going to interpret that usually as being unimportant.

And if it were based on underlying facts, okay, but it's based on a gestalt and an impression about what went on. That's a problem, I think. Dr. Bowman?

MEMBER BOWMAN: Yes, thank you. In terms of these elements and how to utilize the terminology and the idea that the word significant is important for many reasons, I think part of the concerns about the table that the Department mentioned was just that there's value to the narrative explanation as well, I believe that's what I recall from reading in

their response. Maybe if the IH -- we talked about defining the word significant and the different definitions of this word across different fields, perhaps at least whether it's in the narrative or in the table, if the IH says, this is significant low, they should define what elements of the exposure made them say that. That could help, that way therefore it's internally defined in the document that the physician is looking at.

CHAIR MARKOWITZ: Michael Van Dyke?

MEMBER VAN DYKE: Mike Van Dyke. Dr. Bowman, I agree. I mean, I think significant is defined here. That is one term that's defined. The terms that aren't defined are low, medium and high. I think that if you asked any occupational medicine physician, you know, if they're going to make a causation determination, what do they need to know? They need to know level of exposure, how often they were exposed and for how many years because most of these things are chronic long term

exposures.

We've kind of excluded two of those from this situation right here, so to expect a CMC to make a decision based on just the gestalt is pretty difficult. And I'll add that industrial hygienists don't necessarily know the answer. I mean, they don't think that -- I know it takes 10 years, and I'm making this up by the way. We don't think about, we know it takes 10 years to get asbestosis from exposure. That's not the way we think. We think, you know, we know there's an asbestos standard. We know what the level of exposure is in relation to this standard and we know how long a person is exposed. So, it's definitely a different thinking process as well.

CHAIR MARKOWITZ: Steve Markowitz. There's a point you made I didn't understand. You said they are missing two factors? The rubric is missing two elements?

MEMBER VAN DYKE: Frequency and duration.

CHAIR MARKOWITZ: But isn't low, medium, high a compilation of -- doesn't it represent dose, a combination of frequency, intensity and duration?

MEMBER VAN DYKE: Somehow, in a way that's not defined.

CHAIR MARKOWITZ: But would a definition look like? Because it's going to be different for each toxic substance.

MEMBER CLOEREN: It would look like a table.

(Laughter.)

MEMBER VAN DYKE: It'd look like a table, like we've been --

(Simultaneous speaking.)

CHAIR MARKOWITZ: It would look like table, an improved table.

(Laughter.)

MEMBER VAN DYKE: They use intensity terms to have the gestalt for all three of those in one term.

CHAIR MARKOWITZ: Right. Go ahead,

Dr. Cloeren.

MEMBER CLOEREN: Marianne Cloeren. I think there was agreement to use the table if it was determined that an exposure was significant. I think we got that far for the significant, which is good. I just had a follow-up thought related to something somebody said, maybe Mark, maybe something Jim said. I don't remember seeing reference in IH reports -- and I may have missed it, or it may not have been relevant -- to changing standards. I think that would be very important to include as well, like that the standards at the time this person worked allowed a much higher level than is considered safe today.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: I know we had talked about a recommendation along those lines, but just if a standard is referred to, the date of that standard, you shouldn't refer to a standard without staying what the standard is you're referring to.

MEMBER CLOEREN: Marianne Cloeren. But also, I think a lot of people reading it may not take the time to look up whether that standard changed, so I think it would be helpful for the IH report to point out that the standard today is ten percent, you know, of what it was at the time that things were within limits.

CHAIR MARKOWITZ: Mr. Catlin?

MEMBER CATLIN: Yeah, Mark Catlin. If I can just give an example. I was looking in the SCM and it was at Los Alamos exposures to asbestos and there was a report from -- I think it was '86, and it said that the exposures were below the OSHA standard from the summary report. Well, '86 was actually right at the time the standard was changing so were had the standard changed from, I'm trying to remember the numbers, but it changed by a factor of 10 or more and so it would be really crucial for that to be in there.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: I think when we originally talked about this, we talked about most of us think in terms of today's contemporary standards in terms of low, medium and high. So, if we're going to come up with some sort of definition, it needs to be relevant to today's standards and I think that Dr. Cloeren mentioned that by saying that the standards were much higher than they were before, now we're adding another one of those 1995 statements that we don't want to bias it that way. Just because the standards were higher doesn't mean they were exposed to more.

MEMBER CLOEREN: That's true, yeah.

MEMBER VAN DYKE: So, we don't want to bias it the other direction either.

CHAIR MARKOWITZ: Yeah, Steven Markowitz, the other problem is that I mean if you're going by OSHA, they've changed very few standards over the years, and they have very few specific standards. If you're going by -- I don't know how DOE standards have evolved

specifically, I don't know what they were before 1995, but if you're going by the industrial hygiene community which has lowered recommended standards over the years, so which standards? I think it's too much information, and there's too limited coverage by legal standards to make it relevant.

But here's my question: You know, given what Mr. Domina was saying before, does it really make any sense to have a distinction between incidental and more than incidental? Both of which reside below low. Dr. Cloeren?

MEMBER CLOEREN: Do we know why that change was made? Was it in response to something we recommended?

(Laughter.)

CHAIR MARKOWITZ: Right, I think we know that, no.

(Laughter.)

CHAIR MARKOWITZ: I don't know, Ms. Pond, whether you or Mr. Vance want to respond to that or not. If not, that's fine.

MS. POND: I don't know for sure. I wouldn't want to admit -- I wouldn't want to confirm or deny that statement.

(Laughter.)

CHAIR MARKOWITZ: I know Mr. Vance gave us an explanation before actually.

MS. POND: John, did you want to address that?

MR. VANCE: Yeah, I mean this was our attempt to -- we were getting rid of the language that spoke to regulatory limits because there was a very big concern about trying to explain what that meant so we had to come up with some other type of way to describe this that took into consideration lots of different factors and so the industrial hygienists when they were looking at this and considering how to deal with this reality of, yes, we don't really know what standard applied at what time.

You have to look at the totality of the information that you have in front of you

and sort of come to some sort of estimate about what the industrial hygienist thinks could have been likely occurring and as they got into the discussion about like from the '90s on, really you would expect to see things in the file and that doesn't necessarily mean that it was a completely safe operating circumstance, it's just we've got to see something. We want to see something more compelling or convincing to show us that there was something that would've been an occupational risk or a hazard for this individual employee and then this language sort of came out of those discussions.

There was a lot of debate about it and I think that just from the discussion, this is not easy. There's no easy answer. Our folks and the scientists that work on this struggled with this quite a bit to try to come up with something that sort of melded all the viewpoints that have been out there. I think it was informed a little bit about the conversations the Board had.

CHAIR MARKOWITZ: Thank you. Any further comments on this issue? I mean I wanted to come back to this because we had begun this discussion and I think it's important. We don't need to formulate a recommendation, although we could, not this moment, but by tomorrow morning, for example, if we thought there was a direction we wanted to head in.

I remain bothered by the fact that there are six levels. There is very little quantitative data, and there's the occupational questionnaire and yet the industrial hygienist is tasked with choosing one of six different levels to pass along to the CMC to make a decision.

Okay, so if there are no further comments or questions, we're going to take a break actually. Let's just discuss tomorrow morning for the moment. It's 3:15 now, our public comment period starts at 4:15, we would come back at 4:15 in case any public commenters

show up, but there are a few things we're going to deal with tomorrow. One is, hopefully, we'll have, I think, a recommendation or at least a response on the issue of industrial hygiene on the table and the characterization that we discussed earlier.

I think we should consider either a response or a recommendation regarding CMCs and quality and validity. Again, it could be -- if we can agree on a path, it could be a recommendation, or it could be agreement on various elements of a response whereby we disagree and why we disagree with the decision the Department made in response to our recommendation. So, we would address those two things.

I think if there's something that we want to say about this issue of significance, we could formulate that tomorrow. Then a brief discussion, we've been requested to look at the IARC 2A Carcinogens and I think Paragon has identified them, including the candidate human

cancers that would be concluded in this SEM and the request is that we review that not at this meeting, but sometime in the coming months and then weigh in with the Department about our proposal.

Are there any other issues that we should discuss? Because we will have time tomorrow to open up new issues. Again, if you think of any tonight, we can raise them tomorrow, it's fine. Dr. Bowman?

MEMBER BOWMAN: I was just going to say in your list of to-do items for the Board, one of them, which, I'm sorry if I didn't hear it, we were going to provide some additional follow-up questions on the SEM.

CHAIR MARKOWITZ: Right.

MEMBER BOWMAN: With examples?

CHAIR MARKOWITZ: Right. Now that was going to be done after the demonstration of the SEM or?

MEMBER SPLETT: Probably before.

CHAIR MARKOWITZ: Okay. And do we

need further discussion at this meeting about that, or is that something that -- tomorrow? Okay fine.

MS. POND: This is Rachel. We do have, there were a couple of questions from the follow-up questions that we still had. We can provide you those in writing. There were only like two left, I think, on that list so we were planning to provide those responses that we talked about today in writing as well, so we'll do that before the next subcommittee meets and does the demonstration.

CHAIR MARKOWITZ: Okay.

MEMBER BOWMAN: For example, the examples, Gail, that you walked us through the differences and since if we need full Board approval to put those in in order to get a response for us to evaluate, it would be good, I think, to have that written up tomorrow and voted on. If we can submit the questions without the full Board approval then not.

CHAIR MARKOWITZ: Yeah, I don't

think we need full Board weigh in on the questions.

MEMBER BOWMAN: Okay.

(Off-microphone comments.)

CHAIR MARKOWITZ: And when we have the demonstration, it needs to be a subset of the Board. It can't be the entire Board, which means that it can be all but one Board member, so as many people as want to participate. I'm sure there will be at least one who will be otherwise busy, so there won't be a problem. Yeah, Dr. Cloeren?

MEMBER CLOEREN: I do think it's important for that demo that it be set up in a way that it permits both Paragon and Gail and other --

CHAIR MARKOWITZ: Board members.

MEMBER CLOEREN: Yeah, Board members, to be able to show. I think the demo of how it works is great, but I think the demo of the problems that people are finding, I think, would be just as important. So, I think

it should be a two-way interactive demonstration if that's possible.

CHAIR MARKOWITZ: Does that seem possible, Ms. Pond?

MS. POND: Yes, I think so. I mean I know she has examples already, so it will be interactive, especially if we can do it face-to-face. There will be an opportunity for that, more opportunity for that.

CHAIR MARKOWITZ: Face-to-face?

MS. POND: If not, I mean, we can probably work it out through WebEx or something. I don't know exactly what the plan would be.

CHAIR MARKOWITZ: Yeah, okay. Okay, so if there are no other comments or questions then why don't we suspend until 4:15.

(Whereupon, the above-entitled matter went off the record at 3:21 p.m. and resumed at 4:15 p.m.)

CHAIR MARKOWITZ: Okay, let's begin the new session. So the public comment session

is now open. For those of you who are online participating, if, as members of the public, you wish to make a comment, you're welcome to do so. If you could indicate on the WebEx, I think, by raising your hand then the people here can see you and then we can put you on the schedule, which is quite short at this point, so please indicate if you'd like to speak within the next five minutes or so.

So, let me welcome Ms. D'Lanie Blaze as our first speaker.

MS. BLAZE: How's that?

CHAIR MARKOWITZ: Good.

MS. BLAZE: Thank you. I'm D'Lanie Blaze of CORE Advocacy for Nuclear and Aerospace Workers. I mainly represent claimants who are affiliated with Santa Susana Field Laboratory and its related work sites, Canoga and DeSoto Facility, near Los Angeles, California. It's a privilege, as always, to address the Board and I thank you all for traveling to be here and for offering the

opportunity to provide public comment.

Today, I want to talk about the removal of information from the SEM for Area 4 of Santa Susana. In 2017, the propulsion workers and related activities were removed from the SEM in response to a FOIA where I requested information about the directive and the rationale to remove this information. The contractor, Paragon, indicated that it had removed propulsion workers and activities because these employees are not considered to be eligible for the program under Part E, but this is incorrect. These workers have always been eligible for the program. Not only is this incorrect, no other information was provided regarding where the directive to remove the information had originated or what documentation was used to support the removal.

Mr. Turcic had authored the Established Eligibility Decision for Area 4 Santa Susana during his time as the program director in 2005. In his decision, the

propulsion workers certainly were never excluded. In fact, the decision that he issued provides that any Department of Energy contractor employee who can establish employment for the company at a location where DOE conducted operations may be considered to be eligible for the EEOICPA, and that means any DOE contractor or subcontractor employee who performed job duties inside Area 4.

Based on the multiple Department of Energy-funded propulsion programs that occurred in Area 4, which began in the 1950s, there was no basis to remove these workers and their activities from the SEM. These DOE funded operations began in the '50s, the locations where the work occurred in Area 4 are still included in the SEM and Paragon is in possession of worker DARs showing verified Area 4 employment among propulsion workers, who performed associated activities inside the covered area.

So, it was shocking that this

information was removed, and to date, Paragon has not disclosed at whose direction this occurred or provided any information as to what information was used to support this move. We have had some issues with Santa Susana since the program's outset. Mr. Turcic indicated in the 2005 eligibility decision that it had been DOE and Boeing's goal in 2002 to limit the number of Santa Susana workers who would be considered covered under the EEOICPA.

This resulted in a three-year argument with Department of Labor during which all claims associated with Santa Susana, Canoga and DeSoto were placed into pending status. During this period, several workers died without ever understanding why their claims had stalled. Since then, we have had multiple incidents, all verified by DOE and the national office, where Boeing has been found to routinely submit incomplete and misleading information during the employment verification process, resulting in the summary

disqualification of workers who clearly qualify for compensation and medical benefits under both Part E and Part B.

There's no shortage of well-documented examples, and I can keep you guys here for a week going over them in detail, but suffice to say, from establishing covered employment to providing incomplete information during the creation of the NIOSH site profile that resulted in the omission of nearly 50 radiological facilities that operated at Area 4 in excess of 50 years, all verified by the Federal EPA during their historical site assessment of Area 4, we have documented efforts by the contractor to seriously engage in instruction of the program.

It came as no surprise to me to discover that the propulsion workers who were removed from the SEM seemed to make up the largest number of employees who DOE and Boeing had initially hoped to exclude from the EEOICPA back in 2002 and this raises some concerns

about Paragon's failure to disclose where the information came from to support the removal of the information from the SEM.

So I would respectfully encourage all involved to ensure that no information is ever removed from the SEM based on a contractor's assertion or those of any agency, but rather through the careful and objective evaluation of documentation that effectively contradicts that which was initially used to justify the inclusion of the data in the first place.

Ideally, it is my humble opinion that such an objective and qualified evaluation would probably be best conducted by the Board.

So those were my prepared comments, but since I'm the only commenter present, I wonder if I might touch on a few other topics just very briefly, if I can take some extra time?

I think that it is quite valuable to have leadership here, but my observation is

that they're very adept at informing all of us about how things should be happening, and that's not how things are actually happening at the claims examiner and the authorized representative and the claimant levels. For example, the DARs are still not being reviewed thoroughly, and since we have witnessed the death of institutional knowledge with the decision to divert claims away from seasoned, experienced claims reviewers and create a situation where claims examiners are, for the most part, totally confused because they lack familiarity with site specifics and the unique complexities associated with so many work sites.

CEs routinely express that they're just completely overwhelmed. They're making inappropriate decisions that require a hearing, oftentimes resulting in the need to re-do dose reconstructions multiple times or re-do IH evaluations because of information that they missed either by not reviewing the DAR or by

not understands how to identify covered employment or other information that is significant and relevant.

In my review of my current case load of Santa Susana cases, for example, we used to always have our claims adjudicated by Seattle District Office, but now it appears that the majority of my cases have been routed to Jacksonville District Office, which does not have the benefit of established institutional knowledge over the course of the program. Every claim, even SCC claims, are now routinely heading for hearings and even when we're at a hearing, we still have to educate the hearing reps about site complexities and the published guidance from the national office about which they remain unaware and we're five years into the removal of the jurisdictional purview.

So I reiterate that the decision to divert claims away from the regional district offices was the single most damaging decision that could have been made for the claimants.

They can no longer count on qualified, thorough review of their cases.

Lastly, speaking of Jacksonville District Office, I currently have a claim there where the claimant was coded terminal back in March, and when I spoke to the claim examiner to encourage his swift correction of several errors in this claim, he responded by saying that since the claimant was coded terminal so long ago, but still hadn't died, it was the District Office's position that he was never actually terminal and he had no impetus to move quickly on the claimant's behalf. He requested a deathbed terminal statement from hospice, and they indicated that they're ethically prohibited from making such a specific declaration and could only provide a letter indicating that the claimant has six months or less to live.

I called that CE on Friday to discuss the urgent remount order issued by FAB in the second hearing that we've had on this

case. Today is Wednesday, and as of yet, I have not received a return phone call on behalf of this claimant. He's also had two dose reconstructions due to overlooked covered employment and other errors that have occurred during the claims process, and I think if we had a more seasoned and experienced claims examiner at the very beginning, this claimant would not be experiencing this level of delay.

So, I respectfully submit the jurisdictional purview should be restored. The claimants deserve thorough and qualified review by seasoned CEs who have some familiarity with their work sites and five years into this, we're still seeing examples of why this was a really bad idea. That's it for me today. As always, thanks for the opportunity to bring information.

CHAIR MARKOWITZ: Thank you. Will you be submitting written comments?

MS. BLAZE: If you'd like.

CHAIR MARKOWITZ: Well, certainly

the SEM part.

MS. BLAZE: Okay.

CHAIR MARKOWITZ: Let me ask, Carrie, do we get a verbatim transcript of the public commentary?

MS. RHOADS: Yes.

CHAIR MARKOWITZ: But, still, because we may be having our demonstration with the SEM sooner rather than later, formulating our questions, if you could submit the written comments about the SEM sooner rather than later, that would be helpful.

MS. BLAZE: Certainly.

CHAIR MARKOWITZ: Thank you.

MS. BLAZE: Thanks.

CHAIR MARKOWITZ: Carrie, anybody else?

MS. RHOADS: No, I think that's it.

CHAIR MARKOWITZ: Okay. So then we are finished for today. Tomorrow, I don't have the agenda in front of me. What time will we? 8:30, I think, tomorrow? Yeah, 8:30 tomorrow.

Anything you need to say, Ryan, at the close of the meeting today?

MR. JANSEN: No, I think that's it. The meeting is adjourned.

CHAIR MARKOWITZ: Thank you, all.

(Whereupon, the above-entitled matter went off the record at 4:27 p.m.)