

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

+ + + + +

THURSDAY
NOVEMBER 15, 2018

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The Committee met in the Room S-4215,
U.S. Department of Labor, 200 Constitution
Avenue, Washington, D.C., at 8:43 a.m., Steven
Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

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

MEDICAL COMMUNITY

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

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KIRK DOMINA
RON MAHS
DURONDA POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

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

8:43 a.m.

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

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

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

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

4 Copies of all meeting materials and
5 public comments are or will be available on the
6 Board's website under the meeting headings. The
7 Board's website can be found at URL
8 dol.gov/owcp/energy/regs/compliance/advisoryboard
9 [.htm](http://dol.gov/owcp/energy/regs/compliance/advisoryboard) or you can simply Google Advisory Board of
10 Toxic Substances and Worker Health.

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

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

22 The FACA requires that minutes of this

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1 meeting be prepared. The minutes of today's
2 meeting will be available on the Board's website
3 no later than 90 calendar days from today, per
4 FACA regulations. But if they're available
5 sooner, we'll have them up on the website before
6 then. We'll also be publishing the full
7 transcripts, verbatim transcripts of these
8 meetings, and they will also be put on the
9 website.

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

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

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

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

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

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

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

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

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

23

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MEMBER BERENJI: Okay.

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

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

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

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

19 MR. VANCE: Yes, they maintain data on
20 all public submissions, and you can actually get
21 an update on the data status, what they're doing.

22 And then we actually have a contract manager who

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

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

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

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

23

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

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

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

6 MR. VANCE: Yes.

7 CHAIR MARKOWITZ: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MR. VANCE: Great question. So --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 MR. VANCE: Right.

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

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

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

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

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1 MR. VANCE: Yes.

2 MEMBER MIKULSKI: -- the public?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 MR. VANCE: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 the site exposure matrices.

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

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

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1 and search on through the Site Exposure Matrices.

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

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

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

17 Yes?

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

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1 MR. VANCE: Right.

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

7 MR. VANCE: Right.

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

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

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

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

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

8 MEMBER REDLICH: You have a job title.

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

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

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

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1 standard that the claims examiner can establish
2 in the case.

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

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

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

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

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

3 CHAIR MARKOWITZ: And which seven do
4 they choose?

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

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

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

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

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

22 MR. VANCE: And that's what the

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

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

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

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

3 CHAIR MARKOWITZ: Sure. Thank you.

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

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

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

15 MR. VANCE: Well, all I --

16 MEMBER POPE: To develop more
17 information.

18
19 MR. VANCE: What I can say to that is
20 just that, you know, we do collect information
21 from lots of different sources, and I would say
22 that my recommendation, whenever I'm talking with

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

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

6 MEMBER DOMINA: And when we were just
7 talking about Rocky Flats earlier where those
8 5,000 boxes that people know have been hanging
9 out there for at least two years. So could those
10 boxes be sent to Paragon to go through to look
11 for chemicals and stuff? Because obviously NIOSH
12 isn't going to do it. And to me, that stuff is
13 doing the claimants a disservice when we know
14 that there's potential information in there that
15 could help them on their claim, you know. It
16 could be the same thing at Hanford because when I
17 look at this I see all kinds of shortcomings.

18 MR. VANCE: Right.

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

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

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

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

23

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

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

6 CHAIR MARKOWITZ: Dr. Cassano?

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

22 MR. VANCE: Now, the industrial

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

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

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

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

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

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

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1 establish that causation threshold.

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

4 MR. VANCE: That's correct.

5 MEMBER CASSANO: Okay. Thank you.

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

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

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

7 MR. VANCE: Right.

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

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

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

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

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1 about what we know welders were doing at Rocky
2 Flats.

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

22 And, again, getting back to what we

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

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

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

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

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

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

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

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

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

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

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

6 MR. VANCE: Right.

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

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

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

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

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

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

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

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

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

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

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1 it to us.

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

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

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

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

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

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

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

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

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

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

22 CHAIR MARKOWITZ: No, no, you can, why

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1 don't we --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 All right. Thank you.

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

16 MS. HEARTHWAY: Thank you.

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

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

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

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

12 CHAIR MARKOWITZ: Right, right. I did
13 notice that in Paducah there are about 85 job
14 categories and, in Portsmouth, there are about
15 125 job categories, and those are very similar
16 facilities, which was interesting, that kind of
17 variation. I'm asking about this or commenting
18 on this because when we get to one of the COPD
19 recommendation or another one of the
20 recommendations where there's a list of job
21 titles, job categories that are specified for
22 presumption, and we're interested in expanding it

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

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

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

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

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

3 MEMBER DOMINA: Well, I was just
4 thinking back to what Carrie just said because
5 when we were here about, I don't know, two and a
6 half years ago I think it was, the amount of time
7 that the claims examiner spent on a case was
8 minimal in our opinion. I believe I heard 30 to
9 45 minutes. We can pull it up in the old -- so
10 that was one of the things that drew the ire of
11 the Board on the limited amount of time that they
12 spent on it. Because, you know, we deal with
13 people's lives every day, and it's not easy.
14 And, you know, we see the personal side of it
15 face to face and not on a piece of paper, and I
16 just feel that it's a disservice to our workers
17 who are, a lot of them who are military vets but
18 they're also cold war vets, and, you know, for
19 me, it's my age bracket now, you know. And we're
20 cleaning up these sites, and it's not getting any
21 better.

22 And so I just think that I agree with

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

8 CHAIR MARKOWITZ: Dr. Redlich.

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

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

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

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

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1 welding.

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

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

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

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1 establishing X, Y, or Z factual finding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 CHAIR MARKOWITZ: Mr. Domina?

5 MEMBER DOMINA: I just kind of want to
6 piggyback on what Dr. Redlich said because I went
7 through these with her about two years ago, and
8 so maybe we can pull up uranium miners and stuff
9 in here because several of them are just like she
10 said, and every one of them, I believe there were
11 17 of them because they stumbled onto this
12 looking through the claims because they're
13 supposed to do, like, four or five. And they
14 went to the same doctor, and every one of them
15 said this can't be caused by aluminum. And when
16 you bleed it down, and it's been a while since I
17 looked at this, it shows uranium miners being
18 exposed, some of them were less than 12
19 substances. And I just, you know, I ain't a
20 uranium miner, never been a uranium miner. That
21 just seems a little odd to me. And then when
22 aluminum was always the top one that they said

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1 couldn't have caused his respiratory type
2 illnesses.

3 CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

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

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

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

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

20 MEMBER FRIEDMAN-JIMENEZ: Could I make
21 a comment?

22 CHAIR MARKOWITZ: Sure.

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

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

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

9 CHAIR MARKOWITZ: Thank you. Dr.
10 Silver?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 1400-page submission looking for any references
2 to industrial hygiene or monitoring records or
3 anything that related a toxic substance to what
4 he was claiming as the diagnosed condition. And
5 I want to say on, like, page 495 or something
6 like that, there was actually an industrial
7 hygiene profile based on complaints that he was
8 presenting to the Department of Energy about his
9 work location and they went through and profiled
10 his employment exposures, and we were able to
11 identify, like, four or five toxins linked to his
12 disease. We proceeded with the characterization
13 of those exposures based solely on how the
14 Department of Energy was characterizing this, and
15 that was done absent the Site Exposure Matrices.

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

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

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

15 CHAIR MARKOWITZ: Mr. Domina?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MR. VANCE: Well, the only comment I

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

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

11 MR. VANCE: It wouldn't matter.

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

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

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

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

12 MR. VANCE: Thank you.

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

17 (Whereupon, the above-entitled matter
18 went off the record at 10:27 a.m. and resumed at
19 10:38 a.m.)

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

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

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

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

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1 awkward because there were big time gaps between
2 back and forth, including the fact that the
3 previous Board ended in February earlier this
4 year and we received the response for some of the
5 recommendations from DOL in August of this year.

6 So we're going to resume some of those
7 conversations.

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

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

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1 opinion about the next steps for those
2 recommendations.

3 So our first recommendation, this was
4 October 2016, was we recommended that a certain
5 circular policy of the program called "Post-1995
6 Occupational Toxic Exposure Guidance," that that
7 be rescinded. And just to describe, for those of
8 you who don't know this, this was the policy that
9 the Department had where all exposures after
10 1995, it would be assumed that they were within
11 the regulatory standards and it would be assumed
12 that they were unlikely to represent a
13 significant exposure and we thought that really
14 was a false assumption and argued against that
15 policy. And they agreed with us, and they
16 rescinded the policy. If only they had continued
17 that policy on our recommendations for the rest
18 of the recommendations, this would be a short
19 session.

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

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

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

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

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

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

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

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

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

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

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

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

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

16 So any comments on this? Dr. Silver?

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

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

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

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

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

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

6 CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

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

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

4 CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

9 CHAIR MARKOWITZ: Other comments?

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

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

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

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

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

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

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

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

17 CHAIR MARKOWITZ: Well, sure. I mean,
18 it's reasonable to say that whatever entity does
19 this work should have the appropriate expertise
20 in X, Y, and Z to ensure that it's a high quality
21 --

22 MEMBER BERENJI: I think we have to be

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

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

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

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

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

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

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

18 CHAIR MARKOWITZ: Yes, Dr. Silver?

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

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

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

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

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

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

12 Any other comments? Yes, Dr. Dement?

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

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

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

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

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

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

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

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

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

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

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

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

4 Moving along here at lightning speed.

5 Recommendation number four was we recommended
6 that the compensation program establish a process
7 whereby industrial hygienists may interview the
8 claimant directly. This was part of our attempt
9 to supplement the SEM and perhaps overcome some
10 of its limitations by developing alternative
11 sources of exposure information. And so we hear
12 about all the questionnaire, we hear about the
13 SEM, we hear about the records from Department of
14 Energy, we hear about the industrial hygienist
15 review, but the industrial hygienists ought to
16 have the ability to actually interview the worker
17 if they need to clarify certain things.

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

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

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

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

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

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

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

16 CHAIR MARKOWITZ: Presumably.

17 MEMBER BERENJI: Oh, we don't know?

18 CHAIR MARKOWITZ: Well, we don't know.

19 We only know for the recommendations we've made
20 so far the extent to which they've changed the
21 procedure manual. But if there is a new
22 procedure whereby the IH can call the claimant

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

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

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

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

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

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

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

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

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

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

22 Recommendation number six was that

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

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

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

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

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

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

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

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

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

10 CHAIR MARKOWITZ: Dr. Silver?

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

22 CHAIR MARKOWITZ: Dr. Redlich?

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

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

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

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

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

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

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

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

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

8 MEMBER CASSANO: One thing we might
9 ask is that at least the exposure history
10 questionnaire go to the industrial hygienist and
11 --

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

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

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

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

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

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

16 CHAIR MARKOWITZ: Mr. Domina?

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

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

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

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

22 I think we should move on. So we're

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

3 MEMBER REDLICH: I don't mean to --

4 CHAIR MARKOWITZ: Yes.

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

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

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

22 CHAIR MARKOWITZ: I'm sorry. A

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1 deadline for the DOL responses?

2 MEMBER MIKULSKI: Yes.

3 CHAIR MARKOWITZ: To us?

4 MEMBER MIKULSKI: Yes.

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

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

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

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

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

7 And our idea was, basically, if you
8 were a pipefitter, if you were a maintenance
9 mechanic, and you had a year's worth of work as
10 one of those, in one of those jobs or any
11 maintenance construction job prior to, we
12 initially said 2005 but we later modified it to
13 1995, prior to 1995 that that meant that you had
14 sufficient exposure if you developed an asbestos-
15 related disease to say that there was causation.
16 So one year of exposure in those job titles prior
17 to '95.

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

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

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

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

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

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

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

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

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

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

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1 exposure to asbestos to cause an asbestos-related
2 disease. That's a formula you can work with in a
3 presumption and resolve claims pretty quickly.
4 So I don't know whether their retention of this
5 1986 was kind of an oversight or whether it was
6 intentional, but, frankly, it perpetuates a
7 scheme that makes no sense. And so I personally
8 would like to see that language eliminated from
9 the procedure manual or at least this specific
10 issue of dates being resolved.

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

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

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

3 CHAIR MARKOWITZ: Right. We
4 originally wanted 2005 as the cutoff date,
5 meaning prior to 2005 we would assume exposure
6 was significant. And then when they got back to
7 us, we modified our date back to '95. It had to
8 do with their procedures. They needed our
9 rationale for use of a date, they needed a
10 specific rationale, 1995 DOE issued an important
11 health and safety order and so they used '95 as a
12 cutoff date. We couldn't come up with a policy
13 rationale underlying a 2005 date. They also felt
14 that most of the workers who they included a 2005
15 date would also be included in the 1995 date, so
16 it wasn't, we weren't losing a whole lot. So we
17 compromised on that point and changed the date to
18 1995.

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

22 CHAIR MARKOWITZ: Yes, go ahead, Mr.

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1 Domina.

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

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

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

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

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

14 CHAIR MARKOWITZ: Mr. Mahs?

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

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

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

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

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

22 MEMBER CASSANO: Yes. I think, and

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

10 CHAIR MARKOWITZ: Yes, Dr. Dement?

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

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

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

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

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

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

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

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

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

21 CHAIR MARKOWITZ: Okay. So --

22 MEMBER CASSANO: The other part of

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

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

10 CHAIR MARKOWITZ: Yes, Ms. Pope?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MEMBER REDLICH: Okay. We can find it

17 --

18 CHAIR MARKOWITZ: Page 3 of 12.

19 MEMBER REDLICH: And we had agreed to make -

20 -

21 CHAIR MARKOWITZ: Go to Chapter 15.

22 It's actually in the exhibit, the appendix to

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

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

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

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

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

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

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

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

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

18 CHAIR MARKOWITZ: Right.

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

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

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

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

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

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

22 CHAIR MARKOWITZ: That makes sense.

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1 Anybody want to work with Dr. Redlich on this?

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

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

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

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

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

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

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

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

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

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

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

22 So we're back to this challenge of

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

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

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

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

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

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

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

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

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

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

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

7 CHAIR MARKOWITZ: Great. Yes, Dr.
8 Berenji?

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

22 So I feel that, if we can come around

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

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

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

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

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

12 CHAIR MARKOWITZ: Dr. Silver and Dr.
13 Dement.

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

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

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

21 CHAIR MARKOWITZ: Dr. Dement.

22 MEMBER DEMENT: There's some

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

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

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

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

7 We need to close out this discussion.

8 We're going to take a break for lunch. We're
9 going to start again promptly at quarter of one.
10 That's in 40 minutes, so please be prompt because
11 we have a lot of work to do.

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

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

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

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

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

22 So we've raised this repeatedly; we've

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

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

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

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

4 So I referred to this yesterday.
5 These are the audits that Dr. Armstrong does.
6 There are three available on the website, the
7 first three quarters, or at least three from
8 2017. He has certain forms. He looks at 50 CMC
9 reports per year. There seemed to be 20
10 causation reports, 20 impairment reports, and 10
11 other reports.

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

20 PARTICIPANT: QTC.

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

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

5 MEMBER REDLICH: Whose assessment was
6 this?

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

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

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

7 Dr. Silver?

8 MEMBER SILVER: Tori was first.

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

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

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

3 Dr. Silver?

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

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

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

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1 categories and has work exposure to one of now
2 eight solvents for ten consecutive years prior to
3 1990, then they would be eligible for
4 compensation.

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

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

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

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

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

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

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

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

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

19 (Laughter.)

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

22 CHAIR MARKOWITZ: Okay. I will work

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

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

10 MEMBER REDLICH: You can summarize it.

11 CHAIR MARKOWITZ: Yes.

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

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

22 MEMBER REDLICH: So I think they

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

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

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1 MEMBER REDLICH: No, I think it's page
2 186 of the procedure manual, Chapter 18, clinical
3 course and system in chronic respiratory disorder
4 may include the following disorders. And it has
5 a list of hypoxemia, air flow obstruction,
6 pulmonary hypertension, sarcoidosis.

7 CHAIR MARKOWITZ: Is that in the
8 matrix?

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

12 CHAIR MARKOWITZ: Under what section?

13 MEMBER REDLICH: Under -- let's see.
14 I think it's under the beryllium -- I mean, it's
15 --

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

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

20 CHAIR MARKOWITZ: Oh, I see. Okay.

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

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

3 MEMBER CASSANO: They agreed. OWCP
4 procedure guides now requires evidence
5 communicating the existence of long-term
6 prolonged pulmonary disease process. Version
7 1.1, Chapter 18, and it's on page 200 and 201.
8 It's useful in establishing uniform guidance for
9 physicians to consider when assessing a claim.
10 However, OWCP considers an important goal
11 pertaining to the reviewing physician allowing to
12 determine whether the available medical evidence
13 constitutes establishing chronic respiratory
14 disorder such they agreed at the Board's
15 recommendation to procedural guidance in order to
16 assess the chronic respiratory disorder.

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

21 MEMBER REDLICH: Well I think that's
22 okay.

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1 MEMBER CASSANO: Yes.

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

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

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

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

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

22 MEMBER REDLICH: Correct.

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

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

6 CHAIR MARKOWITZ: I'm sorry?

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

10 CHAIR MARKOWITZ: Section 8?

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

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

15 MEMBER CASSANO: The old rehashes.

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

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1 we should address.

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

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

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

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

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

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

13 MEMBER MIKULSKI: I can help you.

14 MEMBER CASSANO: Thanks you. Anybody
15 else?

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

22 MEMBER CASSANO: This would probably

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1 be weighing medical evidence. So my --

2 CHAIR MARKOWITZ: Number two.

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

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

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

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

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

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

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

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

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

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

16 MEMBER CASSANO: It fits into all
17 four.

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

20 MEMBER CASSANO: I thought somebody --

21 CHAIR MARKOWITZ: Dr. Dement?

22 MEMBER DEMENT: I think it's very

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

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

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

12 CHAIR MARKOWITZ: Okay. That's fine.

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

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

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

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

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

22 But it's almost like a blank slate, at

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

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

10 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

22 Okay. So the floor is open for

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

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

15 CHAIR MARKOWITZ: So to review some
16 CBD claims?

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

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

22 MEMBER CASSANO: Well, I think the

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

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

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

19 MR. VANCE: I think it does do
20 benzene.

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

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

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

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

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

17 MEMBER DEMENT: And just a comment on
18 it. It may be worthwhile just taking a look at
19 some existing presumption in those areas. For
20 example, leukemia and benzene, and it goes into
21 250 days of exposure to benzene. But it has a
22 latency requirement that I'm not sure I would

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

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

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

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

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

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

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

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

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

14 CHAIR MARKOWITZ: Any other comment on
15 that?

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

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

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1 TCE and kidney cancer has come up.

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

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

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

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

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

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

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

22 MEMBER BERENJI: Agreed.

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

7 CHAIR MARKOWITZ: Accepted facts,
8 statement of accepted facts.

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

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

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

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

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

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

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

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

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

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

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

21 MEMBER REDLICH: Exactly.

22 MEMBER DEMENT: And so I think we

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

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

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

22 So I think looking at that, an updated

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

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

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

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1 appropriately decided.

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

4 MEMBER REDLICH: Sure.

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

8 MEMBER REDLICH: We did get that also.

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

11 MEMBER REDLICH: That's right.

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

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

17 CHAIR MARKOWITZ: Okay.

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

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

3 CHAIR MARKOWITZ: Okay. So --

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

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

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

22 MR. VANCE: The answer to your

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

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

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

22 CHAIR MARKOWITZ: Right. So it's the

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

4 MR. VANCE: Yes.

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

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

10 CHAIR MARKOWITZ: Right, right, right,
11 right.

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

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

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

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

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

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

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

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

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

22 CHAIR MARKOWITZ: So while we're

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

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

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

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

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

9 CHAIR MARKOWITZ: Dr. Cassano?

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

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

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

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

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

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

13 (Laughter.)

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

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

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

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

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

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

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

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

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

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

18 MEMBER BERENJI: Is that two separate
19 things?

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

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1 time.

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

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

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

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

22 CHAIR MARKOWITZ: So I'm glad that we

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

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

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

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

16 MR. VANCE: Yes, I think --

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

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

21 CHAIR MARKOWITZ: Yes, okay.

22 MEMBER BERENJI: And how is that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 MEMBER REDLICH: Correct.

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

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

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

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

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1 the claim.

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

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

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

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

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1 you an answer on what you're asking for.

2 CHAIR MARKOWITZ: Yes, sure. John?

3 MEMBER DEMENT: Having been on the
4 Board before, we sort of divide up into various
5 groups and we went off and we looked at pieces of
6 the process, lots of different pieces, let's say
7 on the IHC, OHQ, and it was helpful. But I think
8 at this point the most helpful was to find the
9 difficult cases. How will we define those cases,
10 and look at the process in totality, and how was
11 the OHQ used in making those statement of facts.

12 I think Carrie pointed out sometimes
13 in the medical records, there's something buried
14 in there. They're voluminous, and we will all
15 probably use a small portion of the time looking
16 at those in great detail. But I think they're
17 helpful and certainly the IH and the CMC. So I
18 would rather look at a smaller number of cases,
19 but look at them in great detail.

20 CHAIR MARKOWITZ: So what do you mean
21 by most difficult cases?

22 MEMBER DEMENT: The ones that -- some

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1 of the cases are -- I would say the ones that --
2 some of the cases that have presumptions but were
3 denied. To me, that list is something that most
4 likely would be more useful.

5 MEMBER REDLICH: I mean, I think from
6 the work that you did, I think that -- and sorry
7 I couldn't pull it up for everyone. But we had
8 seen before in terms of what number of cases and
9 how many accepted or denied under different
10 pulmonary conditions, I think it's obvious where
11 one would want to review cases.

12 MEMBER DEMENT: Yes. But I think
13 collectively we can do a better job in dividing
14 up and reviewing a piece and coming back. So I
15 don't know. We have a lot of different views and
16 expertise on the Board. And I'd just like to see
17 us review a smaller number or in greater detail
18 look at the whole process. I mean, how you would
19 define that is a challenge, of course.

20 MEMBER REDLICH: I think I agree. I
21 think that there is benefit with people, even
22 just the ones that we had reviewed. Like, Kirk

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1 picked up on pieces that I didn't, John also.
2 And because we were sort of each keying in on a
3 different piece and had different expertise. And
4 it's probably where if we reviewed five to ten
5 cases, we would then have a better idea of where
6 that, in and of itself, would I think help target
7 our efforts.

8 MEMBER DEMENT: Yes, we beat up on the
9 SEM a lot. And it's a useful tool in lots of
10 cases. In the cases we reviewed, the SEM was
11 very useful and it came to a conclusion that were
12 in the case. So I'd just like to see how it's
13 used or maybe some of the areas that could be
14 enhanced. That's all.

15 MEMBER REDLICH: And so we have been
16 picking on the issues. There are plenty of areas
17 where there aren't issues, and we agree.

18 CHAIR MARKOWITZ: I don't think we
19 beat up on SEM. People may have beaten up on the
20 SEM. But no, in all seriousness, if the
21 industrial hygienists are now looking at over
22 half of the cases, at least the cases with

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1 questions in the last two years, that is a huge
2 evolution in the program. Correct me if I'm
3 wrong. Because if prior to that you didn't have
4 IH review, you had the SEM. You had a couple
5 other --- maybe DAR from DOE. That doesn't
6 really give you a whole lot of detail about
7 exposure.

8 So the SEM was central, but it strikes
9 me that there are multiple sources now for
10 information about exposure. So that's a big
11 change. But that argues for two people, or
12 members of the board from different backgrounds
13 looking at each claim that we look at, because
14 they're going to have different perspectives and
15 see different things. That means we'll probably
16 review fewer claims, right, because there are
17 only so many of us, but it's probably worthwhile
18 doing.

19 MEMBER REDLICH: And we did put up
20 like a standardized form that everybody sort of
21 took, and I sort of synthesized everybody's input
22 together.

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1 CHAIR MARKOWITZ: Right, right. Could
2 you share that form?

3 MEMBER REDLICH: Sure. Yes, we could
4 modify it.

5 CHAIR MARKOWITZ: So Dr. Redlich is
6 going to provide a claims review form.

7 MEMBER REDLICH: It was focused on the
8 pulmonary side.

9 MEMBER CASSANO: And I have another
10 one that I can order that we use for the --

11 CHAIR MARKOWITZ: Dr. Cassano is going
12 to provide a claims review form.

13 MEMBER CASSANO: We'll combine them.

14 MEMBER DEMENT: I would suggested even
15 if we divide into the actual worker reviewing in
16 detail, that we all get the files. In some
17 cases, it was useful to be able to reference back
18 some of those comments. So I think we should all
19 get the same cases to take a look at.

20 CHAIR MARKOWITZ: So the sequence is
21 going to be that we're going to get information
22 about -- data about denied claims, accepted

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1 claims, the most common denied conditions. Then
2 within certain categories, chronic respiratory
3 disease, cancer, neurologic disease, the same
4 kind of data. And then when we look at those
5 data and then decide on which kind of claims we
6 were going to request. Is that right? Which and
7 how many. Yes, Dr. Dement?

8 MEMBER DEMENT: Just one
9 clarification. I think last time I was given a
10 file that basically a claim I went through and
11 summarized for this. But I think you can
12 generate the same thing for your system. I don't
13 think there's anything that I generated that
14 can't generate. So it's sort of an unnecessary
15 process for me to get this huge file and have to
16 deal with it when I think the program can provide
17 those summaries quite straightforwardly.

18 MR. VANCE: Yes, I mean, we can --
19 right now, with everything being imaged, it's
20 much easier to collect and try to divide up
21 information based on its categorization in OIS.
22 So it just depends on what you're asking for and

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1 then what can the program do to accommodate that
2 request.

3 MEMBER REDLICH: The way we had it
4 before was well organized. The questionnaires
5 labeled what they were all in a folder for that
6 person. The one area that we did not have
7 necessarily a lot was on medical records.

8 MEMBER DEMENT: No, I'm speaking of
9 just the file that was used to generate those
10 summary tables that we'd generate by case. So I
11 think an unnecessary intermediate step and a lot
12 of work on my part.

13 MEMBER REDLICH: Sorry. I
14 misunderstood. Okay.

15 CHAIR MARKOWITZ: With our request
16 when we formulate would be for them to do that
17 for the respiratory disease, for cancer, and for
18 neurologic disease. Is that right, John?

19 MEMBER DEMENT: Yes, that's the case.

20 CHAIR MARKOWITZ: So John and Carrie
21 and I and anybody else who wants to volunteer
22 will work on formulating that request. Anybody

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1 else? Okay. I got you. Okay, good.

2 So is there anything else about claims
3 review that we want to discuss? Dr. Friedman-
4 Jimenez, do you have any comments or do you want
5 to provide any input? Okay. George knows where
6 to find us. We're going to take a break in 15
7 minutes. Yes, George?

8 MEMBER FRIEDMAN-JIMENEZ: Yes. No, I
9 think we're going the right direction. I just
10 have a question. Will there be an opportunity
11 for continued dialogue on some of these
12 recommendations that have been declined and will
13 come back with a revision? Will we do that at
14 the next meeting? Is that the planned process?

15 CHAIR MARKOWITZ: Well, I think the
16 answer is yes. There will be continued dialogue.
17 The question is whether we need to -- if we
18 revise a recommendation, we're going to need to
19 agree on it as a group and then submit it to DOL.
20 So it's really just a timing issue. Whether
21 there are certain revisions we could handle over
22 the phone as a Board or whether we need to wait

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1 for the in-person meeting.

2 My preference is to move things along.

3 So if we can get there and do an internal full
4 board telephone meeting and consider some of
5 those and vote on them, then we should do that.
6 Does that answer your question, George?

7 MEMBER FRIEDMAN-JIMENEZ: Yes, I'm
8 little concerned about the restrictions on our
9 communicating outside of a Board meeting because
10 I think it will require some degree of
11 collaboration to revise the few recommendations
12 that we want to revise.

13 CHAIR MARKOWITZ: So you're talking
14 about communication with DOL?

15 MEMBER FRIEDMAN-JIMENEZ: Among
16 ourselves.

17 CHAIR MARKOWITZ: Among ourselves.

18 MEMBER FRIEDMAN-JIMENEZ: Are we able
19 to do that? Can we email a draft of language
20 back and forth without restraint?

21 CHAIR MARKOWITZ: Well, so far, we
22 have no subcommittees. So short of including the

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1 entire board, maybe we are allowed to do that.
2 We're not trying to skirt our commitment to open
3 this. We're just trying to figure out how to
4 work. Well, we're going to think about that for
5 a few minutes and get back to you.

6 MEMBER FRIEDMAN-JIMENEZ: Okay.

7 MEMBER REDLICH: I have one question
8 that you may know the answer or not. It just
9 seems that for some of these claims sort of every
10 disease the person has gets listed. And so from
11 my perspective, there's whole categories. It's
12 just like cardiac disease, it's unlikely that
13 that's going to be work related. So how much is
14 all that other stuff taking up people's time and
15 effort?

16 MR. VANCE: It actually does because
17 don't forget the program, as Dr. Markowitz noted
18 yesterday, was we can actually have consequential
19 effects. So in other words, let's say you have a
20 severe pulmonary problem. That can directly
21 aggravate or worsen a cardiovascular disease
22 process.

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1 So that relationship can be
2 established. So people can file a claim saying
3 that while I was accepted for COPD, now I've
4 developed a much more worse form of
5 arteriosclerosis or whatever cardiovascular
6 problem. And then as long as they have a
7 physician offering a rationalized basis for
8 saying, yes, there is a connection, then they can
9 file the claim and we have to go through the
10 exercise of looking at that other consequential
11 illness.

12 But again, under the nature of Part E,
13 you can file a claim for anything. And so we get
14 claims for all sorts of things. And we have to
15 go through this process for every single one of
16 those claims.

17 MEMBER REDLICH: Because that might be
18 one other area that we could provide guidance on
19 where --

20 MEMBER CASSANO: I don't think there's
21 -- I mean, I see this a lot. I mean, I see
22 people have 45 contentions on a claim including

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1 their hangnails. And you have to go through the
2 process with every single one. I don't think
3 there's anything we can do avoid that.

4 As much as I think we'd like to help,
5 say, no, you cannot file a claim for such and
6 such. But it creates a certain amount of -- I
7 don't want to say animosity. But when you see 45
8 contentions, most of which you know are probably
9 not related to anything work-wise, it sours you
10 to the claimant a little bit.

11 MR. VANCE: Well, and my only comment
12 to that would be so you have to be thinking about
13 this from a medical health science perspective
14 versus that claim adjudication process. When
15 people are talking about prioritizing and
16 figuring out ways to refine these cases in a way
17 that gets them through the process, we do get
18 cases that are -- I've seen them come through my
19 office that are six or seven boxes of material,
20 and that's just on the hybrid material that
21 existed prior to when we started imaging records.

22 So there could be an equal proportion

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1 of those records in our image system. So you
2 have to think and balance the reality of medical
3 health science research that's required in some
4 of these cases against the adjudicatory process,
5 the administrative process of evaluating and
6 making decisions on each one of these disparate
7 types of claims.

8 MEMBER REDLICH: I mean, I would say
9 for -- I mean, you may be doing a whole exposure
10 and association for something like their lung
11 disease. But for their cardiac disease, yes, it
12 might be secondary to their pulmonary. But are
13 you also addressing causation?

14 MR. VANCE: Oh, absolutely.

15 MEMBER REDLICH: So --

16 MR. VANCE: So it depends on the
17 nature of the case. So if I am a claimant filing
18 on -- if I have cardiovascular disease that I'm
19 arguing that's associated with low levels of
20 long-term exposure to radiation, that's the
21 nature of the case. That's what we're going to
22 take in our evaluation.

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1 If I get a claim for someone who is
2 filing Alzheimer's who believes hard metals are
3 contributing to that disease, that's what we're
4 going to have to look for. What is the
5 information that's being presented to us by the
6 person seeking those benefits under the law?

7 MEMBER REDLICH: So I understand that.

8 I just think that there's certain diseases where
9 there's just really no -- there's no literature
10 supporting occupational causes except in an
11 extremely rare case.

12 MR. VANCE: I will give you a quick
13 history lesson that we actually attempted to do
14 that years ago and decided that that was not a
15 wise maneuver.

16 MEMBER REDLICH: Okay. And I
17 understand.

18 MR. VANCE: Yes.

19 MEMBER CASSANO: It is sad but true.

20 CHAIR MARKOWITZ: So we're talking
21 about consequential conditions, right?

22 MEMBER CASSANO: No. We're just

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1 talking about basically -- I don't want to use
2 the term frivolous but claims that have no basis.

3 MEMBER REDLICH: From the perspective
4 of the person, we immediately prioritize what
5 would be more likely to be work related. But you
6 could imagine from the perspective of a claimant
7 that they're just going to write down every
8 condition they have.

9 MR. VANCE: And the other thing --

10 MEMBER REDLICH: And it just seems to
11 be unfortunate that that is probably -- that's
12 what I was sort of asking is if that's eating up
13 a lot of time and resources --

14 MR. VANCE: And --

15 MEMBER REDLICH: -- that is an issue
16 in terms of the operation of a --

17 MR. VANCE: And I've been working on
18 claims for a long time. My other comment to that
19 is that it's always amazing what you ultimately
20 can find in some of these cases. And there have
21 been instances where I've looked at a case just
22 like that and said, that's ludicrous. How can

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1 you possibly make that argument? And yet when
2 we've gone back and looked at it, we're like,
3 wait a second. There's actually some substance
4 to what's going on in this particular case.

5 So you have to be very cautious just
6 because when you first look at it, you don't
7 think there's something obviously there. But
8 when you actually going through the process of
9 evaluating the case and looking at it or looking
10 at the arguments that are being presented by the
11 physician or the epidemiological information or
12 whatever the circumstances are, you may actually
13 have a compensable claim on your hands.

14 So it's a challenge. And when you
15 have a claim with dozens on these things, you've
16 got to look at each one and give them all due
17 diligence and whether or not they are compensable
18 illnesses.

19 MEMBER SILVER: Pretty early on, I was
20 alarmed to see the resource centers casting a
21 very broad net and kind of recruiting claims
22 whatever they might say. They may have had or

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1 perhaps still have some contractual incentive to
2 rack up a large number of claims filed through
3 their resource centers.

4 So that's kind of where it's coming
5 from. I don't think it's claimants trying to be
6 greedy or blaming the Man for all of their
7 diseases of old age. And I think the program is
8 taking really the only compassionate approach to
9 work through them.

10 CHAIR MARKOWITZ: It seems we're
11 taking a break.

12 MR. VANCE: Sorry about that.

13 CHAIR MARKOWITZ: No problem. But
14 we'll back 20 of.

15 (Whereupon, the above-entitled matter
16 went off the record at 2:29 p.m. and resumed at
17 2:51 p.m.)

18 CHAIR MARKOWITZ: Okay. We're going
19 to get started. So the way we're going to work
20 after this meeting is on the various tasks that
21 we've agreed upon. We're going to form a sort of
22 provisional working group on those tasks. They

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1 won't be official subcommittees because they're
2 not really specific to an individual task. And
3 we also want to be able to get to work on those
4 in a timely fashion.

5 So we're going to send around via
6 email a list of the tasks and the people who have
7 signed up. You have the right to add your name.
8 You don't have the right to subtract your name.
9 I'm only kidding. You decide what you want to
10 do. But we'll make sure that there's enough
11 person power to get the task done. So that's the
12 way we're going to proceed.

13 MR. FITZGERALD: And this will be
14 communicated in the email. But as work groups do
15 their work, they should communicate with the DFO
16 through the Board's email address so that the DFO
17 is informed about the progress on that work.
18 Like all work groups, the work is a work in
19 progress until the Board actually meets and has a
20 discussion and on votes on this.

21 CHAIR MARKOWITZ: So I asked actually
22 Malcolm Nelson and Greg Lewis to just give us

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1 five-minute overviews of the work that they do
2 that is relevant to the Board. In the first
3 Board -- you can come on up, Mr. Nelson. In the
4 first Board, they actually had formal
5 presentations from the ombudsman office and the
6 DOE. And we decided there wasn't really enough
7 time in these two days to do that. But I think
8 we have a few minutes now, and I think it would
9 be useful just to get a relatively brief
10 overview.

11 Mr. Nelson, welcome.

12 MR. NELSON: Welcome. First of all,
13 my name again is Malcolm Nelson, and I'm the
14 current Ombudsman for the Energy Employees
15 Occupational Illness Compensation Program.

16 I usually would start out by saying,
17 welcome to Washington but the weather today.
18 It's a little bit unusual. But it's often like
19 this. They often predict snow. And either we
20 don't get any or we get more than we expect. And
21 I understand that today the weather is a little
22 bit worse than they actually had predicted. But

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1 nevertheless --

2 CHAIR MARKOWITZ: We're going to South
3 Carolina for our next meeting, so --

4 MR. NELSON: Yes, good move. Very
5 quickly, this program, as you know, was created
6 in the year 2000. And four years later in 2004,
7 Congress amended the act and at that time in
8 those amendments they created my office, the
9 Office of the Ombudsman.

10 We have really three duties. One, we
11 are to recommend the placement of Resource
12 Centers. And currently, there are 11 Resource
13 Centers around the country that will assist
14 claimants in the filing of their claims.

15 Our second job is to provide
16 information to claimants and on the benefits
17 available under this program and on the
18 procedures for this program.

19 The third duty is that we submit an
20 annual report to Congress. And in that annual
21 report, we are to set forth the number and types
22 of complaints, grievances, and request for

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1 assistance that we receive during the calendar
2 year. And we are to provide an assessment of the
3 most common difficulties encountered by
4 claimants.

5 In order to do that, we rely on our
6 interaction with claimants. A large number of
7 the claimants will call us, email us, or write
8 letters. But what we have found is that in this
9 population, there is a hesitancy to really
10 complain. These workers often feel that they did
11 a very important job for the government. They're
12 very proud of that, and they don't want to be
13 viewed as complainers.

14 And thus, we find that a lot of people
15 really won't call us. But they will if we go out
16 and go to town hall meetings or attend their
17 luncheons. They will come up to us and begin to
18 talk. And in those conversations with us, they
19 will often start to outline many of the problems
20 they have. So one of the more important aspects
21 of the job that I really impress is for our
22 office to try to get out as much as we can to

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1 talk to claimants, to be at the various events to
2 interact with them.

3 The bottom line if you would ask me
4 what the biggest problem is and it's something
5 that's been said over and over the last day or
6 two that this is a complicated program. And as
7 such, most claimants simply are overwhelmed with
8 the procedures and just the mere concept of this
9 program. We find that most claimants do not have
10 an attorney representing them. And if they do
11 have an authorized rep, that authorized rep is
12 usually a family member or somebody else who
13 themselves may not be familiar with the program.

14 And thus, probably the biggest thing we do is
15 really just trying to explain this program to
16 people.

17 This program, and I'm sure most of you
18 know, is somewhat different from most other
19 worker compensation programs. And so many of the
20 claimants try to apply the rules they've seen on
21 TV to court or the rules that they've experienced
22 with maybe their state workers compensation

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1 program to this program and simply become
2 confused and overwhelmed. So a lot of our job is
3 simply trying to explain the rules, point them in
4 the right direction, and explain how to proceed.

5 In that sense, I want to just commend
6 this Board. The recommendations, the findings
7 that you've made over the last year have really
8 in my mind supported many of the grievances and
9 complaints that we hear about this program. I'm
10 not going to go into any detail on them. But
11 just in a sense over the years if you read my
12 report, you will see that claimants have outlined
13 a number of concerns.

14 Many times, they are unable, and as an
15 attorney, I'm unable to put those concerns in a
16 very scientific or medical terminology. And I
17 commend the Board because you have been able to
18 help me and assist me in understanding the
19 medical and scientific aspects of those problems.

20 And like I said, in that sense, supporting the
21 concerns of the claimants.

22 Like I said, I'm going to make this

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1 very short. But I do want to throw out -- I
2 wanted to come up anyhow because I think John
3 made reference to it and I just want to support
4 it. We were talking earlier and we kind of
5 talked about frivolous claims that maybe did not
6 have merit. And just two things that I've
7 encountered with this program and just want to
8 outline.

9 In this program, if a worker files a
10 claim and that claim is accepted, that worker is
11 generally entitled to medical as of the date of
12 the filing of the claim. And therefore many
13 claimants are encouraged or realize that they
14 need to file those claims even before they have a
15 diagnosis that is work related because that's the
16 only way they will get all of their medicals paid
17 for.

18 The situation we see most often is
19 with skin cancer. If a worker waits until after
20 the skin cancer has been removed and they're told
21 they have cancer to file their claim, when that
22 claim is accepted, they will not be paid for all

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1 the surgery that was done before the filing. So
2 we often find that many people will rush to file
3 their claim even before they have a diagnosis
4 just because they know that's the best way to be
5 entitled to medicals.

6 The second is that many claimants
7 thinking that this program is similar to RECA ask
8 for a list of covered illnesses. And especially
9 -- well, under Part E, there is no list of
10 covered illnesses. So we often find that when
11 people go to the Resource Center or come to my
12 office to say, is my illness covered? The answer
13 is, we cannot tell you now, file a claim and it
14 will be determined, so that very often, people
15 will file claims just because they know they have
16 an illness.

17 They don't know whether it's going to
18 be covered or not. But filing the claim is the
19 only way for them to find out if that illness
20 will be covered. So a lot of these claims will
21 turn up to be un-meritorious in the end. But
22 filing the claim was the only way for the

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1 claimant to find that out.

2 If you have any questions.

3 CHAIR MARKOWITZ: Any questions or
4 comments?

5 MR. NELSON: Well, thank you very much
6 for this opportunity.

7 MEMBER REDLICH: I guess just from
8 your perspective, are there problem areas that
9 you think that we have not touched on that we
10 should be addressing?

11 MR. NELSON: I think for the most part
12 you've touched on the main issues. One issue
13 that I've kind of talked to some people about and
14 just one I just like to hear -- I mean, I don't
15 know if the Board as a whole but just somebody
16 who has expertise in this area.

17 An issue we see is with firefighters
18 and other first responders and the types of
19 illness -- the types of toxins they may be
20 exposed to in the course of their employment.
21 That very often I'm encountering cases where
22 firefighters will say, SEM does not show that

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1 they were exposed to any particular toxin or
2 doesn't show all of the buildings and all of the
3 accidents that they went to.

4 And I think what has really pushed
5 this issue forward is the work that was done with
6 9/11 where you do have these programs now where
7 they are covering first responders for specific
8 illnesses. And in this conversation today, I'm
9 understanding that certain states have begun to
10 start presumptions for first responders. And I
11 think that the first responders in this program,
12 hearing about those programs, are starting to ask
13 why something like that is not done for them.

14 MEMBER POPE: I just wanted to thank
15 you, Malcolm, and your office for the work that
16 you do. I know there's a lot of folks out there
17 sick and dying or have already passed away. And
18 it must be an extreme burden on them to try to
19 navigate through that process. And having folks
20 like you -- people like you and your office to
21 provide that support and help is certainly
22 appreciated.

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1 MR. NELSON: Thank you very much.

2 MEMBER POPE: Thank you.

3 CHAIR MARKOWITZ: Dr. Silver?

4 MEMBER SILVER: Yes, I want to second
5 that and particularly commend the report that you
6 put out annually. I think it's a greatly
7 underused resource for this Board. The new board
8 members might really want to look at a few of the
9 recent ombudsman reports. And it'll be like deja
10 vu for this meeting.

11 MR. NELSON: Thank you very much. One
12 other thing I will say it happened last year,
13 some of the meetings, especially during the
14 public comment that some of the people will come.
15 And as opposed to having issues that the Board
16 can directly address, they may have more
17 complaints or grievances. And I just want to let
18 you know that my office is always here and more
19 than happy to assist those people. So feel free
20 to refer them to us either at that time or later.
21 But we will always be more than happy to assist
22 any of the people who come to the Board with

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1 complaints or grievances. Thank you very much.

2 CHAIR MARKOWITZ: Thank you. So I'd
3 just like to make an editorial comment that we
4 accidentally used the word "frivolous" in
5 relation to claims. And I think it's unwise for
6 the Board to refer, accidentally or otherwise, to
7 claims as frivolous.

8 People do the best they can in
9 submitting their claims in the former work
10 program. We realize that we've seen a lot of
11 people at a lot of sites where there are also
12 construction and certainly people from the
13 community now. People don't really have any
14 access and still don't have access to
15 occupational health, occupational medicine,
16 doctors. You talk about well rationalized
17 reports. They can't get them because those
18 doctors don't even exist. And frankly, the
19 primary care doctors aren't knowledgeable enough
20 to provide that kind of input.

21 So people make the best decisions they
22 can based on what they know. And what they've

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1 known for decades is a relative vacuum because
2 that information, they haven't been told about
3 what they were exposed to. And the health care
4 system didn't really help them in understanding
5 that.

6 So people do the best they can based
7 on what they're able to do. So some claims may
8 or may not end up being meritorious or being
9 accepted, but so be it. It certainly doesn't
10 mean that those claims were frivolous. So I'll
11 leave it at that and introduce Greg Lewis from
12 the Department of Energy.

13 MR. LEWIS: All right. Good
14 afternoon, everyone. I guess I'll just go
15 through our role fairly quickly. I could talk
16 for an extended period of time. Usually, I do --

17 CHAIR MARKOWITZ: No, do it quickly.

18 MR. LEWIS: -- this about 30 or 45
19 minutes. But I can go quick.

20 (Laughter.)

21 MR. LEWIS: And you all can stop me
22 and ask questions or ask questions at the end if

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1 you like. So again, I'm Greg Lewis. I'm with
2 the Office of Workers Screening and Compensation
3 Support at DOE which is a part of the Office of
4 Health and Safety.

5 So in addition to the compensation
6 program, I provide records for EEOICPA. We also
7 do the former worker medical screening program,
8 support that. And then the larger Office of
9 Health and Safety does policy and some oversight
10 and some international health programs for DOE.
11 So they do a number of things within health and
12 safety.

13 So for the compensation program, what
14 we do essentially is provide records. We do that
15 in a few different ways, but we provide records.
16 That is our role mostly for individual claims.
17 So when someone files a claim, Department of
18 Labor or if they refer it over to NIOSH, both of
19 those agencies are going to take a look at that
20 claim, figure out where the person says they
21 worked, and send a request over to DOE for that
22 person's record.

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1 We also work with both DOL and NIOSH
2 on a large scale site characterization projects.
3 So that's the big one for DOL, of course, back in
4 the '07, '08, '09 time frame. We worked with
5 them and put together the initial work with DOL,
6 I should say, and put together the initial site
7 exposure matrix. And then since then, input
8 they've gotten or when they're trying to fill in
9 gaps, they come to us for assistance or for
10 verification of what they're hearing. So we've
11 helped add to the SEM over the years.

12 So we do this. We're set up -- each
13 site -- each DOE site has a site point of contact
14 for EEOICPA to basically manage the program. And
15 in fact, directly behind me is Gail Splett is our
16 site point contact for the Hanford site --
17 Hanford and PNNL.

18 These folks are really what makes this
19 program run. They're the ones who have contacts
20 within their site. They're the ones who have
21 developed the search procedure when NIOSH and DOL
22 come in to do research. They're the ones who

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1 facilitate that, bring in site experts to
2 interview, sometimes help arrange for site
3 retirees to come back on site and provide
4 information. They set up the site tours that I
5 know you were discussing. And I know we'll be
6 looking for Savannah River, so we'll be working
7 on that. So the site POCs is really kind of run
8 things out in the field.

9 Now how we respond to records, for the
10 individual request, we initially respond to the
11 employment verification. So it's all for the
12 same person, but we'll kind of break it up into
13 three different types of request. So first we'll
14 get an employment verification. That's just kind
15 of for the basic HR. And so did the person work
16 there, for how long, what job titles, that kind
17 of thing. So those are kind of shorter and
18 faster.

19 We'll also, if it's a Part B case,
20 refer it over to NIOSH. NIOSH will ask us for
21 the radiation monitoring information. And then
22 we'll get what we call the DAR. So you guys are

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1 probably -- most of the ones who've been on the
2 board before certainly are familiar with that.
3 And those that aren't, I'm sure you'll see that.

4 The DAR stands for document
5 acquisition request. So it's kind of just a
6 generic acronym that we came up with back in the
7 early days of the program. But what it is,
8 that's basically everything that has that
9 employee's name on it on site that we can find.
10 Any type of exposure record, first we'll have the
11 full HR file, medical records, industrial hygiene
12 if we have it, radiological monitoring records,
13 incident and accident reports, and anything else
14 we have basically linked to that individual.

15 And for each individual, I mean,
16 typically we will have to go to a number of
17 different locations, but sources I guess I should
18 say for that record. Particularly if it's a
19 long-term career employee, been there many, many
20 years. The contractor could've changed on site.
21 The records management practices could've changed
22 on site.

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1 So for one employee, even for -- let's
2 say for radiological monitoring. For the early
3 years, we might have to go to a collection of
4 microfilm or microfiche. Then it might be -- or
5 actually I should say the early, early years, it
6 might be paper, then it might be microfilm-
7 microfiche, then it might be some early forms of
8 electronic records, a database. They might've
9 updated their database, move to a different
10 platform.

11 So we might have to go to four or five
12 different sources just for one individual's
13 dosimetry records or radiological monitoring
14 records. So it's a little bit complex how we
15 have to put this together. But with our POCs,
16 we're typically able to do that even though we
17 have to go to a number of sources.

18 We handle -- just to give you some
19 basic numbers, we do about 17,000 records request
20 a year. And again, that's between the three
21 types, so that's not 17,000 people. You can kind
22 of roughly divide that by three, although it's a

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1 little more because not everyone gets all three
2 types so to get the number of people.

3 Our DARs average, somewhere between
4 150 and 200 pages. I mean, we have exact numbers
5 of the page counts. But some of the information
6 in there is duplicative because we might have an
7 employment verification plus the HR file or the
8 NIOSH dosimetry records in there. So it's hard.
9 But we may be double counting a little bit. So
10 the actual number is something like 230 pages per
11 DAR. But some of that stuff is duplicative. So
12 I would say it's about 150 to 200 pages is
13 average for the DARs that we provide.

14 But again, it's just that. For a 30-
15 year employee, we've seen files over 3,000 pages
16 for one individual. But for subcontractors,
17 particularly building trades are very tough.
18 They may have been on site off and on for years
19 and we may be able to find very little
20 unfortunately. So it really does vary, but
21 that's just an average to give you an idea.

22 And then in terms of timeliness, we've

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1 made a deal with NIOSH to get to these requests
2 within 60 days. On average, we do that in 34
3 days. That's for all of the different requests.

4 The EVs are a little quicker. The DARs may take
5 a little longer.

6 And then certainly sites have a
7 variation between them. Some are faster, some
8 are slower depending on how the records are
9 organized and how many are digitized, that kind
10 of thing. But I think last year, we were able to
11 get, I think, 97 percent of all responses to DOL
12 and NIOSH in the under 60-day time frame.

13 So I think in a nutshell that's the
14 quick version. But I'd be happy to answer any
15 questions.

16 CHAIR MARKOWITZ: So when the CE makes
17 a request, on average, how long does it take
18 before they get the records from DOE?

19 MR. LEWIS: The average is 34 days.
20 And again, that's done through -- and I probably
21 should've mentioned this. But we've set up we
22 call our SERT system, Secure Electronic Records

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1 Transfer system. So it's an online platform
2 accessible by NIOSH, DOL, and DOE. But it's
3 encrypted per all of the government requirements
4 because of the high volume of PII for some
5 information, medical information in there.

6 So all three agencies can access this
7 system. And so when a CE goes into that system,
8 uploads a request, and they could be sending it
9 to five different DOE sites, one different DOE
10 site, or ten different sites. It doesn't really
11 matter. They kind of select wherever they want.
12 As soon as they hit send, if they send it to
13 Hanford, Gail or one of Gail's staff members on
14 their computer email pops up, it says, you have a
15 claim waiting in SERT. And that clock starts
16 going.

17 So this is 34 days, not business days,
18 not work days, not whatever. So in terms of how
19 many work days, it's a little bit different. But
20 again, a claimant doesn't really care about work
21 days. They care about the time. So it's 34 days
22 is the average.

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1 CHAIR MARKOWITZ: Thank you. Any
2 other -- Dr. Redlich?

3 MEMBER REDLICH: No, just the same
4 question. Are there any issues that we could
5 address that you think would be helpful? Or what
6 do you see as some potential problems or areas to
7 improve?

8 MR. LEWIS: From DOE's perspective,
9 this program is run by DOL. So we make it our
10 business to make sure that we are getting the
11 right records to DOL and NIOSH as fast as
12 possible. And they're our client I guess you
13 could say for this program. In terms of how they
14 adjudicate claims and things like that, that's
15 definitely not our charge.

16 CHAIR MARKOWITZ: Other questions or
17 comments? Dr. Silver?

18 MEMBER SILVER: So when you hear about
19 several hundred boxes or several thousand boxes
20 at particular sites that the advocates feel would
21 be useful and they're not being systematically
22 accessed and reviewed, does that fit within your

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1 gambit?

2 MR. LEWIS: Absolutely. I will also -
3 - we've had many occasions where collections
4 were, quote-unquote, "discovered". For whatever
5 reason a collection was labeled something, and
6 when either DOE was in there looking for
7 something or oftentimes NIOSH actually because of
8 their Special Exposure Cohort research, they're
9 probably the biggest user I would say at many
10 sites of their older project files.

11 If they get in there and find that
12 it's not what the label said it was or, oh, well,
13 this is useful stuff even though you wouldn't
14 think so. We have, many times, gone in there and
15 tried to index the records or get them into a
16 fashion that we can access and respond to claims.
17 And then, of course, if we find such a
18 collection, we will go back to DOL and NIOSH for
19 past names and say, hey, we may need to work with
20 you, DOL, on past denied claims to see if this
21 particular records collection is valuable.

22 Sometimes it's records from the '70s.

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1 So we'd say, okay, denied claims with employment
2 during the '70s. Resend us a list and we'll get
3 you these records, without knowing the specifics
4 and having talked to you about any particular
5 case.

6 MEMBER SILVER: I remember that Los
7 Alamos County had a Quonset hut with records from
8 the old hospital which was sort of under the
9 lab's administration. Was it highly unusual to
10 have this solution come partly from the
11 congressman's office? Are you able to solve most
12 of these problems without congressional
13 intervention?

14 MR. LEWIS: That was a real unique
15 case I will tell you. Because again most of the
16 records that we find are DOE records in DOE
17 possession. Those records, because Los Alamos
18 was a closed city to beginning with, the hospital
19 in Los Alamos was actually a part of the lab for
20 many years. And then they kind of -- they
21 separated at some point. But the medical records
22 for the lab workers just stayed at the lab. They

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1 probably should have gone to DOE back in I think
2 it was mid-60s if I'm remembering correctly.
3 It's been a while since we -- it's been about ten
4 years since we did that project.

5 But in the mid-60s, I think the
6 records should have just gone back to DOE. But
7 for whatever reason, the stayed at the hospital
8 and somehow ended up in a Quonset hut that was
9 owned by the hospital and used for kind of
10 auxiliary record storage.

11 So because they weren't DOE records,
12 it was fairly complicated. I think we ended up
13 having to enter into some kind of contract with
14 the hospital to -- they had to go in and
15 decontaminate these records because there was
16 concerns about Hantavirus, mold. I guess this
17 Quonset hut was leaking and just a holy mess.

18 So we ended up having to enter into
19 the contract with the medical center to do this.
20 And it was I think somewhere around a million
21 dollars I want to say, I don't know the exact
22 number, to clean these records up, get them in

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1 the right condition, and transfer them over to
2 DOE. So yes, most of the time we do not have
3 interaction with any congressional office on
4 projects like this. But that was a project, very
5 different.

6 But we were able to -- that is one
7 example. We were able to get those records,
8 clean them up, organize them. And when claims
9 come in for Los Alamos, that's one of the
10 collections that's checked for records.

11 CHAIR MARKOWITZ: Any other questions
12 then? Well, thank you very much especially on
13 the spur of the moment.

14 MR. LEWIS: At any time. I'd be happy
15 to answer questions anytime.

16 CHAIR MARKOWITZ: Okay. Thank you.
17 So let's get back to our discussion about new
18 issues for the Board. We could just walk through
19 our tasks and see if any of those tasks raise
20 issues. The first is the Site Exposure Matrices.
21 Any questions or issues that we haven't so far
22 discussed? I'm curious about the whole issue of

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1 aggravation and contribution because we were told
2 that the SEM doesn't address that. The SEM has
3 causation, right, disease exposure links.

4 And so the claims examiner is thinking
5 about aggravation contribution in addition to
6 causation. So how do they do that? What
7 resource do they rely on? Their job is to
8 develop a statement of accepted facts. And how
9 do they make their judgment about aggravation and
10 contribution? And it's not easy issue because
11 most compensation systems don't really deal with
12 this to a generous standard in a law. And I'm
13 wondering if anybody had any thoughts on how we
14 might see whether it's being done.

15 So I think that what we can do is ask
16 DOL actually how they address issues of
17 aggravation and contribution. I mean, it's in
18 the asthma presumption, the recognition of that.
19 Perhaps not in the COPD presumption, but I don't
20 know that it's in any other presumptions because
21 they usually focus on causation, but --

22 MEMBER REDLICH: It looks when someone

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1 is asked a question, like a contract physician,
2 if they're asked, could this cause -- sort of
3 they're all lumped together.

4 CHAIR MARKOWITZ: Right, right, right.

5 Yes, it's not in any point in process whether
6 actually a condition is identified as an issue of
7 aggravation contribution as opposed to causation.

8 MEMBER REDLICH: And for something
9 like asthma, there is a much larger list of
10 exposures that can trigger preexisting asthma.
11 Or I'd say there's a larger literature on
12 substances can trigger preexisting than cause new
13 asthma. And so one does think about those as
14 somewhat different processes. But I suspect that
15 for most of these conditions, it's just being
16 considered the same.

17 CHAIR MARKOWITZ: I mean, we come up
18 with -- the thing about chronic kidney disease,
19 this may well be initiated or largely caused by
20 diabetes or hypertension. But there could easily
21 be workplace contribution or aggravation to
22 kidney disease, less so with cancer. And I'm not

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1 sure about neurologic conditions actually.

2 MEMBER REDLICH: Look for pulmonary
3 then.

4 CHAIR MARKOWITZ: Right, right.

5 MEMBER DEMENT: But indirectly, they
6 are considering contribution when you start
7 talking about things like lung cancer and COPD.
8 Because we know one of the major causes of
9 smoking, it's not into the mix here. And we know
10 that smoking will contribute to those risks. So
11 they are considering, at least in my view, the
12 occupational contribution of the disease.

13 CHAIR MARKOWITZ: Right.

14 MEMBER DEMENT: And not necessarily a
15 single causation.

16 CHAIR MARKOWITZ: Right, right. And
17 that's where contribution and causation have
18 merged, right? Something multifactorial has
19 multiple causes. And so for the new members,
20 we've been told previously that actually smoking
21 is not -- the CEs and the CMCs are not really
22 permitted to factor the issue of smoking in terms

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1 of their determination about the work relatedness
2 of the exposures which is interesting.

3 But I think I will formulate a
4 question. And Carrie, if you could write this
5 down, a query for a written response to the issue
6 of how the program addresses issues of
7 aggravation and contribution which actually goes
8 to the task of medical guidance for claims
9 examiners. Were there any other issues on that
10 topic actually that we want to think about?

11 The third task is evidentiary
12 requirements for claims under Subtitle D, lung
13 disease. The first board spent a lot of time on
14 this, and we're not discussing COPD or looking at
15 claims for COPD. That's not a Part D condition.
16 It's just silicosis and chronic beryllium
17 disease. But were there any other issues? Is
18 there any issues that we wanted to think about or
19 revisit in terms of Part D?

20 MEMBER REDLICH: I think one is we did
21 go through -- we had been given a number of
22 specific documents that we had gone through and

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1 addressed. And I think it would just be helpful
2 to know what the DOL has decided, if they agree
3 or disagree just so we know where we stand on
4 those. And if they had decided to modify. So I
5 think it would just be helpful if they go through
6 and respond eventually. It was just a more
7 general statement that they were considering for
8 responses.

9 CHAIR MARKOWITZ: So Carrie, if we
10 could set that as an action item. Do you know
11 what we're talking about, Carrie?

12 MEMBER REDLICH: I can. It's the long
13 response that we gave. Because at the very first
14 meeting, there were maybe 20 specific questions
15 that were addressed related to Part D conditions.

16 CHAIR MARKOWITZ: Right. So we just
17 want the Department's reaction to that.

18 MEMBER REDLICH: Yes, I just think if
19 it's -- and the reason.

20 CHAIR MARKOWITZ: And task four is we
21 discussed the work of the industrial hygienist.
22 Actually, it says any staff positions or any

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1 consulting positions. But the staff positions,
2 really, I think that's Dr. Armstrong. And if you
3 want to look at his work, all we need to do I
4 think is to look at the audits that he conducts.
5 I don't know that he has any other work product
6 for us to examine actually. Do you know? Okay.

7 MEMBER SILVER: On Dr. Armstrong if I
8 may, I've heard of a recurring symptom that some
9 of the physicians would like to have more
10 interaction just to get a physician's perspective
11 on how the program is running from the inside.
12 Am I misreading that? I thought I heard it at
13 the last few meetings.

14 CHAIR MARKOWITZ: No, no. And in
15 fact, it's an action item that we're going to
16 request that he participate in our next face-to-
17 face meeting. He may not be available to appear
18 wherever we are. But at least he could be there
19 by phone and present his work and entertain
20 questions.

21 MEMBER REDLICH: Has he been in the
22 same position the whole time?

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1 CHAIR MARKOWITZ: The last year-plus.

2 MEMBER CASSANO: They didn't have a
3 position for a while, and then he's been here for
4 a year. We had a phone call. I don't know if it
5 was a subcommittee. There was a phone call with
6 him last year. I can't remember if it was a
7 subcommittee.

8 MR. FITZGERALD: Yes, it was a
9 subcommittee. I'm not sure which one.

10 MEMBER CASSANO: And I remember I was
11 on the phone call. And I don't even remember
12 what the subject was at this point. So he has,
13 but I think he has to be requested.

14 CHAIR MARKOWITZ: I would also like to
15 request the toxicology reports. It was mentioned
16 in the procedure manual that questions are
17 addressed to an in-house toxicologist who reviews
18 the relevant literature and comes up with a
19 decision. And if -- whatever recent time period,
20 say over the last 12 months, if we can just take
21 a look at those reports.

22 If they contain personal information,

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1 obviously we want them redacted. But there's the
2 reference to this. It's in the procedure manual,
3 and I think we should take a look at what they
4 look like. And the same thing with looking at
5 the work of industrial hygienist at the contract
6 positions.

7 MEMBER REDLICH: Is there a sort of
8 head industrial hygienist to oversee the others
9 or --

10 CHAIR MARKOWITZ: So it discussed two
11 IHs in house. And I think Dr. Stokes is the in-
12 house toxicologist. Is that right as far as you
13 know?

14 MR. FITZGERALD: I think that they
15 mentioned that there would be contract status.

16 CHAIR MARKOWITZ: Okay. I'm
17 interested in the in-house tox reports.

18 MEMBER REDLICH: Do they then
19 supervise the external industrial hygienists or -
20 -

21 CHAIR MARKOWITZ: Yes, and I don't
22 know if 'supervise' is the right word.

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1 MEMBER REDLICH: Yes.

2 CHAIR MARKOWITZ: They probably
3 monitor the work --

4 MEMBER REDLICH: Yes.

5 CHAIR MARKOWITZ: -- on the outside.
6 We'll get a better sense when we look at the
7 projects. Okay. And maybe all I have -- so
8 we're going to go back to the two requests from
9 DOL. But are there any other issues or
10 questions?

11 MEMBER REDLICH: The one that had come
12 up before is if we have identified cases that
13 we've had questions about how it was
14 communicated, whether there was any process for
15 those to be reviewed or what.

16 CHAIR MARKOWITZ: And I think we got a
17 verbal answer, but I don't recall what it was.
18 So let's re-ask the question.

19 MEMBER REDLICH: Well, I think at one
20 point we were requesting to provide a list of
21 those cases. But I wasn't really clear as I
22 understand it. So maybe we should get some

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1 clarification.

2 CHAIR MARKOWITZ: Okay. So let's go
3 back to two additional requests from Department
4 of Labor. One has to do with addressing
5 radiologic outcomes of radioactive materials.
6 And it's essentially the doctor reviews on these
7 and characterized the appropriate health
8 outcomes, the status of knowledge in relation to
9 I think we've got five or six different agents.

10 I suppose this is an appropriate
11 request. I think we decided to do number two,
12 medical evidence. But in any case, there's a
13 fair amount of work. I know this kind of work
14 that the Department program should have the in-
15 house capability of doing which is not to say
16 that the Board wouldn't assist. But it's part of
17 the reason why we recommend that enhanced
18 capacity.

19 And so the question is whether we have
20 the resources in doing the work. So the floor is
21 open. Dr. Silver?

22 MEMBER SILVER: I think we could be of

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1 service to them if we gently rewrote this.
2 Substances are not radiogenic. Diseases are
3 radiogenic. That's one point. Okay. And this
4 would imply there is such a thing as cold non-
5 radioactive plutonium that has toxic effects
6 separate from its radioactive -- and it would
7 imply the same for americium. And I'm not sure
8 that's true. Are there cold plutonium and
9 americium isotopes? Those may be decaying to
10 something pretty quickly.

11 I think what they were driving at is
12 my interest and I don't want to impose on this.
13 But does radiation cause noncancerous conditions
14 that might be covered by it? So those are two
15 interrelated issues, and Ms. Leiton acknowledged
16 that the latter one was within the scope. But
17 just the way this first one is written I think
18 would confuse their in-house toxicologist. Bring
19 it on if I'm wrong.

20 MEMBER CASSANO: I thought the
21 question was about chemical effects of
22 radioactive materials such as what does uranium

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1 as a chemical do rather than just the
2 noncancerous effects of radiation which actually
3 I think belongs more at the radiation board than
4 this board. The second part, the chemical part
5 probably does belong.

6 MEMBER SILVER: Sure. There's
7 depleted uranium and its chemical toxicity is a
8 big issue. But anyone heard of depleted
9 americium or depleted plutonium? I don't really
10 think that's where the money is. I think the
11 money is on the non-cancer effects of the
12 radionuclides. So my view is this needs to be
13 re-conceptualized but maybe not.

14 CHAIR MARKOWITZ: So after it's re-
15 conceptualized, what's the level of interest in
16 providing some concern? And by the way, I would
17 say that if you don't feel capable of doing it
18 now, it doesn't mean six months from now we
19 couldn't entertain a request. In the first
20 board, there was a considerable -- a greater
21 number of requests. And we got to many of them
22 but not all of them right away. And we didn't

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1 get to all of them actually. Does anybody want
2 to work on this? Okay.

3 MEMBER SILVER: I'd be interested in
4 2.0 perhaps. Let's see how it comes out. I'd be
5 happy to redirect this and see if that's what
6 they really want.

7 CHAIR MARKOWITZ: Okay. So yes,
8 that'd be good. If you could actually send out
9 the questions, what the actual request is and
10 clarification of the request.

11 MEMBER SILVER: And is there anyone
12 remotely interested who would look at my redirect
13 before it goes to the whole board?

14 MEMBER CASSANO: I'll look at it.

15 MEMBER SILVER: Thank you.

16 CHAIR MARKOWITZ: I'll look at it.
17 I'll look at it after Tori looks at it. Okay,
18 okay. And I think realistically it looks like
19 we're not going to take on this issue at the
20 moment. We don't want to hold off DOL in case
21 they want to otherwise pursue it. But we'll keep
22 it somewhere on the burner for further

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1 consideration again.

2 Now as a fourth issue they asked us to
3 consider which is looking at health effect
4 aliases. And actually, when they raised this
5 with me last week on the phone, I asked the
6 question either on the phone or email, I can't
7 remember, but how many are we talking about? I
8 mean, how much work would we be signing up for?

9 MEMBER CASSANO: It's a pretty
10 extensive list. I mean, it's behemoth I think.
11 And more I think medical lexicographer would be a
12 better person to do that than us. I mean,
13 there's no way. I just went and I did a google
14 search. I said, what are synonyms for chronic
15 renal failure, and I got nothing. So I wouldn't
16 even know how to start.

17 CHAIR MARKOWITZ: So what I'll do is
18 frame a clarifying question so we understand the
19 burden of the work. And then we can reconsider
20 it.

21 MEMBER BERENJI: I mean, that would
22 have to come with some additional support because

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1 that's a pretty extensive task to do.

2 CHAIR MARKOWITZ: Yes. Well, let's
3 see what the ask is on that one.

4 MEMBER BERENJI: I mean, we know what
5 the ask is. It's just that what kind of supports
6 do we want to look at. If we can identify
7 medical librarian or someone who is well versed
8 in doing searches to have someone like that as
9 part of the offer, I think that would be
10 reasonable. To do this without any sort of
11 support is just --

12 CHAIR MARKOWITZ: Okay. So we can ask
13 at the same time whether support might be
14 available.

15 MEMBER MIKULSKI: Another idea might
16 to be ask if it's possible actually to merit
17 aliases. I'm sure that there are some aliases,
18 that there is a certainty, no question. But
19 there are some that might be worth looking into
20 and maybe that's a more manageable task.

21 MEMBER BERENJI: That was my original
22 impression that they wanted us to focus on NEMA.

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1 Then I looked at the actual questions and, like,
2 oh, my God. They want us to look at everything.

3 MEMBER CASSANO: This is another area
4 we're seeing what the more common claims are
5 might also direct efforts. I think what scares
6 me -- it may be helpful. What scares me is if we
7 do somehow come up with a list of aliases, I'm
8 afraid that if it doesn't show up on the list,
9 then it gets tossed somehow. And really if
10 somebody is concerned about whether chronic renal
11 insufficiency or end stage renal disease is the
12 same as chronic kidney disease, then you look it
13 up and see what the disease is.

14 MEMBER BERENJI: But see, they don't
15 want to look it up. That requires more work.

16 MEMBER CASSANO: I mean, I don't know
17 every disease out there in the book. I mean, I
18 see diseases that are sent to me all the time
19 that I'm like I don't know anything about this.
20 And you find out what it is.

21 CHAIR MARKOWITZ: That's why you should
22 ask Google.

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1 (Laughter.)

2 MEMBER CASSANO: That's been very
3 helpful.

4 CHAIR MARKOWITZ: Okay. Dr. Silver?

5 MEMBER SILVER: It's really a medical
6 history project too because some of the medical
7 records may have been generated in the late '40s.
8 What were they calling these conditions then?

9 CHAIR MARKOWITZ: Okay. So any
10 another other items? I guess we still need to
11 discuss a little bit about the next board
12 meeting.

13 MEMBER POPE: Dr. Markowitz, do you
14 want to talk about the public comments?

15 CHAIR MARKOWITZ: Right. So was that
16 the public comments from last night or just sort
17 of, in general, how do we approach it?

18 MEMBER POPE: Right.

19 CHAIR MARKOWITZ: So the question is
20 how do we hear other people say but it's a
21 segregated session, right? It's not at the time
22 we're discussing that issue. So it's hard to

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1 remember to come back to that issue or to
2 integrate it into our discussion. So the
3 question is how can we do that? The comments
4 that we think, oh, we should be talking about
5 that, considering that, asking questions about
6 that. How do we remember to inject that into our
7 discussions?

8 MEMBER DEMENT: I thought Carrie had a
9 spreadsheet that she put together.

10 MEMBER REDLICH: I had one. I have it
11 updated for what we had last night. I'll give it
12 to you.

13 MEMBER DEMENT: Which I thought was
14 very useful.

15 CHAIR MARKOWITZ: So you read it?

16 MEMBER DEMENT: No, the ones prior.

17 MEMBER POPE: I think I recall that we
18 had a meeting in Washington. It was after we had
19 visited the Hanford site. And the public comment
20 session after that, there was a conversation
21 about one of the claimants had expressed some
22 type of disease that they had. And there was

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1 some discussion about that and I hadn't heard it
2 before. And it was quite interesting to see.

3 CHAIR MARKOWITZ: So the question is I
4 mean it's yet another thing to read with the
5 spreadsheet. I know it's very useful, but it's
6 another thing to read in preparation with the
7 other documents we read for any given meeting.
8 To me, it's useful. The question still is how to
9 integrate the relevant concerns into our
10 conversation. And I'm starting to think of a
11 mechanism that we can -- kind of a reminder
12 mechanism that we can use to do that. Dr.
13 Silver?

14 MEMBER SILVER: We tend to have a mid-
15 meeting break. In person, it's our lunch break.
16 I just wonder if we could have a brief segment
17 where we put up the spreadsheet of public
18 comments and ask at that moment whether there
19 anything we discussed in the morning bears on
20 public comment and look ahead to see if anything
21 on the agenda in the afternoon bears on the
22 public comments just as a little reminder to

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1 ourselves.

2 CHAIR MARKOWITZ: So we could actually
3 use that spreadsheet as a summary, project it and
4 just have a brief review?

5 MEMBER SILVER: Yes.

6 CHAIR MARKOWITZ: That's a good idea.
7 So should we try that next time? And that can
8 include comments from, say, the session
9 yesterday. Also if any letters or comments come
10 in between now and the next meeting, we could
11 include those as well. So there's an action item
12 for you. Okay.

13 So in terms of the next meeting. So
14 normally we have two in-person meetings a year
15 which would put the next one within probably
16 March or April. I actually haven't looked
17 through the number of claims yet by site to see
18 where. What I looked at whatever a year ago, I
19 think it was Savannah River. But we're just
20 walking down the list and hopefully someday we'll
21 get to Portsmouth which I'm sure we will, but --

22 MEMBER REDLICH: Are there any sites

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1 in Hawaii?

2 (Laughter.)

3 CHAIR MARKOWITZ: Greg, any DOE sites
4 in Hawaii?

5 MR. LEWIS: Yes, but it will take you
6 awhile if you're going by size.

7 CHAIR MARKOWITZ: Oh, we could add
8 other criteria. I think some of the early DOE
9 research was done in Manhattan. How about that?

10 (Simultaneous speaking.)

11 CHAIR MARKOWITZ: And normally these
12 meetings are two days, although sometimes we try
13 to cut them a little short to accommodate
14 people's travel so as to not take up too many
15 days of people's time. And here before we've
16 been able to offer an optional one-day tour
17 usually the day before the -- always the day
18 before the meeting.

19 So we'll try to replicate that. The
20 tradeoff in shortening the full two-day meeting
21 is we may or may not get to all the items. It
22 hasn't really been a problem I think. Maybe

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1 Hanford may have been a little time rush, but
2 otherwise we were okay.

3 But we will descend around times for
4 meetings in the not distant future actually and
5 the location so that you can get them on your
6 calendars to see if there are any conflicts. Are
7 there any other issues around scheduling
8 meetings?

9 MR. FITZGERALD: Just have to look at
10 holidays. I don't think much will be an issue
11 this year. Sometimes it's an issue.

12 CHAIR MARKOWITZ: So we're going send
13 around a list after this meeting of the things
14 that we agreed to work on with people's names
15 attached to it. And we're going to try to send
16 out time frames around that.

17 If we decide we need a full board
18 meeting by telephone between now and April, that
19 would be a two or three or four-hour meeting at
20 most. But the advantage of that is it allows us
21 to move on some items that otherwise would have
22 to wait an additional couple of months. But

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1 remember that takes six weeks at least to
2 schedule, so we're talking January. We'll have
3 it at the second half of January at the earliest.

4 MEMBER BERENJI: To schedule a board
5 meeting, like a teleconference?

6 CHAIR MARKOWITZ: Yes. It requires
7 six weeks lead time in the Federal Register to
8 announce the meeting. Okay. Well, if there are
9 not other comments and questions, then I think
10 we're at the close of business. Any parting
11 words, Doug?

12 MR. FITZGERALD: I just want to thank
13 everybody for their time and dedication to the
14 mission of the Board. And we covered a lot of
15 territory today.

16 CHAIR MARKOWITZ: And I thank Kevin
17 and Carrie and everybody else who helped us
18 produce this meeting and for all their work.

19 (Applause.)

20 CHAIR MARKOWITZ: Mr. Nelson and Ms.
21 Leiton and Mr. Lewis for coming.

22 (Applause.)

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1 CHAIR MARKOWITZ: And thanks to Mr.
2 Vance in being very flexible and fully loquacious
3 in all of his responses. And then for the public
4 who came here as well. I know you came from some
5 considerable distance, so thank you very much for
6 coming.

7 MR. FITZGERALD: The meeting is
8 adjourned.

9 (Whereupon, the above-entitled matter
10 went off the record at 3:48 p.m.)
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