UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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THURSDAY,
NOVEMBER 16, 2017

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The Advisory Board met at The Lodge at Santa Fe, 750 N. St. Francis Dr., Santa Fe, New Mexico, at 8:30 a.m. Mountain Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

JOHN M. DEMENT
MARK GRIFFON
KENNETH Z. SILVER
GEORGE FRIEDMAN-JIMENEZ
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair
LAURA S. WELCH
ROSEMARY K. SOKAS
CARRIE A. REDLICH
VICTORIA A. CASSANO

CLAIMANT COMMUNITY:

DURONDA M. POPE
KIRK D. DOMINA
GARRY M. WHITLEY
JAMES H. TURNER
FAYE VLIEGER

DESIGNATED FEDERAL OFFICIAL:

DOUG FITZGERALD

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

(8:33 a.m.)

MR. FITZGERALD: Good morning, everyone. My name is Doug Fitzgerald, and I'd like to welcome to today's Advisory Board on Toxic Substances and Worker Health meeting. I'm the Board's Designated Federal Officer, or DFO, for the meeting.

Before we begin the meeting, I'd like to cover some general housekeeping items, make sure everyone's safe and comfortable throughout the next day and a half. First, I'd just like to mention that the restrooms are directly outside of the doors to your right -- or to your left, actually. And in the unlikely event of an emergency, please go through the same doors that are marked with an exit sign and proceed cautiously down the stairs and out of the hotel. We certainly hope that's not going to be necessary for today's meeting.

On behalf of the Department of Labor, I would like to express my appreciation

for the diligent work of our Board members over the past several months in preparing for these public meetings and for their forthcoming deliberations.

I also want to thank several individuals for their efforts in preparing for today's meeting, in particular Carrie Rhoads, our committee staff and alternate DFO who makes my job so much easier. Kevin Bird and Melissa Schroeder are side contract staff who always do a fantastic job setting up these rooms, arranging for everyone's travel, and preparing briefing books and setting up our virtual conference meetings.

Before we get started, I also just want to go over a few of the responsibilities of the DFO in terms of its relationship with an advisory board. As the DFO, I serve as the liaison to the Board and the Department. I'm also responsible for ensuring all provisions of the Federal Advisory Committee Act, or the FACA, are met regarding operations of the

Board.

I work closely with the Board's Chair, Dr. Stephen Markowitz, and I'm responsible for approving the meeting agenda and for opening and adjourning meetings. I also work with the appropriate Agency officials to ensure that all relevant ethics regulations are satisfied.

We have a full agenda for the next day and half, and you should note that the agenda times are approximate. So, as hard as we may try, we may not always keep to those exact timeframes. Copies of all meeting materials and public comments are or will be available on the Board's website under the heading "Meetings." The Board's website can be found at DOL.gov/OWCP/energy/regs/compliance/advisoryboard.htm. Or you can simply Google "Advisory Board on Toxic Substances and Worker Health" and it will likely be the first one that comes up.

If you haven't already visited the Board's website, I strongly encourage you to do so. After clicking on today's meeting date, you'll see a page dedicated entirely to this meeting. The page contains all materials submitted to us in advance of the meeting, and we will publish any materials that are provided by our presenters throughout the next 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 at the end of today. If you are participating remotely, I do want to point out that the telephone numbers in the links for WebEx sessions are different for each day, so please make sure you read the instructions carefully.

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

at 4:30 today.

And I just want to say, if there are people in the room today that would like to participate in public comment period and have not already kind of checked in with us to let us know that, please see Carrie Rhoads at the desk over to your right and let her know so we can make sure everyone has the appropriate amount of time to speak.

For those of you listening in on the WebEx, you can email your request to energyadvisoryboard@dol.gov and make that request.

At the time of the public comment period, there will be a different phone number to call in. If you are participating, that number is 1-888-390-3405, and there's a code, 3119415. We'll make the same announcement later as we come closer to the actual public comment period as well.

During Board discussions and prior to public comment period, I request that all

the people in the room remain as quiet as possible since we're recording the meeting to produce transcripts. And in the same vein, if you have a cell phone, please put it on mute. Thank you.

If for any reason the Board members require clarification on an issue that requires participation from the public, the Board members request such information through the Chair or myself.

The FACA requires that minutes of this meeting be prepared and include a description of the matters discussed over the next day and a half, and the conclusions reached by the Board, if any. As DFO, I prepare the minutes and ensure that they're certified by the Board's Chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, per FACA regulations. If they're available sooner, they will be published before the 90th day.

Also, although formal minutes will be prepared because they're required by the FACA regulations, we'll also be publishing verbatim transcripts, which are obviously more detailed in nature. These transcripts will be available on the Board's website by December 16th.

And with that, Mr. Chairman, I convene this meeting of the Advisory Board on Toxic Substance and Worker Health. Thank you.

CHAIR MARKOWITZ: Good morning. I'm Steven Markowitz, and I'd like to welcome the people here today, welcome the Board members, especially Board members who stepped off a plane last night from a different time zone. We're going to try to keep this meeting lively enough to keep you engaged.

I would like to welcome members of the public for coming today, and also people participating on phone or online, I welcome you all as well.

I'd like to thank a few people just

to start off, our people from the Department of Energy, in particular, Lokie Harmon, in the back, and Isaf Al-Nabulsi, who are from the Health and Safety unit at Department of Energy. And they helped, along with Greg Lewis, arrange for our tours, our excellent tours the last two days in Sandia National Lab in Los Alamos. So, thank you very much.

And I'd also like to thank Doug Fitzgerald and Carrie Rhoads for all the work that you do with us to make these meetings happen and us informed about the program. And of course, Kevin Bird and Melissa Schroeder and others who are supporting the meeting.

We'll start off with introductions. First, Board members, and then actually I'd like the public who are here to just introduce yourselves for us as well.

So I'm Steven Markowitz. I'm a professor at the City University of New York. I'm an occupational medicine physician and an epidemiologist, and for the past 20 years I've

been running one of the larger former worker medical screening programs across the DOE complex.

MEMBER SILVER: I am Ken Silver, I'm an Associate Professor of Environmental Health in the College of Public Health at East Tennessee State University. I lived in New Mexico from '97 to 2003. I've been back often.

When I was here, I was very active on the ground with Los Alamos workers and families to first get compensation legislation passed as many of the workers at the other sites were.

And then following up on implementation, I have to observe that the six doctors on the Board have prodigious medical expertise and scientific knowledge, and they've spent their careers in fact-based advocacy on behalf of workers, as have many of the other Board Members.

So I don't think New Mexico has seen such an assemblage of occupational health

talent, free of conflicts of interest since Harriet Hardy went home 69 years ago.

MEMBER POPE: Duronda Pope, United Steel Workers. I'm a former worker of Rocky Flats, 25 years out there. My job with the United Steelworkers is to respond to fatalities and critical injuries that happen with our members, and I've always been an advocate for people that have been injured and hurt or sick.

MEMBER REDLICH: I'm Dr. Carrie Redlich. I'm a Professor of Medicine at the Yale School of Medicine, also a Professor of Epidemiology in the School of Public Health. I'm a physician, pulmonary physician, also occupational and environmental medicine physician, and I'm Director of the Yale Occupational and Environmental Medicine program.

MEMBER CASSANO: I am Tori Cassano, I am a retired Navy Occupational Physician and spent many years in VA, working on the same types of issues for veterans and currently I

have my own consulting company.

MEMBER DEMENT: I'm John Dement. I'm Professor Emeritus in the Division of Occupational and Environmental Medicine at Duke University Medical Center. My areas of interest and expertise are industrial hygiene, exposure assessment, and occupational epidemiology. I've also participated for the last 20 plus years with the screening program for construction workers at BTMED.

MEMBER GRIFFON: Hi, I'm Mark Griffon, I'm an Occupational Safety and Health Consultant, and I also was on the sister board to this Board, sort of the sister board that oversees the radiation side of the program and advises NIOSH, the Advisory Board on Radiation Worker Health. I was on that for over ten years.

MEMBER DOMINA: My name is Kirk Domina, I'm the Employee Health Advocate for the Hanford Atomic Metal Trades Council in Richland, Washington. I'm an active worker

going on 35 years as a reactor operator and nuclear chemical operator, so I work on this program, workers compensation, and short-term/long-term disability. HAMTC currently has about 2,600 active members through fourteen affiliated unions.

MEMBER TURNER: My name is James Turner. I worked at Rocky Flats Nuclear Weapons plant for 26 years. I was diagnosed in 1990 with the chronic beryllium disease.

MEMBER SOKAS: I'm Rosemary Sokas. I'm a Professor of Human Science and Family Medicine at Georgetown University, and an Occupational Medicine physician.

MEMBER BODEN: I'm Les Boden. I'm a Professor in the Environmental Health Department at Boston University School of Public Health and have spent a lot of my life thinking about workers compensation issues.

I was also on the predecessor to the EEOICPA Act Advisory Board, which -- whose name I can no longer remember. And I worked for a

while with the former worker project at Los Vegas, Nevada Test Site.

MEMBER VLIEGER: Good morning. My name is Faye Vlieger. I'm a former Hanford worker. I'm also a worker advocate under the EEOICPA. I was injured in Hanford in a chemical exposure in 2002, and found that it was really difficult to do a labor and industries claim within my claim with the US Department of Labor that I started in 2004. And I continue to be a worker advocate in the Hanford area in Richland, Washington.

MEMBER WELCH: I'm Laura Welch. I'm also an Occupational Physician and Medical Director for the Center for Construction Research and Training which is the research and training affiliate of the AFL-CIO Building and Construction Trades Department. I've been involved in health and safety in the construction industry since the early 1980s, and at CPWR for about fifteen years. I was also on the DOE board that -- the board that advised

DOE administration, the Part E compensation program before they handed it over to DOL.

Part D, I'm sorry, Part D. Yes, you know, I was explaining to somebody the other day, A, B, C, D, E, and I couldn't get the A or the D, so thanks, that helps.

MEMBER WHITLEY: I'm Garry Whitley, I worked at Y-12 National Security Complex for 42 years. I've been retired and working with the Worker Health Protection Program for seven years, and I worked with --- to help clients trying get their claims back out of the ditch when they don't understand them.

MEMBER FRIEDMAN-JIMENEZ: I'm George Friedman-Jimenez. I'm an Occupation Medicine Physician and Epidemiologist and Medical Director of the Bellevue NYU Occupational Environmental Medicine Clinic.

We provide occupational medicine services to low income workers throughout New York City who use the public hospital system for medical care. I'm also an Assistant

Professor of Epidemiology in the Department of Population Health at NYU School of Medicine.

CHAIR MARKOWITZ: If we could have the members of the public -- just introduce yourselves.

MS. TURPIN: My name is Cathy Turpin, and I was employed with Sandia Labs from 1980 to '89 as a supervisor. I have a Master's degree in toxicology so now it's interest. And then I've also filed a claim because I have multiple-sclerosis for those of you that don't know. So I get half-price train rides and half-price bus fares, so I'm here.

MR. LEREW: My name is Tim Lerew. I have the honor this year to serve as the chair of the Cold War Patriot Community Advocacy Group. We now have 55,000 nuclear weapons members. And it's a pleasure to see the Board and the --- the really excellent participation from the public here today.

MS. TRUJILLO: My name is Becky Trujillo and I am a former Los Alamos worker, I

worked up there from 1967 to 1999. Currently I work with the former Los Alamos and Sandia workers program with Johns Hopkins University.

MS. CADORETTE: Hi, my name's Maureen Cadorette, and I am from John Hopkins University. I am an assistant scientist there. I work on the Los Alamos and Sandia former workers program.

MS. PENNINGTON: Good morning, I am pleased to be here. My name is Maxine Pennington. I am a Kansas City plant worker. I was a chemist and chemical lab manager from 1981 through 2013. And over that time saw the changes. I lived through the changes that we saw in chemicals, in chemical use, chemical health safety and environment within the plant and across the complex because chemistry lab managers went -- worked together across the whole site.

MS. JAN MARTINETTE: Good morning, and thank you so much for having this and being open to the public. And I have to admit I drove

from Kansas City, leaving last Friday at noon to get here by myself because all my friends are old and decrepit, I'm sorry. No, I am a spouse. My husband worked at Honeywell from '63 to 2007 when he died of two cancers, esophageal and stomach. And of course I know too much and keep thinking, maybe I ought to say too much so that I can go to prison and get taken care of the rest of my life, because I'm not getting my claim over ten and a half years. I'm sorry, I had to throw that in. Anyway, I appreciate you, I hope that you realize there are people like me out there and in the Kansas City area especially. We've not had anything like this in the Kansas City area for people to be heard, and to hear from you all as to, what else can we do to get the claims, okay? Because I am trying to help anybody I can. I was a three-term state rep, and I know a lot of folks, and I'd like to help them. Please help me help them, will you? I appreciate it. Thank you.

MS. LEITON: I'm Rachel Leiton, I'm

the director of the energy compensation program at the Department of Labor. And I appreciate the Board, all of the work that you guys have done for us, and look forward to the interactive discussion this week.

MS. SMITH: I'm Joleen Smith. I'm the district director of the Seattle District Office for DOL OWCP.

MR. MONTOYA: I'm Jose Montoya, and I worked at Los Alamos for 40 years. I have a claim in, and it seems like I can never supply the right answers. I have had an exchange of letters between the Department and myself, you know, trying to provide whatever information they need, but it seems like it always comes back that they need more information. So I'm running out of answers right now, so I need some help.

MS. PEARSON: I'm Tiffany Pearson. I'm the daughter of a former worker and I'm also the clinical director for Critical Nurse Staffing, who does home care for the workers.

MR. NELSON: Good morning, my name is Malcolm Nelson. I'm the current ombudsman for the Energy Employees Occupational Illness Compensation Program.

MS. BARRIE: Good morning and welcome --- and thank you for opening up this discussion to the participants today. My name is Terrie Barrie. I'm with ANWAG a founding member of the Alliance of Nuclear Worker Advocacy Groups. Besides assisting workers with their claims, one of my purposes is to try to make sure everybody is informed about the program news and changes as widely as possible. Thank you.

MS. JERISON: I'm Deb Jerison, I am the daughter of a deceased, now, laboratory worker, and I'm the director of the Energy Employees Claims and Assistance Project. And a worker advocate for Cold War Patriots.

MS. BLAZE: I'm D'Lanie Blaze, of CORE Advocacy for Nuclear & Aerospace Workers. I help workers of Santa Susana Field Laboratory

where my dad worked on the Saturn V.

MR. BARRIE: Hello. I am George Barrie, I've been a machinist since 1975. I started plant-side at Rocky Flats in '82. I had a radiation exposure, and now I am a disabled Rocky Flats Part E Claimant, and it's still on-going. Thank you.

MS. AL-NABULSI: Good morning, I am Isaf Al-Nabulsi, senior technical advisor at the Department of Energy Office of Health and Safety.

MS. SPLETT: Good morning, my name is Gail Splett. I'm with the Department of Energy Richland Operations Office. I'm the EEIOCPA program manager there.

MR. HINNEFELD: I'm Stu Hinnefeld from the NIOSH -- NIOSH Division of Compensation Analysis and Support. And I was here for an outreach meeting last night, and I am being tourist today.

MS. JACQUEZ-ORTIZ: Good morning, Michele Jacquez-Ortiz on US Senator Tom Udall's

staff. I am going to be presenting this statement a little later in the meeting on behalf of Senator Udall, but just wanted to thank you, thank you all very much for hosting the meeting here in northern New Mexico and allowing the claimants here to participate.

MR. KINMAN: I'm Josh Kinman and I'm also a tourist. I'm with Stu in NIOSH's Division of Compensation Analysis and Support. I work primarily with special exposure, coordinating that part.

MS. MOSS: Hi, I am Rebecca Moss, I am a reporter from the Santa Fe New Mexican. I've been covering you guys for about two years, so thanks for being here.

MS. HARMOND: Hi, I am Lokie Harmond and I work with the Compensation Program at the Department of Energy.

CHAIR MARKOWITZ: Okay, thank you. We're going to, I want to just walk through the agenda for a few minutes so we know where we're heading. And we're going to discuss for a few

minutes the transition to a new Board, this Board's terms are up in February, except for one member whose term ends in March, and the Department of Labor is going to be appointing a new Advisory Board.

And so we need to figure out how to close out the work that we're doing and hand it over. And then we're going to talk about the DOL's responses to two sets of recommendations that we made, a set that we made a year ago, and a set that we made in April.

And we're going to be spending I think much of the day talking about those. I'm not sure how long it's going to take, so I put in time frames, but we'll see how it goes.

And then in the afternoon, we will hear reports from the subcommittees, in particular two committees that have specific issues that they want to raise, the Weighing Medical Evidence and CMC & IH Subcommittee and also the special exposure --- excuse me, the SEM, the Site Exposure Matrix Subcommittee.

And then finally from the Part B Lung Disease Committee. And then we have a 4:30 to 6:00, a public comment period.

Tomorrow morning we resume at 8 o'clock, and we'll hear a little bit on --- from the Presumptions Working Group, but then we're going to deal with a number of different items. We will have time tomorrow to handle business from today that we don't complete.

So some of the items tomorrow we can --- are of lesser priority, not unimportant but of lesser priority. So we can move them or shorten them if need be. But we would like to have some discussion about the changes in the procedure manual.

I would like to take some time if we have it to review the public comments, to make sure that we're integrating what people say into our agenda. And then we need a time table for how we're going to complete our work by February.

Any questions or comments on the

agenda? Any items that I didn't include, or someone would like to add? Okay.

So, let's talk about transition to a new Board. I don't know, Doug, whether you want to say anything about the process, or time table just briefly, just to fill us in.

MR. FITZGERALD: In the nomination notification that went out in the Federal Register, it pretty much laid out the -- kind of the guidelines that the Secretary will follow in terms of looking at a new Board.

It's a new Board, but we don't know what that's going to constitute. It could be the same membership, it could be new members, it could be any combination of those things. The goal obviously is to try to have a new Board seated before the expiration of the terms of the current Board members, which is in February and March of next year.

CHAIR MARKOWITZ: Okay, so I would then like to thank the Board Members for the amount of work that we've done basically since

we started in April 2016 with our first meeting. We've had, this is our fifth meeting in 19 months. We've had four in person, we've had one by telephone.

In addition to our five meetings, we have had 17 subcommittee or working group meetings during those 19 months. So we've done a lot of work, a lot of work to understand the EEOICP because it is a complicated program, and then some work to try to make recommendations that could improve the program.

I -- I've said this before, but I think it's worth remembering that Part E of the EEOICPA is an extraordinarily challenging program. It covers all occupational diseases, and it covers all toxic substances.

And that means it's really a universe of occupational illness, and given the number of exposures that we've heard about in the SEM, 30,000 or more, it's probably a large universe of exposure to toxic substances.

So I can't think of another program

which has had to do this. Agent Orange in the VA is a single agent, black lung which is part of OWCP, is essentially a single toxic substance with a limited number of diseases.

State worker's comp systems frankly don't routinely handle occupational diseases very well. That was part of the problem with Part D from 2000 to 2005 in which Congress wanted the Department of Energy to deal -- to work with the State Worker's Comp system to facilitate claims from energy employees.

That didn't work, and they had to go to Part E to take more direct control of it. So state workman's comp systems don't really address this.

So this is really, I think, a unique program, and an extraordinarily challenging program. And certainly the program at DOL has made tremendous progress in standing up to programs and compensating a larger number of people and processing a large number of claims and they deserve a lot of credit for the work

that they've done.

There have been almost 300,000 claims under the EEIOCPA, if you combine part B and part E, 300,000 claims since 2001 or so. And in Part E, there have been 132,000 claims that have been submitted over the past, well since 2006 or maybe --- well the program began in 2006, right? Or 2007.

But in any case, a very large number of claims, and there's been $4.2 billion in compensation under Part E.

Medical care Part E and Part B are combined on the website so it's 4 million -- $4 billion in medical costs from Part B and Part E combined.

So it's a large program. Part B and Part E combined, compensation and medical expenses are at fourteen plus billion at this point.

And we have our own, taken our own steps to understand this program. And I think our recommendations to date reflect that

understanding. But I would also say that looking at the DOL responses, that clearly there needs to be some back and forth.

They ask for clarification, they ask for some documentation on some of our recommendations, they disagree with some of our recommendations, they accept some of our recommendations, and we'll go through that.

But what I would like to make sure is that in February when we -- when we're done, that we have products in relation to the recommendations that we've made this far.

So we're going to have discussions about the DOL responses. And I think we should then now write our own, when relevant, write our own set of comments about their responses. And not --- not today, we're not going to write those comments today, but we're going to develop those and then submit them before the end of the term of the Board, before February.

That may take another telephone meeting of the Board towards the end of

January. We should agree on the major points of our responses today and tomorrow. We should agree on the major comments we have on -- because there will not be time in the term of the Board to do that in a substantive way by the end of January.

So we should try to agree on our view of the responses. And those will be written up, I used the passive voice there, but they will be written up by volunteers on the Board. And then we will probably have to have a telephone meeting in order to affirm those by --- by vote.

But we'll see about that. But that's I think where we're heading in the next two plus months. Any comments or questions about that? Okay. So let's begin.

We're going to start with the DOL responses to our Board Recommendations from October 2016.

Now, these were on our website, posted some time ago, I'm not sure exactly

when. I know that the -- in the last few days, a more recent set of responses was also posted, but we're talking about our recommendations that we submitted a year ago, and these are DOL responses to our recommendations.

For those of you on the phone, if you can't see them on the WebEx, if you have access to the web, you can go to the website, to our Advisory Board Toxic Substance and Worker Health website. You go to our meetings and you'll see among the materials listed for this is what we're going to go over now.

And we also have it, we have -- the Board has paper copies from the folder, so you can look at that. But you can also look at the board. So we can move up, we don't need to look at the transmittal letter from Ms. Hearthway.

So I think actually it would be most useful, both for Board members and for the public if we actually read the DOL responses. And so I will start off reading the first one,

and then I think we should just go around the table with Ken, maybe you can read regulation, excuse me, the response number two, and then we'll have a discussion.

So Recommendation 1, which we recommended, that a certain circular be rescinded. The OWCP response is, "As OWCP communicated to the Board in the interim response of March 24, 2017, we agree with this recommendation and have rescinded this Circular, on February 2, 2017.

"While OWCP believes there is literature to support that there were greater safety measures in place beginning in the late 1990s, the Circular was rescinded to avoid the appearance that one cohort of claimants is being held to a higher burden of proof than others. We have a plan in place to review cases that may be affected by this change."

So they agree with our recommendation. Any comments on this?

MEMBER SILVER: If I may.

CHAIR MARKOWITZ: Sure.

MEMBER SILVER: I remember being at Terrie Barrie and ANWAG's summit with the agencies two years ago when this was discussed. And the initial rationale was that DOL had received data from DOE to support the 1995 cut point.

And after the meeting, DOE couldn't remember having provided the data to DOL. So I see a pattern here of DOL kind of dropping back to punt, and now pointing to the literature.

So I'm glad they took our recommendation. But if we see a similar pattern of claiming data and then dropping back to vague concepts like the literature, we should be aware of it.

MR. FITZGERALD: Dr. Silver and other members, as you speak, please identify yourself as you're making comments for the transcript, thank you.

CHAIR MARKOWITZ: Yes, Dr. Sokas?

MEMBER SOKAS: Dr. Sokas. And I

just want to support what Dr. Silver just said. The rationale for accepting is a little disconcerting that it's meant not to show the disproportionate burden on any one group but in fact the rationale is that there is no credible evidence that the problem had been alleviated in the late '90s to the extent that it would not be still causing diseases. So again, I'm agreeing with that comment.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: Dr. Redlich. I was wondering if the Department of Labor could let us know what the plan that they have in place is to review cases that may be affected by this change.

CHAIR MARKOWITZ: Ms. Leiton?

MS. LEITON: Hi, this is Rachel Leiton. We have actually, we don't have a mechanism to identify specific 1995 in our system. So we've done more of a manual process. A lot of the cases that might have been referred an IH have been referred to an IH

instead.

We've been able to identify a cohort of them, provide minimum lists to our claims staff to begin that process. We've --- I don't know exactly the number that we've referred back to industrial hygienists for their review for those periods, particularly those that have been denied.

We've been able to go back and look at the ones that have been denied for exposure or causation. And as I said, it's a manual process because we can't specify that it was only 1995 or after, so we've had to look through them individually.

And so it's one of the many projects that we've given to our District Office staff to review as they can, and go back and refer them to industrial hygienists.

Moving forward since the rescission of that, anything that was after the 1995 for exposure analysis was referred to industrial hygienist as appropriate.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: Anecdotally, I'm finding the manual process that's in place a bit spotty. I was with a claimant for a final adjudication branch hearing and the claim being sent to industrial hygienists after their rescission date of the circular and to a CMC after the industrial hygienist. And neither one of those saw that they should not be reviewing it with that circular, yet they both mentioned that circular. I'm happy to report that hearing examiner agreed that it needed to be remanded because it had been done wrong. But I think the manual system has fallen apart.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: Just a quick request. It would be helpful, I think, first of all, I understand this must be a very difficult process going back and manually reviewing all these denied claims.

But I think it would be of interest to the Board if you could report to us on sort

of how many claims have been reviewed and how many of those have been remanded to be looked at again.

MS. LEITON: I'm going to do my best to do that. As I said, it's hard to track them in our system. We just don't have a particular mechanism for it. But I will get you the best data that we can on it.

CHAIR MARKOWITZ: So, I have a question, Ms. Leiton, about the language of the response, the higher burden of proof. Because the original circular was about assuming the significance of exposures before or after 1995. And the concern expressed about higher burden of proof suggests that assumptions or presumptions about exposure by limited -- by certain time periods isn't acceptable.

And that kind of goes to the heart of presumptions. Because presumptions are about, in the absence of data, making certain assumptions about exposures, or it can be of diseases, but mostly we've discussed exposures.

I wouldn't regard that as a higher or lower burden of proof.

But I'm concerned if the Department views it that way because I think presumptions are necessary and important for multiple reasons. But I am concerned if they are judged by --- as being, as representing a differential burden of proof, now that may be a question for the lawyers, I don't know. But I'm wondering about you're thinking about that.

MS. LEITON: So, the presumptions that we made for the 1995 and for these circulars was based on exposure. It was based on a lot of the safety regulations that started very early in the '70s and went through the '80s. 1995 was a demarcation date when certain safety measures were in place.

This is something we outlined in a program memorandum when we issued that circular. When we say that -- when we look at that circular, what it does is it provides a presumption, but it's kind of a, it's an

opposite presumption, and that's one of the main reasons.

Trying to put a line in the sand that says 1995, as you guys pointed out, makes it so that after 1995, we're going to assume it was within regulatory limits for exposure. And that's what we're going to assume instead of going to an industrial hygienist.

And then we would go to a doctor and say this is within regulatory exposure limits. And so that's the presumption that we realized, or -- and we've tried to make presumptions in the past that are kind of similar that used to say well, if they had this condition, it probably wasn't related. That was a long time ago, we rescinded that one as well.

But it was so that we could do something to kind of say, okay, there are some cases that we can make assumptions on. That is probably not a good idea to make negative presumptions of associations.

And that's what rescinding this

circular was trying to do, is saying okay, maybe we shouldn't make negative presumption exposure determinations, and we should say refer these to industrial hygienists. There might be certain circumstances in which, you know, it was a higher level than may have been within regulatory analysis.

And so that's really what that was about. I believe that presumptions, and particularly this program, positive presumptions can be probably more beneficial than anything that we could say that said in the absence of anything further, we're going to go ahead and assume that there wasn't as high of an exposure level. And that's what rescinding these two circulars did.

CHAIR MARKOWITZ: So just to follow up. This is Steven Markowitz. So then this issue of burden of proof is invoked, becomes relevant with a negative presumption, and there aren't that many negative presumptions in the program which is nice.

But the issue of positive presumptions, which the current program has and which we're recommending more of. The issue of burden of proof is not really relevant. Is that -- is that a correct determination?

MS. LEITON: Well, I mean --

CHAIR MARKOWITZ: And let me just finish. I say that because the reason you make a presumption is because you can't really get, you can't prove anything. You can't, you don't have those exposure data, for instance, to prove. It's not a higher burden of proof for people who meet these certain presumption.

So I just want to make sure that this argument about burdens of proof doesn't somehow undermine the development of positive presumptions.

MS. LEITON: No, I don't think so. I think when we used the term burden of proof, or when this language developed, the idea was that if you're trying, if you had a -- when the circular was in place, if you had a claim for

exposures after 1995 only, then we would be looking more closely, probably, at what type of higher exposures you may have had that went beyond the regulatory standards.

And that would be going back to the claimant a lot of times, meaning the burden of proof looks higher because then we're trying to establish a higher level of exposure than we would if we had a positive presumptions.

So it doesn't, if we have a positive presumption, a burden of proof is going to be a little bit less for the claimant because they don't have to -- like for example, the SECs. If they have a cancer, one of these 22 cancers, they were there for 250 days, their burden of proof is going to be a lot less than if -- if they're not.

And so that's kind of the idea behind it. It should not affect, this language itself shouldn't affect the positive presumptions.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: I think the problems --

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: Dr. Cassano, I'm sorry. I think the problem that we're having and communicating here is that your basic premise about what the effect of better workplace protections are.

The work -- within regulatory levels is strictly a regulatory level. It does not, it is not the level of no observed adverse effect. It is at a level that will keep the majority of workers safe if they are using the proper protection.

That doesn't mean that you're not going to see any cases after that. You will see a reduction hopefully in incidence of those cases, but you're still going to see the cases.

So the burden of proof should be the same, regardless of whether it's before or after. And I think that's where this difficulty in communication is.

MS. LEITON: Well, I think the burden of proof is the same, but you're going to be looking at the evidence slightly different if that presumption were still there. But in this instance, since we rescinded the circular, we're still going to refer it to an industrial hygienist.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Kirk Domina. I guess, you know, I look at this, some of it different, and I understand what you're saying after 1970. But you know, I lived through a lot of this, and we were still in a cold war at that point in time. There -- we have no industrial hygienists.

And then you get into, like, the tiger teams in 1995, you also have to look into that point in time, funding goes up and down. We had no funding after that. So they're not going to do anything.

You can put in all these regulations you want, you don't provide money to the

contractors, they're not going to do it. And now for Hanford specifically, you get into the late '90s, so the contractors in the last two years of their contract, they're not going to do anything.

And then you've got two more years when the new one comes in to try and get up to speed, and that is also problematic. When you get into the late '90s, everything's a performance based contract.

And so now you're into this the more you do, the more you get paid. However, when you start bringing in some of the, quote, IH stuff because all of us that have lived it see it, there's several ways to do monitoring and take samples, and there's several ways to make sure you don't find anything.

And that's what we live through today. And we're going to live through it there for the next two years because these contracts are going away and new ones are going to be, RFPs are going out and they're going to

be issued.

And so it's very problematic to me because the contractors these next two years, they're not going to do anything that they don't have to. And I understand you're at a rock and a hard place, but, you know, I live this every day.

And just putting, like, that drop dead date for 1995, we had nothing. We had layoffs in that timeframe. There was almost nothing going on because we had no money. I mean, there's work going on, but far as monitoring, we had no IHs.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So what I'm hearing is a certain level of agreement, actually, that setting the specific 1995 date because there were certain regulations, internal regulations in place, wasn't really an adequate description of what was going on because the regulations don't necessarily match with conditions.

And I just wanted to -- so it seemed

to me that that is a way of thinking about this that many of us on the Board would agree with rather than sort of picking at the burden of proof issue.

So I think we're actually having some agreement there about this, to which we may return later on in discussing other parts of the response to our recommendations.

CHAIR MARKOWITZ: Good point. Dr. Welch?

MEMBER WELCH: Yes, Laura Welch. I want to respond a little bit to the concept of the plan because we've made, as we go forward with the recommendations we've made, including introducing presumptions for specific diseases, they're going to be many people who had filed a claim and had the claim denied because -- but now they would be eligible because there's a presumption.

And I think that this Board and a future Board would certainly want to know what's happening with implementing any new

changes. So I don't know whether that's something the Department of Labor would want this Board to make a recommendation about, but I think you need some way to track this going back.

You know, you told us now that you can't identify particularly all the cases that were denied based on that particular circular, and that's good to know. I mean, and it's the best you can do.

But also at the same time, think okay, well we're going to be going through this, you know, six more times over the next six years as we work through the Board's presumptions. And I think maybe not even built into your whole data system, but some kind of tracking system that documents both the process and the outcome.

You know, when you let people, when you let the regional offices know, how many cases you got from each one, that kind of stuff so it doesn't become just frustrating for

everybody having the Board sitting here saying but how do we know that anybody's claim was really re-reviewed.

And you may have thought about that already, but I think it's just become -- and we have, like, three or four disease presumptions that would bring this up big time.

MS. LEITON: I agree with you. I think that, you know, the Board, when the Board was created, we had procedures in place already and things that we were doing that did not contemplate having to track those particular items.

Now that we have a Board, unfortunately we're not, we can't always anticipate what the Board's going to decide to do in order to go back and say oh, well now we need to find these cases.

I think there -- with conditions, there will be ways to do that because, you know, unfortunately the way our system is built, it was built for case management. It

wasn't really built for necessarily reporting out to others or that sort of thing.

It was built to report on what, or currently tracking our work. But we've obviously, we've done this with SECs before. Every SEC we have to go back and look at cases that have been denied to see if now they'll be eligible because there's a new SEC class.

So we have ways to do it, we're just going to have to -- and I agree, we need to think of that when we see the first recommendation to see okay, well we better try to think of how we're going to be able to go track this, how we can find these cases and develop processes.

Obviously, we're going to want to show that we've done this, demonstrate how we've done it. And in some of these cases, once a presumption is actually established, there will be a circular or a bulletin that tells our claims examiners here's the new process. And at that stage we can try to

identify it and hopefully have a better mechanism for identifying some of these cases.

The problem with exposures and the date is that we don't have a way to say their only verified employment was 1995 forward. We do have ways to look in the system and say it was denied for this particular cancer, and we can go back and pull up all the cases for that cancer.

So hopefully, it won't be as problematic for all the presumptions as it was for that one.

CHAIR MARKOWITZ: That's good to know. Any other comments before we move on? Okay. Can you -- Ken Silver?

MEMBER SILVER: Ken Silver reading DOL's response to Recommendation Number 2. "OWCP agrees that a number of the references provided by the IOM Institute of Medicine may be useful. To facilitate implementing this recommendation, it would be helpful if the Board reviewed the list of references and

narrowed the list specifically to those sources the Board believes are most relevant, with recommendations as to how they could be used in the SEM, site exposure matrix.

"As we reviewed the list of 11 sources, we found that some of the information is not relevant to occupational exposure, some sources are redundant, and some sources contradict other sources listed in the Table.

"OWCP shared this information in the interim response sent to the Board on March 24, 2017, and the Board has agreed to provide more specific and relevant information."

CHAIR MARKOWITZ: So let me just comment that we did receive that letter in March and I didn't move on it right away in terms of presenting it. We were busy with the April meeting in terms of the developing additional recommendations for the April meeting.

But Dr. Welch has taken up at least part of this question in the SEM Committee.

And we'll be discussing it in the SEM Committee. So I don't know, Dr. Welch, if you want to weigh in on whether we need to discuss this or whether we're better off talking about what you're going to talk about in the SEM Committee and then coming back to this recommendation.

MEMBER WELCH: Yes, hi. It's Laura Welch. I think the latter, I think we should just discuss it all as a whole. And then we can -- you can remind me if we want to do it to address the specific language in the recommendation.

We are going to -- we do have a recommendation from the SEM Subcommittee to present to the Board that is responsive to this. And I guess at the same time, in the rationale for that, we could address whether HEPA is relevant to occupational exposures, for example.

But I think the response reflects something that we will have in our

recommendation, that the Department needs some expertise internally that can specifically address the merit of these databases and how to integrate them in.

And the response, I think, reflects the fact that if it wasn't obvious to the people writing the recommendation, that they should include this information that shows a, you know, is a technical expertise missing. But we can discuss that in more detail.

CHAIR MARKOWITZ: So we're going to postpone that and move on really just until this afternoon. Duronda, we're moving ahead to Recommendation number 3, which if you could show on the board. Kevin, if you could advance the board so that people can see.

This concerns the, "We recommend that the former workers from DOE facilities be hired to administer the Occupational Health Questionnaire." So, Ms. Pope, if you want to read the response.

MEMBER POPE: "OWCP agrees that it

is beneficial for former DOE workers to administer the OHQ interview. Currently, the Resources Centers, which conduct the OHQ interviews, are operated by a contractor.

"The contractor employs 17 former DOE employees, 14 staff members and three managers, out of approximately 60 total employees. Former DOE employees work in nine of the 11 Resource Centers.

"When vacancies occur, the program encourages the recruitment of former DOE employees, to take advantage of their experience and familiarity with DOE work processes, labor categories and work environments.

"DEEOIC helps to ensure that all Resource Centers staff are adequately trained and skilled in assisting EEOICPA claimants, including conducting OHQ interviews."

CHAIR MARKOWITZ: Thank you. So, comments? Dr. Boden?

MEMBER BODEN: This is Les Boden.

We seem to be in agreement about the usefulness of having former DOE workers interview their people who really know the work better than anybody else would.

I'm wondering if DOL has thought about doing more than encouraging employment. So for example, there are cases in which outside of this program there are, sorry, preferences given to veterans. And those preferences basically say that if a qualified veteran applies, that person goes to the head of the line.

And I'm wondering if having similar kinds of preferences for former DOE workers would make it clearer about how much we're encouraging employment of those people.

MS. LEITON: I can look at the contracts and how that's done. I would have to, you know, see if there's language we could put in there about that. There may be, so I'll take it back and see if that's a consideration.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I guess from the, at least my perspective on the Board, the intent of the regulation, or recommendation was to get the assistance of former workers who I would say have on the floor or on the production area expertise, as they know the process, they know the buildings, they know the information about site in more detail.

I guess the second point is, rather than passively encouraging employment of these workers, it seems like it could be actually sought, even through specifications of what's required in the contract.

MS. LEITON: Right, which is I believe what Dr. Boden was saying. We'll look into that.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Yes, Laura Welch. Well, one reason we've made this recommendation and also recommended some changes in the OHQ that we thought would be -- collect more information on tasks and exposures.

And the reason we made this recommendation was that a lot of times, that the OHQ really doesn't have much. When we see it for individual workers and the claims, there is really not that much information in it about the exposures that they had.

So we thought well, okay, let's have the interviews done by people who know something about the work site. Now, if that's already been the case, then this recommendation isn't very useful because having people who are knowledgeable in those jobs wasn't fixing the problem that we saw.

Now, it may be the case that the people who are from the sites aren't, you know, the former DOE employees who worked and are doing the interviews are not knowledgeable about the sites because they were in a management position and didn't really know the nature of the exposures.

So we either need to refine this recommendation to make it much more specific,

or what I think we should probably do, and I'm not quite -- I don't know how we can get it done, but if the new OHQ, if the Department is willing to adopt our recommendations, then OHQ, we had within that recommendation specific training recommendations so that people who are administering the OHQ understand the questions that they're asking.

So my suggestion is we should look at this one again in the context of the whole administration of the occupational history questionnaire, not just focus on whether the contract should be changed to encourage DOE workers first. Maybe it should.

But also whether that would have been sufficient to fix the problem that we saw with the OHQ. And if the new OHQ is, could be administered by people without as much experience within the program, I just don't want us to get lost focusing on this if it's not going to fix the problem we were trying to address.

CHAIR MARKOWITZ: Well, you know, this is Steven Markowitz, I want to just respond then move to Dr. Cassano. I agree. I think we can refine our recommendation which clearly wasn't specific enough, and view it as a good if it's accepted without neglecting other aspects that need to be upgraded.

But when in this response, and this I'm going to just raise some rhetorical questions because I'm not really addressing them to Ms. Leiton. But when I saw this I said okay, 17 former DOE employees, what did they do, right?

That's easy enough to find out what they did at DOE. And then who does the OHQ, how many of the OHQs are accomplished by these former DOE workers, or are they done by other people.

And again, that information is a little bit more difficult to track, although the data system may or may not have that. But regardless, the Resource Centers would know

that.

But I don't see the need to go back and forth getting more information about that and then develop, refining our recommendation. I think we can move to refining our recommendation and just, really just specify what we meant by the original recommendation.

So, Dr. Cassano, did you want to say something? Dr. Redlich?

MEMBER REDLICH: No.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: I just wanted to go a little further than Laura indicated. I think we looked in totality how the occupational history would be administered and the information collected.

We saw that that needed some improvements, particularly on specifics of what the workers actually did. And that reflects itself in the updated OHQ.

The other thing that we'll get to I think in some of the other recommendations is

we felt that the information from the OHQ was not being given much weight in the whole process of the case.

And therefore, we recommended that some of the health professionals at least have direct access to the OHQ as opposed to summaries of information from the OHQ from the claims examiner.

So all of these things are really tied back I think more in totality giving the health professionals information that's useful in trying to determine whether the case is a defensible case or not.

CHAIR MARKOWITZ: I'm sorry, Mr. Whitley?

MEMBER WHITLEY: Garry Whitley. The OHQ is an important part because I've seen numerous letters come back from claims examiners when you claim you've had a certain chemical that causes a certain disease come back and say well, you didn't put that on the OHQ.

So it really is important because a lot of claims, they look at the OHQ to see if you said it up front. Keep in mind, a lot of these claimants are elderly people, and you've got a long OHQ and I can do the best, or they can do the best they can trying to go through them and asking you about the -- but they don't remember, they've been retired 20 years. They have no idea what they worked with kind of.

And so, but this is important. The OHQ is very important further down the road in the claim.

CHAIR MARKOWITZ: And I do, I think some of these, Steve Markowitz, I think some of these recommendations tie together in recognizing that the site exposure matrix isn't perfect. And DOL agrees, we've seen that. The public has said this to us.

It's imperfect. It's necessarily imperfect. It can be improved, sure, but it's not going to be perfect. And so there's a need to develop additional credible sources of

information, particularly around exposure, but also around exposure diseases and connections, but typically around exposure.

Other credible sources through this recommendation, through the next recommendation to augment, to compliment the site exposure matrix so that these other sources can overcome some of the imperfections of the site exposure matrix. So that's sort of where these things tie together.

MS. LEITON: Dr. Markowitz, can I just say one thing? I think that focusing on the OHQ and what we can do more specifically in that and how we can train on it is going to be probably more doable for us than trying to focus on what different resources we can get that would be DOE former workers.

Not that we can't or we couldn't change the contract, but the mechanism for how we administer the OHQ, what we actually put in the OHQ, we put forward a draft which I know you'll get into later.

But I think that focus and how we can train people even if they aren't the experts into drawing out the information we need is something that we can dig our heels into more quickly, just as a recommendation.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Yes, I'm a little concerned honestly with that response just because a lot of the rest of the conversation centers around trying to give claims examiners seven years of medical education.

And I think what we've said is that the former DOE workers have years and years of lived experience that gives them, that while training is critically important, and everyone should be trained to the same standard, et cetera, it's still missing that level of deep background understanding.

So I think it does, there is a problem. There's sort of the generic problem is that you can't hire physicians and industrial hygienists to administer the claims

for this program, and you can't necessarily have every single person be a former DOE employee.

But the challenge, which may take longer, of getting more former DOE employees to be administering the OHQ, although that's challenging -- and I think Laura's point was we should probably measure the outcomes to see whether it's really different among, you know, whether the results are different among former DOE employees than people who have been trained but aren't DOE employees.

So I mean, that's actually probably a little project that might be of interest to a sub-section of the board. But I think our concern is that the depth of expertise available through that mechanism would outweigh the challenges of trying to actually hire more former employees.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: Just a final, Dr. Cassano. Just to reiterate what Dr. Dement

said, again all of this is good. But if DOL is not going to utilize the OHQ as prima facie evidence for an exposure, then all of what we're doing is moot.

So, and I think either having the HRP changed to insist on prior worker preference is a good idea. I think putting more into the OHQ. But the real issue is using that OHQ as evidence for exposure rather than having a claims examiner who knows less than the former worker about those exposures have to verify.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: I'm pretty sure I pointed this out in our October meeting. I've had the privilege of seeing many of the questionnaires that the DOE funded Former Worker Programs had developed that are specific to the sites.

And serving on the Medical Evidence Subcommittee of this Board, I know that those questionnaires don't always wind up in the

claims file.

So we've already heard that not all former DOE employees are equally insightful, we guess, in administering the OHQ. But I think those former DOE employees who have administered the site specific former worker program questionnaire might do a better job administering the OHQ because they've seen a lot of the details of the historical plant processes and exposures that are brought out by the former worker program questionnaires.

CHAIR MARKOWITZ: Any other comments on this recommendation? Okay, so let's move on. Recommendation number 4 which is that we, and Dr. Redlich, I'm going to just read the recommendation, but if you could read the response.

"We recommend that DEEOIC establish a process whereby the industrial hygienist may interview the claimant directly."

MEMBER REDLICH: Dr. Redlich. "OWCP agrees that there are certain circumstances in

which it may be beneficial for the IH to speak directly with the claimant. The claims examiners have legal responsibility for adjudication of claims.

"As the examiner's role is the finder of fact and the liaison between the IH and the claimant, OWCP believes that the claims examiner's participation in any discussion between the IH and the claimant would be necessary and beneficial.

"Therefore, in these circumstances, the claims examiner would coordinate any discussion between the IH and claimant. DEEOIC has begun to develop procedures for claims examiners to use when such discussions are appropriate."

CHAIR MARKOWITZ: Comments? Dr. Sokas?

MEMBER SOKAS: I just want to say this sounds like a great response, thank you.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I guess, and if you

could fill us in on what procedures that you are developing and sort of what criteria you would use when you would consider that such discussions are appropriate.

MS. LEITON: And so I believe it might even be on the newest procedure manual change, but I don't want to quote myself. I wouldn't quote me on that.

But basically what we're asking the industrial hygienists to do is when they look at the case, if they believe that there should be further discussion, we reach back out to the claims examiner, we facilitate a discussion with the claimant.

You know, when I talked to my legal counsel, they say the claims examiner has to kind of be there for the discussion so they can overhear it. But it's pretty simple in terms of the IH can reach out to the claims examiner, we facilitate the discussion and it happens.

It shouldn't be that difficult of a procedure to implement.

CHAIR MARKOWITZ: Do you have to change the contract with the contractor?

MS. LEITON: Well, the contractor will probably reach out to our, we have industrial hygienists who are the government officials. And so we have to look at that.

But whether or not it has to be, you know, it might be that we have to have the government IH also there to listen to the conversation since they are contractors, but I don't know the specific response to that. I can look into it.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Just to go back to sort of combine these last two recommendations, a great reason for having that discussion would be if there is an exposure documented on the OHQ that the claims examiner cannot verify. That would be a very good reason for them to talk to the IH directly with the claimant and the claims examiner.

And I think it's a great process to

include the claims examiner, not only because you legally have to, but because they learn. And I think if we can enact that, I think it's good.

CHAIR MARKOWITZ: Steve Markowitz. It's also frankly, it's great education for the claims examiners because they would be listening in on these detailed conversations about people's exposures in the plant, and they're going to learn from that.

And they'll learn that for that particular claim and they'll learn, you know, over time more generally. And since it's coming back, the IH product is coming back to the claims examiners, so the claims examiner will have a better understanding of what the thinking is and where it should go. So I think it's an excellent idea.

Other comments, questions? Ms. Pope?

MEMBER POPE: Duronda Pope. I think this might, by having that conversation with

the IH and the claim examiner, this might eliminate the process of going back to the claimant and asking for more information. They can have that discussion about what is needed in that particular claim.

CHAIR MARKOWITZ: Okay. So we'll move on to Recommendation number 5. And now it's Dr. Cassano's time to read. But let me say that the recommendation is that, "We recommend DOL review policy teleconference notes, redact confidential information, and post the information in a publically available database searchable by topic area." Dr. Cassano?

(Off microphone comments.)

MEMBER CASSANO: Sorry, do you need me to start over from the beginning? Okay, sorry. "OWCP does not support this recommendation. In the past, DEEOIC management and Policy Branch staff had conducted internal policy calls on a monthly basis to discuss specific cases, often complex or unusual in

nature, which may not align precisely with broader policies.

"While we provided the Advisory Board with the policy call notes, the notes nevertheless generally constitute case-specific, pre-decisional internal policy deliberations which OWCP does not believe are appropriate for the general public.

"In this regard, the policy calls are an informal discussion forum for open and candid conversation about the details of individual cases. If the agency participants believed the notes from these discussions were to be shared with the public, it could likely inhibit the open exchange of ideas.

"Nevertheless, DEEOIC carefully evaluates each policy question/determination, and where material is considered to have broad applicability, any resulting policy is added to the Federal EEOICPA Procedure Manual, which is updated regularly and is available to program staff and the public on the OWCP/DEEOIC

website.

"We recently converted the online Procedure Manual to a PDF format, and it is now searchable by topic area."

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Yes, I just want to say I fully understand what, you know, the need for confidentiality and for people to be able to speak freely in that.

And so I was really struck by the richness of those notes. And I wanted to maybe suggest to the Board that we take it back to subcommittee. It may well be that one of the subcommittees may want to just request, you know, again, we've had access to unredacted information that we maintain confidentiality about.

And it may well be that if one of the subcommittees just does this from time to time, we can provide a list of questions or discussions just to say, you know, well this was really interesting, did this find its way

into the policy manual yet.

You know, those kinds of conversations we could have rather than having it be, I don't know. So that's something we could handle internally.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: I have perhaps a less generous view when I looked at the policy notes. I don't remember seeing the names of particular agency personnel. But if they were there, those could easily be whited out.

Environmental and occupational health is all about making decisions in the face of uncertainty. And if we want the DOL decision making process to be transparent and open, we may as well lay it out there so that the claimants and their advocates can see what's being batted around behind the scenes and take their best shot at revising their claims.

CHAIR MARKOWITZ: So let me say this, Steve Markowitz. You know, to me, this

is a tradeoff between transparency and the need to think out loud without coming to a decision, the need to bat around ideas and in a non-public setting, which is important.

And transparency, which is important, and DOL comes down the side for the need to have that forum to think out loud. And to me, that's frankly understandable.

But what I would like to know is when this pre-decisional discussion leads to a change in the policy, the procedure, which in the response it says, "When it's considered to have broad applicability, it's then added to the Procedure Manual which is updated regularly."

So how quickly does that happen? Who shepherds that through so that there isn't this silent period where, in effect, there's a new policy or procedure being applied but it's not yet part of the openly available procedure manual or policy documents.

MS. LEITON: So, our policy branch

is the one that reviews all of these, conducts the policy teleconference calls, updates the procedure manual, you know, does the circulars.

And what we do in that branch is in some cases we've come across specific cases that have, we say oh, we've already got guidance out there that's not in compliance with what we're saying we should be doing.

And we'll go and immediately change it by doing a circular or a bulletin, or we'll say this needs to change right now and here's what we're going to do about it.

Some things are a lot less broadly applicable. They may be, and ultimately we will go through, every time we change our procedure manual, we go through any policy call notes to see if there are things in those policy call notes that should be changed.

But they may have affected one or two, maybe, you know, half a percentage of claimants, of cases that we currently have or that we see. So it's not as urgent to put that

particular nuance in the procedure manual.

And I say nuance because sometimes it's not specifically outlined already in our procedures, it's just something that came up that wasn't contemplated specifically.

So it's kind of hard to explain, but when you're writing out procedure manuals, we try to keep them, you know, broad enough that there's some room for actually looking at a particular case and making a determination.

And the circumstances in a particular case may be such that oh, well this might happen in another case and we should probably put it in our procedures.

So bottom line is if it's something that's a big change from what we've done before, we will immediately put it out there, put a circular out there, and then go back and look at other cases.

If it's something that is a nuance that should be and better be, it's better to have explained in a procedure manual, we look

at the last six months or whatever every time we update our procedures to make sure that anything like that is incorporated.

CHAIR MARKOWITZ: So, there may be a discussion involving these calls, which will affect -- which are around the particular case but aren't broadly applicable, but may well affect a handful of other, a limited number but a handful of other cases.

It sounds like that doesn't necessarily enter into either the procedure manual or circular, bulletin, or the like. But could there be a mechanism where you make a decision on a particular case and you understand that it's not broadly applicable, but it is going to apply to at least a limited number of other cases, could you make that available in some formal way so that people can understand the claims process as much as possible?

I don't know what the mechanism is, so --

MS. LEITON: Well, sometimes that could be done through our precedent setting procedures. We have decisions out there, a database on our website that you can look at and see precedent setting decisions. And you'll see specific cases for really kind of maybe oddball things that you wouldn't normally see.

But that's one way we can go back and look at these types of cases and say oh, and we put it out there as precedential, and people can go through those. And we've got them divided by subject.

You know, here's something on conflict of interest, or here's something on survivorship that's kind of unique. And that's one way that we try to do that on a case by case basis, so people can go back and say oh, I see that this happened here and maybe we can apply that in another case.

CHAIR MARKOWITZ: Thank you. Dr. Boden?

MEMBER BODEN: Les Boden. So this may reflect my ignorance about exactly how you do things. First of all, let me say I agree with Dr. Sokas that this is a reasonably convincing argument. You do need to be able to brainstorm about things, to think about them and not necessarily have every word displayed in public.

So I do understand that. My question goes to the process by which you end up with a new procedure or policy. Is there a step where you tell the public we're thinking about doing this and we would like your input?

Because that might be a useful thing that goes somewhere between, you know, transcribing your internal conversations and giving people the chance to look at what the prospective policy change is and giving them a chance to get back to you about their own thoughts, which I think could only be helpful to you in terms of promulgating these procedures.

And I guess the other question, the other thing that would be good is for every change like this, is at least a brief description about why the change is happening.

MS. LEITON: Okay. It gets really complicated when you start saying that all of our changes to our procedures should undergo public scrutiny. Then that's kind of like a regulation that undergoes public comment, that requires us to respond to all those public comments, and it's a very large, bureaucratic kind of nightmare to do that.

And in terms of obtaining, you know, it's the more public comments you get, then we have to stop at every point we try to make a decision to say oh, we need to ask somebody else if this is the right way to go and/or, you know, and then you get 50 different opinions from 50 different members of the public.

And then we're having a public debate about how we move forward in our procedures, and that's where we struggle with

that sort of thing. And it not only applies to my program, but broadly.

When you start doing, going down that road, it will affect all the other worker's compensation programs we have, and it may even go beyond that. So that's where we get ourselves into a little bit of trouble.

We do try to explain in our circulars and our bulletins when we make changes, the background behind them. And you know, when we make changes to the procedure manual, your suggestion about maybe putting a little context behind why it's done, that could probably be done in our transmittal where we describe the changes that we're making.

CHAIR MARKOWITZ: Other comments? Okay, so we're going to take our 10:00 a.m. break. We'll resume at 10:15. Thank you.

(Whereupon, the above-entitled matter went off the record at 9:58 a.m. and resumed at 10:16 a.m.)

CHAIR MARKOWITZ: Okay, we're going

to get started again. We're going to say that, now we changed the situation with the mics because apparently on the phone there's some difficulty hearing.

So now you have, for the Board members, you actually have to press the button, Dr. Boden, you have to, Ms. Leiton, Dr. Boden, as in the previous meeting when you sat next to him, you may need a reminder.

But in any event, you have to press the button, bring the mic closer to you so everybody can hear. Okay. So we're going to continue on Recommendation 6 which says that, "We recommend that the Department of Labor explore the feasibility of prospectively having new case files made accessible to the claimant through a password protected electronic portal."

And then, we're going to discuss 6 and then we'll move to 8. So, Dr. Griffon, if you could give the response, the DOL's response to number 6? Oh, Dr. Dement, yes okay, sorry

about that.

MEMBER DEMENT: Is this on? Okay. Okay, I'll take number 6. It says, "OWCP supports the first of these two recommendations. We agree that claimants are entitled to access their own case files. To implement this recommendation, DEEOIC plans to leverage technological solutions utilized by other divisions within OWCP.

"While implementing this recommendation may seem simple on the surface, it requires that the new interface/portal be programmed to assure that each claimant can only see his or her own specific and targeted information from our claims and document management systems.

"This activity will begin in FY 2018, if OWCP is able to obtain additional resources. To access this new interface, DEEOIC would need to create new tools to implement methods, authenticate users accessing the portal, including and maintaining two-

factor authenticated username and password access and systems provisioning that assures that case specific access to only what the user is authorized to see.

"Additionally, DEEOIC systems are not currently able to be accessed outside of the DOL firewall, so there would be additional security measures and costs to develop and maintain the integrity of our claimant's private data and to protect against the vulnerabilities created by public access.

"Costs would include those for initial start-up and annual maintenance. We would also need to modify our existing IT contract and procure new contracts for identity proofing. DEEOIC will need to develop new procedures, procure additional resources, issue contract modifications and develop training."

So, basically their response is it's not currently technically feasible and they have to get these additional resources.

CHAIR MARKOWITZ: So, my question is

to what extent has this been done? And black lung program, the federal employees compensation -- and other parts of OWCP since it could be facilitated in EEOICPA?

MS. LEITON: So that is kind of what we're eluding to here. We have in our FECA program, it's something that they are starting. And hopefully this year they're going to start this.

We're going to try to piggyback on what they're doing, which is this two factor authentication process. And it costs a certain amount of money to do it per person or something.

I'm not as familiar with the details of exactly what the mechanisms for making it happen are. But I do know that I've spoken with them. We want to piggyback on it as soon as we see how it works for them, and then do it ourselves for our claimants.

I think it's a very valuable thing. In fact, Doug, you might have a little bit more

information about it.

MR. FITZGERALD: This is Doug Fitzgerald. Could you hear me? Yes, this is a challenge across government, not just for the energy program and OWCP. But Rachel's correct, the FECA program, the Federal Employees Compensation Program has been pursuing this for some time.

And one of the advantages FECA has, the Federal Employees Compensation Act program, has over energy is that they're dealing with federal workers. And so you can kind of allocate the work across federal agencies and give people user authentication authorities within federal agencies to grant access to the claims files.

You don't have that same ability when you're going outside our firewalls into the public. So it's going to be the kind of the forerunner for OWCP, but we still have the challenges of trying to create that two factor authentication process that can be done in an

affordable and secure manner in order to make sure that the PII in all these files is not going to be compromised.

CHAIR MARKOWITZ: So for people who are unfamiliar with two factor authentication, you probably actually are familiar or will soon be familiar because it's increasingly used where you enter your user name and password and then they, the company or agency sends you in email or text another password which you then have to enter. So there's two levels of entering into the system.

So comments or questions on this. Okay, so you know, it would be nice to know at future board meetings, I think it will be half of the future at the next board, it would be good to have some periodic very brief report back on progress on this so we know what is actually happening with this recommendation.

MS. LEITON: Absolutely.

CHAIR MARKOWITZ: Because the description makes it look like it would take an

awful long time, actually.

MS. LEITON: Yes. With any IT project, it's hard to quantify. And I think that the department and OWCP is going to be cautious in providing a specific timeline. Now, some of these things move a lot quicker than we anticipate, and some of them take longer.

So I know that it's a priority for OWCP. I really want it to work and to happen because I think, you know, with the energy document portal, submitting things electronically has been a big help.

I think that this would be even a bigger help, we wouldn't have to be shipping case files through the mail. I mean, there's a lot of incentive for it. So hopefully it will happen sooner rather than later. But it's hard to quantify now, but we will provide updates.

CHAIR MARKOWITZ: Let's move on. So we're going to do Recommendation number 8 because that's the way it's dealt with in the

DOL responses. And while Mr. Griffon is getting ready to read the response, let me just read the recommendation.

"We recommend that the entire case file should be made available to both the industrial hygienists and the contract medical consultants when a referral is made to either, and not be restricted to the information that the claims examiner believes is relevant. The claims examiner should map the file to indicate where relevant information is believed to be."

So, for the person operating the screen should go on to the next page. It's the first full paragraph, it beings with, "With regard." That's good.

MEMBER GRIFFON: Okay, and this is Mark Griffon, this is the Department of Labor's response. "With regard to providing the industrial hygienists and contract medical consultants with full access to the case file, we do not believe such access is appropriate for several reasons.

"First, we believe there are potential challenges associated with industrial hygienists and contract medical consultants (CMC) developing their own set of facts after review of the file, thereby usurping the primary function of our claims examiners as finders of fact, and in particular, those facts that need to be presented to these consultants.

"In addition, claimants often submit voluminous amounts of medical documentation (sometimes thousands of pages) regarding all medical treatment that they've received during their lifetimes. Many of these documents are unrelated to the medical condition being claimed, or the reason for a referral to a CMC.

"While it is never the intent of a claims examiner to conceal information, it has been OWCP's experience that it is operationally inefficient, and often uneconomical, to supply superfluous documents to the CMC when only parts of the medical information is pertinent to the issue at hand (e.g. completion of an

impairment rating for an accepted lung condition.)

"Finally, when cases are referred to industrial hygienists, the claims examiners are seeking guidance on a particular set of circumstances.

"It would be inappropriate for an industrial hygienist to be required to sift through all of the various employment, exposure and medical documents in order to make his or her own determination regarding which documents are to be reviewed.

"It is the claims examiner's responsibility to determine the questions that are being asked of the specialist, and to provide them with the documents that are relevant to the issue of concern.

"Finally, it has been OWCP's experience that the contractors performing this work do not want to be required to sort through potentially thousands of pages of documents for each claim, most of which are not relevant to

the question being asked of them."

CHAIR MARKOWITZ: Okay, so comments? Dr. Cassano?

MEMBER CASSANO: This was a recommendation that came out of my subcommittee, and I have several issues with the response. First of all, your statement about the industrial hygienists and the CMC's developing their own facts.

I think what you want are the appropriate and relevant and necessary facts for a claim to be adjudicated properly to get to the proper people. The industrial hygienists and the CMC have a lot more experience in determining what those facts are in order to adjudicate the claim than the claims examiner.

I will also tell you that at Veteran's Affairs, that it is settled case law that the physician doing the exam or the claim gets the entire claims file and has to state that they have read the entire claims file.

That's Nieves-Rodriguez vs. Peake if you want to look at it.

I don't think energy employees should have less protection than veterans, and I am a veteran myself.

The other thing is, yes, some of these case files are 3,000 and 6,000 pages long. I've been through them. And that's the purpose of the claims examiner mapping them because then the industrial hygienist only has to go to the industrial hygiene information.

And then they have it at least available so that if they have a question or they think something's wrong, they can go back to the file and determine what really is going on.

I think that's what you really want to do, and there's all of this stuff that isn't procedure, it isn't law. It's just it's too hard to do, and by the way, we don't, you know, our CMCs don't want to do it. Well, then maybe they're not the right CMCs.

But if you map the file and you need that information and you use that information, then I think you shouldn't have a problem because there is not another agency that has that problem with a physician or an industrial hygienist going through all the information. Thank you.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Okay. Laura Welch. I think that the answer here is really interesting because in a way, you've summarized what I see as a conflict in approach between the way the Board, or maybe the occupational physicians on the Board and the industrial hygienists on the Board would approach a case, and the way EEOICPA approaches the case.

By saying that it would be inappropriate for an industrial hygienist to be required to sift through all the various employment, exposure, and medical documents in order to make his own determination regarding which documents are to review.

The role of the industrial hygienist is to go through the exposure, employment, and medical documents to determine relevant facts. So that's the conflict. You know, we see that that's what the industrial hygienist has to do is look at the available information.

You're saying the claims examiner does that first, and tells the hygienist what to look at, and we're saying you're likely to lose something in that process, particularly on -- well, this is just because I'm a doctor.

You know, on the medical side, we see that frequently where there's some useful information that may not be obvious unless you're trained to look for that information related to that exposure.

But I think, you know, I mean, I think there's some famous line that doesn't come to my mind right now, but it's an existential difference in opinion here, and I don't quite know how we get around it.

If the problem is the volume and the

time it would take for claims examiners to go through, and certainly if you're asking for an impairment rating, you don't necessarily, it's not a causation question so it's not as much information. So how do you get through that procedurally, we can work on that.

But we need to come to some understanding, or at least maybe I think the Board needs to make a firm statement that we do think it's the role of industrial hygienists and the CMC to go through the records to be sure that every relevant bit of information is being used in the determination.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: Now that we have, oh okay, it's on. Dr. Sokas. I want to second what Drs. Cassano and Welch, or third I guess what Drs. Cassano and Welch have said.

That for example, just as an example, one of the COPD claims that has maybe 2,000 pages in it, you can kind of find actually some really interesting information

back in the medical logs from, you know, 30 years ago when they were being seen at the clinic, and you've got all that information.

And then all of a sudden there's a two week hospitalization for respiratory problems and then follow up issues. And that's just scribbled in these little notes that don't necessarily have the hospital record even attached to it, if that wasn't found.

So there clearly are times when it's needed. Now again, maybe not for impairment, and maybe not for home care, you know, certification. So that would limit the workload. But absolutely for causation, absolutely for causation.

Any physician who reviews a chart for causation and doesn't have access to everything is really blinkered and challenged, I think.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So let me preface this with a warning, I am not a lawyer. One

statement in the response was that you seem to believe that allowing the industrial hygienist or the CMC to see the whole file would undermine the claims examiner's role as a finder of fact.

I don't think that's the case at all, and I'm not quite sure why that's in there. If you have a judge on a case, the judge is the finder of fact. That doesn't mean that an expert can't look at whatever they think is appropriate and provide expert opinion about that.

So it just seems to me that that argument doesn't hold water. I'm not quite sure why it's in there.

CHAIR MARKOWITZ: Ms. Pope?

MEMBER POPE: Duronda Pope. I just wanted to echo what everyone has already said. In particular, I was on the subcommittee with Dr. Cassano.

We identified these issues with the claim examiner mapping out the different facts

that were within the case, and we understand that the cases might be overwhelming in terms of the volume.

But I think it's essential that this information goes directly to the CMC because of the fact is that the statement here said that they don't want to be doing the work of going, required to do the work I think is their obligation. It's their job to go to sort through that information.

I mean, the claimant's health, you know, depends on it. And I think it's an obligation for them to go to sort through that information.

CHAIR MARKOWITZ: Dr. Cassano? Oh, I'm sorry, Ms. Vlieger, was your --

MEMBER CASSANO: Yes, just to, I just want to clarify that I think you're correct. For impairment ratings or for home care or something like that where all of that is already established.

But I can't tell you how many times

when I have gotten a statement of case from a claims examiner, and it says this, that, and the other thing, and I go through the claims file and I go oh, this person also worked here, this person also did this job, this person also did such and such. And oh, they had this medical problem while they were actively working, or on active duty in my case.

I can't tell you how many times that happens. And then when I write my medical opinion, include that. And the case is accepted because of that. And sometimes it works in reverse too.

If, you know, I see something where, you know, somebody has done something outside of covered work, that obviously is more relevant, and I include that because the claims examiner has not.

So I don't see the Agency's problem with this, I really don't.

CHAIR MARKOWITZ: I'm sorry, before you go, Ms. Vlieger, can you just clarify? You

said you've reviewed cases, claims examiner. Is that in the DOL EEOICP system, or is that in a different system?

MEMBER CASSANO: (Off microphone comments.)

CHAIR MARKOWITZ: Okay, fine. Ms. Vlieger?

MEMBER VLIEGER: First of all, I want to say that I deal with a large number of claims examiners and a large number of hearing examiners in what I do in my advocacy. And I respect many of them, most of them.

However, instead of thinking that these are finders of facts, I'm finding that they are filters of facts. And many of the most pressing and imminent things that should be going to the IH and the CMC are left on the cutting room floor.

That, when you're dealing with a worker population that is most likely not college educated and does not understand that that is relevant and it should have been in the

file, and then they're dismayed when they are provided with what they think and what indeed has been relevant facts, and they are ignored, pushed aside.

Said again, you did not provide, you did not complete your burden of proof. So I find that when we have all of this information in the file, particularly nuclear chemical operators, and people think that that's somebody like Homer Simpson sitting in a back room pushing buttons, when in fact they're in the field and all these chemicals.

So a referral goes to an IH or a CMC that's limited to three to seven chemicals that are the most innocuous things among the entire up to 3,000 chemical list on the SEM because that's what the SEM is because it's already been filtered for them.

And we've already admitted, the SEM is inaccurate, incomplete, and inconsistent. Yet, that is the rationale why it's sent. And then you get GIGO, garbage in, garbage out.

You get a domino effect by claims examiners saying well, this is what I can send, and so the industrial hygienist looks at it and says hey, part of my contract, I can only look at what you've sent me, I agree. That' doesn't cause anything. Domino effect.

It goes to the CMC. CMC says well, I'm not going to contradict an IH. They must know what they're talking about. So then we get a domino decision. Oh no, this condition is not related to work.

So instead of limiting the CMCs in what they can do, because they're intelligent people, I believe they're forced to be filters of fact instead of finders of fact.

CHAIR MARKOWITZ: If I could make a comment, John. So you know, I have a question for the group. It would be a cost to giving a whole case file to the IH and the CMC to look at. And I don't mean a financial cost. There is that too, but that's not of our concern.

Which as to do I think with

efficiency of the operation. And you may say it's less important, but at least we need to put it on the table and have it out there and discuss it. I would like to hear DOL's opinion.

But there are presumably some cases that the claims examiner doesn't refer to the IH or the CMC. And that CE feels she or he has enough information on hand to make that decision, deny or approve.

Well, should that case also go to the CMC or IH because the CE could easily have missed important information if the scenarios we're proposing here are accurate.

So should it be then that every single claim goes to the IH and the CMC because we don't really believe that the CE isn't capable of appropriately finding or asserting the facts.

But anyway, so that's one issue, so that every claim would go to the IH CMC. And if not, then which ones. And then what does

that do to the operation of the system.

And so I think, and I think Ms. Leiton can potentially probably provide more about the impact on the efficiency. But it ought to be a consideration and a concern of the Board. Dr. Dement?

MEMBER DEMENT: I want to defer to Dr. Cassano.

MEMBER CASSANO: I think, Steve, the only ones that would go to the CMC are the ones that the claims examiner is going to ask the CMC for an opinion on.

So if the claims examiner can adjudicate the case appropriately and award the case, then -- they can't hear? And award the case, then there's no reason for it to go to the CMC.

But if they have a question that's going to go to the industrial hygienist or the CMC, then those are the cases that need, where they need to have all of the information.

That's the same in the system I work

in. You know, there are lots of claims that are approved at the claims examiner's level, but then others have to go to an MD or further.

CHAIR MARKOWITZ: So just a clarification. You're saying that all claims that are denied by the claims examiner without involving the CMC --

MEMBER CASSANO: Only if causation is the reason for denial.

MEMBER SOKAS: That's right because there's a lot of other reasons to deny. They weren't working during the time period, et cetera. So it's not all the cases, it's just those specific --

MEMBER CASSANO: Causation.

CHAIR MARKOWITZ: Okay. Dr. Dement?

MEMBER DEMENT: I guess just a follow up response. I think the intent of this recommendation actually links back with many of the other recommendations with regard to enhancing the occupation history questionnaire to get more specific information to allow the

industrial hygienist to directly speak with the claimant, and in this case, having the industrial hygienist to have all the facts before them to make a determination.

So you know, we can look at them independently, but I think it's more of our recommendations collectively that that process be more information intense for those individuals making the decisions, or making recommendations.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: We were, we discussed who got to go first. This is Laura Welch. I just would also add that overall, I think one of the wishes of the Board is that there be more process evaluation and quality assurance.

So that question of if you initially started with the case files being sent when a CMC or industrial hygienist was asked to consult, there could also be a QA review of case files that where there's a determination made by the claims examiner without additional

input from.

And on a regular basis to see if that is working well, if additional training needs to be made, you know, so that one could then adjust this process going forward.

CHAIR MARKOWITZ: Mr. Whitley?

MEMBER WHITLEY: Rachel can help me here, but the claims examiner really can't say this claim's exempt. The claims examiner makes the recommendation and then it goes on up the line to be.

I've seen many claims that the claim examiner made a recommendation for that claim to be accepted, and then they get a letter that says it's been denied. On final adjudication.

CHAIR MARKOWITZ: So do you want to, do you have a comment on Mr. Whitley's, because that's a different kind of comment. Do you want to comment on that, and then we'll move on to other other comments from the Board?

MS. LEITON: Sure. If a case is accepted at the recommended decision level and

it goes to FAB, to Final Adjudication Branch, they would never automatically, they wouldn't deny it. It would be remanded for additional information.

And then there would be a new recommendation made, and then it would go back to the final adjudication branch with a new set of appeal rights.

And I just, one other word about the claims examiners, you know, I understand the Board's concerns with the fact that they're not doctors and they're not scientists, but they are trained in how to evaluate medical and scientific evidence.

They're not just, you know, I mean, there's a lot of training. A lot of these examiners have been doing this kind of work for 30 years plus. So I just want to make sure they're not being dismissed as they don't really know what they're doing because they have been trained in the evaluation of evidence.

A lot of our hearing reps are lawyers, and not to dismiss what you guys are saying, I just want to make sure that that's also clear is that they're trained. They do understand how to evaluate medical evidence. They issue very thorough recommendations. And then there's a right to an appeal.

But I will address the other section that you wanted me to address later, or you want me to go ahead and address that now in terms of the burden it would put the process for if all cases for denials went to a CMC or IH.

CHAIR MARKOWITZ: You might as well make that comment now, and then we'll continue the discussion.

MS. LEITON: Okay. So I think what you're suggesting, and from what I'm getting from all the comments is you're not suggesting every case go to a CMC and IH. If it's because we don't have a diagnosis or we don't have, you know, there's no survivorship eligibility,

there's no evidence of employment, obviously those are not going to go to an IH or a CMC.

One thing that we do try to make a point about is to go to the treating first, because if we go to a CMC for everything, then we are accused of being the people who just have government doctors making decisions for us, and we don't want that.

So the first opportunity is going to go to the treating physician. Oftentimes, treating physicians don't have the information, as you all have already discussed.

So at the end of the day, what you're saying is we go to treating, we do whatever we can, and we're still looking at a denial. At that point, we go to an IH and/or a CMC depending on the circumstances, and determine.

That would be, it would create some delays in our processes in terms of how quickly a decision is made. And you know, there's always going to be criticisms for that process.

Well, you know, are the CMC's issuing decisions properly, et cetera, et cetera.

But you know, we could evaluate that if that were a recommendation you were to make in terms of what we think the impact would end up being on our claims process, on the timeliness of our decisions, and that sort of thing.

And I did just want to also mention that our government IHs, we have two of them, do have access to the entire case file. If there's a question that arises from one of the contract IHs, they can ask it and they can provide that information.

And at any time, if a CMC, whether a contractor or a fed has a question, they can go back to the claims examiners. I just wanted to make sure that that was clear as well.

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

MEMBER FRIEDMAN-JIMENEZ: One of my many hats is as an impartial specialist

consultant for the New York State Workers Compensation Board where I make the final adjudication when there's a disagreement between the treating physician and the independent medical examiner.

And in this process, I wouldn't even think of taking a case where I did not have access to all of the information. And frequently I see that sometimes the treating physician doesn't have access to exposure information, for example, and makes an incorrect judgment because of that.

I don't see the problem in providing access to the information if it's needed. That doesn't obligate the CMC or the IH to review every single page of thousands of pages of documents, but it makes it possible for them to answer a little hypothetical question that comes up when they're thinking about how could this have been caused or what, the finder of fact is important but it's not clear always what facts need to be found.

And sometimes this depends on a mechanistic hypothesis of how the causation occurred. And this fact may be something that's important to decide the case, but is not something that a claims examiner, or even a treating physician would have thought of as something that's important to find out.

So I think that the access to the information would be important for the CMC and the IH in making these causal judgments. So I want to weigh in on that side. So, thanks.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, it does seem like there's tension between this sort of efficiency point of view, which is what DOL has described, and the can the person who's the more expert get the full picture so they could look for things that might not otherwise be directed at them.

And it does seem to me number one, that indexing the file, or whatever we called it, is actually a way to help the CMC or the

industrial hygienist avoid going through the whole file if they don't feel like doing it, on the one hand. And there are probably other things you could do.

I seem to remember a number of files that had, you know, 1,000 page medical record that was duplicated in the file. And certainly, I don't think any of us would object if the second or third copy of the 1,000 page medical record were not sent on.

MEMBER BODEN: I want to go back to a question for Steven -- Dr. Markowitz. So, I wasn't quite sure what the point of your hypothetical was about sending everything to the IH and the CMC.

Was it to raise the question about how much do we trust the claims examiner to make decisions about what goes and what doesn't go, or was it to point out that that's the logical, you know, end point if you really take this to the extreme, which I don't think any of us were thinking about doing.

CHAIR MARKOWITZ: No, I was trying to get the issues out on the table.

MEMBER BODEN: Okay.

CHAIR MARKOWITZ: I was trying to broaden the conversation --

MEMBER BODEN: Right.

CHAIR MARKOWITZ: -- beyond just let's consult the experts.

MEMBER BODEN: To --

CHAIR MARKOWITZ: Look and consider the impact on the system.

MEMBER BODEN: Right. Okay.

CHAIR MARKOWITZ: I didn't have an opinion about it.

MEMBER BODEN: You didn't have an opinion. Right. So, but then we do have to think about not only the costs in terms of the DOL and their consultants, but we also have to think about the costs in terms of delay for the claimants.

CHAIR MARKOWITZ: Right.

MEMBER BODEN: So, if everything

goes out, then it's going to take longer.

CHAIR MARKOWITZ: So, Ms. Leiton has her hand raised. You can speak, but I have a question related to this perhaps you can answer at the same time.

I read this language where you use the word "usurp," "that the CE's prerogative to be the finder of fact would be usurped." It's a strong word.

And so, what happens now when the claims examiner sets out facts and then consults with the IH or the CMC, and the IH and CMC makes --- they weigh in on the questions, but also make observations about the facts and give that feedback to the CE?

Does the CE then change the facts, which they should because they now have an expert weigh-in, perhaps an unintended expert weigh-in on those facts?

MS. LEITON: Okay. So, that question goes to what Dr. Boden was talking about with regard to the finders of facts, and

the lawyers are the ones that weighed in heavily on this particular issue.

So, you know, there is a certain chain of custody that our lawyers refer to when they talk about the claims examiners making the decision on this, but I -- at the same time I want to point out that, you know, oftentimes the entire medical case evidence does go to the CMC.

And early on in our program, in every situation we sent all of the medical evidence to the CMC.

As the program has moved forward, you have Part B, you have Part E. You've got a whole subsection of decisions that were made about a cancer over here or a --- and then you have another condition over here.

We want to make sure the focus on something that's already been accepted doesn't --- isn't something that the CMC is going to be reviewing.

So, you know, in some cases, like we

said, with thousands of pages, the relevancy isn't --- we're not trying --- the claims examiners aren't trying to say, "Oh, well, you know, we want to try to hold back information that might be relevant."

And I understand everybody's argument that, well, the CE doesn't always know what's relevant, so it should all go to the CMC.

I think that sometimes there are things that just have already been decided, already been adjudicated, it can be incorporated and so if we accepted this case under Part B for X, Y and Z. That being said, if a CMC wants more information, we're happy to supply it.

With regard to indexing, we do index our cases. We don't have a way to provide that yet to physicians or contract industrial hygienists in an index format where they only see the index.

That's not something that we're

capable of doing yet and that is something that we contemplate for the future.

I don't want to say absolutely yes right here, but I think, you know, it is a doable thing. And so, it's really -- I just want to make sure that -- a lot of times everything will go.

If we have a new case file and we're sending it to a CMC and we've got, you know, a small pile of documentation and we give every single piece of medical, we will.

The OHQs can go to the IHs. The government IHs have access to the whole case file. So, there are combinations of getting this information to the appropriate specialists.

And your question, Dr. Markowitz, I might have gotten lost in your question. I'm sorry.

CHAIR MARKOWITZ: That's fine. Let me try to focus it on --

If the CE finds facts and then has

questions, sends it to the CMC, and the CMC answers the questions, but also says, "I need to amend your facts because the facts don't represent the case," and then gives that feedback to the CE, does the CE then amend the facts?

MS. LEITON: The CE -- it depends on the circumstances. I mean, you know, a lot of times the CE is going to be making the coverage determinations.

So, if a claimant were to say --- if there's some conflict with regard to whether an employee was at a particular site, that sort of thing, a CMC coming back and saying, "Well, the claimant said, X, Y and Z," we have to verify that against all the other evidence in the case file.

However, we have had circumstances where the CMCs have come back and said -- first of all, I don't think -- well, we've had it go both ways.

Sometimes they say, "I don't think

he had this diagnosis, and I don't think I should be issuing a decision on causation because of this diagnosis."

And then we have to go back and say, "Okay," and oftentimes we'll follow back up with that physician and say, you know, "This is the evidence we relied on. If it, you know, to come to this determination. Please help us understand this."

If they say, "Well, I think this other condition is implicated here," we definitely review whatever that doctor says and we'll revise our --- I mean, our statement of accepted facts is what we send to them.

Our recommended decision is what we actually make a decision on at the end of the day. And that's going to incorporate anything that we've received from a CMC or a treating physician.

So, yes, we will revise our determination at the end of the day based on a CMC especially if it's going to impact a case

in a positive way.

It becomes more problematic, for example, if we say, "We've already accepted this diagnosis in a final decision," and this doctor says, "I don't think he was ever diagnosed with that."

Oftentimes we're not going to go back and revisit that just because we've already made a positive determination on the case.

So, it gets a little tricky in those circumstances, but we definitely consider it particularly when it might affect whether a case could be accepted versus denied.

CHAIR MARKOWITZ: Thank you.

I don't know who's next. Who wants to speak next?

Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Just a very quick comment.

In the meantime while you're developing an indexing system, a very quick and

dirty way to find what you're looking for in a long medical record is a searchable PDF file.

I just want to make sure that the PDF files are all going to be searchable because there are different kind of PDF files.

As long as it's searchable, it's actually relatively easy to find what you're looking for in a 2,000-page document. If they're not searchable, it's a problem.

MS. LEITON: Well, we actually index them as the documents come in. So, we have an index system. So, when a piece of a record comes in, we'll just document it as this is medical. We can index it right there as medical.

When you talk about PDFs, we actually have TIF files. And so, when it comes to searching the actual document, that's not something, unfortunately, that --- we followed the -- it's an OWCP-wide kind of a system. And so, there are certain issues where PDFs haven't been part of our system. But in terms of

indexing, that's completed at the front end.

CHAIR MARKOWITZ: Dr. Welch.

MEMBER WELCH: I certainly appreciate what you're saying about how if an industrial hygienist or a CMC has a question, they can always go back to the claims examiner, request more information.

But I guess what I've seen in --- the process I've seen in claims that I've reviewed is that the --- what the CMC will receive is a statement of accepted facts.

And the whole process, the way the statement of accepted facts is sent and also the process reviews that you've done, the message to the CMC is, answer these questions that I have for you. They're very specific questions that I have for you and I want you to answer them.

The message is not, if you have any other questions or if something doesn't seem right to you or if there's something else you'd like to look at, let me know.

And so, even though that opportunity is there, I don't think that really solves the problem that we have been talking about.

I mean, it's not --- it's great that it is --- and even telling the CMCs or industrial hygienists, I think it's -- with the industrial hygienists, it's a little bit easier if we have this process where you say, "If you want more exposure information, let the claims examiner know and we can facilitate a discussion with the claimant."

That, I think, is easier. It's harder to the CMC to say, "If you want more medical information, let us know," because the CMC wouldn't know what's in the file that they haven't seen.

So, the process of being able to go back and ask for more information is good, but it doesn't totally fix the problem.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: Yeah. I just wanted --- Rachel, I don't think anybody here

believes that the claims examiner's job is easy.

I don't think anybody here believes that they are not well-trained at the level they need to be trained at.

And I don't think anybody here is saying that they are not conscientious or trying to hide information.

I think the issue is -- and I think we've all seen it whether it's in reviewing cases or in other areas such as Dr. Jimenez and my expertise, is that many times because the unique expertise is not there, the questions that are asked are not actually the right questions to be asked.

And when somebody with more expertise in that area looks at a claims folder, they say, "Oh, no, we need to go back up and go to this exposure and develop it this way."

And I think, again, it becomes a learning experience for the claims examiner.

It's something that can be developed as training documents as to why, you know, there's a particular exposure/medical outcome link and I think it just improves the process.

I know that, you know, initially a claim might be slowed down by that. Nobody is saying that everything should go or even all the denials at this point should go. I think the denial issue can take place in the audit system somehow.

But if the claims examiner has a question for either the IH or the CMC, they should just have that information available to them because, quite frankly, from an efficiency perspective, it's a lot less efficient to have a claim keep coming back on appeal or to have it come back three years later as a newly-opened claim with new medical information. It's much more efficient to get it done right the first time.

CHAIR MARKOWITZ: So, I have a question -- Steve Markowitz.

If you have multiple finders of facts, you have the CE and you have the IH and you have the CMC, multiple finders of facts, how are differences resolved? What's the hierarchy?

Because the current system, the CE is in the catbird seat and then they use the expert resources and, obviously, use them for their expertise, presumably, most of the time correctly. But if you have multiple finders of facts, how do you resolve differences?

Dr. Sokas.

MEMBER SOKAS: Well, so, I mean, I would phrase it differently. The experts are providing recommendations. The CE and the final adjudication board makes that determination. So, that's how that happens.

The real question -- and, again, I want to echo what Tori was just saying -- is that we fully understand that the expertise of the CE exceeds that of any of the physicians in terms of the regulatory aspects of the process,

of the statutory requirements, of the language being used, of what, you know, the different terms mean. I mean, there's no question about that.

But if the CEs were -- and that for most of the cases, the CEs can make the determination. But if the CEs were trained to the point of not needing CMCs, why are you spending money on CMCs, is the question.

So, if you're going to spend the money on a CMC, you may as well get the full benefit of that, which is having someone who's really coming from a different perspective able to look at it in a different way.

And then providing whether or not it then gets used may not be relevant, may have been to something that, you know, this --- but at least have the information there.

CHAIR MARKOWITZ: Dr. Boden.

MEMBER BODEN: So, in a way, this is a minor technical point, but it's also a troublesome one to me.

If these files --- and I understand this is a legacy issue for you --- are in TIF format, that means that the CEs are going to have a hard time looking for stuff, too, because they're not going to be searchable.

So, I think that's an efficiency problem that the Department might consider if there were a simple technical fix to it, and there might well be. I'm not an expert in that area.

But certainly when --- if a large file is sent to a consultant, either medical or IH consultant, either medical or IH consultant, it is a --- when I got to look at those files, the first thing I did was to make them in PDF format and then to use optical character recognition to make them searchable.

I'll bet I'm not the only one who did that. So, having that available, I think, is just sort of a simple technical fix that might be valuable both to the CEs and to the consultants.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: Ken Silver. A question for Dr. Cassano.

Is there a difference between mapping and indexing? I have the impression from your bringing it up ---

MEMBER CASSANO: It's really no different other than --- see, we've had the benefit of seeing how they index their files in their electronic system.

So, the only difference with mapping and indexing is a lot of times in a flat file, all of the industrial hygiene information is in different areas.

So, what might be useful is to put it all in one area, map that area in this way and index it to that area rather than saying "page 15 is this exposure, and page 28 is that exposure, and page 573 is, you know, something else."

There's a very slight difference, but indexing is as slight as mapping.

MEMBER SILVER: Well, I did have a couple of other comments. I think a distinction between "training" and "education" is in order here.

The claims examiners have certainly been trained to the required regulations and the procedures. And from the get-go, I thought they needed a career ladder so that they could progress along in this field and truly become the peers of the IHs and the physicians.

And the occupational epidemiologists, we spent time together in graduate school learning about chemical causation and there are certain concepts that may not always be reflected in the regulations and emphasized in the procedure manual.

Dr. Sokas referred to a temporal relationship between a hospitalization years before and the onset of chronic disease later.

I'll mention it again, a classic teaching example is an acute sign like a skin rash followed years later by damage to the

internal epithelial cells of the lungs, for example and I'm not sure that the claims examiners would know what they were looking for.

There's also the ethical issue. I didn't really dwell on it, but when I reviewed some of these files, I couldn't help but notice people were jammed up in the claims system so long they lost their home, their marriage fell apart, new mailing addresses for the claimant.

When the doctors read these files, they probably see people going back for repeated exams for the wrong disease and probably even the wrong procedures for the wrong disease, which raises the ethical issue of performing due diligence, you know, saying statistics or, in this case, claims files of people with their tears wiped away.

So, we fall back on our not just education, but our training and ethics in this field and we want to look at everything to make sure the first person gets a high level of

determination. Oh, and Homer Simpson became a safety thingamajiggy.

CHAIR MARKOWITZ: Ms. Vlieger.

MEMBER VLIEGER: Yes. Faye Vlieger.

I agree that there's a difference between training and education. It's not exclusive to the claims examiner, though. In the number of claims that I see, there's a tiny percentage over the entire program.

And unfortunately, it appears that when there are changes in the procedure manual, and I know there was an extensive training push from all the claims examiners to be brought up to date, that information is not, for whatever reason, always in place with all the people adjudicating the claims.

From the CE, to the IH, and the CMC, I wonder what the process is to bring them up to date on the changes in the procedure manual, the changes in the presumptions, bulletins and circulars that come and go, and then the challenges that do come from policy calls.

In recent claims that I have seen, a number of claims for lung conditions when it went to the CMC, the smoking history was attributed to the cause of the disease and their opinion was that the disease had no basis in occupational exposure.

These claims were at the hearing level and I have yet to --- I think they're going to be remanded, but the hearing officer also, you know, looked at it and said, "Yes, it's a valid point."

So, I know that claims examiners are getting things through their routine training. I don't see it happening at the IH and the CMC levels because when these errors are repeated over and over again in at least four hearings I've had in the last four weeks and I see a tiny percentage of the claims, I have to question how many other times is it happening and the claimants have no idea of their rights to rebut this false information.

CHAIR MARKOWITZ: This is Steve

Markowitz.

Is there a question in there? And the question I heard, I think, was whether the CMCs and the IHs learn, understand, are updated on the procedure manuals and policies, et cetera, of the program.

Is that a question ---

MEMBER VLIEGER: That's the question.

And then the other question is, I know --- I see no effective auditing before these are sent on a recommended decision to deny.

And so, we're --- and it's a long process to get to their, you know, this is months to get to that thing --- to get to that hearing in front of the hearings examiner with the final adjudication branch.

And it appears to me that there's not effective training going on and that there's not effective auditing going on of the changes that have been made, the current

changes that should not be popping up in these decisions.

So, my question, what is the training for the CMCs and the IHs for the changes that are made, to bring the program up to speed?

CHAIR MARKOWITZ: So, I'm going to make a comment on that and then ask Ms. Leiton to address that.

I suspect some of the reluctance to diffuse the function of the finders of facts is that the CEs are steeped in the program and the procedures and the policies and they really -- they get the program.

And my sense is the external industrial hygienists and CMCs probably don't because -- for a number of reasons. One is they're not called upon and they're not internal to the program. They're external experts.

And that part of the reluctance to diffuse the finder of fact function to them is

they don't understand the rules of the program that are relevant to the finders of fact.

So, that's a comment or is it a question, but, Ms. Leiton, if you could just address that?

MS. LEITON: Sure. I think -- well, when it comes to the IHs, we have our internal IHs -- and you did make a distinction there, Dr. Markowitz -- who are often in the middle of creating the new procedures. So, they're very aware of the new procedures.

When it comes to the training of our contractors on new procedures, whether it's the IH or the CMC, I think that's an area that I'd like to look at a little bit more closely before I make a comment on it given that the training itself is actually a contractual thing. But the amount of it, how often they're updated on new policies, I don't have that information right -- with me right now, but I think it's a valid thing to look at.

When it comes to auditing -- well,

when it comes to the training of the claims staff, you know, we do have a process for training on new circulars as they come out, new bulletins as they come out.

Oftentimes management in the district office will consult with our policy and they'll conduct training on their own in the district offices for claims examiners.

With regard to audits, we do do an accountability review every year in every office, as you know, of the work that's being conducted and, you know, we change out what we're auditing depending on what the issues are that are most prevalent.

And, you know, we make that determination at the beginning of each year --- fiscal year looking back.

So, for example, if we determine, and it may be something that we look at how the changes are implemented, what we've done, you know.

In coming years, we can look at the

specific --- when we're looking at case files since we pull them randomly, we can pull out what we want to make sure that we've looked at whether these policies and procedures have been incorporated. And a lot of time we do that anyway, but we can hone it in to specific topics.

So, meaning if there's an issue with whether or not this particular circular was --- that was rescinded was actually conducted properly, we can look at that issue in our audits --- our annual audits.

So, I think that might have answered the questions that were brought up.

CHAIR MARKOWITZ: Yes. Dr. Boden.

MEMBER BODEN: Les Boden.

So, this is a little tangential, but something occurred to me when Ken was talking about training and education.

I don't know if the Department already does this, but I think it would be of value to actually have some professional

education on industrial hygiene and occupational medicine specifically as it refers to particular exposures and diseases that the CEs are likely to come upon.

That is not to turn them into industrial hygienists or occupational physicians, but to give them a feeling that they are --- number one, a feeling that their ability to understand these cases is respected, and; number two, to give them --- allow them to have a little more insight into how industrial hygienists and physicians think about these things.

I know you do a lot of training on the sort of legal and procedural parts of their jobs, but I don't know if you actually have professionals come in to talk to them about decision-making and how occupational physicians or industrial hygienists think about these kinds of decisions.

MS. LEITON: This is Rachel Leiton.

Our industrial hygienists have gone

around to -- individually, personally and done training with our staff. The ones that are government IHs, they have done that in the past.

And I think that it's always a good thing and I would like to see more of it as well, you know, resources allowed.

And, you know, we have done that sort of thing where DOE has come, for example, not exactly what you're talking about, but DOE has come and provided us with their experts on a specific facility.

We'll talk about the history of the facility, what they did there, that sort of thing, and we do that every year. We try to do it at least three times a year with different facilities and I think that's been very helpful.

So, that sort of an expertise, whether it's a doctor or an industrial hygienist, I think it is very valuable and I appreciate your comments.

MEMBER BODEN: And it might also be valuable because people have to deal with a lot of pulmonary disease, if an expert like Dr. Redlich were called in one afternoon and people had a professional education seminar about this thing.

And I think it would make them feel better about their work as well.

CHAIR MARKOWITZ: Other comments, questions?

Okay. Let's move on to Recommendation No. 7, which is that we --- and, Mr. Domina, I'm going to ask you to read the response, if that's all right.

So, I should just parenthetically state that asking people to read and going around the table may or may not be the best system, we may want volunteers. But the reason I employed this as a default because sometimes I -- at Passover, the Jewish holiday, I run the service, the Seder, and we tell the story of the liberation of the Jews from Egypt, and I go

around the table and people read their section. So, that's where I got it from, but it may not be appropriate here.

In which case, I think we're going to move to volunteers. But in any case, Mr. Domina.

Now, "We recommend that the Department of Labor reorganize its occupational physicians into an office comparable in an organizational structure to the Office of the Solicitor of the Department of Labor with physicians organized in groups to support OSHA, MSHA, OWCP, and other units, as well as to provide overall support to the Department of Labor."

MEMBER DOMINA: Due to your rationale, I'd be more than happy to volunteer to read.

CHAIR MARKOWITZ: Thank you. And let's do it in English. You don't even have to do it in Hebrew.

(Laughter.)

MEMBER DOMINA: Well, that would be kind of like Japanese. You won't understand that, either.

"The Board has recommended that a separate agency within the Department be established to provide medical advice to OWCP on the basis that it would help ensure quality, consistency, and objectivity.

"While OWCP appreciates the Board's recommendation regarding the provision of medical advice specific to the EEOICPA program, OWCP believes that further information needs to be provided to the Board for it to have a fuller understanding of the current structure OWCP has in place to provide medical advice to the EEOICPA program.

"In particular, OWCP will provide information on the role of OWCP's Branch of Medical Standards in Rehabilitation, BMSR, and the medical staffing of that branch, as well as the use of contract medical consultants and the process OWCP uses to review the reports of

these medical consultants.

"OWCP believes that following the exchanges of this information, some of which are already occurred, the Board will be in a better position to provide recommendation that is tailored specifically to the EEOICPA program."

CHAIR MARKOWITZ: Dr. Sokas.

MEMBER SOKAS: So that's, I think, an appropriate approach. It would be nice to have that information in the response as opposed to will be provided in the response, but the goal really was to make sure that a single physician was not in isolation and that the whole program wasn't held hostage to the fact that there was no physician there for X period of time.

So, the question about how many physicians are within OWCP and how does the Department ensure that within different agencies there is the ability, for example, to communicate, to cross-cover, to --- even for

purposes of audits, basically, to have multiple opinions that are not necessarily contracting opinions, but, you know, just being able to go around the corner and ask somebody, "Did you see this? What do you think?"

I mean, that's the kind of situation where it is challenging in occupational medicine because sometimes you're in settings where it doesn't allow for that. But where it can allow for that, it enhances the practice, basically.

CHAIR MARKOWITZ: This is Steve Markowitz.

And I would add it also makes it more attractive work for the physicians. I guess there are many jobs in occupational medicine and very few physicians, very few new ones being trained each year, and it is tough to attract good occupational medicine physicians. So, an interesting interactive work environment is attractive.

Other comments? Dr. Friedman-

Jimenez.

MEMBER FRIEDMAN-JIMENEZ: In our occupational medicine clinic at Bellevue NYU, we have occupational medicine rounds.

We discuss cases among our three physicians, industrial hygienists, ergonomists and others and it's really valuable. It's almost an exercise in continuing medical education.

We all teach each other stuff and, you know, I've been in this 30 plus years and I'm learning from other people on rounds.

I think it's really important to have a community that doctors who have to make these kind of decisions can bounce cases off of and get feedback on how to think about it on something they may or may not know. I think it could be great.

And maybe -- I don't know your experience at Yale, Carrie, but I would bet that most of the academic occupational medicine clinics around the country have some kind of

rounds.

And maybe we could incorporate this into a regular rounds type of experience or accessibility that the physicians could access if they feel that they want to reach out for additional opinions.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: I would just add that some sort of discussion is helpful both educationally and also to provide greater consistency, which I think is really important for a compensation system.

And we clinically in our practice, we have a kind of conference at the end of every clinic to discuss cases, but it creates consistency among the different attendees.

CHAIR MARKOWITZ: Dr. Sokas.

MEMBER SOKAS: And just, again, within DOL, the Office of Occupational Medicine and Nursing in OSHA does exactly that.

They have regular meetings to discuss their own internal program for their

compliance officers, as well as they host trainees. And the trainees provide --- and supervise them to provide lectures.

I mean, in addition to the collegiality, there's kind of the incentive that comes when a trainee is asking a question or providing a different approach. And then it really challenges the attending or the physicians in the group to answer those questions.

So, it's just the idea that there is a need for collegiality. There's some that's internally available, but some that could be. The other thing that has happened in the past, I don't know if it's still happening, is there are collaborative activities between NIOSH and OSHA and there's no reason why there couldn't be some cross-collaboration for continuing education, but the biggest issue is just that day-to-day being able to walk around the corner and talk to somebody.

CHAIR MARKOWITZ: Any other

comments?

Yes, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Yeah. Occupational medicine is so broad and there's so many thousands of toxins and hundreds of diseases that we deal with that no one can know everything.

And I think that it really could be a great resource if we figure out a way to make expertise of multiple physicians available, accessible to the CMCs and the medical director, if they choose.

CHAIR MARKOWITZ: Okay. So, you know, if there is additional information that the program wants to provide on this issue as is cited in the recommendation, we're very happy to receive it.

And, you know, if there's need for further discussion, assuming we have a telephone meeting with the board in January, we could discuss this further. Otherwise --- yes, Ms. Leiton.

MS. LEITON: We'll definitely provide the information about what OWCP has, the resources we have, how we collaborate within OWCP.

When it goes beyond -- when these recommendations go beyond OWCP and into the Department level, OSHA, MSHA, that becomes a whole different ball game.

And, you know, we really have been told to focus on our OWCP program, so I just want to make sure that that's clear in terms of scope and what we're looking at.

So, we'll provide you with what we have internally and what we can do within that realm.

CHAIR MARKOWITZ: So, how many full-time physicians or Ph.D.-level people are there within OWCP on the staff?

MS. LEITON: I will get back to you. I don't want to quote incorrectly on the record.

CHAIR MARKOWITZ: That would be

useful.

Dr. Sokas.

MEMBER SOKAS: There's at least one more physician that I hired into DOL.

(Laughter.)

MS. LEITON: Are you talking DOL or OWCP?

CHAIR MARKOWITZ: I'm talking about OWCP.

MS. LEITON: Yeah. We have Ted -- and we also have Dr. Armstrong. We have others and I'll look and see what other...

CHAIR MARKOWITZ: Okay.

Ms. Vlieger.

MEMBER VLIEGER: So, in these questions we pose concerning collecting medical evidence and how a medical opinion would be properly informed, did anyone ask the Department's doctor about our recommendations?

MS. LEITON: Yes. He was involved with all of these responses.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: If NYU drafted Yale to follow through on a proposal from Georgetown with Hopkins sitting in the audience and it was about holding grand rounds, I would jump on it. And it's not just because I'm a sleepy east Tennessee state university.

CHAIR MARKOWITZ: Dr. Sokas, did you want to --- okay. If there are no further comments, we'll move on.

So, now we're going to discuss the DOL responses to our April 2017 recommendations. This is going to be a little bit on the Board's part of thinking out loud.

I say that both for the Board's purposes and also the public because we received these responses last week and we haven't really discussed them either at a committee level or all that much among ourselves and some people may not have had all that much opportunity to look at them.

So, I know the public, this was made available to the public just this week. We're

going to try to --- we're going to again read them even though some of them are a bit long, but it's important to be as inclusive in this discussion as possible.

On asbestos, which is the first one, asbestos-related diseases, and if you could just --- Kevin, if you could just bring the page further up to summarize the recommendations, there's --- we want to look at the table at the bottom of that page.

If you can bring it up a little further and if you could make it any bigger, maybe people could see it. So, basically our recommendation was to take several --- the spectrum of asbestos-related disease.

And you can see in the second column we deal with cancer of the --- mostly lining of the lungs, sometimes abdomen, called mesothelioma.

And then in the third column we discuss asbestosis, scarring of the lungs due to asbestos, or scarring of the lining of the

lung, the asbestos related pleural disease. And then in the fourth column we address cancer of the lungs, ovary, and larynx.

And we have made recommendations for presumptions by DOL on duration of how long a person would need to be exposed before it was presumed that their exposure was significant to cause that asbestos-related disease --- again, I'm talking about exposure to asbestos --- what job titles would be included in these presumptions --- and in every case it was maintenance and construction job titles --- what calendar years of exposure to asbestos we're talking about.

And here, there was discussion among the board members at the April meeting and we settled on this presumption about exposure to asbestos prior to 2005.

And then finally we recommended that in all instances, that the minimum period of time between when the person first reports exposure to asbestos in their job and when they

developed the disease, be 15 years across the board.

So, that's the --- that was our recommended presumptions for asbestos-related disease.

So, there's a long DOL response to this and there are a few issues that really need significant discussion, but I do think it's worth the time to read this unless --- okay. Great. We have volunteers. Go ahead, Dr. Sokas, beginning with "With regard."

And, Kevin, if you could bring us to the next page? We're not going to read the whole thing and then discuss it. What we should do is read a couple paragraphs and then have a discussion, and then move on.

MEMBER SOKAS: Okay. "With regard to Recommendation No. 1-1, OWCP agrees that the 250-day aggregate duration of exposure is a reasonable standard to apply when assessing presumptive standards for asbestos-related health effects pertaining to the following five

asbestos-associated conditions: asbestosis, asbestos-related pleural disease, lung cancer, and cancer of the ovary and larynx."

The next one?

CHAIR MARKOWITZ: Yes.

MEMBER SOKAS: "OWCP currently makes a distinction between 'exposure presumptions' and 'causation presumptions.' The Division of Energy Employees Occupational Illness Compensation, DEEOIC, or 'the program,' has determined that certain presumptions may be made as to the nature, frequency, and duration of a specific exposure.

"Presumptions are based on knowledge and evidence OWCP has obtained through industrial hygiene knowledge of labor categories and work processes and environmental health and safety practices in existence. Therefore, OWCP's exposure presumptions are specific to certain labor categories, work processes, and/or time frames.

"If an exposure presumption exists,

the claims examiner will apply the criteria to the specific toxic substance.

"As long as all criteria have been met, the case does not need to be reviewed by an industrial hygienist.

"With regard to exposure to asbestos specifically, the program recognizes that asbestos is a toxic material that was present in all DOE facility locations. However, OWCP assumes different levels of exposure depending on the employee's labor categories and years of employment.

"The program has developed a list of labor categories considered to have had significant exposure to asbestos at high or low levels referred to by the board as Attachment 1.

"If an employee worked in one of these labor categories before December 31st, 1986, the program considers that he or she had significant exposure at high levels.

"If the employee worked in one of

the labor categories --- sorry --- if the employee worked in one of the labor categories between 1987 and 1995 in one of these labor categories, the employee is presumed to have significant exposure to asbestos at low levels.

"While employees in all other labor categories or during other years of employment are assumed to have had some level of exposure to asbestos, the level of exposure is determined by guidance from an industrial hygienist on a case-by-case basis.

"OWCP applies these exposure presumptions before applying any causation presumptions."

CHAIR MARKOWITZ: Okay. I think we should stop here and discuss it. The subsequent paragraphs are related, so we may double-cover a little bit, but that's okay.

Dr. Welch.

MEMBER WELCH: Well, I was just going to say I think that the subsequent paragraphs, I mean, because here the response

is restating the current approach, and our approach was clearly different.

So, if we're going to talk about the exposure presumptions, I think we probably have to jump to the later paragraphs that are part of that; don't you think?

CHAIR MARKOWITZ: Yeah. I think --- that's fine. I mean, frankly, in our recommendation we combined exposure and causation presumptions for the purposes of exposure. We didn't make that distinction. So, let's read on and then we'll discuss.

(Comments off mic.)

MEMBER BODEN: "OWCP currently applies a causation standard to the conditions of the asbestosis, laryngeal cancer, ovarian cancer, and mesothelioma, using criteria specific to each of these conditions.

"For all four conditions in order to apply a presumption that the condition is related to exposure to asbestos under Part E, it must be a medical diagnosis of the

condition, and the employee must have been employed in a job that would have brought him or her into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate workdays.

"Exposure can be determined by existing asbestos exposure presumptions as outlined above, or through an industrial hygiene assessment.

"The program also applies varying latency periods to each of these conditions. For asbestosis, latency is 10 years after initial exposure; for laryngeal cancer, it's 15 years; for ovarian cancer, 20 years; and for mesothelioma, it's 30 years.

"The program has not yet created a presumption for lung cancer as it relates to exposure to asbestos. However, OWCP agrees that sufficient literature exists to develop one.

"OWCP reviewed the Board's recommendation that the latency period for all

of the listed conditions be 15 years and agrees to change the existing latency standards for all conditions except asbestosis.

"Since the current latency period of 10 years for asbestosis is claimant friendly and OWCP's research confirms that this period is scientifically valid, OWCP will retain the existing 10-year latency period."

CHAIR MARKOWITZ: So, we should just continue the next two paragraphs.

MEMBER BODEN: Okay. I'll read another paragraph and then I'll pass.

"In developing the labor categories for use in asbestos exposure presumptions, the program primarily relied on the scientific research conducted and complied by the Agency for Toxic Substances and Disease Registry, ATSDR, within the Department of Health and Human Services, HHS.

"They published a booklet on January 29th, 2014, entitled 'Case Studies in Environmental Medicine, Asbestos Toxicity.'

"Pages 31 through 32 include a list of occupations they determine to entail significant asbestos exposure. OWCP worked with its contractor Paragon who created the SEM, to review the list and tailor it to the labor categories relevant to the DOE complex.

"The scientists at Paragon are former DOE nuclear workers and very familiar with labor categories at the DOE facilities.

"OWCP included in its policy more specific definitions where appropriate like 'maintenance mechanic' instead of 'maintenance worker,' excluded some on the ATSDR list that were clearly not DOE related like 'longshoreman,' and further tailored the list to DOE job descriptions."

I pass.

MEMBER WELCH: "In determining the causation standards, the program also relied on this publication along with updated information from the International Agency for Research on Cancer, IARC, and articles and publications

based on human studies, including the American Journal of Epidemiology, American Journal of Respiratory and Critical Care Medicine, the American Journal of Industrial Medicine, and the Journal of Occupational Medicine and Toxicology.

"In reference" ---

CHAIR MARKOWITZ: Let's stop there for a second.

MEMBER WELCH: Okay.

CHAIR MARKOWITZ: So, the floor is open. So, Kevin, if you could turn it back to the table of our recommendations?

Okay. Dr. Welch.

MEMBER WELCH: Well, I think that if we look at what we recommended versus what we've gotten so far, is that we have a clear statement about agreeing on the latency, that DOL likes the 15 years, the Department likes the 15 years, and we'll keep the 10 years for asbestosis, and we'll develop one for lung cancer because lung cancer currently isn't part

of their causation presumptions. So, I think that's a good response to what we recommended.

I think that the other parts of the table we might have to go a little bit deeper into their responses because, on one hand, the response says that they currently use the 250-day aggregate workdays, but, in addition, and it seems a little contradictory, they're requiring different levels of exposure depending on the employee's labor categories and years of employment.

So that -- the 250 days for the specific conditions in our table where we have 250 days, we seem to be in agreement, but how those 250 days are applied is then interpreted based on labor categories, which is somewhat --- so, I think -- I think so far we've gotten an answer to the latency question, but we haven't really gotten a specific answer to the job titles and the calendar years.

CHAIR MARKOWITZ: Dr. Welch, you have additional comments or ---

MEMBER WELCH: No.

CHAIR MARKOWITZ: Okay.

MEMBER VLIEGER: Dr. Markowitz, on the paper that was just provided to us at break, its title page has recommendations. There are attachments in it.

The attachment is referenced in this document that we are discussing and it has the labor categories listed, but my question about the labor categories that are listed is that -- - and we've discussed this a number of times -- - the labor category names are not consistent across the complex.

And we have that problem within the SEM. And the people who provided this list, provided the list in SEM.

So, I'm looking at Member Domina, you know, because we've had this discussion a number of times about the SEM not being accurate for all the names of the construction and maintenance workers. So, I would like us to discuss that at some point, too.

CHAIR MARKOWITZ: So, I'd like to comment on aspects of the response so far. I looked up the ATSDR document because it's the source document for their labor categories. It seems to be the starting point supplemented by other things.

And, actually, I would request these references that are listed here, IARC, American Journal of Epidemiology and the like, to know which specific studies are being used for this.

In looking at the ATSDR document, which we are -- in the field are fairly quite familiar with the Agency for Toxic Disease and Substance Registry or --- Toxic Substances and Disease Registry, part of the Centers for Disease Control. So, they reference two NIOSH documents, 2003 and 2008.

And what those documents are, some of us may be familiar with, it's the annual report from NIOSH on work-related respiratory disease.

And if you go to those sources,

which I did, and you look at the job titles and where they got that list from, it's from people who died from asbestosis.

It's the mortality --- it's the national data based on death certificates of who died going back in time, 1990s, 1980s, who died from asbestosis.

So, asbestosis requires --- we generally consider that asbestosis requires the highest dosage level of exposure to asbestos of all the asbestos-related diseases. And, furthermore, to die from asbestosis means you really had a very heavy level of exposure to asbestos.

And, you know, Dr. Welch can comment on her former worker program, I can comment on ours. We don't see all that much asbestosis anymore, and we don't see any deaths, really, from asbestosis to speak of. So, that's the source document for the list.

And that's why that list is restricted to a certain number of the classic

occupations which are relevant and exclude, appropriately, irrelevant like shipyard workers and the like.

I think that list is too restrictive, but that's the -- that's where it comes from, just so we know.

And it says here that "Paragon reviewed that list and tailored it to labor categories relevant to the DOE complex."

And this -- I'm going to amplify on Ms. Vlieger's comment here. In our former worker program which we have at 14 different sites in the complex, we have thousands of job titles over the years, over 20 years, and it's hard to categorize them sometimes.

Some of them are easy, plumbers and pipe fitters and the like, but some of them are clearly variants of more dominant categories and we have to call Mr. Whitley or we have to call other people to understand them. That is a very difficult task and this has been discussed for years in the former worker

program meetings.

For years, how can we join all the data in the complex so we can make sense of it as a whole? And one of the leading obstacles was that we could never quite figure out what a job title in 1970 at Y-12, which was different from the same job in 1990 at Y-12, how that compared to a job at Hanford, which would appear to be similar in 1975 and the like.

So, I'd really like to know how Paragon did that because we couldn't figure out that puzzle. And I don't -- it's hard. It's just hard.

And but in our recommendation on the presumption, we said maintenance and construction. So, that task has to be done in order to accomplish that recommendation.

Those individual specific job titles if this recommendation is accepted, someone has to do the work of aggregating them into those categories to which you could actually work with those presumptions.

And Paragon may have started that task in creating the attachment, but my guess is that, you know, they only got so far because it's a very difficult task.

It's doable, though. It is doable. It may take a little bit of time, but it is doable and I think justified in terms of an approach, but let me stop here.

Dr. Boden.

MEMBER BODEN: So I'm, again, not expert in a lot of these things, but I have a question which is -- so, we have -- in the presumptions we have these broad categories of construction/maintenance workers, and I try to ask myself the question, "How many construction or maintenance workers would we like to drop from this list if we're thinking about it in terms of individual, more narrow categories?" And not being an expert, I couldn't come up with any that I could think about.

If there are a small number of jobs that are construction or maintenance where

there was very unlikely to be any asbestos exposure, it might be easier to list those jobs and say, "Okay, we won't count them," than to list all the construction and maintenance jobs where there might be exposure.

So, I phrase that without a question mark at the end, but there is a question mark which is, is that a reasonable way to proceed? Are there lots of construction worker or maintenance worker categories that wouldn't have been exposed to asbestos in sufficient quantity to be part of this presumption?

CHAIR MARKOWITZ: We have some maintenance workers here, but who wants to speak first?

Dr. Welch.

MEMBER WELCH: So, when you look at the list of job titles on Attachment 1, most of them are construction worker trades probably disproportionate to the employment at the site.

And I think, you know, if you look back, partly that's a question of the job

titles for what I've always called production workers, are much more complicated.

The construction workers are their construction trades. So, it's a little bit easier to see that they're included here.

And in the next paragraph of the response to the recommendations, DOL does point out that, you know, 15 of the 17 construction trades are already included on the list.

So, but the reason we have information on construction trades really goes back to the work that Mt. Sinai did and Dr. Selikoff did in screening construction workers in the United States.

And information that -- I mean, if you really dug into it that Sinai did in projecting asbestos-related disease into the future, there's been a couple of really good analyses, but the data is limited on -- the epidemiology, even, forget industrial hygiene, epidemiology is limited on job titles outside of construction trades and it's limited within

the construction trades.

And John and I know, like, every single paper that one could rely on to make a table like this and it's always going to be too narrow, too restrictive. Whether you used death certificates which would clearly be the most restrictive way to identify job titles associated with asbestosis, or whether you used all the existing epidemiology, it's too restrictive. It's going to be too narrow.

And so, it's my opinion in this case you have to make exposure presumptions that are relatively generous because there is not going to be information that allows you to make a determination by job category.

I understand what you said, Dr. Markowitz, that Paragon should go through the list and identify which job titles fit into these categories with construction and maintenance and I think that's reasonable.

I think trying to get information that makes it more specific or for specific job

titles, we don't want people to get hung up on the absence of industrial hygiene or epidemiology, there has to be good judgment, but, you know, this is a production job where they would -- it's similar to some of these construction trades where we know that exposures would have been significant had we categorized them as a construction worker.

And maybe we can, you know, we can help with that, but it really can't rely on published epidemiology to add a job title to this list. It has to be expert judgment extrapolating from what we know about existing exposures and risks across all occupations, taking that information and putting it into -- and that's why as a recommendation we came up with construction and maintenance because we understand, as a group of people who have worked on this for a long time, that that will be relatively inclusive.

It could include some people who didn't have exposure. Okay. But it's going to

include most of the people who did who had a significant occupational exposure to asbestos. I don't think one can get more specific without excluding large categories of workers.

CHAIR MARKOWITZ: So, I'm just going to amplify what Dr. Welch said.

You know, you can study plumbers because there are a lot of plumbers. And you can study them at sites because there are a lot of plumbers at sites, pipe fitters and the like, and that applies to a lot of the broad categories on this list.

There are many job titles which are very specific which there aren't enough people to study. You're never going to study them because there aren't enough people to study. So, you make your -- this is really just reiterating what Dr. Welch said.

You make your decision on did that person work there or do similar work to another recognizable job title, say, maintenance, and we can say, "Yeah, they were likely exposed to

asbestos in that era in a significant way."

That's the way we exercise occupational medicine judgment and it's legitimate and accepted.

Mr. Domina.

MEMBER DOMINA: Well, just a comment on these lists and how they come up and job titles because I'm a metal trades guy and HAMTC is the only council in the country that sets jurisdiction for different job titles. It's not set at the international level on the east coast.

And so, when you start getting into the nuts and bolts of this for Paragon to try and do this and not work with HAMTC or even the building trades out there, they're doing a disservice to these people because it is into the nuts and bolts part of it.

And that's why when I look at some of this that, you know, like I think I've discussed before, our ironworkers build scaffolding. Everywhere else the carpenters

do, just as a for instance, you know. So, it depends -- that puts you in certain areas or not.

And then since 1990 or '92 we have craft alignment, which means another craft can assist another craft for doing work.

And so, for Paragon to try and do this without using the expertise of us at Oak Ridge, Pantex, anywhere else, is doing a disservice to the workers.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: Just to respond to the issue of how we make inferences about particular trades or crafts in the absence of occupational epidemiology, it's sort of the experience that we've had in the BTMed program.

We'll never study all the crafts individually from a health outcome perspective. It's just not possible to do it and have any statistical power in any one study.

But from the BTMed experience, we have lots of different trades and occupational

titles. We try to consolidate those as best we can based on what we consider a similarity of their specific task.

And what we find, invariably, across the construction trades, they all report tasks that we a priori as hygienists will say, "Those are significant asbestos exposures."

It varies somewhat by trade and job, but across the board they've all had, in my view, significant past occupation with asbestos exposure.

There's some comments in here about some of our lists. We have teamsters. We have a category of security and others. And I would just say based on what these workers have reported in their own occupational histories collected by our staff, they, too, have reported asbestos exposures. That's why they're summarized on this list.

We're not necessarily suggesting that teamsters be listed in the presumption, but I think we ought to recognize that just

because they're teamsters does not mean they don't have occupational asbestos exposure.

CHAIR MARKOWITZ: Mr. Whitley.

MEMBER WHITLEY: To add to what you said, it's really impossible to do especially in the building crafts and trades because over the years the international unions have combined -- they've combined crafts, they've combined names and there's no way possible to do that.

But let me bring up another point that always bothers me when we say maintenance/construction. Until the late years when we think that maybe we're doing things right with asbestos, we put up a yellow tape or a yellow line on the floor or a piece of plastic chain, and the guy on that side of the chain was dressed out, HEPA filters taking in asbestos. The guy on this side of the chain was his supervisor, the IH person, maybe the HP person. All those people were on the other side of the thing and those guys can get

exposed on the other side of that piece of plastic tape as good as the guy taking it there or maybe worse.

CHAIR MARKOWITZ: Mr. Domina. We're going to take a few more comments, then we're going to break for lunch, then resume after lunch.

MEMBER DOMINA: Well, I think yesterday when we visited the machine shop down at Los Alamos is a prime example.

You take a building that was built in 1953 and I ask specifically how many different air zones that they had. And they got one and it vents to the atmosphere. The beryllium machine shop was a part of that.

And so when you add all those years together and you look at some of the buildings that we have worked in and then, yeah, they vent to the atmosphere, yeah, because you can see the atmosphere when you look up through the vent.

And so, these different things and

based on how hard the wind blows on any given day, what doors are open and not open, it can, you know, they've come in and done studies on airflow in the buildings that I've worked in and you can't replicate it twice, you know.

And a different piece of machinery is running on the outside of a doorway and I just think that, you know, looking at all of this, yes -- and I know this is difficult, but it's hard -- you can't really exclude people when, you know, we have people that are janitors with CBD, just as a for instance, or asbestos, you know, COPD, all those different things and they're not supposed to have been exposed to any of that.

And so, I just think that, too, like I said when we looked at that building yesterday and you asked us specific things because, yes, some buildings have different air zones, but then you find out later when they're having to do a modification, that there was supposed to be a divider up in some air space

that nobody ever goes into that the divider was never there.

CHAIR MARKOWITZ: By the way, I forgot to mention on janitors and cleaners -- Steve Markowitz. I'm glad you raised that because when I look back at the ATSDR document, they didn't list janitors and cleaners as heavily exposed to asbestos, but when you go back to the references to NIOSH 2003-2008, they are there. And somewhere along the line they got dropped from the list and were never carried forward.

Ms. Pope.

MEMBER POPE: Yes. I was just going to echo what Garry and Kirk are saying.

Being on the floor there, we used to joke around that yellow tape, you know, as long as you don't cross that yellow tape, you wouldn't be exposed.

And it was just common knowledge -- I think the different sides are unique in terms of the job titles.

My husband was an operator and he was definitely -- the work assignment that you were assigned to didn't necessarily mean you were confined to just do an operator work, you were also doing removal of asbestos, but I think those job titles are unique to those sites.

CHAIR MARKOWITZ: Okay. We're going to stop here. I see Ms. Vlieger, we have Dr. Cassano. We'll resume at 1:00, but we need to break for lunch. So, thank you.

(Whereupon, the above-entitled matter went off the record at 12:02 p.m. and resumed at 1:05 p.m.)

CHAIR MARKOWITZ: Okay. Let's get started. We're talking about asbestos and we were --- actually, there were two people who wanted to make comments. Dr. Cassano -- Ms. Vlieger wanted to make a comment. She's not here yet, but, Dr. Cassano, you can make a comment.

And we're going to go back to read

the rest -- or much of the rest of this and -- I think we'll just read the rest of it after Dr. Cassano's comment and carry on then.

MEMBER CASSANO: And I think we finished sort of the discussion on the different employee categories. So, I wanted to talk -- and I'm not the most expert on the '87 to '95, but it's the same issue '87 to '95 and after that.

And it's an issue that's come up before with the term -- I'm trying to figure out what, in practical terms, the difference between "significant exposure at high levels" and "significant exposure at low levels" is.

We had had a big discussion the last meeting about the word "significant" to begin with, and the fact that they were trying to banish it from all discussion because it's a meaningless term. "Significant," to me, means something different to somebody else.

So, if you could, explain from a practical standpoint what that means for

workers who have a claim, if there is any practical meaning.

CHAIR MARKOWITZ: So, I'm tempted to put off that question until we read the rest of it because we deal with dates. We begin to get back to the date of 2005, so would you mind just holding that and making it part of that discussion?

Oh, she does mind. Okay.

(Laughter.)

CHAIR MARKOWITZ: She minds. Go ahead, Ms. Leiton.

MS. LEITON: Well, I can put it in the context of what you're saying. For the '87 and the -- when we say "significant" and we're applying these exposure presumptions, if it says "significant," then we're going to use the exposure presumptions that are in our already existing policy because the problem with the word "significant" is that it's written in the law; "at least as likely as not significant exposure to..." And so, that's why we continue

to use the word "significant."

And in the context of our exposure presumptions if it fits into one of those two signifcants, whether it's high or low, we'll still apply those other presumptions that we have in that presumption, if that helps.

MEMBER CASSANO: So, there is no difference?

MS. LEITON: Well, there is a difference between high and low, but I think if we're going to be referring it to a doctor or something like that, there's going to be a difference.

And the way that I think your question is, is how is that -- how is that difference applied in this particular presumption for our overall exposure assessment for the -- for the ones that fit into that category that are in the labor categories and all of that, we're going to fit it in there.

If they don't fit in there, then they still have high or low levels of exposure.

We can say that high or low significant exposure levels to a physician.

(Off mic comment)

MS. LEITON: It will to a physician in some cases.

CHAIR MARKOWITZ: Okay. So, any volunteers to read?

Dr. Welch. So, we're in the paragraph that begins "In reference to the Board's recommendations."

MEMBER WELCH: And then you can take the next really long one after that. This is Laura Welch reading.

"In reference to the Board's Recommendation No. 1-2 to apply asbestos presumption to 'All DOE workers who worked as maintenance or construction workers at a DOE site,' OWCP needs additional information and clarification.

"Included in the Board's reference materials was a listing of all 17 construction and trade worker/labor categories related to

asbestos exposure. 15 of which are already included in EEOIC's presumptive labor category listing.

"The two remaining categories include teamsters and administrative, scientific, security jobs.

"OWCP requests that the Board clarify whether their recommendations are that OWCP should include these remaining two labor categories and whether there are additional specific labor categories the Board believes should be included in the listing.

"OWCP also requests that the Board provide the research relied upon that supports the inclusion of the proposed new labor categories."

CHAIR MARKOWITZ: So, I think we should stop here because then we get into the calendar period. This is just where it's still now discussing the occupational categories.

And so, I would like to just -- this is Steven Markowitz -- I'd like to just

straighten something out.

I don't know if teamsters and administrative, scientific, security jobs appeared in the attachment to the asbestos recommendation.

If it did, it was inadvertent and it was unintended and it was -- and we wouldn't apply it because those are different categories of jobs than the construction list.

I don't think it was. But regardless, I think that may have appeared in the COPD presumption, but we can set that aside.

The DOL is requesting clarification on the labor categories that should be included in the listing, and I think that we should provide them with some clarification about that.

Other comments?

Yes. Dr. Welch.

MEMBER WELCH: I mean, we spent some good time talking about this before we read

this paragraph --

CHAIR MARKOWITZ: Right.

MEMBER WELCH: -- because what we said is construction --- what you said in particular was that for the maintenance jobs, that Paragon would need to go through the list of all the job categories and assign the appropriate ones that would be considered maintenance to use this maintenance or construction worker at a DOE site as part of the presumption, if I understood what you said.

CHAIR MARKOWITZ: So, can I clarify?

MEMBER WELCH: So, this discussion sort of jumps into the labor categories that are construction only, but doesn't really address our recommendation that maintenance workers be included. Yes, so maybe you should clarify.

CHAIR MARKOWITZ: Let me clarify.

I hope I wasn't requesting that Paragon sort through the list of job titles and decide which ones are maintenance and which

ones are relevant within maintenance, but I was -- I hope what I thought I did was set out that that task needs to be done, which job titles constitute maintenance more than which maintenance job titles are exposed or not exposed to asbestos because it's unclear and there are a lot of specific job titles and that sorting has to be done, and it can be done.

That was what my intent was, to identify which job titles -- when the CE gets a claim and the claim says "I was X," and that X is a very specific job title, how does the CE, or with expert help, categorize that as a maintenance or construction or, if necessary, something else? That's what I was driving at.

Other comments and questions?

Okay. Good. So, let's move on.

MEMBER WELCH: So, I think that in the Department's response to our recommendation, the question of including maintenance workers as a general category is not specifically addressed.

CHAIR MARKOWITZ: They don't discuss -- they don't accept or reject the maintenance category.

MEMBER WELCH: Correct.

MS. LEITON: May I clarify?

CHAIR MARKOWITZ: Sure.

MS. LEITON: I believe when you guys say "maintenance and construction," we're referring to both being qualified, not just construction workers.

Is that your question? Yeah, I think we were being inclusive of maintenance workers as well if you're going to provide us more information about what should be included in that category.

CHAIR MARKOWITZ: Right. So, are we to interpret the response is that you basically accept our recommendation?

MS. LEITON: Well, I think we're saying that if you could provide us with more specifics on both of those categories, that would be helpful in reviewing this presumption.

CHAIR MARKOWITZ: All right. Okay. Interesting.

Okay. Our next reader. Ms. Vlieger.

MEMBER VLIEGER: These are comments from before we left for lunch. So, the Department is using the term "significant exposure" again, and I thought we had beat this horse already to death.

Okay. And then what is a safe level of exposure? If we're determining what's significant and what's not, what is a safe level?

So, because what we're having is the Department in their current IH and CMC reports, they're saying low, medium, high levels, and even at high levels they're saying it's insufficient for the disease.

So, what levels are we -- I mean, I know we can't quantify them because there is no safe level of exposure, but the Department has begun -- in their IH reports, has begun saying,

"Well, this worker because we know," and I don't know where the "we know" comes from, "this worker had low levels of exposure, this worker had moderate levels, this worker had high," but where are we defining that since there's no monitoring data?

CHAIR MARKOWITZ: Our recommended presumption doesn't address that issue about lesser exposures to asbestos and at what level you would consider it significant.

What we're saying is for this class of workers, this time period, meaning these criteria in the table, those are significantly exposed, it's a safe presumption that they have significant exposure, and you can relate it to the outcome.

And then there are people who don't meet this presumption for which an analysis has to be done. And then that question you're raising is relevant to them and we haven't addressed that.

I mean, it is something that

could/should be addressed in the future, but we're kind of starting with the more straightforward issues, I think.

Okay. Let's continue.

MEMBER CASSANO: "In reference to the Board's recommendation to apply an exposure presumption prior to January 1, 2005, as indicated above, OWCP currently has guidance concerning presumptions to be made regarding the level of exposure to asbestos.

"Our procedure manual states that the claims examiner is to assume high or low levels of significant exposure to asbestos depending on the years of exposure.

"Anything after 1995 is referred to an industrial hygienist for an individual assessment and then a physician must conduct a medical assessment.

"Then the program reviews the evidence for causation presumptions depending on the latency periods.

"In the Board's presumptions this is

suggested not only that a presumption be made that the claimant was significantly exposed to asbestos before 2005, but also that the exposure was sufficient to presume that the asbestos exposure was at least as likely as not a significant factor and aggravating, contributing to, or causing a listed asbestos-associated condition.

"While OWCP rescinded the EEOICPA Circular No. 15-06, that circular simply stated that the claims examiner should presume that any exposure after 1995 was within safety regulatory limits and, therefore, need not be reviewed by an industrial hygienist.

"That circular does not address causation and the program has continued to refer cases for an exposure and causation assessment for the listed conditions prior to accepting for causation where the employee was employed after 1995.

"The Board recommends changing the current guidance to allow for acceptance of

these medical conditions under broader circumstances.

"OWCP agrees to changing current latency periods for all of the conditions as recommended and to changing the duration of mesothelioma to greater than or equal to 30 days.

"However, with regards to the 2005 date, OWCP seeks additional clarity as to the underlying research and the rationale supporting the selection of that date as a temporal basis for application in the Board's presumption.

"While OWCP agrees with the Board that it is difficult to assign a temporal threshold for use in a presumption, more specific documented basis supporting the date of 2005 is necessary to satisfy the legal requirement that all presumptions must have significant -- sufficient," excuse me, "scientific rationale to withstand judicial scrutiny.

"Our research indicates that DOE's predecessor, the Atomic Energy Commission, began developing health and safety standards as early as 1973. After the Occupational Safety and Health Act of 1970 was passed, those standards became longer and more detailed as the dissemination and enforcement of enhanced safety measures progressed over the next two decades.

"Those safety measures were standardized in 1995 with the issuance by DOE of Order 440.1 and, accordingly, we could agree that 1995 creates a clear demarcation date for causation purposes with a solid supporting rationale that would withstand judicial scrutiny.

"To move that date out to 2005 on the assertion that it is likely -- that it likely took another decade for exposure levels to be significantly lower, it is much more problematic.

"The 2005 date without additional

support, places OWCP in a position of being unable to legally defend the presumption should it be challenged by an employee who only worked after 2005.

"Accordingly, OWCP requests that the Board provide more substantive medical, health, scientific justification or specific DOE operational data that supports the scientific basis for its selection of January 1, 2005, as the exposure demarcation date for use in the recommended presumptions."

CHAIR MARKOWITZ: Okay. The floor is open.

Ms. Vlieger.

MEMBER VLIEGER: One of the rebuttals to this circular when it was placed in effect came from United Steel Workers and also from other organizations that cited DOE's own inspections of lack of compliance with these rules.

So, as a starting basis, even DOE's own inspections showed that they weren't in

compliance. So, I think we can start there and move forward, but that was distributed to the Board, that letter with the references.

And Carrie can bring it up again, but, you know, we've already discussed the fact that even DOE admitted that they weren't following the rules.

CHAIR MARKOWITZ: So, we need to -- Steve Markowitz. We need to look at that.

Dr. Boden.

MEMBER BODEN: So, let me refer back to a discussion that we had earlier in the day in which I think we agreed that even though 1995 was the date when this circular was approved, that there was -- nobody really believes that on the day the circular was approved that everybody came into compliance.

So, it seems to me that having that date is a kind of artificial, absolutely minimal date where we might think that people are starting to come into compliance, but we would need -- it seems unreasonable to have

that as the date just because there was a piece of paper that was put out at that time.

And I thought when we were discussing our earlier Recommendation No. 1, that that was indeed part of the discussion that we agreed about. We had a little discussion about that at the beginning of the day, I think.

MS. LEITON: I think that we agreed that finding a line in the sand, say 1995 or 2005, is a challenge in and of itself.

We're talking about presumption, positive presumption of causation exposures, which sets the bar pretty high in terms of we're going to automatically assume that all the evidence is there, this person was highly -- significantly exposed, we've been presuming a causation and we're going to go ahead and get this person compensation.

And that's where we run into what line is that, how do we determine it, and how do we support it if it goes to court? And the

person who works after 2005 or 1995, even, says, "Well, why isn't mine, you know, in this presumption?"

And so, documentation in support of any of the dates -- I mean, I think that what OWCP is looking for here is 2005. What are we relying on for that documentation and how can we -- how is that line in the sand going to be supportable and what can we rely on to say it's supportable.

CHAIR MARKOWITZ: So -- Steve Markowitz -- I'd like to point out that this paragraph is internally contradictory in that it says on line 8, "The satisfied legal requirement that all presumptions must have sufficient scientific rationale to withstand judicial scrutiny."

So, the 1995 date didn't have a scientific rationale as a policy rationale, which clearly was acceptable in terms of the program.

And later on in the third line from

the end of the paragraph it says that the "OWCP requests the Board provide more substantive medical, health, scientific justification or specific DOE operational data."

So, now science is okay or operational data, if you can demonstrate that there was exposure that we can make a presumption about.

Neither of those things, scientific or operational data, is the same as policy as DOE Order 440.1. So clearly, there are three possible rationales for setting a date.

And I'm not sure exactly -- I don't think -- I would -- I mean, we'll look at what Ms. Vlieger was referring to, but we can take a look for operational data to demonstrate excessive exposure during the relevant time period. Maybe we could make a request to DOE for that to see if that exists.

The rationale that you've heard here on the Board is that of reality. And the reality is that a paper order doesn't translate

into instant action and it takes time for it to happen.

And it's limited, in part, by what Mr. Domina referred to before, which is the ups and downs of funding and contract periods and the like.

I don't know if a description of that reality -- I don't know if that constitutes science or operational data or policy, but it seems very real to us and people who have worked at the plant and the people who have had longtime experience in occupational medicine knowing the way that policy and reality interact.

Mr. Domina.

MEMBER DOMINA: I guess for me, I'm thinking a couple of different things about this because I think that maybe that how we got to the rationale of the 2005 date, I think it was when we were talking about this circular at Oak Ridge last year and Mr. Vance was talking about the tiger teams. And then they picked

'95 because it was approximately seven, eight, nine years and we found that that didn't work.

But then now you get in today's world where you do an open-air demo for D&D and where you have a contractor -- and I believe this event happened in 2005 because -- or, excuse me, 2012 at Hanford, but it's on -- a professional cinematographer did it on open-air demo with asbestos, it's outside the area above the limits.

And so, I think we also have to look as even after '05 and a lot of places are going through D&D modes. And so, it's not just construction and maintenance anymore. Now, we're into tearing things down and then the evidence is gone.

And I think that's probably why when we were in Richland this spring I said, "Go big or go home," wanting 2015, you know.

CHAIR MARKOWITZ: But if you picked 2015, it wouldn't solve this particular problem.

MEMBER DOMINA: I know, but it's just -- I think you got to get outside of the maintenance and construction part of it, too, because the type of work that goes on here today and has been going on for 20 years, too.

Some of the D&D stuff started in the '80s, I mean, at least for us, and I just don't want people to lose sight of that.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: I'm going to give you an example of I think what people are talking about, and then I think I may have another way of looking at this.

And, again, we're thinking out loud here, but I can tell you in the late '90s when we were decommissioning NPTUs, which are the nuclear propulsion training units, which are under DOD auspices, instead of using contractors who would have required personal protective equipment at that time, they grabbed a bunch of Navy kids and went in -- and I was putting kids on the asbestos medical

surveillance program in the late '90s and early 2000s because what they did was they'd rip something out and say, "Gee, this is lagging, it looks like it may be asbestos," and then they'd test it. They wouldn't test it before the kids went in and they weren't using wet process.

So, maybe the way to look at this is instead of looking at a date of the claim, we should say something like if they were working in a building that was built before 1978 and there is no documentation that the asbestos was abated, then the claim should be --- the presumption should apply because I believe it wasn't used before --- it was supposedly not used after 1978.

And if there was an abatement and there's no asbestos in the building, you should be able to do it because that's how it's done in other areas.

MS. LEITON: This is Rachel.

Just administering something like

that, would we have all the information to do that, would be our challenge, I think.

CHAIR MARKOWITZ: Other comments or questions?

Dr. Boden.

MEMBER BODEN: So, again, thinking out loud about this, part of the issue with a presumption when it's actually carried out in practice, is that a positive presumption can have a little bit of a feeling of a negative presumption.

That is, we have to be careful for people who don't meet the presumption that they're treated as if there was no presumption rather than somebody thinking, well, they didn't meet the presumption, so that's one strike against them.

So, in your case, Kirk, the one that you described at 2015, the fact that this presumption didn't hold shouldn't stop anybody from saying, "Hey, there was open-air demolition of an asbestos-containing building."

And I guess our problem is figuring out how to balance the fact that no matter what you say, a positive presumption always carries with it a -- for people who are administering a program, a bit of a negative afterthought.

And I think that's a problem that the program just has to think about. We won't have a solution for that problem, but it is important.

CHAIR MARKOWITZ: Other comments?

Okay. So, let's move on to -- do you want to --

MEMBER REDLICH: I guess -- I mean, all of this comes up in the setting of a disease that a person has that's being attributed to asbestos exposure.

And so, my first question would be, what are the major diseases that are being claimed?

MS. LEITON: Well, I thought in the context of this discussion we were talking about the conditions that the Board was

discussing.

CHAIR MARKOWITZ: Are you talking about the asbestos diseases?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: So, which of the asbestos diseases --

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: -- arrives most frequently?

MEMBER REDLICH: Yes. I'm just saying based on what really are you seeing as the most common --

MS. LEITON: Lung conditions are by far our highest claimed conditions and the ones that we've seen manifest the most in Part E.

The -- all of these are lung conditions. If you're talking about splitting them out, probably asbestosis of these conditions would be one of the highest, but there's a lot of things associated with asbestosis which turns into other conditions, as you know.

So, those lung conditions could, you know, we also have -- obviously we have a lot of COPD which isn't asbestosis, but that is another very highly claimed condition. I'm not exactly sure what --

MEMBER REDLICH: The reason I was asking the question is, I think if someone had mesothelioma, I think there would be a presumption everyone would potentially look at the other jobs that the person had, but it would be a very high chance that that was related.

That's an uncommon cancer and that's one of the few examples which was really -- does not have other causes.

The other conditions -- well, ILD is also not as common. A condition I think -- so it's the COPD scenarios and probably -- and lung cancer I guess would be the two most common.

MEMBER WELCH: Exactly.

MEMBER REDLICH: So, then COPD is a

separate presumption so then we're getting to lung cancer where we, you know, have an interaction where asbestos can cause it and also can interact with smoking.

So, is that -- I just wanted to --

MS. LEITON: I'm not real sure what the question for me is.

MEMBER REDLICH: So, I'm just trying to get a feel for where this whole issue is most likely to come up because it -- that could help also potentially just sort of come up with a reasonable --

MS. LEITON: I mean, to parse out the various claims of conditions, lung cancer versus asbestosis versus mesothelioma, I'd probably have to go back and do a little more research.

I wouldn't want to misspeak here. I mean, I know that asbestosis is a high condition. Lung cancer is going to be less, but we have a lot of them. And mesothelioma, like you said, is going to be a fewer number

that we have, if that's what you're asking, but we can get more specific statistics on that.

MEMBER REDLICH: I think that's enough.

CHAIR MARKOWITZ: We should move along.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: We've got a lot to cover.

MEMBER CASSANO: Just one last question.

So, if you had a mesothelioma in somebody that worked after 1995, you would deny that claim?

MS. LEITON: No. Anything after 1995 would be referred to a specialist, if necessary. But a lot of times in the cases of mesothelioma, we're going to have a case that's already made.

We're going to have the exposure information. We're often going to have a doctor that says, "This is related to their

exposure to asbestos," and we won't have to go further than that.

CHAIR MARKOWITZ: Okay. Thank you. So, let's continue to Recommendation No. 2, which is work-related asthma. And I'm going to turn this over to -- oh, sorry about that. Yeah. I'll read this.

"In response to Recommendation 1-3, OWCP agrees that all claims for the six asbestos-related associated conditions named above that do not meet the exposure criteria shall be referred to industrial hygienists, the CMC as appropriate. By way of further answering clarification, OWCP currently stipulates in program policy that any case assessed for causation under Part E that does not satisfy an established presumptive standard, must undergo a case-specific assessment including review by an industrial hygienist and qualified physician," and then it references the procedure manual.

And then finally, the program

addresses Recommendation 1-4 in the answer to the Board's Recommendation No. 3 about COPD.

So, any comments on this issue of cases that don't make -- we've covered this numerous times.

Okay. So, let's continue then. So, I'm going to turn this over to Dr. Redlich who is a world-recognized expert on work-related asthma and has vast experience in her program at Yale in dealing with workers with work-related asthma.

MEMBER REDLICH: Okay. So, this asthma recommendation had four parts to it. The first was that the Department of Labor should just use the term "work-related asthma" to incorporate both new onset occupational asthma, and also work exacerbated asthma.

And so the DOL's Response No. 1, if someone wants to read it -- it's an easy one.

MEMBER WELCH: Right. "OWCP agrees with Recommendation No. 2-1 and has already modified the procedure manual to incorporate

these into the September 2017 revision."

MEMBER REDLICH: Yes. So, that's why I put a check here next to that one. So, we can move on to No. 2.

And Recommendation No. 2, if someone wants to read that one -- well, actually, I'll summarize.

So, the recommendation basically related to how one would make the diagnosis of asthma. And recommending that a physician -- a treating physician diagnosis of asthma should be sufficient to recognize that the person had asthma and that additional testing such as a bronchodilator or methacholine challenge was not necessary. And the rationale for that had been given.

So, the DOL's response is...

MEMBER CASSANO: "OWCP also agrees that a diagnosis of asthma by a treating physician should be sufficient without specific references to the tests listed in the Recommendation 2-2. However, the physician's

opinion should include appropriate medical rationale based on objective findings to support the diagnosis as is required for any other diagnosis claimed under the program."

MEMBER REDLICH: Okay. And so, I think we all agree with that.

What I did do next was to then look and see in the procedure manual how that had been incorporated. And my understanding was that this was already incorporated.

And so, the actual procedure manual mentions under -- this is the section of the updated manual if you go down to Part 5b, "A qualified physician has diagnosed the employee with asthma."

And then, you know, a medical diagnosis should be made when the physician is able to identify the presence of, you know, what we talked about, reversible airflow obstruction.

So, then it says, "However, a physician can also rely on other clinical

information to substantiate his or her diagnosis of asthma," which I think is what we recommended and what we agree on.

The next sentence, "So, the examples given, for example, spirometry for measurement of FEV1 and FVC is the most reliable method." And then it goes on a twelve percent improvement FEV1.

So, I was going to open this for discussion and I would just say that the concern was that that -- the way that was worded in the manual was confusing.

Laura.

MEMBER WELCH: Well, I guess we need to get some clarification because it says that "Recommendation 2.1," which is the definition of work-related asthma, "has been incorporated in the procedure manual," but it doesn't say that the medical criteria for diagnosis has been incorporated. So -- if you look at the responses.

So, I don't know whether this --

there's a plan to change this or was Department thinking that the language that was already there was consistent with the response to our recommendation?

MS. LEITON: Well, we talked about work-related asthma changing that. We changed the definition to say "or other evidence."

So, what is it that you feel wasn't incorporated in the procedure manual?

MEMBER REDLICH: Okay. So, this section is moot by my reviewing the two versions of the manual. So, this is a new section that hadn't been in the previous manual.

MS. LEITON: Correct.

MEMBER REDLICH: And so, the concern we have is that this issues a great majority of patients who are diagnosed with asthma and never have a positive bronchodilator or methacholine challenge performed for a number of reasons and they're also imperfect tests.

So, to require that -- and I know

it's not -- but the way it's worded as the examples given are -- you do mention that in the wording, and I can go back -- so, I think the -- however, physician can also rely on other clinical information.

MS. LEITON: Those were just examples that could be used.

MEMBER REDLICH: We probably can go on. I just say it might be helpful to give the examples that we were talking about such as a, for example, a treating physician's diagnosis of asthma.

MS. LEITON: Qualified as physician has diagnosed the employee with asthma. I mean, what we're trying to say here, and I think that it's understood by our claims staff, but we can make sure, is that if a physician diagnoses it and provides medical rationale, that's sufficient, but here are some examples of some other ways that they could support that.

CHAIR MARKOWITZ: Steve Markowitz.

I think we're talking about what you consider to be objective support for a diagnosis because everything in that paragraph is about breathing tests of one type or other, simpler ones or more complicated ones. And if I'm a clinician reading that, I'm going to say to myself, "They want breathing test confirmation."

When, in fact, what we think is that if a person has wheezing on a physical examination, that's objective evidence of asthma and that should be sufficient in accommodation with the history to make a diagnosis of that.

MS. LEITON: And if the doctor says that to us, we'll likely accept that as the doctor's diagnosis of asthma.

You know, it's very rare that our claims examiners are going to go questioning that.

If a doctor says, "they have wheezing, this is the history of this patient,

here is why I believe."

Now, these are also examples that we've provided in addition. We usually -- when we train our claims staff, we try to make it clear these are examples.

Unless we say you are required to have these other things in there, if you have a doctor's diagnosis of it and not just a diagnosis, but some explanation of how they came to that diagnosis, that's usually going to be sufficient for our claims examiner.

I'm looking to Jolene just because she runs the district office and I wanted to get her confirmation on that, but she's nodding her head yes. So, I think that we will look at the totality of it. These are just examples.

CHAIR MARKOWITZ: Who -- Dr. Boden?

MEMBER BODEN: Can I just clarify what I think people are saying?

They're not disagreeing with your examples. They're saying it would be very helpful to have an example that was other than

a breathing test example.

So, for example, the one that Dr. Markowitz just gave, which would then clarify that the other evidence is not just breathing tests.

MS. LEITON: We can do that.

MEMBER BODEN: I'm sure you can.

MS. LEITON: It would be helpful to have an example in --

MEMBER BODEN: It's easy.

MS. LEITON: Yes.

MEMBER BODEN: It was just a matter of --

MS. LEITON: And it may be in training that we can do that, but we can also add it to the procedure manual.

MEMBER BODEN: Thank you.

CHAIR MARKOWITZ: Steve Markowitz.

Maybe physicians -- treating physicians who look at this array of letters and support and they would interpret this as being we need a breathing test. So, it should

in there so that people other than CEs can interpret the problem.

Dr. Cassano.

MEMBER CASSANO: Just another practical question here.

So, if somebody actually did preimpose bronchodilators on a patient and submitted them and it was less than 12 percent improvement, what is the claims examiner going to do with that?

MS. LEITON: They are going to listen to what the doctor's official assessment is.

MEMBER CASSANO: Even if --

MS. LEITON: Even if it's not -- the doctor will be explaining his rationale.

CHAIR MARKOWITZ: Let's move on.

MEMBER REDLICH: So, the next two recommendations, Nos. 3 and 4, both relate to how one then decides that the asthma is work related. And it describes using the criteria of temporal association, you know, relationship

between exposures and onset of asthma or worsening of asthma symptoms, and it also makes the point that a specific triggering event, it can occur, but is not necessary.

And, also, that exposures such as dust and fumes are frequently causative and one would not necessarily need a single specific exposure.

And so, the DOL response is up here, if someone would like to read it.

MEMBER CASSANO: "For Recommendations 2-3 and 2-4 in its most recent update to Chapter 15 of the procedure manual, OWCP applies the policy regarding the assessment of work-related/occupational asthma that comports, in part, with these recommendations.

"OWCP policy requires evidence of a contemporaneous diagnosis of occupational asthma during covered Part E contractor employment or the well-rationalized opinion of a physician after a period of covered

employment as recommended in 2.3.

"The policy differs slightly from the recommendation in Recommendation 2-4, by requiring a triggering mechanism that occurred to cause, contribute to, or aggravate the condition.

"Legally, OWCP must require evidence that a toxic substance was the likely trigger for the condition because the condition can only be accepted as a compensable covered illness if it is at least as likely as not that the exposure to a toxic substance was related to employment at a DOE facility, 42 US Code Section 7385 subsection 4(c)1(b).

"A mere temporal association without identification of a toxic substance would not satisfy the statutory requirement for eligibility. In addition, neither heat nor cold as referenced in the Board recommendation can be defined as a toxic substance under this definition."

MEMBER REDLICH: Yes. So, I looked

at the manual, which is the next two slides. So, I could go with what the manual says, and this is in Appendix 1. So, it gives the definition of "work-related asthma" as new onset and both work exacerbated.

And then "The CE does not apply a toxic substance exposure assessment to a claim for work-related asthma, including the application of the SEM or IH referral process because any dust, vapor, gas or fume has the potential to affect asthma." And we agree with that statement.

"Given the scope of potential occupational triggers that can affect asthma, the CE relies exclusively on the assessment of the medical evidence by a qualified physician."

And then it goes on to give the criteria in the next section. And so, it's cut off a little bit. This is the next part of the procedure manual.

"So, once having established" -- sorry -- "once having established the diagnosis

of asthma, the following criteria are available to demonstrate that the employee has work-related asthma."

So, there are two ways this can be done. It says, "A qualified physician who during a period contemporaneous with the period of covered Part E employment diagnosed the employee with work-related asthma." I think we would agree with that.

And, also, I think everyone recognizes that the great majority of patients are not actually recognized as work-related asthma at the time.

So, then -- and that is taken into account under No. 2. "After a period of covered employment, a qualified physician conducts an examination of either the patient, available medical records, and he or she concludes that the evidence supports that the employee had asthma, and that an occupational exposure to a toxic substance was at least as likely as not a significant factor in causing,

contributing, or aggravating the condition.

"The qualified physician must provide a well-rationalized explanation with specific information on the mechanisms for causing, contributing or aggravating the conditions. And the strongest justification is when the physician can identify the asthmatic incident that occurred while the employee worked at the covered work site, and the most likely toxic substance trigger." And then it says that "the temporal association is not sufficient."

This is the last part of the manual. And then I've written there at least what my concern is that the response in the manual, I would say that's more than a slight difference from our recommendation in the way that it's worded.

And then also there is a somewhat internal inconsistency between this opening sentence that any dust, vapor, or fume has the potential to cause asthma.

And then there's sort of a statement that you need to identify a specific toxic substance.

So, I thought that we should open this up for discussion.

CHAIR MARKOWITZ: This is Steve Markowitz. So, you know, looking at this, the third line, the CE does not apply a toxic substance exposure assessment to a claim for work-related asthma.

And yet in the response, it says that there needs to be identification. OWCP must require evidence that the toxic substance was the likely trigger for the condition.

So, that's a direct contradiction. And I think if we modify our recommendation in number three to include not just some temporal evidence, but that the workplace had vapors, gas, dust or fumes, right?

Because we know that's a precondition for the asthma. And we know that OWCP recognizes that.

If we're to add -- modify our recommendation to include that, that would seem to satisfy the whole toxic substance issue.

MEMBER REDLICH: And I -- yeah. And I also add this, that it did seem that a lot of this discussion centered around the definition of a toxic substance.

And so -- and because of, I think, everyone's familiar with being over the Part E addendum that states that. That mentions a toxic substance.

So the NI -- this is how the NIH, our National Institute of Health defines a toxic substance, which, I think, is a very reasonable definition.

It's a material which has toxic properties. It may be a discrete toxic chemical or a mixture of toxic chemicals. For example, let's only discuss the reaction we get around toxic substances.

More specifically, lead chromate is a discrete toxic chemical. In fact this is a

toxic material which is not consistent with an exact chemical composition, but a variety of fibers and minerals.

Gasoline is also a toxic substance, rather than a toxic chemical. And it contains a mixture of many chemicals. And it goes on to say that toxic chemicals may not always have a constant composition.

So I think this is a well-accepted that the notion of a toxic substance that can -- does not have to be a single identifiable chemical.

CHAIRMAN MARKOWITZ: Oh, I'm sorry, Dr. Sokas.

MEMBER SOKAS: And I think the word trigger is also a little bit problematic. Because it implies kind of a discrete event that is captured in a moment in time.

And just a different word would be adequate. Or, you know, just referring to the association, to the relationship of the exposure preceded the outcome.

MEMBER REDLICH: Yes. I think you're referring to one.

MEMBER SOKAS: I think that is a response.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: So, what you were talking about in terms of the contradiction seems to read as a different description of what the claims examiner does versus what you're asking the physician to put in the report.

So, I'm not sure, it seems inconsistent to us. But I think Ms. Leiton could explain that to us.

MS. LEITON: Yeah. What we're telling the claims is they don't have to do a standard IH assessment for this particular circumstance.

And that they would rely on the physicians to relay that information that the exposure to toxic substances in the workplace is what was the contributing factor to this

incident.

It's not saying that we are -- we don't want that piece of it to be there. So we need to have a piece of it to be there.

That there was exposure to toxic substances in the workplace. And it was the contributing factor to the asthma.

But, given that asthma is so unique and so different from so many of other our conditions, we don't require that those go through the SEM or the IH assessment. Because we're already making an assumption that there was going to be exposure.

But we do need to have a medical doctor tell us that there's that link there. And that's what we're trying to relay here.

CHAIR MARKOWITZ: But then would it be sufficient if the physicians said, the worker was exposed to dust in essence? Vapors or --

MS. LEITON: We're getting into the argument that comes up in the next -- in the

COPD section where are -- where the -- what that means becomes important.

And one of the main reasons that's one of the big reasons that's important is when you come down to offset. And we need to identify specific exposures that we can get in that.

We'll have the argument later. But, yes. I mean, since there consent, if the doctor is going to say that there was -- for asthma cases it's going to be slightly different because of the fact that asthma is known to have been a -- that those exposures to gases, BG's whatever, so it is treated slightly differently.

But, I don't want to -- I don't want to over speak on this topic. Because it gets a little bit complicated.

But I think that the basic question about requiring a medical doctor to say that it was related to a toxic substance would be what we're looking for here. Rather, then having

the claims unit go through a whole IH SEM assessment.

MEMBER REDLICH: Yes. And so a big part of what I do is to train physicians on how to affect and diagnose this related asthma.

And this is the bulk of my practice. Patients referred. And I can say that number one, the great majority of pulmonologists, internists, and occupational medicine physicians actually have very little experience recognizing and diagnosing work related asthma.

And the great majority of these cases that are diagnosed, the case specific toxic substance is not identified. It is usually a mixture of exposures.

So, I think just in terms of how one communicates and educates that in the guidelines that one set out, it would be, you know, scientifically based on what the practice actually is.

And otherwise it would just be very confusing to any practitioner to -- that being

asked, you know, what is the specific substance? And it would be well, I'm not sure whether it was, you know, this mixture of the irritants or that.

They usually -- and I think the point that Dr. Sokas made is that most cases of work related asthma develops over a period of months or years and are not recognized after one single event or a discrete event.

And so it's just maybe in the wording of how this is described as what is expected of the physician.

MS. LEITON: Yeah. I think it requires a little bit further thought. And particularly when it comes to the vapors, gas and substances in it.

So, I agree with you that there could be better clarification for the physicians on that issue.

CHAIR MARKOWITZ: Yes, Dr. Welch?

MEMBER WELCH: So, if we could get a few questions. And I want to -- I think we

should be clear.

One is the question of whether under the statute you're required to have a trigger? And the statute says that the physician has to say that the exposures caused, contributed, or aggravated.

And it wouldn't necessarily require a specific trigger. That's kind of built into some understanding of what occupational asthma is.

And I think it would be fairly simple for the department to take out the discussion of a trigger as long as the physician is providing a rationale that the exposures that were at work were a substantial contributing factor in the development of work related asthma, which already has built into the diagnosis of counsel relationship with exposures at work.

So getting rid of the trigger wouldn't, I don't think, make it any harder. It's the in trying something that we often

don't find.

The other question is what mixtures would be acceptable for the physicians to say was the cause or contributor to aggravated exposure. And you know, if I were writing a report, I would know that I should stick in, even if I might say, vapors, gas, dust and fume, including vapors, dust, as well, you know, just so that there's something, there's a hook.

But not everyone, not treating physicians wouldn't necessarily know that that's necessary for the claims. And I don't know how you get around it.

Because in a way it's like vapors, gas, dust and fumes, and definitely we'll talk about that when we talk about COPD. That is the -- there are many things that are in the causative pathway.

And any exposure and any worker who has asthma, work related asthma or COPD in these facilities, we could probably identify

some specific components of that. Even though the cause is the multiple exposures, not one specific one.

And it's probably possible to identify specific ones, but how you can communicate that to make it work in the -- if there's a need for the department to hear a link to specific exposures when a diagnosing physician knows that's combined exposures.

It's sort of a -- it's a way to facilitate a claim. But it's not really -- it's not clear to me how you could make that case unless you have it because people understand the law very well and what the department needs in terms of communication of a claim.

So, I think the trigger thing we could -- we would encourage in the next revision because they are in the middle. Remove the discussion of a trigger that's not required.

A trigger is not required. An

aggravating cause is required. Or a contributing, aggravating cause is required.

Okay. But how to get around the VGDF, maybe we'll be into that mode.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, I think if I may quote an old saying, what we have here is a failure to communicate. But not a failure to communicate between people, but between more on medicine and the law.

But the law is very clear. You're stuck with passive substance. Right?

And the question is, how -- and you have a very admirable statement in the events. You know, just about anything can cause -- can exacerbate or aggravate or cause asthma.

And I think the problem then is bridging. Which means you have to either be really good if the CE could communicate to a doctor that we need you -- if this is the case, we need you to say that there's a toxic substance in there.

Now there's another issue that I think brought up before Carrie, when we were discussing this, which is that perhaps the administrative guidance within the program is too narrow in its definition of a toxic substance.

And it simply needs to be a little broader that would include, you know, mixtures or things that are harder to identify as having specific components would be -- should be acceptable.

And that that could be communicated as well to the physician who's providing the diagnosis.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: So asthma's difference, would it be helpful to have some preparatory language in this part of the procedural manual along the lines of, asthma can be highly variable in onset presentation aging post response and clinical course?

Just to restrain the claims

examiners from going down their usual rabbit hole of reductionist medical tests and pursuit of a specific substance?

MS. LEITON: Are you asking me that question?

MEMBER SILVER: No. What I did ask you -- I was daring to ask you as the world's expert.

MEMBER REDLICH: So I would say as a pulmonary expert that actually there is no single one definition of asthma or one diagnostic testing criterion. And it is considered a very heavy continuous condition with a number of variable features.

I would just also while we're not sort of knit picking about the wording that could confuse people. See also in the new manual, the qualified physician must provide a well rationalized explanation with specific information on the mechanism for causes.

And after years and years of research, there's still a lack of understanding

of the mechanisms by which numerous agents cause asthma. And so I think that that is not something I as an expert in the field would have trouble describing the mechanism.

So I don't think that should be perfected or suggested. Is that that could scare someone from making the diagnosis.

CHAIR MARKOWITZ: So we need to wrap this up and move on. But, Dr. Cassano?

MEMBER CASSANO: Just a follow up to Dr. Boden's comment about the, you know, what's in the statute. You quote 42 U.S. Code, which is your regulation.

It is not law intended. And therefore could be changed if you did the hard work to change it.

CHAIR MARKOWITZ: Mr. Turner?

MEMBER TURNER: James Turner. I'd just like to know how much money has been spent on this program since it first started back in 2000?

CHAIR MARKOWITZ: In view of

overall? Or part of the whole?

MEMBER TURNER: The entire program.

CHAIR MARKOWITZ: Well, I looked at the website recently. I mean, Ms. Leiton can respond.

But, I saw 14.5 -- 14.3, .5 billion has spent on compensation in medical care. Yeah. About 14 billion since 2000.

Which includes both the radiation side Part B and Part E.

MS. LEITON: Yeah. That's the payout. That's for compensation of medical benefits to recipients.

And just U.S. Code versus CFR, the U.S. Code that's referenced here is to the statute rather than the regulation.

CHAIR MARKOWITZ: Okay. Mr. Griffin? Yeah, yeah. Go ahead.

MEMBER GRIFFON: This is Mark Griffin. Yeah, I just had to go back. I'm not sure I'm going to be happy with going back here.

But, this statement about the CE does not apply in toxic system exposure system to a claim for work related asthma, including that patient or the SEM or IH assistant or referral process. Because any dust, vapor or gas or fume has the potential to affect asthma.

So I mean, what I'm trying to wrestle with is, does that mean there's a presumed exposure anywhere on any VA site to test gas vapor or fumes?

And therefore you're saying you don't get an assessment because we're assuming any employee at any of these sites has exposure to that. Has a potential for significant exposure for more significant exposure in one or any of those.

Is that why you don't require the assessment? I'm just trying to understand.

MS. LEITON: That's a very good question. And one that has very significant implications, were I to say that.

MEMBER GRIFFON: Yeah.

MS. LEITON: I'm not saying that.

MEMBER GRIFFON: I'm just wanting to get it on the record.

MS. LEITON: I need to look at --

MEMBER GRIFFON: Because it's bothering me.

MS. LEITON: This chapter and the way it's worded a little bit more carefully in light of the vapors, gasses, dust and fumes conversation.

CHAIR MARKOWITZ: Okay. Any other last minute comments? Let's move onto COPD, Recommendation Number Three.

I guess Dr. Welch, if you want to just summarize it. Or I can leave it up to you, the recommendations so people are oriented.

Maybe just summarize this.

MEMBER WELCH: Yeah. And it's Laura Welch. So the recommendation was a presumption for COPD.

And essentially it said, a claimant

with a physician's diagnosis of COPD who worked either in any of the labor categories in Attachment 1, which should be expanded to include all construction maintenance done. Or, with reported exposure to VGDF with relevant tasks on the occupational history for a period with an aggregate to at least five years and deemed to have sufficient exposure to toxins to aggravate, contribute to, or cause COPD.

And then the second part, that shouldn't be the only way people get a claim. They should be evaluated even if it's fewer than five years.

CHAIR MARKOWITZ: Okay. So, we need a leader?

MEMBER WELCH: Well, I can start. We'll see how long it is before I lose my voice.

OWCP will consider modifications of the current COPD presumptive standards. However, we have a number of questions and concerns with this recommendation as stated.

COPD's current procedures provide that a claims examiner conduct an exposure to asbestos at a DOE facility with the Part B definition of causation for COPD when the following criteria are met:

One, the diagnosis of COPD has been established by the medical evidence. And two, the employee must have been employed for an aggregate of 20 years in a position that would have had significant levels of asbestos exposure.

In order to meet the criteria for exposure sufficient to make the causation presumption, the claims examiner must determine that either the employee was employed in any of the labor categories discussed above for an aggregate of 20 years prior to 1986, or an industrial hygienist has provided a well rationalized discussion of case specific exposure at high levels during any time period.

The Board has recommended that the duration of exposure should be five years. And

cites an article from Dr. Dement that is based on the study of former DOE workers who self-reported both labor categories and exposure.

This exposure limit conflicts with the results of OWCP's own search of other medical and scientific information, using the literature described above in response to recommendation number one.

Accordingly, in order for OWCP to consider these two presumptions further, OWCP requests the Board provide additional medical or scientific studies that specifically reference these issues.

With regard to the Board's discussion of labor categories and recommendation 3(1)(a), OWCP requests the Board to provide the information about labor categories as described in response to recommendation number one.

Concerning the Board's reference to vapors, gasses, dust and fumes, the reg list specifically states that a condition can only

be accepted as a compensable-covered illness if it is as least as likely as not exposure to a specific toxic substance -- specific toxic substance was related to employment in a Department of Energy facility.

This program has defined a toxic substance for purposes of claims administration as any material that has the potential to cause illness or death because of its radioactive, chemical, or biologic nature. Vapors, Gasses, -- vapors, gasses, dust and fumes is a broad reference that encompasses many different specific toxic substances.

Exposures to vapors, gasses, dust and fumes apply to virtually all circumstances that exist in either occupational or non-occupational settings.

OWCP has evaluated the literature submitted by the Board. And while it appears that different groupings of individual toxic substances can be categorized under the lexicon of vapors, gas, dust and fumes in scientific

studies, there's not one consistent list of toxic substances in the literature that represents these groupings.

In addition, the Program is legally required to offset awards for any condition, including COPD, to reflect tort recovery tied to specific toxic substances. Therefore, OWCP is unable to implement this recommendation.

However, if the Board develops a list of toxic substances that represent vapors, gases, dust and fumes, we may be in a better position to consider this assumption. For all the above reasons, OWCP is not able to accept this recommendation related to COPD as written.

OWCP welcomes recommended revisions to these presumptions after consideration of these concerns.

CHAIR MARKOWITZ: Okay. Comments? Okay. So let's start with Mr. Domina.

MEMBER DOMINA: I just have two words: tank farms. And we were all there. I mean, and those are gasses, vapors, fumes.

And so, I guess to me it appears something to that effect probably wasn't taken into consideration when this was put in. Because there's a laundry list of reports over the last 20 or 30 years of doing that. And this stuff is going on today because of the adverse effects of how it affects our people. Because when you have different people from different walks of life and then they get a whiff and people's noses instantly start bleeding, have trouble breathing, this falls under vapors, gasses, and fumes.

And it's a toxic soup of mixtures that are, you know -- and so I'm trying to figure out how that does not fit. How you can't -- you can eliminate vapors, gasses, fumes.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I guess just a few comments about what I think is the essence of the Board's recommendation with regard to this general category of vapors, gas, dust, and

fumes.

And our study, which is referenced in the responses to comments, they point out that the exposures were self-reported, both with regard to job category and exposures. We accept that. We acknowledge that. It's a weakness of any study that's retrospective in nature and done to look at relationships with disease. In most cases, those relationships are dampened by missing information, exposure misclassification, rather than enhanced.

I think the other comment is our VGDF exposure matrix which was in fact developed by specific toxic substances, a list of them, that were then collectively looked at in our study.

And what we found was each one of these materials by themselves had a relationship of increased risk of COPD in general. Our biggest relationship, our strongest relationship was when we took all of those collectively as a measure of exposure,

all vapors, gas, dust and fumes.

When we looked at the literature, it's entirely consistent with the body of scientific literature. And so this recommendation is simply trying to bring this presumption in line with the vast body of scientific literature in this area.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: I'm trying to figure out from the discussion why the Department is forcing the issue to a single discrete toxic substance when a toxic substance can be a mixture.

So, I realize the Department needs to recover on tort claims. And I believe the majority of those are under the asbestos tort situation. So if the Department is erring on the side of not accepting this recommendation because you might miss recovering some money from toxic torts, I think that's a separate issue than saying that we're not going to look at COPD claims in this manner.

CHAIR MARKOWITZ: Let me just make a comment. Steve Markowitz. I've never heard of a toxic tort asbestos claim for COPD, actually.

I mean, just so people understand, the toxic torts on asbestos are for lung cancer, mesothelioma, asbestosis. They're not for COPD.

MEMBER VLIEGER: I understand. But the Department has extended that if it's not an asbestos claim but asbestos could have contributed or caused the accepted condition, they are recovering tort money because it's an asbestos-related disease.

So recently an asthma claim was recovered against tort money from an asbestos claim because the Department contended, through the CMC and the IH, that the asbestos contributed or caused the asthma.

So my point is, if the Department's concerned about now recovering some money against tort claims in asbestos situations from COPD, I think that the claims that were

actually made on the asbestos tort claims were asbestos disease.

And so, having seen what happened with the asthma case that was an asbestos tort claim, and that was specifically stated in the Department's reply, if it's a recovery issue, I think that needs to be addressed somewhere other than the COPD and asthma claims.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: It's just two points. One is that it looks, from that NIH definition, which I think is pretty clear, that if DOL were to, you know, basically accept the NIH definition of toxic substance that that would go a long way to helping with this particular recommendation.

And again, to Dr. Dement's point, there's lots of information about welding, as an example, of kind of a bunch of different exposures all kind of blended together that has clearly been associated with COPD development and other types of, you know, dust exposure.

So, really, that study was meant to come up with a reasonable duration. It wasn't really the only study that supports this relationship.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Yeah. I mean, it would be relatively easy to come up with a list of agents that are vapors, gases, dust, and fumes. SEM has 14 of them that are related to COPD as it is.

But I guess the question would then be the duration. Because what we have established, I think what the literature establishes, is that five years of mixed exposure to these agents is sufficient to be considered, under a presumption, causative under the definition of the law.

But if you said, well, we had to say it was five years for any one of these substances, that would limit the compensability, because it's really due to the combination effects. And most of the workers

that we see are construction workers with silica, asbestos, and welding together.

And so, you know, even if we could provide such a list, I don't think it's going to solve the problem. Our recommendation and the current presumption are so far apart that I'm not quite sure how to approach them. I mean, there are lists. I mean, we can make a list. It would probably have about 40 things on it. And then that would leave out some people.

But it would probably be, you know, generally accepted. You could peer review the list. It would come from existing literature. And that, in a way, seems to be one of the biggest problems, is the exposure. But then, you know, your current presumption requires 20 years of exposure to asbestos. And we're saying five years of exposure to a range of compounds. I'm not quite sure how you get that closer together.

And I don't know if that's something

you could comment on or help us with.

MS. LEITON: This is Rachel. It's a difficult thing to comment on off the cuff. But I do want to say that I do recognize that our presumption is about exposure to asbestos versus exposure to VGDF.

And I think the biggest challenge is, we've suggested here that you provide us a list, then how that does lists apply to the literature with regard to the length of exposure? Tying those together is what we would need to do, one way or another.

A list is something I think would definitely be helpful. And then how that applies to the five years in literature would also be helpful.

How we get from A to C, I don't have the answer to that yet. But I think that those two things might be helpful in assessing that.

CHAIR MARKOWITZ: Steve Markowitz. But I think a list -- we've heard that there are 30,000 or more toxic substances in the SEM.

Any list we come up with is going to be short relative to that. It's going to shortchange what we know about VGDF.

So I'm skeptical about our ability to come up with a list. If I think about someone who's working at Paducah, in the Gaseous Diffusion Plant, and they're a production worker and they report exposure to VGDF, I know they were exposed to toxic substances.

If a person, on the other hand, worked in an office at some distance from the production site at the same facility and they reported the same VGDF exposure, I don't know whether that could contribute to their COPD or not.

And so that's kind of a problem. Because we do need to focus, I think, a little bit. But I'm concerned about focusing too much, because I think it won't work effectively as a presumption.

And the way to focus it I don't

think is by listing toxins, but by perhaps listing broad occupational categories and work sites, because we can get away from the -- there's a comment in here about non-occupational settings have VGDF exposure.

So, you know, I wouldn't -- in the school setting, I wouldn't say someone, except if they're a laboratory teacher, I wouldn't say, if they report VGDF, it's causative or contributive to COPD, because it wouldn't be sufficient.

But that doesn't pass the laugh test at the Gaseous Diffusion Plant. So there should be some way we can recommend VGDF, which is clear from the epidemiology that that's the reported exposure that relates, aggravates, contributes, or causes COPD, in which we can accommodate the workers in the complex that we know had that exposure on a routine basis.

Dr. Welch?

MEMBER WELCH: So I guess my suggestion is, there's something between the

individual chemical, like, you know, bis(chloromethyl) ether and VGDF. There are groups of chemicals, respiratory irritants, organic solvents, that I think would be accepted under any NIM definition of toxic substance. Because they're considered -- it's a chemical class of some kind.

And, you know, if it's necessary to have a list, it would be better if it's longer than just the 14 that are in the SEM. And then there would be people who don't fit but should go for an industrial hygiene evaluation.

But I think with the -- I think we could give it a try and then circulate it around, and if it doesn't pass the laugh test within the Board, whatever the list is, then we wouldn't do it.

But I think -- because, I mean, my sense is that's the place to start to try to push this. You know, we're really far apart and there's many different questions within this.

And once we come up with a list then I think we're going to start pushing that five-year question. You know, how do we know that five years is a good presumption?

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I think Laura's point is well-taken. I think we could produce a list, some of which would be specific substances, either from the work that we've done ourselves or the literature. I mean, the literature has specific substances.

But in our own work, and in the literature, many of the exposures that are sort of sub-parts of VGDF are in fact mixtures of their own. For example, cement dust we know has silica in it. But not much of it is silica. The vast majority is materials that, for regulatory purposes, are considered nuisance dust, have a very high exposure PEL. And nonetheless, the literature still supports that those exposures to those materials that have these high exposure limits are related to

COPD.

So it will be a mixture of things. Some specific compounds, some, like wood dust, it's a mixture as well. A lot of them are going to be mixtures. And the question is, would that be sufficient?

MEMBER WELCH: John, those, like cement and wood dust, are accepted causes of COPD in the SEM already. So I think then we're starting to look at things that are within the rubric of what the Department has considered as toxic substances in the past.

MEMBER DEMENT: Yeah. And the precedent is already well accepted that mixtures are considered causative. It's just how we build that to expand it to the concept of VGDF, which is a bit more broad than just some of those mixtures.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I have a question for John. In the literature, have you

or anyone else looked for an interaction between VGDF exposure and specific job titles and/or industries to see if there's an interaction effect here?

MEMBER DEMENT: Not that I'm aware of. The only real interaction that's really been looked at in any great detail, and where the data really exists in sufficient quantity, has been the smoking.

And that's been variable too. Some of our own work suggests that they're additive. Some work suggests that they're maybe more than just additive. So we would say, from our work, smoking is at least added to COPD.

But to look at -- even in our own studies, we can't even look at specific job titles or jobs. Except in a very few cases where we have lots of workers. So to expand that to different industries and combinations would be pretty tough, just from a numbers perspective.

CHAIR MARKOWITZ: Other comments?

(No audible response.)

CHAIR MARKOWITZ: Okay. So, I want to skip -- I'm afraid recommendation number four is going to take longer than -- may take longer than 15 minutes. So I want to skip to five. I'll start --

MEMBER REDLICH: Can we just -- before we leave COPD --

CHAIR MARKOWITZ: Sure.

MEMBER REDLICH: I just wanted to bring it to your -- the DOL's attention that the most recent procedure manual, some of the information, just sort of the basic information for how one diagnoses COPD, is just sort of factually not accurate. It mentions bronchoscopy. I won't go into all the detail, but there is a table in the appendix that gives criteria that just -- I'd be happy to go over it with someone, but it's just not -- it's just inaccurate.

It also mentions that the person has to be a non-smoker. And it then defines a non-

smoker.

MEMBER WELCH: Actually I think that that table, if I remember correctly, it's if the claims examiner is going to accept a work-related COPD without a CMC they have to be a non-smoker.

It doesn't require them to be a non-smoker to get a medical diagnosis of COPD. It has to be related to the causation issue. But it is very hard to parse through the different tables.

MEMBER REDLICH: It's just a bit confusing. And there's some room for improvement.

MS. LEITON: I mean, I can't address that right here, right now, without looking at it specifically. But we'd be happy to talk to you.

You know, the Department would be happy to talk to you after. A lot of these criteria we developed, we developed in consult with other medical professionals as well.

So I think it's just a matter of maybe it's a communication issue. But we're happy to look at it with you at some point.

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CHAIR MARKOWITZ: Okay. And Ms. Vlieger, did you want to make a comment?

MEMBER VLIEGER: I have just a question. And it's come up a few times in discussion and in some claims I've seen that have been remanded.

The CMC cites that the reason the person has COPD is due to smoking and not 20 years of being a welder and other instances of the same kin.

And I thought there was something in the directive that the claim could not be worded that way or it could not be denied from smoking?

MS. LEITON: We've in fact told our CMCs that smoking is not to be considered. And that they are to be looking at the occupational exposure to toxic substances.

So, if you're seeing that, please bring them to our attention, because we may have a training need.

MEMBER VLIEGER: Was there a policy guidance or something that is out there?

MS. LEITON: It was probably in their training. I would have to go back and look.

MEMBER VLIEGER: Okay. If you could provide that to the Board, because if that's in that gray area of materials that are published we may need to address that.

MS. LEITON: I'll provide what I can contractually.

CHAIR MARKOWITZ: Okay. We're going to skip recommendation four, just for time purposes. We'll come back to it. But let's address recommendation five.

Recommendation five is that the Board recommended that the Program enhance scientific and technical capabilities to support the development of policies and enhance

decision-making with respect to individual claims. And to inform the assessment of the merit of the work of the CMCs and the IHs.

So, the response is that OWCP agrees that it would be useful to have additional scientific and technical research capabilities to support Program policies and procedures.

While the primary responsibility and mandate of the Program is to adjudicate individual claims, OWCP recognizes that with the complexity of Part E exposure and causation issues it is helpful to be able to generalize whenever possible. To that end, the Program contracted with a group of scientists, Paragon, mostly DOE former workers to create and update the SEM on a regular basis.

In addition, OWCP has the medical director for the Program, as well as general technicians, to assist with overall concerns or issues.

As mentioned above, the medical director conducts routine quarterly audits of

the reports of the CMCs. The Program also employs toxicologists to research current studies and assist the Program with causation presumptions.

Beyond that, OWCP contracts out for medical consultants and IHs to provide opinions on individual claims. OWCP looks forward to any additional assistance the Board is able to provide in this regard.

So, I'm not sure what that response means. Because, on the one hand, you agree it would be useful to have additional resources, and then you basically recite your current resources and, I think, suggest that they're adequate.

And our recommendation -- and this is largely based on the work that we've done so far and what we've seen, is that the kind of conversations we have around this table, we suspect they're not happening within the Program, and in part because of access to appropriate expertise.

We're not saying there is none. We're saying it's insufficient to deal with some important issues. So that's -- anybody else have comments about that? Dr. Cassano?

MEMBER CASSANO: Just a question, actually. Paragon, you say they are scientists and technicians, what are the -- what is their background? Am I supposed to know that already? What is the mix? Are they industrial hygienists and physicians or technicians or what? Because you say they're former DOE workers, mostly.

MS. LEITON: I believe we've provided the Board with the credentials of our SEM team. But I can go back and look again. I know that a couple of them are industrial hygienists. But I believe we've even provided CVs. But --

MEMBER CASSANO: For the Paragon?

MS. LEITON: It's not? Okay. Well, we can look into that again. I thought we had provided it. I know we've provided it in some venues. So we'll look into getting you that information. Was there a second part, I'm

sorry, to that question?

MEMBER CASSANO: No, I just wanted to know more about how that --

MS. LEITON: Sure.

CHAIR MARKOWITZ: So I take it that the -- oh, Dr. Boden?

MEMBER BODEN: In my mind, I translated your response as, it would be nice to have more people, but we don't have the resources or capabilities for hiring them. Is that a fair translation?

MS. LEITON: I think that the mandate that we were given, and the funding that we're given, is to adjudicate individual claims. We weren't given the mandate to do additional research to provide presumptions to the Program, or get resources to help us do that.

So, there's where the rub comes. Where does the -- where fit that resource, outside of what we've already been able to do internally and with contractors, into a whole other section that doesn't really exist since

they created the Program to adjudicate claims.

And we're able to get some overhead for policy and the things that are absolutely necessary -- and I'm not saying that this isn't necessary, but that decision isn't always ours to make.

MEMBER BODEN: So what I don't understand about that is, you have to develop policies to run this program. I don't know which part of the budget it might come from.

But to inform those polices, wouldn't better science and medicine perhaps industrial hygiene -- our suggestion is that you need additional resources to do that. And that would seem to be a core part of the Program. So I don't really understand that, I suppose.

(No audible response.)

CHAIR MARKOWITZ: That's okay. Not every question requires a response. That's okay. Some questions are rhetorical. Dr. Sokas?

MEMBER SOKAS: And I'm also kind of

interpreting the response a little bit to mean, and why don't the Board do it. And I just did want to point out that most of us have day jobs, you know what I mean?

The radiation board does have a budget to hire and oversee others. And Mark may be able to speak to that, but the issue of resources is a real one. Not just for the Department, but also for those of us who have other jobs and fit this in, you know, on nights and weekends.

MEMBER REDLICH: I also, from the 70-plus cases that I reviewed, think that some investment in what we're referring to could end up being quite cost effective. Because there were a number of cases that, eventually, the correct decision was made, but it went through multiple, whatever you actually call it, you know, reconsiderations that took a huge amount of time and effort to do, where I think with some of these presumptions, and just general guidelines, it was very apparent very early on

either this should be an accepted claim or not.

And what impressed me was how much time it took to sometimes come to a decision. Which I don't think is good for anyone involved for such a protracted process.

CHAIR MARKOWITZ: Any further comments?

(No audible response.)

CHAIR MARKOWITZ: Okay. So, we're going to take a break for 15 minutes, which means we come back before four o'clock. We're a little bit behind our schedule so please be prompt. Oh, three o'clock. Three o'clock.

(Whereupon, the above-entitled matter went off the record at 2:41 p.m. and resumed at 3:01 p.m.)

CHAIR MARKOWITZ: If everyone can take their seats, please. Okay. We're going to start off with, I think, a relatively short recommendation, number six.

In which we advised -- we recommended that the finding of two borderline beryllium

lymphocyte proliferation tests be considered to be equivalent of one constant BeLPT for the purposes of claims adjudication.

And the DOL's response was that it does not support this recommendation. The recommendation is inconsistent with the explicit statutory requirement that beryllium sensitivity is, established by an abnormal BeLPT performed on either blood or lung lavage cells. And 42 U.S.C., they give reference -- which, Kevin, if you could just -- number six. Recommendation number six. There you go. That's it.

I'm reading the middle of that first paragraph. While the Board may be of the opinion that the BeLPT is not a perfect test or that false negative and positive BeLPT results can occur. DOEOIC is bound by the specific, clear, and unambiguous language of the governing statute.

In the Program's administration of Part E, the OWCP has adopted a limited number of exceptions to the statutory requirement for the

submission of an abnormal BeLPT. However, all of those limited exceptions are based on the presumed existence of an abnormal BeLPT that cannot, for scientifically accepted reasons, be obtained.

The Board's recommended presumption seeks to equate two borderline BeLPTs with an abnormal BeLPT, which cannot be done under the statute.

Okay. The floor is open for comments, questions? Dr. Welch?

MEMBER WELCH: So, maybe this is an absurd concept, but to me if something's not normal, then it's abnormal. So a borderline is abnormal.

And so it's a little bit of wordsmithing within the statute, which maybe the Department doesn't want to do. That's the only way I could see making it work. Because I do think the literature strongly supports the fact that if someone has repeated borderline tests, that's the equivalent in terms of its predictive

value for being sensitized as one single abnormal.

But it's whether you want to do something that is a little bit of wordsmithing to make it work. But otherwise, I mean, obviously you're saying you can't do it because it's statutory. That's the only thing I can come up with.

CHAIR MARKOWITZ: Maybe if we can get the scientists to say somewhat abnormal instead of borderline. Dr. Redlich?

MEMBER REDLICH: Well, I think that there's already, as the response indicates, exceptions that that have been made. And some examples are given, such as if someone is on steroids. And so this could be another example of an exception for why there might not be a positive test. That's just a suggestion for how to deal with that scenario.

CHAIR MARKOWITZ: So if I understand, you're saying that a borderline result occurs in part because this person isn't able to develop

an abnormal result?

MEMBER REDLICH: Yes, if their immune system, for one of many reasons, may not be able to mount a sort of what is considered -- which is somewhat -- the cut-off between abnormal and normal for any test is somewhat arbitrary. But I think we do have other exceptions for situations where there is not a clear positive or abnormal result.

CHAIR MARKOWITZ: So the question is whether we could somehow -- Dr. Welch? Your card is up. Did you want to say something else? Or Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I think to say that if it's not normal it's abnormal is too much of a generalization. It really depends on the specific test that you're talking about.

But clearly if you have a test where the biology enters into how -- how from the normal average it is, when a test is equivocal, it provides less negative evidence. Less evidence against a diagnosis then a normal test

would provide.

And in the label of diagnostic testing, you would have a likely ratio that would not be the same as either a normal test or an abnormal test. So I think it does give you some information based on the biology that Carrie is talking about.

What I think what we would really need to do is look at the literature and what has been reported. I don't know the literature on beryllium.

And if anyone has looked at the abnormal, the equivocal tests and if they behaved diagnostically in a different way than normal tests. So, I defer to people who actually know something about beryllium.

MEMBER WELCH: Well, just to -- just to -- it varies some good literature that looks at the predictive value of repeated borderline tests compared too within the lab normal.

And it does good. It gives you the same predictive value if you have repeated

borderlines.

However, the Department of Labor says they can't use that because the statute requires an abnormal BeLPT. So it's not about the predicted value of a borderline test. It's about how you interpret the test.

So, I think what Carrie's suggesting is that one could, in arguing on behalf of someone who has repeated borderline that then as a clinician you believe that that is the equivalent of a single abnormal would be to write a rationale.

Then the way we can write a letter saying this person's on steroids and that's why their test is normal. Could say they have an inadequate immune response. And that's why their test is borderline.

So that's something -- but that's not something that can be set by the Labor Department. It would have to come in from examining physicians, I think.

MEMBER CASSANO: You know, having

written policy based on laws for many, many years, usually a Secretary is given broad authority to interpret the law.

And I think if in many of these situations if we gave you a reason that two borderline LPG -- BeLPTs would be equivalent of an abnormal BeLPT, you know, I think you should be able to make that change without running afoul of the law.

You know, and we inter -- most agencies have the ability to interpret the law in a way that it's consistent with current scientific evidence.

And I think you're well within your purview unless your Secretary is not allowing you to do that kind of stuff.

CHAIR MARKOWITZ: Well, I just want to get back to Dr. Redlich's point about the exception that's made under Part B, of people who cannot, for a scientific reason they cannot develop an abnormal BeLPT.

Can we develop that kind of a

rationale? Do we know enough people who -- enough about people who essentially only form borderline abnormals to be able to create that case?

MEMBER REDLICH: Yeah. I mean, I think Dr. Welch just commented on that. That there is the literature that the predictive value was two borderline tests give the equivalent of an abnormal.

CHAIR MARKOWITZ: Well, I was referring to more like -- more mechanistic information or information about cell behavior. Not epidemiologic performance of BeLPT.

Do you know what I mean?

MEMBER REDLICH: I could look at that.

CHAIR MARKOWITZ: Yeah.

MEMBER REDLICH: I don't -- I think in all of the issues and recommendations, I don't think we could do one of the major points. I think it impacted relatively small number of people, so.

CHAIRMAN MARKOWITZ: Okay. Okay. So, I -- you know, people have their name cards up. But I think they've already spoken.

So, unless there are any further comments, we're going to move on. And we're going to do recommendation number seven.

Yes, I'm sorry, Mr. Turner?

MEMBER TURNER: Yes, I just want to say that I've diagnosed with CBD, I was allowed to test and everything. They had a doctor, another doctor to fight me.

And they said that -- the other doctor said that it isn't there, the CBD. So sometimes it depends on the company doctors, you know, the other doctors.

CHAIR MARKOWITZ: Yeah. Okay. Thank you. So we're going to go into recommendation number seven and hold off on the occupational questionnaire.

Seven relates to the quality assessment of contract medical consultants. Which is also the topic of the subcommittee for

weighing medical evidence and the CMC and IH subcommittee.

So, I think I'll turn this over to Dr. Sokas. We're going to blend discussion of this recommendation with that committee's report.

MEMBER SOKAS: Dr. Sokas speaking. Yes, this is the recommendation that we came up with was based on our previous request for content related quality assessment audits.

And we had been told repeatedly that they were available on the website. And the only thing that -- at that point was available on the website was a February 2015 process related audit that basically was from the different regions showing what went out and what came back. But had no content quality assessment at all.

So, our two subcommittees, the weighing the medical evidence and the CMC/IH subcommittee had jointly requested a meeting of some of our members just to meet and greet with

IH, that would be a special vendor for the Program, just as kind of an informal.

So several of us on July 11 met with Mr. David Lovett and with Dr. Armstrong and with the Program leadership and Ms. Rhoads as a kind of informal getting to know them, getting to know their credentials.

And I'm going to preface this by saying that Dr. Cassano chairs the weighing the medical evidence committee and participated in both of the things I'm going to describe now.

And I would ask any of the members of either of those subcommittees to just jump in if there's something that you want to add or correct on anything I'm going to say right now.

So, as the recommendation response here notes, at that meeting, the scales fell from all of our eyes. And were realized that in fact the medical director was performing quality assessments on the -- on 50 randomly selected charts every quarter.

And that we had completely been

talking past each other. So each time we raised it in a Board meeting and were given that, you know, website.

The Program thought it was responding to us, and we were just getting frustrated. Which is why we came up with that recommendation even.

So, it was, in my mind, one of the most helpful small group meetings ever. Because I don't think we to this day would have figured out what was going on otherwise.

And so since that time, and everybody on the Board has seen it, and I think there have been -- the medical audits have been posted and we've had a chance to review them.

We then subsequently on October 23 had a joint meeting of again, the two subcommittees. The two topics that were discussed and the two conclusions -- I'm really sorting this out -- that came out of that subcommittee meeting were that the work of the two groups was so congruent that really we

should recommend to the full Board that we be merged.

Or that, you know, this was obviously going to be a recommendation for the next constituted Board. But that it's somewhat artificial to distinguish between the work of the two committees. And we wanted to proceed together.

And then the second thing that came out of that meeting was we wanted to review the current quality auditing process. And so what I would like to suggest we do now, and if Kevin could put -- could switch to that, I'd like to switch us into a look at two particular documents.

One is the worksheet that we used for reviewing for causation. And I'd just like to go through and take us through it a little bit step by step and make some specific suggestions to it.

So, if we could actually go to the page preceding that. Which lays it out. And I

don't know if he can expand that a little better, or I can read it.

It's -- there's the objective. It's a quarterly audit to look at medical consultants' activity and their quality of their written reports.

It talks a little bit about the scope. But what I want to get into is the methodology. And I'm going to read you the second paragraph of the methodology.

And I mentioned where we may wish to make some suggestions. And then there's a particular question that I wanted to go to.

So, the second paragraph in the methodology says, the reviewer will review case docu -- and the reviewer is Dr. Armstrong. It's the Medical Director.

The reviewer will review case documents submitted by the district office to the contractor via the client portal. The reviewer shall code case actions deemed to be appropriate Y, as a yes.

The reviewer shall code case actions deemed inappropriate as an N. The reviewer will provide a thorough explanation of all items coded N.

In addition, any exceptional work is to be noted. The reviewer will utilize a manual score to record all responses.

So, I think based on all of our multiple discussions over the past year and a half, that really this is starting at step two. That reviewing what went out to the CMC should be the second step, not the first step.

And in fact the first step should be to review the entire case file to access whether what went forward from the CE was complete and appropriate. And have that as the initial step.

Now, as you'll see subsequently, the reviewer does have access obviously to the full case file and can use it. But that's not listed in the methods here.

And that's -- and that I think is, as Dr. Cassano has mentioned in the past, that is

problematic when we're not making full use of what the CMC should be doing. Which is actually reviewing the entire chart.

So then I think if we go to the next page that Kevin has, this -- this is fairly much a yes or no process. And you can read through the first one is, did the CMC provide a clinical history or summary?

Did the CMC answer each of the claims examiner's questions? Did the report contain rationalized medical conclusions? Did the CMC appropriately apply ‘‘at least as likely as not’’ standard?

What I would like to suggest we focus on is this next question number five. Was the CMC medical opinion based on the accepted facts of the case as listed in the SOAF?

And so instead, I think that question really needs to be reframed. And again, this is a topic for us to discuss in terms of providing recommendations.

But that the real question is, was

the CMC's written medical opinion based either on formal DOL guidance and/or the latest scientific information? And if there's a discrepancy, how did the CMC handle it?

And did the CMC argue for the claimant? So those are the kinds of things you want to really have from a medical assessment for the quality of the audit.

And that would have picked up a lot of what we saw in some of the stuff that we reviewed, where you had CMCs who were off the ranch basically saying, oh COPD it's not related to anything but smoking. You know, that kind of thing.

And we've seen that. So, I think -- and the rest of it is just again, it's sort of -- and I'd like us too then actually -- I don't know if we want to talk about this now.

But I would like us to go through one more document. Which is the -- if there's any comments or questions on this right now, we could entertain them.

But I would like to have us look at a document that Kevin has to put up that you all have in your packets. That the Board has in its packets.

It's the September 2017 document from Mr. Vance to Ms. Leiton that basically is the fourth quarter 2016 CMC audit. Yeah?

MEMBER CASSANO: Before you go on -- oh, Dr. Cassano. Just as a point of clarification to this.

To put this all and to wrap this sort of all up, it sounds like we're all -- we're constantly harping on the same thing. Because we're constantly harping on the same thing.

The auditor cannot determine whether the CMC's decision is valid unless he knows what information the CMC made that determination based on. And you know, if the statement of accepted facts is lacking or missing or faulty in some way, then the CMC is going to come to a wrong decision.

And nobody -- you can't determine

that until you see the actual file. And that's the purpose for both the recommendations to this and the purpose for the recommendation of combining the two committees.

And you know, it's just hard to look at -- look at one part of a process and say that that part of the process is wrong when you don't -- or faulty, when you don't know whether what they based that part, that decision on was correct or not.

And that's our dilemma and that's why we keep coming back to this.

MEMBER SOKAS: Although to clarify, we -- the reviewer can have access to what was sent forward to the --

MEMBER CASSANO: Right.

MEMBER SOKAS: To the CMC. So was able to see what the CMC had to work with as well as what was available in the charts.

MEMBER CASSANO: And maybe a side question to that is, how does anybody audit what the CE is sending to the industrial hygienist

and the CMC to determine if that's acc -- if that's correct or accurate or whatever.

MEMBER SOKAS: And that wasn't part -- that's not in an explicit step in this audit. But it's -- but we would like to -- I think we should add it as a suggestion step.

So this report reviews five cases that were plucked out of the 50 reviews for being problematic by the reviewer, by the medical reviewer.

And I just want us to kind of go through them. And I'm going to raise just a couple of questions.

My concern is a little bit that we have a process with the form that you just saw. The process really encourages missing the forest for the trees.

That you look at very specific, very small issues. And you don't really look at kind of bigger picture issues.

So we look at the first case. This is an individual who's had at least ten

different episodes of either basal cell or squamous cell carcinoma of the skin removed, in many instances apparently, in multiple locations.

And the CMC review was twofold. The first concern was that the AMA guidelines were not appropriately looked at for ratings. Because there's no loss of -- this individual suffers, they're saying no loss in their activities of daily living.

And you step back though and look at somebody who appears to be routinely and recurrently going in for these series of operations. And to say that that has no impact on their daily life seems to be a little myopic in terms of two perhaps rigorously applying the AMA guidelines.

The second note, which is really interesting. But, you know, was that in fact the CMC report used the wrong name and the wrong claim file.

But they, you know, were able to

figure it out anyway. So that was a little bit of a quality assurance thing there.

The second one that -- the second case I also found somewhat problematic. And again, Mr. Hanson's report is, I think, helpful because he does kind of comment on things a little bit more.

But this is a claimant who has two accepted conditions un -- well, three accepted conditions. But unspecified myeloid leukemia is one. And -- oh, wait. I'm looking at the wrong. Sorry, sorry, sorry.

Okay. There's an additional case. So, this one the issue was that the CMC specialty was not noted. And so that was the discussion there.

And this was about proportioning home care. So again, for some of this I didn't have a lot to, you know -- to comment on this.

But the one I wanted, there are two more that I want too really kind of raise as potentially along this same line. Of missing

the forest for the trees.

On number three, there is an individual who has metastatic lung cancer to the bone. And the reviewer was trying to use metabolic bone disease impairments to accept the impairment.

And was also concerned that the claimant was at -- was not stated to be at maximum medical improvement. And so Vance pointed out that if someone has a terminal disease, MMI is not really what you're worried about here.

And so, I mean again, this is looking too narrowly and precisely and missing some of the big picture, I think. And again, you know, that maybe a systematic issue with the way the form is developed in the slide and all of that.

There's another case on a home care review which I don't have any particular comments on. But this last one, number five, again there is a concern.

This is someone who has accepted

conditions that include acute myelo -- AML, acute myeloid leukemia and rheumatoid arthritis. And for assessing impairment, the thrombocytopenia and anemia were not included because they were not considered consequence illnesses for some reason of the AML.

Which again, without the entire record would be hard to figure out why not. Unless it proceeded the AML.

But also the individual has rheumatoid arthritis. Which again could produce both of those conditions.

So the question is not the meticulous and rigorous application of the AMA guidelines, the question really is to step back a minute and say, wait a minute. Is this an accurate use of consequent medical conditions or a refusal to identify consequent medical conditions?

So, in general, I'm just making a general statement that I think both the form and the way the form is being applied is a little too narrowly focused on the specifics of -- of

the use of the AMA guidelines for a variety of reasons.

And not so much stepping back and looking a little bit more at the -- at the issues that I think those of us on the Board would like to see.

Which is, really do we think the CMC did a -- did a good job in terms of looking to make sure that thrombocytopenia and anemia were not consequent illnesses and shouldn't be included and that sort of thing. Right?

So, I think at some point what we probably would need to discuss and whether it's today or whether it's, you know, in the future, but what is the -- what's the approach that we think could be the most helpful in terms of, you know, looking at the current quality assessments.

I mean, there may be opportunities within OWCP because there are other positions within OWCP who could, you know, kind of get together and say, oh well, I would do this, or I

would do that, or I would do something else, that aren't so much dependent on the -- on the specifics of the EEOICPA Program as they are on the medical, you know, kind of looking at the big picture medical as well as the AMA guidelines.

So I think that's one potential action. Another potential action is to have a working group of the Board to offer to do some of that for, you know, kind of jointly reviewing some of these.

And maybe, you know, kind of checking to see what -- what -- but I think the goal in any of these quality assessments should be to have two or three people look at the same set of information and see whether they agree on what the appropriate outcome should be.

And whether it's members of the Board doing that on a spot check basis, or whether it's an internal process within OWCP that it's developed, but that would enrich the practice and make the quality assessment piece a little

bit more.

And so it needs two things. It needs changing the methods in the form I believe. But it also needs changing the process to make it a little bit more again, collegial, but, you know, having more than one set of eyes put on the thing.

And I -- this is actually kind of they may have other things to add and other members of our two groups may have other things to add.

MEMBER CASSANO: I don't really have anything else to add. Just a point that what you are -- what the CMC, at least as far as we -- you could discern, the CMC made the correct determination.

But it was the reviewer that took exception.

MEMBER SOKAS: No, no, no. I -- you can't tell that.

MEMBER CASSANO: You can't tell that?

MEMBER SOKAS: You can't tell that.

But I don't want to say that.

MEMBER CASSANO: Okay.

MEMBER SOKAS: What I want to say is that Mr. Vance then reviewed and reported up what was done and qualified and changed some of the recommendations based on that.

And throughout, it was very clear that if a -- if a determination was -- had already been made to the benefit of the claimant even though there was some concern about that as a quality improvement method, that did not go back to adversely impact the claimant.

So, very clear throughout that there was, you know, a careful vetting. That made sure -- and really walking it back a little bit.

I mean, the whole comment about, you know, you can see from the way it's presented, there was a, we didn't do -- we didn't need to do anything about this one because, you know, it did adversely impact the claimant.

So that was the standard for actually going back and changing anything. This was

meant to report back to the contractor how to, you know, kind of pull up their socks and get the right name on the letter at least. You know, that kind of stuff.

CHAIR MARKOWITZ: I have a question. Steve Markowitz. I didn't see in a template where the reviewer records the specialty of the CMC.

But appears to have been addressed, at least in part on some of the claims in Mr. Vance's report. So do you see that?

Do you see where they reported who -- anything about the qualifications of the consulting person?

MEMBER SOKAS: I'm sorry, there are three different forms. And I only showed you the one form. And I don't know if it's in the other form.

But, there's one that looked -- so this one is just for causation. Which frankly the thing that I cared most about.

The other two forms are for maximum

medical improvement for the percent impairment rating. And then the third one is for, do they really require -- see how much home care is really required, because that, as we all know, is a huge issue.

CHAIR MARKOWITZ: Steve Markowitz. So they -- you know, they provided us with all the audit sheets.

And I'm looking at all of them. And I --

MEMBER SOKAS: Even there --

CHAIR MARKOWITZ: Oh, I'm sorry. I'm sorry. In one of the four the area is the first question.

Was the appropriate medical specialist assigned? Although I'm not sure which type of review this was for.

But, I don't see why that question wouldn't apply to all the reviews. You know, for the review on impairment, the review on causation, and the like.

I was just wondering whether you --

you detected --

MEMBER SOKAS: Yeah. I didn't look at that.

CHAIRMAN MARKOWITZ: Additional comments? Dr. Silver?

MEMBER SILVER: Please refresh my memory as to the selection process for the 50 CMC reports that are being audited. We know they're distributed among the different program issues, causation, what not.

But, could a CMC slide through as long as a year without ever having their work audited?

MS. LEITON: They are randomly selected. I would have to look and see if there is, you know, if there's some that have been overly looked at and some that haven't been.

I'd have to check into that. But they are random in terms of the audit itself. Random based on the three different topics in this.

CHAIRMAN MARKOWITZ: Dr. Welch?

MEMBER WELCH: If you're reviewing two hundred cases a year, it's -- I don't know how many CMCs there are, but it would seem like that wouldn't necessarily capture everybody.

Unless maybe there's less, you know, just one hundred physicians. And I don't know the answer to that.

MEMBER SILVER: So if I may, I think that we're down to some of the concerns we've heard from the claimants and the advocate community that there are some CMCs that keep making the same mistakes over and over again for many years.

And maybe a bigger sample needs to be drawn.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, I'm wondering if hearing what people have said, whether a sample that's completely random is the appropriate approach. Or whether there might be some complaint mechanism so that you could identify people that at least had had concerns expressed

about their reports.

Spend some of your time looking at those particular CMCs.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I think maybe another way to look at this is rather then a random audit of let's say a quarter is to do something closer to a peer review type process. Where you actually -- where the -- each CMC has to submit a certain number every quarter.

And those then are reviewed. So that you know that you're capturing all of the CMCs. And that maybe a better way to do it.

And then you can also at that point, the person that's looking at that looks at not only internal consistency, but also CMC to CMC consistency. So you get a better idea of how they're actually performing.

I think that's the -- no disrespect, but I think using the complaint system is -- anybody that's denied is going to complain. And therefore everybody is going to -- everybody's

going to have to get looked at.

MEMBER SOKAS: So one way -- this is Dr. Sokas again. One way we had kind of kicked around a little bit this morning that you might be able to do it is before, you know, just right after the examination itself, but before the determination is made, you know, send out one of those surveys that we all get when we go see our primary care physicians.

That, you know, just kind of ask, how did the process go? Were you treated with respect? You know, dah, dah, dah, dah.

And so you might be able to identify at least in the -- in the instance, you know, somebody that you have a little bit of concern about. And review them.

Although obviously it's not going to be the -- it won't be the --

MEMBER CASSANO: Unless everything is done on paper. Then there's no interaction anyway, so.

MEMBER SOKAS: Oh, you already --

okay. Never mind. Never mind.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: To answer your question regarding the forms, only one of the forms does not have the question about an appropriate medical specialty. And it's the final review causation supplementation.

And that's the -- so the other ones do have it on it. Causation is the one where it's most crucial.

CHAIR MARKOWITZ: Thank you. Dr. Boden?

MEMBER BODEN: So Dr. Cassano, just to clarify my thought about the complaints. I was actually thinking about complaints from representatives and not from individual claimants as a possible way.

You know, if you've got a thousand complaints from one representative, you might not even look at them.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: The -- what I had

for a thought for how to collect complaints within the Department from people who actually see a high number of these reports, would be through the FAB office as they review the files.

And they do see a number of repetitive mistakes, the Final Adjudication Branch, which actually sees and goes through these.

CHAIR MARKOWITZ: Dr. Sokas? So, no. I'm sorry, Mr. Domina?

MEMBER DOMINA: I just have a question really. When you have a CMC in the program, once they're in, are they in for life?

Or do they have to reapply every two or three years? How does that work?

MS. LEITON: The CMCs themselves are selected by the contractor. They have various mechanisms in place for review.

Which I am not familiar with it off the top of my head. But we could look into that. But, they're not necessarily in for life.

I mean, if we identify problems,

we're going to relay those to the contractor. And the contractor is going to have to take whatever action is appropriate.

But again, there are certain rules or contractual obligations that they have. And I am not familiar with the contract that closely right now.

We can see what we can provide you after.

MEMBER DOMINA: Well the reason I ask is because under Washington State Workers Comp, they used to put them in for life. And that was problematic.

And so they have to reapply every three years to stay in the program. So I was just curious for comparison.

MS. LEITON: Yeah. It's not a lifetime thing.

MEMBER DOMINA: Yeah.

MS. LEITON: And the contract may change. I mean, you know, we have to re-compete the contract on a regular basis.

MEMBER DOMINA: And then so on a regular basis for the contract to be competed, what is that time frequency? Three years? Five years?

MS. LEITON: I'm not -- I don't know off the top of my head. I'll have to look at it.

MEMBER DOMINA: Thanks.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: I just wanted to mention -- this is Dr. Redlich. I just wanted to bring up one or two reprisals we presented previously when we had reviewed that COPD part B cases.

So a week prior to coming out, we had reviewed about 80 Part B cases. And those included, I think it's slide three.

But those were the cases that we had reviewed. A mixture of BeS, CBD, and I just -- this discussion had reminded me of sort of what our conclusions were from reviewing these cases.

We agreed with a number of the

decisions that were made. I think the BeS were relatively straightforward.

And we had actually gone through and different members of the team had actually gotten a form and evaluated them. I say for the purposes of the Part B changed since the information we had, which was generally the summary documents rather than the original records were sufficient.

And I realize that would be different for other areas. But I think the common findings, that -- and I think that this -- the positive side I think that some of the concerns we found are easily adjustable by the recommendations we made.

As far as the sarcoidosis and CBD claim, I think the most common issue was the -- sort of misapplication or understanding of the sarcoidosis presumption.

And then the other was some issue about whether there was really the exposure when it seemed that it was relatively clear that

there was.

And I think in a number of the cases there was, you know, eventually there was a correct decision. It was just the time it took to get there.

And then the other thing that we did notice that I just wanted to mention was that we looked at 30 of the 60 cases had a CMC report. And as well as, you know, over half of them were the same CMC.

And I think everyone agrees who looked at these, is this particular CMC he did have appropriate credentials. But there clearly wasn't a relevance to this.

And you know, I think there was agreement among -- every case was reviewed by at least two of us that, you know, his was -- I think was -- accounted for almost all of the decisions that we disagreed on.

And so I'm not sure if the current review process has a way to pick up on something like that. I will say from my review that this

CMC would benefit from either additional training or maybe not, you know, to find an alternate CMC.

Because as again, in terms of his occupational expertise was limited. And so those were the major questions that, and conclusions I think that we came to from review of a pretty substantive number of cases.

CHAIR MARKOWITZ: Thank you. Dr. Sokas?

MEMBER REDLICH: And then the other thing that we did notice which I just wanted to mention was that we looked at 30 -- about 60 cases had a CMC report. And of those over half of them are the same CMC.

And I think everyone agreed that this particular CMC, he did have appropriate credentials but there clearly was a bit of an attitude. And I think there was agreement, every case was reviewed by at least two of us, that his I think accounted for almost all of the decisions that we disagreed with.

And so I'm not sure if the current review process has a way to pick up on something like that.

I would say from my review that this CMC would benefit from either additional training or maybe to find an alternate CMC. I think in terms of his occupational expertise was limited.

And so those were the major questions and conclusions that we came to from review of a pretty substantive number of cases.

CHAIR MARKOWITZ: Dr. Sokas.

MEMBER SOKAS: Just as a question I'm just wondering if -- so that sounds like a different, a change in the methodology of the causation question, that there might be another step or another question that could be added.

I'm trying to figure out if there's a way to tweak what's there that would allow that kind of -- and maybe just changing that one question to sort of amplify it a little bit might help.

It wouldn't show the pattern though. So I guess my question is -- gets more to some of the other discussion about how do you sample. Is random the way to go, or if you have a question about one record that you reviewed do you then want to maybe continue to sample that individual.

I'm just looking for a way to operationalize what you just said.

MEMBER REDLICH: Dr. Redlich. The other thing we had done is Dr. Dement had put together a summary of the data each year of the number of cases under different conditions, those that were accepted, those that were denied.

And I think looking at that, the numbers are not so huge that one couldn't target the CBD denials. I think it would be a manageable thing to review.

And the lung cases may be somewhat different than the others. I think they may be easier to review.

CHAIR MARKOWITZ: Dr. Welch.

MEMBER WELCH: I know when I was working doing quality assurance at a hospital there's only so many things you can look at. And that we would have departments pick a particular topic and change the topic around as a special topic.

Say let's say for example, I liked Dr. Cassano's suggestion of doing a peer review based. If we're looking at the CMC not qualifications but results, the CMC audit I think it would really make sense to make sure you're sampling all the different CMCs and that would then probably catch that question of what you'd seen.

But the other thing is to say well okay, in this quarter let's also add a review of lung disease cases, or add a review of particular target areas that would allow you to catch the same question in a different way, particularly if you're going back and adding the question for the causation cases whether the

statement of accepted facts from the claims examiner to the CMC reflected all the accepted facts that the medical reviewer would have wanted to go to have that there.

That's going to vary probably by diagnosis and complexity because some of the diagnoses are more complex. And to look at the way the whole system processes big number claims might be useful. So to look at COPD cases unless that's sufficiently covered, look at COPD cases, look at other lung disease cases. Not with every time but just a periodic evaluation so that there's different ways of picking the quarterly cases, both peer review, maybe random. The different types of evaluations but also the different diagnoses.

And I don't know whether your committee is going to come up with an array of choices that might make sense of the different kinds of quality reviews you could be doing.

MEMBER CASSANO: I just had a question. I'm looking at the forms and I'm not

seeing it.

The CMC's medical specialty that's reported on this, is this determined based on board certification, or is it just determined on what the contractor says the medical specialty of the person is?

There are lots of people that say they do occupational medicine and they'll write down on many forms that their specialty is occupational medicine and they really have never had any formal training at all in occupational medicine, especially this aspect of it.

They do a lot of worker's comp and that's relatively -- treating an injury is the same whether it's occupational or it's not except for some important pieces.

But this kind of occupational medicine is not something that somebody without appropriate training can do. So I was wondering if we could answer that.

MS. LEITON: This is Rachel. We first of all require board certification.

Usually when we say a board certified orthopedic surgeon or pulmonologist we would expect that they be board certified in that specialty.

When the claims examiner refers a case they would ask for that usually if it's a pulmonologist or what type of specialty they want to have a look at the case file.

Beyond that in the way that the contractor looks at it I would have to look at the contract.

MEMBER REDLICH: Dr. Redlich. I would just agree that I think it would be very feasible to do some targeted reviews.

Because from the cases we reviewed some were very reasonably determined. The beryllium sensitization ones we agreed with and you could easily target which areas would warrant further review and which seemed to be very appropriate.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: I want to go back to Les Boden suggesting that the authorized

representatives be a source of information about CMCs who might come under greater scrutiny.

I remember hearing about for lack of a better name Dr. Attitude from the claimant community months before this subcommittee found problems with a number of his or her work.

So I'm not exactly sure how the claim files that went to your subcommittee were selected. If it was a random selection process then the problem of CMCs with attitude may be big and broad.

If a random selection process turned up a repetitive problem with one claims examiner that suggests further random sampling -- I'm sorry, CMC, that if additional random samples were drawn and scrutinized by your committee it would show up again and again.

I don't want the doctor's name to be bandied about. Everybody is entitled to due process and I'm sure he or she isn't here.

But the authorized reps should be listened to earlier in the process.

CHAIR MARKOWITZ: Steve Markowitz. I have a question. I noticed on Mr. Vance's review of Dr. Armstrong's work at the end it says that the contractor would be given the opportunity to respond in writing to each deficiency.

So does QTC provide report back to all about the findings of the medical review?

MS. LEITON: I'm going to say I would expect that they would. I have to follow up with Mr. Vance to make sure we've gotten those.

CHAIR MARKOWITZ: The other question I have is when I look at 2017 the two reviews by Dr. Armstrong in reviews from your 42 cases and he profiled the deficiencies, I don't see any attempts to connect the results from the two reports. In other words to look for patterns above and beyond any given reporting period.

So if there's a problem in the earlier reporting period I don't see any decisions to see if that is still a problem six months later in the subsequent report.

A broader time frame, but I still don't see that kind of assembly of information to kind of a bigger picture to see the judgment performance.

MS. LEITON: So you're asking if we have a follow-up process for after the report to see what's been fixed and what's been done about it in QTC or within the --

CHAIR MARKOWITZ: In part. But if Dr. Armstrong detects a pattern of a problem does he look for that pattern six months later when he's doing his re-review of another 40 or 42 cases?

MS. LEITON: He should be.

CHAIR MARKOWITZ: I don't see any evidence of that.

MS. LEITON: I don't think we have a documented process for it. It may be more verbal. But I will look into it.

CHAIR MARKOWITZ: Mr. Domina.

MEMBER DOMINA: I guess it was me and Faye that actually brought up some of the issues

with a certain CMC.

And it was, you know, I'm not a doctor or nothing, but when I go through and read stuff and you read attitude or however they're addressing it.

And so what caused further review is I only had five or six claims that Dr. Redlich asked me to review. So I started pinging every one of them that was sent to us randomly.

This individual had 18 of them. And it was a pulmonologist.

And the other thing that bothered me is that, you can shut me down if I say something I'm not supposed to say, but I guess my issue is just from a good ol' boy's standpoint is what is an East Coast, very East Coast know about a uranium miner who are all west of the Mississippi.

And so for somebody to not see, probably never seen one in person. Because what bothered me about it, it reminded me of that black lung doctor at Johns Hopkins that approved

one case or something in like 40 years. He was a hired gun for the big coal companies.

And so I guess maybe I look at it a little bit different way.

But when I see something in there and the way in my opinion disrespected the workers it's very problematic for me because I am a worker.

CHAIR MARKOWITZ: If you had your card up I'm going to assume you want to speak. Ms. Vlieger.

MEMBER VLIEGER: Just to follow on. Kirk and I met because we needed to review our cases and then we found that this commonality existed. So we reviewed all the cases on the disks that were sent to us, not just our two to five cases we were assigned.

We did not look for this evidence, we just found it. And so we tabulated all of the physicians that were sent claims of the ones that we were sent to review, the committee was sent to review. And then we found this

incidentally.

We had heard among the claimant community that this was going on, but I didn't set any stock by it because there wasn't numbers to prove it.

But then when we saw these numbers, then all the claimants that we had been hearing from, it became quite evident that this particular CMC was being sent this particular type of claim and his usual answer was no. And so that's why it was really disturbing and why we felt we had to report it to the committee.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: Another question. How are these kinds of issues with -- when the CMC errs, like they find an error. Obviously that goes back to the contractor. But how is this reflected in the performance standards in the contract? Do you know that offhand or not?

MS. LEITON: I don't know that offhand.

MEMBER CASSANO: Because that would

be interesting to see if there is some type of recourse for the agency to be able to say whatever contractor you are your people need to get better at this so that -- otherwise we're going to terminate you.

MS. LEITON: I mean there are definitely mechanisms for quality evaluation and reporting that they have to do to us and things like that. But again I don't have the contract in front of me.

MEMBER CASSANO: But these issues are, most when I've seen those performance standards they're very check off the box kind of thing. Is it the right name and the right person and the right disease and all that sort of stuff rather than these more squishy for lack of a better term issues about how the physician comes to their decision and if they seem biased in any way.

That's hard to determine on a check sheet.

CHAIR MARKOWITZ: I think before we

move on, so a question for Dr. Sokas and Dr. Cassano. We need to move on to the recommendation number 7 as it relates to this, but was there something else you wanted to discuss before we move on to that recommendation?

MEMBER SOKAS: No. Really I think the suggestion to change the form itself to include both the methodology change that the reviewer would review the whole record to add in the part about whether the CE sent the appropriate information.

And then expanding question number five. So those specific changes in the form we can craft.

And then the other piece was -- and I think we got a lot of good discussion today about providing a number of alternatives for improving the quality review process that we can then formulate and have as part of a phone call later on.

CHAIR MARKOWITZ: So I have a

question. Our chartered mission, task number 4 relates to this and we are supposed to advise the Secretary on, quote, the work of industrial hygienists, staff physicians and consulting physicians of the Department of Labor and reports of such hygienists and physicians to ensure quality, objectivity and consistency.

So we've just looked at -- referred to the medical director's reports. Have we done a sufficient review of those and the process that we can -- that we are comfortable with the quality, objectivity and consistency.

MEMBER SOKAS: I think that's for the next board.

(Simultaneous speaking.)

MEMBER SOKAS: I don't mean to be flip about it. This is Dr. Sokas. I think the answer is I think we can come up with some recommendations now based on what we have seen, but between now and next month I don't think we're going to come up with what you're suggesting which is a full review of everything.

I think we're going to come up with some intermediate steps maybe, but not the big this is our report back on all of this.

CHAIR MARKOWITZ: Okay. My point wasn't that we should accomplish this by February, but that it should definitely be on the radar.

MEMBER CASSANO: At the moment though we do not have enough information for I think all the reasons we went through to be comfortable with the objectivity and the quality of the reports.

CHAIR MARKOWITZ: Of the medical director's reports.

MEMBER CASSANO: Are you talking about the medical director reports or the CMC reports?

Or the audits? I don't think these audits provide us with enough information yet to determine the objectivity and quality, medical quality of the CMC reports.

MEMBER SOKAS: And I don't think we

had actually used that language to frame what we were doing. We were mostly responding to our recommendation 7 in trying to move forward on it.

CHAIR MARKOWITZ: Okay. So I just think it should be -- whatever product we have it should be there. If we haven't done it, fine.

So we're going to move to the recommendation unless there are any last comments.

MEMBER REDLICH: Dr. Redlich. Just quickly though I think it is clear from the limited review we've done to date that this is an area that needs further review.

And I think it just also highlights a point that has been made. And I see this perspective living in the pulmonary community that most pulmonologists don't really deal with occupational diseases. That I guess is just something that the DOL should be aware of in terms of selecting pulmonologists.

CHAIR MARKOWITZ: Okay, so let's move on. Recommendation number 7. It's requesting that DOL provide the board with resources to conduct a quality assessment of a sample of 50 contract -- I'm sorry.

MEMBER SOKAS: I'm sorry. So Steve, I think -- I'm sorry, this is Dr. Sokas speaking. I think that whole discussion was our attempt to respond to OWCP's response to that recommendation.

So we're in the process of saying okay, so let's rethink -- so what we're talking about is let's rethink the auditing procedures, let's rethink what are options for peer review whether it's board members doing it.

But I had thought that the response to this was it's already taken care of and our response to that is no, but this is the way we want to approach it. Not necessarily going back to the original recommendation.

That was made prior to understanding that there was any kind of quality assessment

going on. We had no idea that these were being conducted back when that recommendation was made. So I think that's an outdated recommendation we don't need to spend any time on right now.

CHAIR MARKOWITZ: I would disagree and I'll tell you why, but if there's other people who want to speak.

One of our chartered tasks is to advise on the work of industrial hygienists and staff physicians and consulting physicians of Department of Labor and reports of such hygienists and physicians to ensure quality, objectivity and consistency.

So I don't know why we would entirely rely upon the staff physician, the medical director, his review of claims as the total basis of our willingness to ensure that the claims, that the CMC work and the IH work is of quality, objectivity and consistency.

So unless I'm missing something.

MEMBER SOKAS: You're missing

something. This is Dr. Sokas again.

No, so the next steps I believe we were proposing was that we would now recommend changes to that process and an approach that either through some alternative mechanisms for reviewing the reviewer.

So it's not what you just said. Now, it may be that some of that original recommendation could find its way back into that, but I think the original recommendation did recognize what was currently happening.

We have to see what was happening and then adapt our recommendation based on that.

CHAIR MARKOWITZ: Steve Markowitz. So the idea is for an independent look at the same claims that the medical director is looking at and then compare.

MEMBER SOKAS: That's right, yes.

CHAIR MARKOWITZ: Does that address the issue of consistency?

MEMBER CASSANO: I think that's something we need to build into the new process

is how do you address consistency and objectivity as well as accuracy if there such a term accuracy in developing an opinion.

I think that all has to be built in. What we're doing is as Rosie said this was written before we knew that the medical director was actually doing the audit.

So what we just discussed was the fact that okay, we looked at some of the medical director audits and we find this process insufficient as well as having no process at all, and now we need to move forward and develop a process that actually meets the requirement of what our mission in that subcommittee is.

CHAIR MARKOWITZ: Dr. Boden.

MEMBER BODEN: So I'm trying to think about this as if I was trying to design a research project whose goal was as stated in our terms, our charter.

And first of all, it occurs to me that we've been talking about different objectives as we've gone through this discussion

one of which is sort of finding people who really are individuals who aren't doing a good job.

That's not I think exactly what our charter says that we should do. Our charter is talking about sort of a population view of where the population now is CMC reports and we want to figure out whether they're good or not.

What concerns me is of course that there are different kinds of CMC reports. You've got your four different evaluation forms.

And that within each of those there are different specialties, different diseases that are being looked at.

And my sense is, I haven't sat down and tried to figure it out, that that's actually a fairly -- that would require a fairly large population of reports to actually answer the question that's posed to us in the charter.

And that we probably don't have the bandwidth to do that ourselves. And so there's a question in my mind now about how one might go

about trying to answer those questions.

I think that the reports that are done now are focused on finding specific problems and giving feedback on those specific problems to the contractor so that they can get individuals to do things like say whether or not they have a conflict of interest.

But I think what we're talking about is a bigger project, potentially a very important project but I don't know where the resources would come from to actually do that.

We might be able to focus on a specific subset of let's say causation cases, a pulmonologist or something like that, and then be able to get enough cases to look at so that we'd have a sense of overall how is the contractor doing. But I'm not sure we can do more than that.

CHAIR MARKOWITZ: Just to clarify. Steven Markowitz. So you began by saying if you were designing a research project. I don't think the program is necessarily all that

interested in the research.

But the question then is the proper evaluation in support of this task, does it encompass the same kind of parameters you just mentioned.

MEMBER BODEN: I thought of that question as a researcher. I don't think of this as a research project. I think of it as an evaluation project.

But you still have to have enough cases to look at within a particular spectrum of cases to be able to do the evaluation.

And a statistician looking at that would use the same power calculations as he would use for a research project to figure out how many you would need.

MEMBER FRIEDMAN-JIMENEZ: I think one way to evaluate this that would give us -- we could evaluate the director by just doing a random sample of audits, of reviews of the same cases that he had reviewed.

That would give us some insight into

the CMCs also depending on how many we've reviewed of each CMC.

So the question is what we really want to evaluate, the director or the CMCs or both.

But I think this would have to be something that would be done by contracting someone else to re-review blindly those same cases.

CHAIR MARKOWITZ: I would just point out that task number 4 of the board is both assessing the staff physician and the CMC as well as by the way the industrial hygienist about whom we haven't spoken at all. And we need to put that on the radar because we have failed to do that. We have not discussed at all unless I forget how we evaluate the industrial hygiene function. I don't know whether it's staff IHs or the contractors, but regardless we haven't done that.

MEMBER BODEN: So, I think what we can do is to think about designing an

evaluation. I don't think we have the time to actually do an evaluation so that was my only comment except to say I guess it matters that we have way more physicians on the board than industrial hygienists.

MEMBER SOKAS: And I did want to kind of push back a little on that. If you broadly interpret evaluate the work of the industrial hygienist in fact the recommendation that the industrial hygienist should be able to speak with the claimant came out of that particular look at what the industrial hygienist should be doing.

CHAIR MARKOWITZ: Steven Markowitz. But that's not the same as evaluating their work.

MEMBER SOKAS: So it's a different interpretation of the word evaluate, right? I mean, you're right, it's not the same, but when we looked at that task the first thing that came up wasn't are they doing the right job it was how can they do their job better. And that was

the response to that.

CHAIR MARKOWITZ: And that perhaps is more important but it's not looking at objectivity or consistency. Dr. Welch.

MEMBER WELCH: Well, also I think the other thing to remember is that the CMC process has been going on for a long time, but adding industrial hygiene review to a large number of cases or all the cases where there's going to need to be an exposure determination is a new addition.

I mean, it's good to be able to do some assessment of that as we go forward so that things don't get off on the wrong track, but most of the cases that we reviewed when we started this, when the board started its work didn't include industrial hygiene opinions because that was only just being implemented.

So we have less experience with it. So what we saw in the file reviews was a lot of issues related to CMCs so I think that's what drew the initial focus in that direction.

CHAIR MARKOWITZ: I forgot to mention by the way our public comment period begins in 15 minutes. If there are people who want to make public comments you need to sign up with Ms. Rhoads.

MR. FITZGERALD: Who just walked out of the room. But when she comes back in please see Carrie Rhoads over here at the desk if you're interested in speaking.

MEMBER CASSANO: One more question. Vis-a-vis the discussion is there a similar audit process of the industrial hygiene function as there is for the CMC?

MS. LEITON: We just started with the IH contractors in 2016 so we have not developed that yet. I just made a note to make sure and see what -- they may have done some work on it that I'm unaware of, but it's definitely something that will be followed up on.

MEMBER CASSANO: If you need our assistance in determining how to establish that audit function I think if we get it right from

the get-go and we're happy with the function from the get-go we won't be coming back to this in a year and saying well, we have to fix something.

MS. LEITON: Makes sense. Thank you.

CHAIR MARKOWITZ: So are there any final comments as we're going to take a few minutes break? Okay, good. So we're on break. We'll resume promptly at 4:30 and start the public comment session.

(Whereupon, the above-entitled matter went off the record at 4:15 p.m. and resumed at 4:30 p.m.)

CHAIR MARKOWITZ: It's 4:30. We're beginning the public comment period. We're going to turn it over in a minute to the moderator.

We have 90 minutes. We have 17 people who have requested to speak so that's five minutes per person.

And it's hard to stick to five minutes per person which means sometimes I have

to suggest that it's time for you to wrap up. And I don't mean anything personal by it and we'd all like to hear more but we have our time limits here. So we really need to ask you to stay to five minutes.

Also just by way of reminder this is not really a question and answer session. You may have questions. The board isn't really going to answer those questions. We'll take note of questions but we're not really going to answer the questions during the public comment period. Maybe afterwards or tomorrow if you're still around.

So let me turn it over to the moderator who has some instructions I think to include people on the phone.

THE OPERATOR: Yes, this is the operator. Are you ready for me to put you live with the other parties?

CHAIR MARKOWITZ: Yes.

THE OPERATOR: Okay. One moment, please. And I do just need to let them know

we're recording this portion.

Thank you all for standing by. At this time I do want to inform all the participants on the phone line that your lines are in a listen only mode until the public comment section.

We are also recording today's conference. If you have any objections you may disconnect now. And Dr. Markowitz, you may go ahead.

CHAIR MARKOWITZ: Okay. Our first speaker is Michelle Jacquez-Ortiz from Senator Udall's office. Welcome.

MS. JACQUEZ-ORTIZ: Thank you, Chairman Markowitz and members of the board. My name is Michelle Jacquez-Ortiz and I've had the privilege of working for a United States Senator for almost two decades, since before EEOICPA was enacted and have watched the senator over the years.

I will say that he has a lot of important issues that come before him but this

one, RECA and this program are very near and dear to his heart.

He shared a statement that I wanted to take an opportunity to read into the record.

Thank you Chairman Markowitz and members of the board for holding this hearing in Santa Fe, New Mexico. Coming here allows claimants from northern New Mexico who have become sick through exposure to radiation or other toxic substances to talk to you in person and to tell you their stories in their own words and to give you their suggestions based on personal experience.

Thanks also to members of the board for bringing your expertise to bear on this important issue and for your hard work.

My history of fighting for compensation for U.S. Department of Energy employees injured by radiation or other toxic substances through work dates back many years.

As a member of the United States House of Representatives I hosted the first

public hearing in New Mexico along with my Senate colleague Jeff Bingaman to gather testimony from workers from Los Alamos National Laboratory who became sick as a result of their work at the lab.

The stories we heard from these patriots were heart-wrenching. In 2000 I sponsored a bill in the House to provide compensation and testified before a House subcommittee for the pressing need for just compensation.

Since Congress passed the Energy Employees Occupational Illness Program Act in 2000 I have worked hard to make sure that the program is effectively implemented.

There are two issues I would like to bring to the attention of the board.

First, I followed the work of the board closely and appreciate that each of you takes seriously your responsibility to make recommendations to the U.S. Department of Labor.

DOL should prioritize board

recommendations intended to assist claimants. The community of claimants from the Cold War era are getting on in years. Many have already waited too long for their claims to be evaluated.

Board members who volunteer their time would appreciate that their high-level work receive due consideration.

I am pleased that Ms. Julia Hearthway has been appointed director of the Office of Workers Compensation Programs and I am hopeful that we will see timely responses to DOL.

Second, the board manages a labor-intensive workload, reviewing and making recommendations on complex occupational health science issues.

I am concerned that this workload strains the board's limited resources and suggest that DOL strongly consider providing the board with a technical contractor to assist it.

The National Institute of Occupational Health and Safety, for example,

retains a contractor to support its advisory board. It is critical that the board's work is completed in a timely manner and DOL should make sure that the board has adequate support to fulfill its duties.

Thank you for considering my comments. I appreciate the board's hard work on these issues. Ensuring that DOE workers who were unknowingly exposed to harmful substances while working to keep our nation safe is important work.

Sincerely, Tom Udall, United States Senator.

And we are sending an electronic copy so it gets posted online as well. Thank you.

CHAIR MARKOWITZ: Thank you very much. The next speaker will be Ms. Martha Trujillo.

MS. TRUJILLO: Good afternoon, Mr. Chair, members of the board. My name is Martha Trujillo. I live in Pojoaque, New Mexico which is just 25 miles north of Santa Fe.

I'm here. My father passed away 10 years ago. He and my mother both fought for a number of years to get compensated. And about one month after my father passed away he did receive his compensation.

That's 10 years ago and I would gladly give back every penny just to see my dad here again.

That said, I hope I don't get too emotional here but this is a very emotional thing to talk about. And to represent many people in our community who are now struggling and trying to get compensation.

I'm here with Mr. and Mrs. Valdez. They are my neighbor and they were lifetime friends of my parents.

Mr. Valdez was a custodian who worked alongside my dad for 30 years. And it has been a number of years that the Valdez's have been trying to get compensation.

And it's been a number of years that they have been receiving letters saying that

they don't have enough proof and they don't think that now our last letter that we got from trying to meet a deadline for 30 days before we are totally denied.

So as I said earlier Mr. Valdez spent 30 years working alongside my dad. And the other two people who worked alongside my father also passed away and they were compensated. They were compensated about three or four weeks after they passed away and so their widows received the money.

This is not a great story for Mr. Valdez to hear because his wife now is thinking does my husband have to pass away before I get compensated, or if he would ever get compensated.

We live in Pojoaque. It's a rural area. Many of the individuals who worked at the lab from this area gave their heart and soul to their job.

My father, there were 12 kids in our family and as a custodian he knew how important

that job was for him to go back and forth on top of that hill.

Again, I would give back every penny just to have another 10 years with my dad.

But I thank you for the hard work that you're doing. I wish that there were more individuals who could be representatives who could help individuals such as myself who are just trying to figure out the paperwork that is needed.

I appreciate your comments, Kirk, about how the workers are in need of something and should be compensated today while they are alive. Thank you.

CHAIR MARKOWITZ: Thank you. I failed to mention that there are some resources for people who have questions or issues with claims that they want to address. The ombudsman's office is represented here. DOL district office or resource center is here as well as the former worker medical screening program for these sites here in New Mexico.

So for those in the audience here who want to avail themselves people are here to speak to. So thank you very much.

MS. TRUJILLO: And I thank you for that. I will tell you that we have gone through two advocates who have said there's no chance of us being able to get compensated.

We have been through the Johns Hopkins. We have been through a number of private doctors who do not understand how to send the reports to help us.

So we've been to a number of people and advocates and have not been able to move forward. But I do thank you.

CHAIR MARKOWITZ: Thank you. Mr. Tim Lerew.

MR. LEREW: Dr. Markowitz, fellow board members and the very good representation that we have from the public that we have here today.

My name is Tim Lerew. I have the honor this year to be the chair of the Cold War

Patriot Executive Committee.

Two weeks ago it was my pleasure and the pleasure of some of the folks in the room today to take part in more than 10 observances at the National Day of Remembrance on or around October 30.

That day was chosen because that was the day the original Energy Employee Compensation Act was signed into law taking effect the following year.

We now have 55,000 members throughout the country, but I realize that's just a small portion of what may be close to 1.5 million individuals and the number keeps on getting revised upwards.

Talking with Gail out at Hanford nearly 400,000 in eastern Washington from World War II until now have worked in the nuclear weapons complex.

So maybe close to a million and a half individuals have been affected by their national security work.

Let me start and I'll probably stop with it as well. Our sincere thanks to the brave men and women who often in quiet and secrecy with their L and Q security clearances sacrificed their health and in many cases their family member's lives to provide for our collective national security which has also kept the peace since the end of World War II.

Specifically to the matters that have been before you today I'd recognize and encourage each one of you as board members to take Martha's story and others that you hear every day and every week and use that as strength and power to recommit to the next two years that you might be able to offer this board's work.

The work that you started, I think I was with you for those initial meetings in Washington, D.C. about 20 months ago. It's important work. It's hard. It's slow. But I've seen progress.

Department of Labor asked for your

input and they've received it over the last 20 months. If you're able to continue and offer the continuity of service and continue the good work that you started you will continue to see progress from your good efforts.

Specifically I'd like to speak very briefly to presumptive causation. As Dr. Boden and others have noted on the board today the positive effects of presumptive causation could help many with pulmonary and many other illnesses.

But of course when you have a positive correlation you sometimes get the negative where maybe a claims examiner might say you don't meet that criteria so you're not going to be compensated.

We need to all be on guard for that. But I have seen a willing partner from Department of Labor for many of their 400 claims examiners to take the excellent input that you've made and continue to carry that forward.

We've already seen it reflected at

least in some part in the policy and procedure manuals that have been going forward.

And finally, your work is made possible through some of the political work. And really these people that are represented here through legislation.

The National Defense Authorization Act. An amendment thereof that made this board possible. It happens every year in Congress.

We continue to work at Cold War Patriots to advocate for legislative changes when those are necessary to constitute boards like yours or when it's appropriate to maybe help Labor and other agencies with some of the details of how they interpret legislation and make things go forward.

So let me conclude with our thanks to the brave men and women who've made our collective national security and our global security possible.

And thank you for the hard work that you do as volunteers to honor those men and

women with the work you do today and every day going forward. Thank you.

CHAIR MARKOWITZ: Thank you. Mr. Raymond Singer. So I'm not sure you were here for the introductions so the comments are limited to five minutes if that's all right.

MR. SINGER: Hello. I'm Raymond Singer. I'm a doctor of neuropsychology and I specialize in neuropsychology, neurotoxicology and forensic applications.

I've seen some of the workers at Los Alamos after they've been injured and I've seen other energy workers including workers at Hanford Nuclear Works.

And I'm really not sure exactly what you would like me to talk about today, but I could talk about the types of injuries that neurotoxicity can cause which really are any injury to the psychological processes or neurological processes.

This could include anxiety, depression, psychosis, panic attacks, learning

disabilities, memory disorder, and/or neurological degeneration that can be diagnosed as dementia, Alzheimer's disease, Parkinson's disease, other motor disorders.

Anything that the brain supports can be damaged by neurotoxic substances. Any toxic substance that gets into the bloodstream that travels to the brain or gets translocated through the olfactory lobe can damage the brain and damage neuropsychological processes.

Some of the barriers the workers will have to getting a proper assessment of their condition are that the doctors, the psychologists, the medical doctors and so forth may not be in tune with the latest advances in toxicology and they may not be able to connect the dots between toxicology, neuropsychology and neurology.

Another set of barriers is that the as you probably all know that toxic chemical injuries, especially neurotoxic chemical injuries are hidden or they -- it's not as

obvious as having an industrial accident or getting struck by a car.

The effects can be cumulative. The brain does not easily repair itself so the damage that low-level exposures cause can accumulate over time.

So a person may be relatively well for a number of years until they succumb to the injury and then it's more difficult for many doctors to make that connection.

The workers that I've seen have had a very difficult time getting compensation, extremely difficult. So some of the barriers I've spoken about.

Other barriers are the neuropsychological testing may not be up to you might say current standards. And the neuropsychologist may miss some of the subtle effects of the neurotoxic substances.

The types of substances that can be neurotoxic include solvents and that's one of the most common neurotoxic substances that the

workers will encounter.

One of the subjects who I evaluated from Los Alamos had heavy exposure to solvents over a number of years. And it really wasn't surprising that he had developed severe neurotoxicity yet I don't understand why it took him so long to get compensated for his injury. That I don't know.

Solvents are among the neurotoxic substances. Pesticides, metals, mercury, lead, many other metals as well as I'm not sure if the workers will have that much exposure to mold, but mold is another neurotoxic substance that we have to watch out for.

CHAIR MARKOWITZ: Dr. Singer if you could just wrap up.

DR. SINGER: That's it. Thank you very much.

CHAIR MARKOWITZ: Next is Mr. Paul Griego.

MR. GRIEGO: Thank you for having me. It's good to actually see real people and real

faces. This is kind of amazing.

I'm Paul Griego and I'm a former radiation worker. And I was in addition to working in a health physics laboratory I was involved in the 1977-1980 Enewetak Atoll Atomic Cleanup in the Marshall Islands.

And I was in the radiological element as a soil sampling crew. I was working basically at the most radioactive place on earth.

And one island for example, Runit, where we built a huge containment dome with 110,000 cubic yards of radioactive waste was the site of -- it's only 97 acres and it was the site of 17 atmospheric weapons tests.

One of those tests failed to go critical and it blew up, spreading unspent weapons grade plutonium throughout the island. And we were there to gather that up.

It was a humanitarian mission with the hopes and belief that we were going to be able to return the islands to the natives. It

was their ancestral homeland.

Well, I've been denied health screening program under the workers compensation program and the Pacific Proving Grounds have years from 1947 to 1962. Well the cleanup operation was in '77 to 1980. And it was clearly the department -- well the radiological element was clearly the Department of Energy.

I have all the documentation that the company, the contractor I worked for was contracted with the Department of Energy. It was a Department of Energy funding, Department of Energy oversight, Department of Energy, the nuclear waste itself is Department of Energy.

Yet I've been turned down because the Pacific Proving Grounds special exposure cohort stops in 1962.

So I filed a petition for an amendment to the special exposure cohort to include the 1977-1980 atomic cleanup of Enewetak Atoll with NIOSH.

And NIOSH it was my understanding is

where I needed to file the petition. Subsequently they've sent it to the Department of Labor. Their letter and they assigned it a set number and off it went.

Well, now it's in oblivion. I don't know where it's at and who to speak to, where to go. I need help. I need help navigating the procedure and being able to get the amendment to that special exposure cohort.

And what I have is not anything gray, it's black and white. I worked for the Department of Energy contractor as a radiological element. I was there 24/7. I went to the contaminated islands, the toxic islands to dig soil. I didn't have any radiation protective gear whatsoever. I didn't even have a pair of garden gloves. And we were collecting samples.

I got through the Freedom of Information Act where ERDA did a report, there's my name, and I did 235 soil samples one day. To give you an example what we were doing, working

10 hour days six days a week.

And mostly it was with military. It was about 3 percent civilians with hands on participation.

And now I'm at a point where I don't know where to go, who to talk to, what the next step is, who I might be contacted by, why NIOSH turned it over to the Department of Labor. Where do I go?

CHAIR MARKOWITZ: You need to wrap up.

MR. GRIEGO: Okay. And so I realize that the atomic cleanup was a failure but we did our best. And I feel that success has many fathers and failure is an orphan. And I am the orphan.

And my coworkers those of us, we've reconnected, mostly military through a Facebook group. We're finally getting recognition from media. We were in the front page of the New York Times earlier this year, front page of the Seattle Times. A book just got published in

September.

We're in the front cover of the American Legion magazine. At this very moment the Australian Broadcasting Corporation is doing an in-depth documentary about the atomic cleanup.

Yet my government doesn't recognize me, doesn't recognize our work, doesn't recognize our participation in the Cold War and our participation as radiation workers.

And so that's why I'm here today, to talk about our plight, not being recognized, not being able to make a claim because I'm outside of a date yet we're talking about 1962 to 1978. Plutonium has a half-life of 24,000 years. And the dome -- anyway, the radioactive waste when I was there was not much different than it was a day after the nuclear weapons test because of the half-life of most of the radioisotopes that we're dealing with.

And we drank water from a desalinization plant and later we find that

cesium and strontium is inside the coconuts. And if the coconuts which are nature's finest desalinization plant tree can't filter that out then certainly a desalinization plant by humans can't filter cesium and strontium out.

And I'm suffering a lot of ill effects health-wise and in our group it's every year we lose anywhere from eight to nine members from cancers.

And again they're military. They have access to the Veterans Administration hospital. They've got access to medical care but I don't because I served as a civilian.

CHAIR MARKOWITZ: Thank you. I need to end your comments but thank you very much. There was a NIOSH person here. I think she's left, I'm not sure. But there was a NIOSH person here.

MEMBER GRIFFON: Yes, my guess is that NIOSH referred it back to DOL to determine -- because this is probably not a covered period. And it's a question of the coverage.

CHAIR MARKOWITZ: Okay fine. So we need to move on but thank you.

MR. GRIEGO: All right. Well thank you.

CHAIR MARKOWITZ: Thank you. Dr. Sood.

DR. SOOD: Chairman Markowitz I thank you for this opportunity to make a public comment to the advisory board.

I'm board certified in pulmonary medicine and occupational medicine and the only occupational pulmonologist at the University of New Mexico and in our great state.

I routinely take care of energy workers and I am quite familiar with the problems that exist in this program.

Before I came here I reviewed the procedure manual. I also reviewed the advisory board recommendations and I also reviewed the DOL response to the advisory board recommendations on the internet. Thank you for posting them there.

I want to specifically comment on four issues. The first one is shortage of providers for energy workers and then I want to talk about asthma, COPD and chronic beryllium disease recommendations.

To begin with I wanted to let you know that energy workers in New Mexico are primarily taken care of by primary care providers. There's just not enough specialists in this state to take care of them.

Not only is there a severe shortage of providers but those taking care of energy workers tend to avoid any interaction with the division of energy employees occupational illness compensation program for multiple reasons.

I know of providers who have signs that will say that we are unable to take care of uranium and energy workers. And there are multiple reasons for it. I'm not going to go over them.

At the University of New Mexico we

have a specialized occupational lung disease clinic for energy workers. Our clinic is overbooked routinely above 200 percent of capacity and it still has a six month long wait time, a wait time that no physician would ever wish for his or her patients.

In an attempt to provide care for energy workers in their own communities we've started a novel project, which is a program to build and sustain teams of rural professionals. But obviously more needs to be done.

I want to talk a little bit about asthma diagnosis and causation. In my experience work-related asthma is undercompensated and underrecognized but a very common condition in this cohort.

I'd like to emphasize and I really appreciate the board's attempt to put together simple, practical and clearly written strategies in diagnosing asthma and establishing its work-relatedness that an average clinical provider in New Mexico can understand and use.

There are certain things that I do want to point out. For instance, using a methacholine challenge test in the diagnosis of asthma is not practical in New Mexico. There's only one laboratory that does this test and really has a three month wait time.

Bronchodilator reversibility of FEV1 which is one of the lung tests that's mentioned in the procedure manual is neither a sensitive test nor a specific test for the diagnosis of asthma.

It's not uncommon for New Mexico workers given our culture to underestimate their symptoms, to ignore the connection with the workplace and to not see a physician for years after the onset of symptoms. I really mean years after the onset of symptoms.

And it's also not uncommon for our physicians to make diagnosis years after the presentation, to make the wrong diagnosis and to ignore the connection with the workplace simply because they don't ask the question about the

workplace.

For instance, evidence of contemporaneous diagnosis of occupational asthma during a covered party employment will simply miss many cases of work-related asthma.

Further, an unsophisticated energy worker cannot specifically identify one of potentially hundreds of causative exposures or triggering mechanisms in the workplace.

Indeed most physicians including university-based pulmonologists would fail that test.

The requirements for work-related change in FEV1 peak expiratory flow rate, bronchial hyper-responsiveness, positive response to specific inhalation challenge that the procedure manual mentions to establish occupational causation are neither simple nor practical in our clinical environment.

I want to make some comments about COPD. There are multiple statements in the procedure manual about COPD diagnosis which are

inaccurate. I'll give you some examples.

A bronchoscopy is noted in the procedure manual. No one uses that to make a diagnosis of COPD.

But an abnormal diffusing capacity is helpful which is not mentioned in the procedure manual.

A diagnosis of COPD can be made in the absence of spirometric obstruction. This is also not recognized by the procedure manual.

Importantly the chronic bronchitis phenotype of COPD which in my opinion is the number one phenotype of COPD that I see in dust exposed energy workers is based upon the presence of symptoms. It's all about symptoms.

There are often no abnormalities on spirometry or imaging in these patients and that needs to be recognized in the procedure manual.

The procedure manual talks about a history of smoking and in my opinion it's irrelevant to the diagnosis of occupational COPD.

I want to make some comments on COPD causation as well. I want to point out that COPD saturated irritant and dust exposure is a very common condition that we see in energy workers.

This exposure does not necessarily have to be silica or asbestos, but it often includes mixed and poorly characterized dust such as construction dust and fumes such as diesel exhaust.

A 20-year exposure duration is set at too high a threshold when studies already indicate that five years or less duration exposures may also be substantial contributory factors.

There's something that I really liked what the advisory board said. A general simple term vapors, gases, dust and fumes.

I think as a risk factor it's well recognized by the scientific literature and certainly something that was recommended by the advisory board and that DOL did not think that

was useful. I think DOL should revise their stand on vapors, gases, dust and fume exposure.

I want to end by talking about CBD presumption or chronic beryllium disease presumption in beryllium exposed patients with sarcoidosis.

I want to tell you about my own experience with the beryllium lymphocyte proliferation test. Most insurance companies do not cover it and it costs $1,000 and most patients cannot afford that.

When we do the beryllium lymphocyte proliferation test on the lavage during a bronchoscopy and send it to Oak Ridge, Tennessee, Denver, or Cleveland the cells die. It's really a useless test in the state of New Mexico simply because the lavage fluid cells die and so you really can't use it.

Given the limited availability of the beryllium lymphocyte proliferation transformation test in the blood and bronchial lavage fluid in New Mexico and the significant

rates of false negative tests which have been well published in the literature in my opinion covered beryllium exposed employees who are diagnosed to have sarcoidosis should be presumed to meet the more likely than not criteria for CBD under part E.

Even if the results of the beryllium test are normal or in my case often the test is not performed because people can't afford to pay for it.

This is recommended by the advisory board and I wholeheartedly agree with the same.

I actually want to conclude by recognizing the efforts of the advisory board in this regard. This board represents outstanding multidisciplinary scientific expertise and I really have to tell you that you provided simple, practical, easy to read recommendations on asthma, COPD and sarcoidosis last CBD, a feat that I have to tell you unfortunately does not always happen with advisory boards.

I thank the board members for their

recommendations for these diseases and urge DOL to accept the same.

Just one final word to the division. I think you do a wonderful job. But I think making simpler rules will keep our patients in New Mexico healthier and I think it'll wind up saving a lot of money for the program by keeping it simple. Thank you so much.

CHAIR MARKOWITZ: Thank you. Next is Ms. Maxine Pennington.

MS. PENNINGTON: Thank you to the board for this opportunity to see you in person. I do want to say that I participated online and my heart was warmed the first charter meeting at the end of the day. I go there's a board that has done a quick study and has been involved a long time. Because it's always been apparent that you understand the complexities, the intricacies and the tough job you have.

But seeing you in person today I still have that opinion that you're a great diverse board and I hope that you're crazy

enough to be nominated and accept a re-up on your board position if that's offered to you. So please.

Today I'd like to address the board on basically two topics. I was a chemist at the Kansas City Plant, a non-nuclear production facility from 1981 to 2013. I was a chemist, a chemical manager, the lab manager, program manager, various jobs over the years.

But because of that I lived through the years of kind of the change in emphasis or really a big starting of emphasis on environment health and safety beginning around 1990.

But things didn't change immediately as has been brought up today.

One specific topic that I want to bring up, and I did send in this as a written comment so you probably have this in your board packet and that is the presumptions that are used from the new procedure manual exhibit 15-4 on neurosensory hearing loss.

There are three specific -- a

diagnosis of sensory neuro hearing loss in both ears. Ten consecutive years of employment in one job category before 1990 and exposure to any of the seven specific organic solvents linked to sensory neuro hearing loss.

And specifically trichloroethylene was used gallons and gallons in degreasing and other cleaning operations throughout the plant at Kansas City Plant and at other sites through 1990 that's true.

But I don't understand in these presumptions, specifically the completed before 1990.

And I provided as an attachment to my written comments a copy of a three-party agreement for the elimination of chlorinated and fluorinated hydrocarbons, CHCs and CFCs at the Kansas City Plant signed by the president of the Kansas City Plant, the contractor at that time, the president of Sandia National Labs because the design agency directs every change that happens at the plant. So that was signed by

Sandia president.

And then a high official in the Department of Energy. So those were the three parties that signed an agreement on July 10, 1990 to make a plan, a three-year plan that by July 1993 that CFCs and CHCs, the solvents would be eliminated to the greatest extent possible.

So again I ask. And during that time then there was major funding. So all of the scientists, engineers, lots of R&D projects happened at the plant using those solvents because the design agency accepts no changes of material going into a nuclear weapon unless there are lots of scientific studies, comparisons.

So 1990 to 1993 was a very, very active set of years for exposures to CHCs to the solvents.

And I'm a chemist. You would think maybe I would know but I thought the reason, all of us thought the reason was environmental. We were saving the ozone. We did not know about

neurosensory hearing loss associated.

Worker safety was not emphasized. It was the environment and how do we eliminate waste.

In fact the whole program that was funded during that time 1990 to '95 was called pollution prevention program. And environmentally conscious manufacturing. It wasn't about worker safety, it was about the environment.

So I believe that 1990 is an inaccurate year to stop for evaluating exposure to chlorinated solvents.

And in fact I did a little more homework recently and I went to the Kansas City Plant. They're still using trichlor, still have material standards, still have vapor degreasers. But there is much more worker protection now, personal protection requirement.

Then the second part of that says 10 consecutive years of employment in one job category where job is interpreted by examiners

as one job title.

The corporation changes job titles all the time. If that was meant to be that it would be evaluated based on 10 consecutive years of working with chlorinated solvents then I believe the policy should be changed to that rather than one job title.

And again this is an example and I do know from personal experience that it's a set of presumptions that should be positive but it's used in a negative to deny or make a recommended decision of denial and with no referral to industrial hygiene.

CHAIR MARKOWITZ: I'm sorry, it's time to wrap up.

MS. PENNINGTON: Okay. The second is asbestos and beryllium, very common in the literature to have lots of occupational medical studies.

There are many toxic substances that were specific to nuclear weapon production. Things like polychlorinated biphenyls and that

went through way past 1979 when the transformers were taken out. It went into the nineties, lots of polychlorinated biphenyl.

Lots of other mixtures that individually there are recognized human carcinogens by NIOSH and others. But in the review of the cases of our plastics workers because there hasn't been a specific to a chemical compound or element, to a specific target cancer those claims are being denied.

So my question is I understand it's a very difficult task, but in the absence of common epidemiology studies or occupational medical studies how can these folks who obviously a high percentage have developed cancers after working in plastics production at our plant be considered.

CHAIR MARKOWITZ: Thank you very much. The next speaker is Jan Martinette.

MS. MARTINETTE: Thank you, thank you. I'm so impressed with all of you and I've been in a lot of committees like this over the

years in politics and everything else. And I know it's a difficult thing because you're always making enemies some way shape or form, right?

Anyway, I hope you all are going to make some good friends here because we've got problems we need you to help us with. And I've been taking notes all day and they're not very organized so I won't be very organized, I'm sorry.

My husband worked at Kansas City Honeywell Plant for 44 years. And he died 10 and a half years ago and I have not gotten one penny. And I have filed and filed and filed and filed and gotten denials and denials and denials.

I don't understand it. But here are some of the things that have happened that you might be surprised about.

Actually what he did there, the two main things first of all was plastic chemicals. His department made molded plastic foam. You

know how your dishes come in plastic foam squares. Well that's what his department did to ship the bomb parts that were being made in the Honeywell plant.

And so there's a professor at Missouri University that did publish and do research that says do not heat plastic baby bottles. Well here they are making plastic foam squares, having to put I don't know exactly because I wasn't there and I'm not supposed to know but a hot thing down in that plastic that's the shape of the bomb part to melt it so that those parts would fit in there and not rattle around in the shipping to the other plant and probably even in the bombs, I don't know.

But anyway, his whole department would have to stand in that room and make sure that the temperatures were right and the chemicals were right, that they had their little box the right size and the right mold and put it down in there hot as it could be and that whole room -- this is what I heard from all of them --

the room turned brown, the walls were brown, the ceiling was brown, the ventilation system was ruined, the floor was brown. They were a mess.

And they had no protection. They didn't give them anything to wear or breathe through or anything.

He did that for 44 years and these other guys with him. And several of them died right away. And then one of the little incidents that I didn't find out about until after he died is he'd had to travel to these other plants to make sure that when their parts got there they were safe, they were whole and not broken, and that they fit where they were supposed to fit.

Now some of these plants had the uranium in them and the dangerous chemicals there. Some didn't.

But he traveled a lot and I have not gotten credit for that. They told me oh no, he didn't get enough exposure when he went to all these plants. Well, pardon me. But anyway.

So he would go to all these plants and make sure everything was done right and then come back and start all over again.

Well, there was one right down here, Sandia. I didn't know till after he left and I happened to find his travel vouchers. In 1970 he had to take a trip in a private vehicle it was mentioned and he and another one of his coworkers that worked for him in that department took my station wagon to Sandia full of chemicals because the mold down here at Sandia was bigger than the one in Honeywell. They couldn't use the one in Honeywell. Had to take it down there because they couldn't depend on the airlines getting it there before the half-life was gone or whatever.

Now I never knew that till after he died. I even carted my kids around in that station wagon for all these years also. And I did get cancer in '81. I don't know that it was part of that and I've never looked into it. But I was so shocked I couldn't believe it.

But anyway I'll go on to the next thing that I really feel was really detrimental to his health was that he got a contract from DOE. He was the supervisor of this department. Got a contract from DOE saying that the PCBs in all of their lines in the plant that were supposed to lubricate the parts or whatever they do with them, I'm not supposed to know but maybe if I tell everybody you'll put me in the penitentiary and I don't need my claim, right.

Anyway, so they told him that the PCBs were so carcinogous and had been there of course forever coming through those lines that they needed to be diluted 50 percent.

Now it was his job and his people in his department that were to get all of the PCBs out of that line, drain the lines, and then put the new stuff in that was 50 percent diluted.

So they got that done with no big problem. Okay. Fine. A year later guess what? A new order from DOE saying well, that wasn't enough. It's still too carcinogous.

Now I don't know how much of the whole plant was getting exposed to this but his department especially because they had to drain the lines again.

Well, they were having trouble with it and so one Saturday he and one of his best employees in the department and a plumber came in on Saturday to drain the lines because they were getting clogged.

The stuff in any kind of a dip was thickening and they couldn't get the stuff out. So of course they had a big barrel down here, the lines were the whole length of the building or whatever it was and they started putting pressure on the line.

Well you know what happened. When it broke through all three of them got completely drenched. I have not gotten a cent.

And the poor dear person that had worked in Gary's department, he's still alive but he's a vegetable. But my husband's dead 10 years ago.

Okay, now why am I not getting the credit that I need. I decided about five years in I can't stand to live the rest of my life under this pressure. And I re-signed up. And here I am, pressure. My doctors are saying I've got terrible depression. Well, too bad. I can cry if I want to. I'm sorry?

CHAIR MARKOWITZ: I'm sorry to interrupt you but we really need you to wrap up your comments.

MS. MARTINETTE: Well, okay. But I don't know why I cannot get the claim. I have the same toxicologist supposedly. Every denial. Every denial. I keep filing.

And the person who signs the denial will not tell me who this toxicologist is.

CHAIR MARKOWITZ: There's some people in this room here. I don't know how much contact you've had but I suggest you start with them.

MS. MARTINETTE: I have had contact with everybody under the sun and I don't know

why. And I've done research like crazy. The PCBs are cumulative. They will cause any kind of cancer. They're trying to make me find research that says one chemical causes one cancer and that's not true. It's not the way cancer works.

And then, one more thing. I asked for a legal hearing which we're allowed to do. We got everybody in there and two weeks ahead the gal in charge of the hearing called me to tell me what was going to happen.

And I said now you've read all my stuff, yes. No, but I'll get it read in two weeks. I said ma'am, I wrote it. I can't read it in two weeks.

Anyway, she shows up, makes a comment that she thinks that this molded plastic foam has bread mold on it. Thank you for listening.

CHAIR MARKOWITZ: Thank you. Next speaker is Ms. Cathy Turpin.

MS. TURPIN: Welcome everybody to New Mexico. There's people that have come from far

and wide. I'm a native New Mexican so it's my right to welcome you to New Mexico.

And also to thank the board for all their diligent effort and all the work. So I've looked online at the SEMs and there's been a lot of work done and there's a lot of work to do.

And so thanks to everyone who's come. Sorry I get sidetracked. Anyway, so that's a short and sweet.

And so some of the things that I had put have already been addressed like list of afflictions, diseases, conditions, whatever you call them that people can refer to. And it sounds like the experts have referred to those.

So, short but sweet but there is, boy, the task is insurmountable. So thank you.

CHAIR MARKOWITZ: Thank you very much. Next is Ms. Terrie Barrie.

MS. BARRIE: Thank you, Dr. Markowitz and members of the board. My name is Terrie Barrie and I'm a founding member of the Alliance of Nuclear Worker Advocacy Groups.

I want to thank all of you for your intense work that you've done over the past 18 months or so. It's impressive. I am in awe of all of you.

The Department of Labor and the EEOICPA stakeholders could not have asked for a better board and I am sure that Secretary Acosta values the expert advice that you give to him and will reappoint all of you in the near future.

I'm worried that DEEOIC may be inadvertently duplicating some of the board's responsibilities that are explained in the statute and they're in your charter.

For instance, and you've mentioned this during the discussion today, the DEEOIC medical director had conducted audits of the CMCs. This is laudable. I have no complaint about that.

However, the statute and the charter requires that the board conduct -- to advise the Secretary on the quality, objectivity and

consistency of the CMC reports.

Additionally, the revision to the procedure manual includes a section that the DEEOIC toxicologist and I quote will determine if an individual claim evidence should be applied broadly as programmatic guidance and decide if it warrants the establishment of a new health effect or a modification to the causative threshold applied to the program guidance, end of quote.

This too I believe, and I might be wrong, but this too I believe falls under your responsibility especially since DEEOIC has requested the board to advise on presumptive diseases.

It's been mentioned also that you do put in a lot of time and energy into this. And you do need support staff. Michelle Jacquez-Ortiz from Senator Udall's office mentioned that you'd be provided with a technical contractor to assist you similar to the one the NIOSH board has.

And I concur. You do need this. Someone to go over the SEM step by step. Someone to look at the IH reports and report to you.

Department of Labor obviously can do the same thing. They can do their review. The technical contractor can do their review and report to the board and then you discuss and decide and advise.

NIOSH's board does something similar. The dose reconstructions, they take 10 I think at a time, 10 sets and go over the dose reconstruction. They review it and report to the board and discuss.

Something similar I think like that can happen.

The problem is that the resources, the money is always an issue. But I think that if the Department of Labor puts technical contractor in as a budget line in next year's fiscal budget request Congress will consider it.

And an alternative in the time being

till that is done I'm sure that the Secretary could expand the role of the ombudsman's office to assist the board. They also have very talented people, detail oriented and I can't speak for the ombudsman but he's highly qualified and knows the program and knows what is needed.

So thank you for your time and I hope to see you next spring.

CHAIR MARKOWITZ: Thank you. Next speaker is Mr. Eric Bustos.

MR. BUSTOS: Thank you board members for being here today and welcome to New Mexico. I worked for Los Alamos Laboratory for probably seven years. My father was a plumber there and he died a year and three months ago from liver cancer. That was his determined cause of death.

Two weeks ago we were supposed to have a meeting with NIOSH and it was scheduled. We never heard from them. Still to this day we haven't heard from them.

Our advocate was there. We were at

her house. We were waiting for the call. Never showed up. Never got there. She called three times from there. We stayed there two and a half hours. Nothing ever got happened about that.

Probably three months ago I got diagnosed with liver cancer myself. And I worked for parks and recreation up in Los Alamos for 11 years. Moved a lot of dirt, a lot of field work that we were there.

They haven't determined how I got it but I have it. And I just want to know why nobody has contacted us in this situation. And that's about it.

CHAIR MARKOWITZ: Thank you. Our next speaker is Ms. Stephanie Carroll.

MS. CARROLL: Hello. Thank you for all your good work. I am just so pleased that the board was mandated.

And I agree with Terrie about you needing some technical assistance. And it was mandated in the act. It reads the Secretary may

employ outside contractors to support the work of the board. And I hope that that gets enforced and that you do get the help that you need.

I just spent the last two days with the beryllium health safety committee. There was a beryllium symposium, it happens every four years so it was very interesting and we did talk about the borderline BELPTs.

Now one thing to keep in mind is that the law actually doesn't call this test a BELPT. The BELPT was -- it is a test that was patented by the University of Pennsylvania. Dr. Rosfam was the lead in that. So that test is not a lymphocyte proliferation test that is discussed in the act.

So one thing that could happen is that a physician could look at the test results of a lymphocyte proliferation test, not the BELPT, and determine that it's abnormal.

The stimulating index doesn't have to be -- it doesn't have to be the BELPT that is

abnormal. So if a physician finds a lymphocyte proliferation test abnormal that should qualify for beryllium sensitization.

One of the things that has also happened is Dr. Sara Clarke spent six years studying Rocky Flats workers and performing lymphocyte proliferation testing.

Once she passed away all of her information was pretty much buried. I had to FOIA everything. I couldn't find much on Sara Clarke. But I did find letters that were sent to the workers telling them that their lymphocytes were responding to beryllium which proved that they were exposed to beryllium in their jobs.

These letters were hand delivered or sent to the workers because when I ordered the Department of Energy records I never get this letter. It's like everything was destroyed at the site.

So some of my workers do have the letter.

There is a policy at EEOICPA Department of Labor that they will not accept any of her reports saying that there is a lymphocytic process showing exposure to and reaction to beryllium.

They won't accept it. I don't know where the policy is written. But if you send in one of these reports it won't be accepted as consistent with beryllium sensitization.

The new procedure manual I completely object to. If a new procedure manual is going to be put into place I think that everything in writing that has been produced for a policy should be kept online. That means every bulletin that has ever been written. Because we have 10, 12 years of policy for some workers that now is no longer in existence.

So I would like to see everything that has gone into policy for this program to be put online, especially the telephone conference calls.

I have one here from 5/11/11. It

doesn't need any redaction because no telephone conference calls have personal information on them.

But this one was a question concerning the existence of CBD under part E. A physician narrative. They were quoting the procedure manual at that time saying that a part B final decision under EEOICPA approving beryllium sensitivity or CBD is sufficient to establish the diagnosis and causation under part E.

However, if there is no part B decision a positive LPT result is required to establish a diagnosis of beryllium sensitivity and a rationalized medical report including a diagnosis of CBD from a qualified physician is required to establish CBD under part E.

That is completely unfair. It's inconsistent with the intention of Congress to have the part E chronic beryllium disease claims have a different diagnostic criteria than everything else under part E for this program.

So to require a BELPT to have a physician supported diagnosis of CBD approved under this program under E is completely unfair. It's arbitrary. It's capricious. Especially if you compare it to the Norman case that was won by an attorney in New Mexico.

So the question was from the national office in order to establish CBD under part E is a positive LPT always required. Does the individual have to establish beryllium sensitivity or can the individual present a qualified medical opinion of established CBD.

They came back and said you must have an LPT, a positive BELPT, and you also must have the diagnosis with the well rationalized letter from the physician.

This is the other thing. Under part E a sarcoidosis claim should be able to be approved. Sarcoidosis should be under SEM. It is nowhere in SEM.

If sarcoidosis isn't under SEM then a granulomatous lung disease should be.

Sarcoidosis is found to be caused sometimes by titanium and other metals. Those cause granulomatous lung disease. It's nowhere in SEM.

The other thing I found was old SEM reports actually have references to a library that DOL has in support of every one of their SEM reports.

So if you do have a question about old SEMs that are discussing asthma or COPD you can request the references in the documentation that provided the information for SEM. Of course that was gone when it was made public, all of that library is not accessible to us. But I have a few of those. I'll make sure you get a few copies.

CHAIR MARKOWITZ: Ms. Carroll, start to wrap up.

MS. CARROLL: Okay. The other thing, one more thing. During the meeting yesterday Bill Stangie, Jackie Rogers, Dan Fields, Dr. John Price and Paul Womback, Kathy Creek from

Los Alamos, we were talking about getting statistics for each site's beryllium sensitization claims and chronic beryllium disease claims approved by year.

That can happen because under an SEC they go into the computer, they put an ICD-9 code in and they can make reports of approvals for certain illnesses. It's easily done.

So we need to do that. They all went to Washington, D.C. requesting that they can get those stats because it will help with the former worker program. Bill Stangie really wants those statistics. I would love to see them.

And it will also prove that this procedure manual and the changes in policy have had an effect on how many people are approved for lung disease and especially chronic beryllium disease and BES which I am completely interested in.

So thank you very much. I appreciate you all being here and allowing me to speak. And I would love you to help get those stats.

Bill Stangie and all would be very interested. Thank you.

CHAIR MARKOWITZ: Thank you. Is Ms. Priscilla Covis here? So next will be Mr. Rendell Carter.

MR. CARTER: Thank you, Mr. Chairman and committee. I appreciate the opportunity to speak.

I am a claimant. I have been diagnosed with light chain deposition disease and if you'll indulge me, I know this isn't a question and answer, how many of you have heard of light chain deposition disease?

It's a very rare condition but it's tightly related to multiple myeloma. It's often a precursor.

It was discovered because my kidney function had decreased to 50 percent and my primary care physician insisted on following why I have a trend of decreasing kidney function over the past three years.

In fact if you project my kidney

function decline if I had not received treatment it would have declined to the criteria to meet multiple myeloma within one to two years or if you believe my nephrologist within six months.

However, I also qualify for smoldering multiple myeloma because I have a plasma cell population of 10 percent. And I have no myeloma defining events. The kidney damage is not sufficient to qualify as a myeloma event. Therefore I don't qualify as full or symptomatic multiple myeloma.

So having gone through this process it was very confusing at first and one of my biggest concerns about this process is it's very hard even for a research scientist as myself at Los Alamos, I've been there for 34 years, it's difficult to navigate as a lay person.

Initially I was diagnosed with multiple myeloma because my physician misunderstood the criteria. And so that's what I applied with. I applied with light chain deposition disease/multiple myeloma.

Along the way the claims examiner without giving me sufficient time and didn't know what kind of evidence they needed, I submitted all my lab reports.

Without giving me time to respond or get my physician to respond he sent it to the contract medical consultant and asked him only two questions. Is this multiple myeloma and secondly is it a cancer.

And technically it is not either one of those. Even though they are caused by the same underlying condition and the only difference between smoldering multiple myeloma and light chain deposition and fully symptomatic multiple myeloma is the level of bone marrow cells involved, their percentage, and a myeloma defining event.

So it's easily demonstrated that within two years I would likely have qualified, but I've been denied the claim.

My other concerns. It would stand to logic that if the same cause causes multiple

myeloma in these other immunoproliferative neoplasms that it would be equally likely that they would be caused by radiation as multiple myeloma is.

Yet that logic which stands to reason is not accepted as a reason for a claim.

Secondly, because my disease is very rare there needed to be more dialogue between the claims examiner and perhaps the contract medical consultant.

I went to MD Anderson to get the best treatment I possibly could. I had two physicians even write a letter stating this relationship and yet it was never shown to the contract medical consultant in the first place.

Secondly, he wasn't even asked what's the likelihood of this disease being caused by exposure. And by the way I'm also in the beryllium monitoring program for the same exposure reasons as well as I was exposed to solvents.

But there is not an occurrence in the

matrices that the Department of Labor uses between light chain deposition disease and those exposures.

So secondly, there's a lack of interchange in order to fully develop the case.

Third, I have been told by the final adjudicator in the process of appealing which is pending that my research that I supplied with peer reviewed journal article reference and citations was not enough. That I needed my doctor basically to supply the same information in a fully rationalized meaning citations and peer reviewed work.

Unfortunately these doctors are extremely busy and they don't get paid to write these extended descriptions. And so I feel that's -- I think the burden should be on the Department of Labor to refute my physician's opinion, not the other way around.

I did find thanks to the ombudsman recommendation last night that in the procedure manual there is in the matrix 17-7 a reference

to cancers, multiple myeloma, and other immunoproliferative neoplasms.

Yet that connection was never made by the claims examiner or the CMC or anybody else.

So I think I have grounds for an appeal and I will try that.

So lastly, and I'm almost done, it has been very difficult to find information about how these decisions are made of what is a special cohort, why it was made a special cohort and furthermore what a physician would have to do to suggest that I qualify for one.

And also, what conditions have been considered for special cohorts but have not been found. So navigating this system has been very difficult for even a research scientist and a layman.

And I have not gotten an authorized representative because I thought it should be navigable by an ordinary citizen. And it appears I'm going to have to get more resources.

CHAIR MARKOWITZ: Thank you. If you

have a moment after the meeting one or more of us may want to talk to you.

MR. CARTER: Certainly. And I have a written letter that states this as well as some of the supporting evidence that if there's a place to submit that. Thank you very much.

CHAIR MARKOWITZ: Next up is Marla Ortiz Gabriel Dunn.

MS. ORTIZ: Good afternoon Chairman and members of the board. Thank you for this opportunity today.

I'm here to speak with you about my dad's claim. My dad worked for Los Alamos National Lab. His name was Dan Ortiz and he became ill after working with toxic substances during his employment.

After leaving the lab on a mandated medical retirement and despite having worked tirelessly to help establish this very program actually he became a victim yet again of the bureaucracy of the DOL claims process.

And I just want to briefly recap what

he and I and our family went through to get his claims processed.

Initially he filed his claim in 2002. I don't remember the exact date. I think it was late 2002. And I began helping my dad as his authorized representative in about 2004.

Luckily I was at a time in my life where I had time to be able to help him navigate a very difficult process.

What we experienced from time to time was my dad's file being misplaced. It got transferred to different district offices. We were never told about it so we'd follow up with one office and after many, many days sometimes they're saying oh, now it's in Seattle, and oh, now it's in Washington, D.C.

Other times it was reassigned to other claims representatives. It was always just starting from the beginning because they weren't familiar with the claim. We couldn't just keep it rolling smoothly.

So despite my dad having over 20

years of compelling medical records and supporting documentation, evidence that supported the claims of his medical records he was denied every single time. At least the initial claim was denied.

And not trying to be negative here but we often did think that DOL's default response was just claim denial.

And these are the words that kind of come to mind when dealing with the claims process. It was confusing. It was complicated. Frustrating, disheartening and discouraging.

And I really feel for people that don't have an advocate that can help them because I don't think my dad could have done this on his own. Or it would have been very, very difficult for him.

I was in college at the time. Fortunately I was in a kind of academic mindset so whipping out an appeal letter was pretty easy to do. Figuring out the compensation packet was pretty easy for me to do, but not everybody has

that type of person that can act on their behalf.

After a decades long road of suffering injustices and declining health my dad's DOL claim finally about five and a half years later he did receive full compensation for his claim. And my dad finally had a moment of peace after as I said many decades.

But it didn't end there. The claims dysfunction continued unfortunately. In 2013 my dad's illness really began accelerating and he was eventually approved for 24/7 home healthcare benefits.

And I want to touch upon a few of what we experienced there. My parents' home has a lot of steps so he was approved or actually they put in claims to get ramps installed in my parents' home. And my mom had to pay out of pocket for portable ramps inside because the claim was initially denied.

There were some outside elevation differences and those were more of a

construction project.

And my dad got to use the outdoor ramps one time, his final return home from the hospital. I don't even think it was a week before he passed away.

Additionally we were trying to get a shower remodel, a walk-in shower so that we could put my dad in the shower, or actually wheel him into the shower. And although that claim was approved for the work it was difficult to find a contractor. They got caught up in I guess the vendor system to work with DOL to get that to become a DOL vendor.

And my mom had to change the contractor that she chose because there was somebody else who had already been through the process and so they were able to navigate it a little bit better.

It was very late in the game however at that time. And although the contractors were there working on making the renovations it was two days after my dad passed away that that was

finished.

So he never even had the opportunity to use the shower.

This is why I have come before you today because submitting a legitimate DOL claim should not be this difficult. Injured workers should have a much more streamlined process and not have to endure yet additional stress and anxiety.

And I just want to get a little personal perspective of my dad. I think about how happy and excited he must have been to have been offered a job at Los Alamos back in the day. I was six months old. That was quite a while ago.

And he must have thought what a promise of a good salary, the potential for professional growth, benefits, everything that a young family man could dream of.

And never did he think that his job would cost him his health and ultimately his life. And that is something that none of us

should ever have to experience in the pursuit of happiness.

I respectfully ask that you streamline the process to accept the recommendation of the board as they have a wealth of expertise in these types of issues.

And the claimants have endured enough and should not be subjected to a very difficult and arduous claims process. And I thank you all for listening.

CHAIR MARKOWITZ: The next speaker is by phone actually, it's Ms. Donna Hand.

MS. HAND: Yes.

CHAIR MARKOWITZ: Welcome.

MS. HAND: Thank you very much. Thank you board for being there. We're trying to make it brief since I know it's been a long day.

I want to correct something that -- just about the recommendations of number 4 in the Department of Labor's response.

It says at least as likely as not

that exposure to a specific toxic substance. Specific is not in the statute at all nor is it in the regulation.

What it says is exposure to a toxic substance was a significant factor. Not just significant, but a significant factor. And they define significant factor as meaning any factor.

So you've got to go by the definitions that's already been established back in 2000, 2001, 2004 and in 2005. So these are definitions that's already established by the statute which is binding.

So there is no specific toxic substance that's required and a significant factor meaning any factor.

Also the toxic substance is defined as any material. So ionizing radiation. So any material that has the potential. It doesn't have to definitively do it. To cause illness. It doesn't say what type of illness. To cause illness because of its radioactive nature, its chemical nature, or its biological nature.

These are definitions that are very binding. So whenever you look at any SEM or toxic substance or relation to that you have to take into consideration this is what Congress -- this is what the statute said.

The Secretary also at her discretion to put into the regulation, they give their own interpretation at that time which makes it binding also because it's in the regulation.

So policy is not. Policy has to be discretionary. You cannot mandate.

You also have work-related. This exposure comes out of work, arise out of work. So it's not labor category. It's just like what more is there to say.

We have assemblers that assemble parts but that part of their assembly had to go into a furnace. So at that point they're exposed to asbestos. Asbestos isn't just in the ceiling and the tile and the pipes. They had the vermiculites that cleaned up mercury. They had the creosotes. It's a form of silica is a

form of asbestos.

So you can't just narrow it down to a specific time, labor category, or chemical. And that's not what was required by the statute.

Also doing a lot of the programs at the facility they added on square footage. While they were adding on square footage the products was still going on. They didn't stop production.

So when you've got this going on as well, all these dust, fumes and vapors going on while they were still working on the product. So they were exposed that way.

And we're having a lot of diagnosis from pulmonary doctors saying they have COPD/asthma. They have COPD/bronchitis. They have COPD/emphysema. And Department of Labor is not coming back to us and saying we treat those as two separate illnesses. We have to have two separate diagnoses. It's a pulmonary disease. And this is what the doctors -- it's pulmonary specialists are diagnosing it as.

Just briefly is that the exposures for all the other illnesses that you're going to accept so you have to go by the criteria of the statute.

It says in any other case a contractor employee shall which was mandated be determined for purposes should have contracted a covered illness through exposure at a DOE facility if it's at least as likely as not that exposure to a toxic substance was a significant factor in aggravating, contributing to or causing the illness.

And again if you're using work asthma you have to see a trigger. What about the childhood asthma that then was aggravated by the chemicals that they started working at? You're ignoring that part of the worker's claim.

And then the second part of this is it is at least as likely as not that the exposure to such toxic substance was related to employment. And so did it arise out of work.

And the regulations which the

Secretary used at their discretion defined exposure to mean did they come in contact with it.

And at the very beginning of the program in 2005, '06, '07 and '08 was it plausible. Did they have the potential. It doesn't have to be 100 percent exposure, was it plausible. Did they come in contact with it. That was all that was required.

I'll have other issues such as the work day, the work day one single shift. If you do it for five years, well if they worked 60 hours a week or more you may have one year as far as we're concerned really be two years' worth of work. So that issue there needs to be addressed.

I thank you again for your time and I will send an email out and hopefully it will be put on for everybody to read about the other issues and concerns.

And again thank you, thank you, thank you to the whole board. We really appreciate

you.

CHAIR MARKOWITZ: Thank you, Ms. Hand. Ms. Vina Colley on the phone.

MS. COLLEY: Yes. It's been a long day and I couldn't hear all the conversation because there was such bad reception but my name is Vina Colley and I am with Nuclear Whistleblower Alliance, National Nuclear Workers for Justice and Craft for Residents and Environmental Safety.

And first off I want to say I appreciate having this opportunity to speak again. And as in the past I would like to invite you to Portsmouth, Ohio and Paducah, Kentucky. Paducah facility and see how these workers are being left out of the process.

I would ask the board why has DOE excluded from their respective TBDS the processing of the Russian uranium at Paducah, Portsmouth and Allied, Honeywell and especially since the U.S. Senator Mitch McConnell, DOE and my representative in Ohio were all aware of this

transition that DOE and this uranium 1 Russian uranium that came to our site.

When were they going to tell the workers about their exposure?

I also heard people on this line talking about CPD oil. And in our facility the CPD oil that was leaking from upstairs, from I don't know where, but that CPD oil was radioactive oil.

And at our site they took CPD piping and put it up along the duct work around the top of the facility to catch this oil. And there was a congressional hearing telling Senator Glenn and after he contacted us are you sure that that is just regular oil and it's not radioactive oil.

So what has happened, these workers have been in these buildings and this oil has been leaking with radioactivity the whole eight hours that they were on plant site. So whoever goes around and picks out one certain chemical that we were exposed to. And then they'll send

me 20 other chemicals that I was exposed to. But still it's not causing me no problems.

And another problem with this program is the consultants are not getting our records. I had a consultant say that I worked at Paducah. I've never worked there.

He also said that I smoked a pack of cigarettes every day for 20 years and I've never smoked.

And he also said that he didn't have any records in his file that said I had pulmonary edema. So they dismissed my pulmonary edema.

So now I've had to get an attorney to help me with my claim. The statements of cause are never accurate. The DOL denies all bases on inaccurate and erroneous information written into the recommended decisions and the hearings.

And I also have to mention about the yellow tape. So all these sections they had a radiation leak they put yellow tape around it as if the radiation would stay inside that tape.

And I want to go back and mention the tape from Russia. After the cutoff none of these workers and none of us were told about the downgrading of Russian uranium. So I'd like to know how the board is going to address this. Are we going to open up every claim that's tied to Paducah, Portsmouth and Honeywell and Indianapolis. We need answers.

And we need you to come to our community so we can ask the answers and you can talk to people. People are having problems again I talked to a lady yesterday. Her father-in-law died of lung cancer and they can't even get survivor's benefits. The program is so screwed up.

I appreciate all the work that you guys are putting into it but it seems like to me that someone's making a lot of money because the workers are dying and they're not getting their compensation.

This program now is 17 years down the road. I've been working at this since 1987 and

I filed a complaint about our facility in 1983.

So why is it taking so long to get these workers compensated. It's ridiculous. The government admitted that they made us sick, and they admitted that Portsmouth and Paducah wasn't told that we had plutonium. And we've had plutonium since 1953.

When they finally come out with it after we broke the story, four whistleblowers from Paducah, myself and Mary Burke Davis, they admitted that they had plutonium at the site and they admitted that they made us sick. And they had a press conference saying they were going to help us.

Why aren't they helping us? You still there? Hello?

CHAIR MARKOWITZ: I'm sorry, I need you to wrap up your comments.

MS. COLLEY: Well I want to ask again that you come visit the sites at Paducah and Portsmouth and let's find out what's going on. Why aren't these workers getting compensated.

How can you tell us that you exposed us to plutonium and then turn around and ignore your own facts and findings, the Department of Labor and Department of Energy find their own facts and findings that we have plutonium.

And they also admit that we have recycled or downgraded this uranium, highly enriched uranium from Russia. So when are we going to tell the workers. What have you told the workers because I haven't heard anything about it. Thank you very much.

CHAIR MARKOWITZ: So we're running late and we have one last speaker so if it's all right with the board I'm going to ask is Mr. Gary Van der Boegh on the phone?

MR. VAN DER BOEGH: Yes, he is.

CHAIR MARKOWITZ: Okay. So we have five minutes if you can restrict your comments. We'd appreciate it.

MR. VAN DER BOEGH: About three more minutes I get it's a DOE meeting. Always a pleasure. You all are doing a fabulous job.

You know that I have to tell you all straight up the truth. And I do appreciate all the people who are making comments today. You all are as I've said in emails to you all all throughout the day that I could. I'm kind of homebound with bronchitis myself today. I'll try to get through this. But I've got enough documentation to you to show you my concerns.

All of you have to realize I'm the only sick nuclear worker that's an authorized representative that so far has gone out himself and classified himself as AR-C-0001 for a reason.

We're not intimidated by anybody. And when I say we are not, we are the workers of Paducah Gaseous Diffusion Plant that for some reason as Ms. Colley has mentioned are being denied their due process, number one, and their statutory regulatory claims which are obvious to everybody even when we hold hearings it's laughable.

So if you all want to sit in on a

hearing where you've been asking the very questions that we've been documenting at the hearing the claims examiners do the best they can with what they've been told to do. That's it.

We know where the problem is. I'm a Lockheed Martin former employee. I don't work for Lockheed but how in the world would anybody ever want to have their claim reviewed by a Lockheed Martin subcontractor who was acquired by Lockheed for the purposes of this very reason to deny your claims based on their own medical opinions and not even look at the records.

Go to the Charles Stone v. DOE and 12 other CBD claims and you'll see what's going on. This is not funny anymore. We've got dying workers. I'm getting sick and tired of having to put in front of a staff hearing officer. Mr. Gerard O'Hara you should be ashamed.

When RSV Trucking is hauling uranium all over the United States out of Paducah and all over across the river we never knew it. I

didn't know it. It started in '92.

And watch Tucker Carlson on November 2, 2017 and the cat is out of bag.

Dr. Markowitz I want to thank you. You've always been there whenever I've had a chance to contact you and talk with you.

We're not getting paid for beryllium. It doesn't matter if you have all the criteria. Look at the claims. The CMCs are hired to refute their own -- and they're not even seeing the medical information. Go to Charles Stone. That was in the record. We got attorneys involved.

It's shocking and it's shameful. Now if you go back and look I've already uploaded all of this a year ago on December 21 to the President of the United States.

I'm not afraid of going to Congress, people. Just don't be afraid of communicating the truth. If you're really involved in exposing a problem then understand the statutes are the requirement. They're not some rule even

in the Bingham case. You're not supposed to be waiving the statute because somebody decided that Gary Van der Boegh won three CBD claims and now President Obama had to stop the claims.

And we've got a senator in Kentucky that quote controls the claims. Dr. Markowitz and the board I want you there for a long time because we're now Nuclear Whistleblowers Alliance and we're at Rocky Flats working with Allied Chemical in Paducah, Kentucky.

Thank you so much. You're going to hear a whole lot more.

CHAIR MARKOWITZ: I just have a quick question. So we'll go tomorrow 8 to 11 so we'll start at 8. But does anybody have a plane flight between say 10 and 1 tomorrow? That's what I'm trying to figure out is when you have to leave. 10:30? 10:30.

Okay. Also in case you need to get rides with each other I suggest you be fully packed with your bags ready. We can work out tomorrow or even work informally tonight to

figure out how to get to wherever you need to go.

So what time do both of you need? Okay. The meeting is adjourned. We'll figure this out.

(Whereupon, the above-entitled matter went off the record at 6:15 p.m.)