UNITED STATES DEPARTMENT OF LABOR

ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

MEETING

TUESDAY
OCTOBER 18, 2016

The Advisory Board met in the Comfort Inn Oak Ridge-Knoxville, 433 S. Rutgers Avenue, Oak Ridge, Tennessee, at 8:30 a.m., Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

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

MEDICAL COMMUNITY:

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

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

DESIGNATED FEDERAL OFFICIAL:

ANTONIO RIOS

ALSO PRESENT:

RACHEL LEITON, Director, DEEOIC*
GREGORY LEWIS, Director, Office of Worker Screening and Compensation Support, DOE
JOHN VANCE, Branch Chief, DEEOIC Policy,
Regulations and Procedures

*Participating by phone
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CHAIR MARKOWITZ: Good morning. We're going to resume the meeting of the Advisory Board on Toxic Substances and Worker Health. We're going to continue with the discussion from yesterday led by Dr. Laura Welch on the site exposure matrices.

Member Welch: Yesterday we generally finished and concluded our discussion of what other data sources should be added to SEM and the process for that. So we are ready to come up with a couple of more recommendations.

Kevin, if you just go down a couple of slides. I'll tell you when to stop. Yes. Institute of Medicine had recommended that DOL add the nature and extent of exposure to the SEM. And the DEEOIC staff thought that would be difficult and we agree.

It would be really hard to actually put that into the SEM. But as we heard at the
last meeting, they've developed a contract with
an industrial hygienist who could provide that
nature and extent for individual claims rather
than trying to add it to the SEM. And I think
that makes sense because you really want to look
at it for each individual.

But we also agreed that the process as
we understood it was not going to allow the
industrial hygienist to do that because currently
the industrial hygienists get the information the
claims examiner sent them on exposure which would
be SEM and the Occupational History
Questionnaire, neither of which have nature and
extent of exposure in it.

Our next concrete recommendation was
that we think there should be a process where the
industrial hygienist interviews the claimant
directly when that's necessary to adjudicate the
claim. And in addition to which we know that
would help. If it's a regular group of
industrial hygienists, it would help them
understand the sites better. Because every time
they talk to a worker, they're going to understand more about what happened at that site and also the worker's perspective on the kind of personal protective equipment or training they received. So they'll become more knowledgeable.

Let's discuss that point before we move onto another one.

MEMBER SOKAS: I was just going to suggest that we discuss it and have a Committee discussion and then vote to make it a recommendation.

MEMBER WELCH: Yes. Steve and I had just talked briefly about how to do that because we didn't vote on the first one, adding other databases. But I didn't really want to reopen that discussion again.

But I think on this one, we could discuss it and vote as a board. It's a little simpler. I would agree with you. Do you have any comments you want to make? Anyone on the Board have comments to add?

MEMBER BODEN: First, questions.
Something I don't know how it worked. But the Former Worker Projects did a lot of work actually interviewing workers at the sites and getting information about the exposures, etc. How does that relate to this process at this point? Is that information used? And, if so, how?

MEMBER WELCH: John, could you? You could address the site assessment process at least.

MEMBER DEMENT: I guess I will answer the question as directly as I can. We recognized in the Former Worker Projects to get a nature and an extent through a worker interview is pretty difficult.

So we decided two issues. One we would concentrate on location and task. At least for construction traits that's a driver of a lot of issues on exposure.

And then on the extent we decided and I think it's actually in the Occupational History Questionnaire currently to ask about frequency of doing the task. That gives us at least a handle
on both the exposure the task is a driver on, sometimes the magnitude of exposure, so the characteristics of the exposure, and then the frequency of doing the task. So that's how we came up with it.

And we use it as an algorithm in many of our analyses to actually separate individuals into at least low, high and medium types of exposures. And it's proven to work reasonably well for most things.

MEMBER BODEN: Does that carry over now to the EEOICPA process?

MEMBER WELCH: I also heard you say that you were asking about the site assessments that were done before the program began, too. And those are based on existing records on the sites. And those existing records were available to the DOL contract that created the SEM.

But I don't think anybody has ever looked to see whether everything -- If I have a worker with an unusual exposure at a site, I'll ask John to look in the database and tell me more
about it, particularly a task. Sometimes workers
tell me about a task and I have no idea what the
exposure would be. He can sometimes find it in
the site assessment that was done when the
program was started or in databases that he has.
But whether all those exist in the SEM, I don't
know. They should because we were using existing
records, but some worker interviews, too, which
aren't necessarily in the SEM.

MEMBER DEMENT: I don't know to the
extent to which the SEM has actual task. I mean
I know there's some in there. But I don't know
the extent. It's hard to search from each site
and look in in terms of task.

To me, the Occupational History
Questionnaire in conjunction with the SEM in
allowing the hygienist to go back and ask more
specific questions about task that may not be
covered well would be an advantage to the program
in terms of trying to get to the nature and
extent of exposure.

MEMBER BODEN: It also sounds to me
like we should be keeping this in mind when we're making recommendations for changing the Occupational History to make it more -- to have it as relevant as it can be to the question of nature and extent of exposure.

MEMBER DEMENT: I don't think we can -- I don't see how it's possible for us to separate the Occupational History Questionnaire from the SEM and the IH assessment. To me, they're all sort of part of the whole process. So I don't know.

I guess I would like to hear from DOL when they would plan to have an updated Occupational History Questionnaire because I think to me that's the start of the exposure assessment. We really need to have it in our hands to be able to make intelligent decisions about this whole continuum of process for exposure assessment.

CHAIR MARKOWITZ: So I would just make a couple of comments. One is I would remind the Board that I think DOL has invited us to assist
them in improving the Occupational History Questionnaire.

But just to respond to Dr. Boden's comments about Former Worker Program, it's a screening program. I run one of the larger Former Worker Programs at many, many sites, not the construction workers but the production, engineering, administrative, maintenance personnel with hugely varied tasks and exposures. So it's much more complicated than the construction site.

Our Occupational Histories don't go into the depth that's needed for this decision making around claims. It can be useful. It's not going to solve the challenge for the claim in part because it's a screening program and in part because we haven't devoted the resources for that kind of in-depth assessment of their exposures.

So it can be useful. It should be used. But it's not going to answer the problem.

MEMBER DEMENT: I agree. And I think to require an Occupational History Questionnaire
a priori it's just a whole -- Just think of the number of exposures and tasks and things that workers are doing, many of which are not going to lead to much in terms of exposure assessment.

That's the reason we think that having the IH ability to go back when specific exposures are identified as potentially contributing to this, causing and contributing to this condition. And allowing a more detailed discussion about exact tasks that the worker did would be a much more intelligent way of approaching the process.

MEMBER CASSANO: I think our work subcommittee will have something to say on this issue, too, because what we noticed is a lot of times is the CE determines what information actually goes to the industrial hygienist. So we'll be talking about that some more as well.

MEMBER WELCH: Les, did you have another comment? Your light is on. You don't have to talk.

MEMBER BODEN: I was actually thinking that one of the things that would be worth
thinking about in all aspects of this is the
lynchpin role of the CE and guidance to the CE.
And the decision making process I think will be
essential to our fulfilling our mission.

MEMBER REDLICH: Following up on
Leslie's comment, I was going to mention this
later. I probably know less about aspects of
this process than others. But from some of the
cases that we started to review, the SEM
inserting that actually complicated the process
and came up with an answer that it would have
just been better had there been no SEM in there.

There were some basic assumptions and
this was related to cases such as COPD. So I
think in certain cases it may not be an issue as
so much fine-tuning and fixing it. But maybe
it's not needed.

MEMBER WELCH: I guess in my mind and
on my paper I drew a Venn diagram. We have the
SEM. We have the Occupational History
Questionnaire. And we have the industrial
hygiene interview. And they will overlap. But
the chance that all three overlap with the same
information is pretty small because they're
approaching it in a different way.

   So the SEM is a great place to keep
track of those 17,000 different chemical
exposures and what sites they were used at and in
which tasks. But there are a lot of diseases
that are not addressed by the way the SEM was
constructed.

   So I think what you're saying is
completely right. I mean I've certainly seen
cases like that, too. And we have to be sure of
that.

   MEMBER WELCH: So you have the
expertise to know which of those sources of data
is most useful.

   MEMBER REDLICH: Well, yes. But on
the other hand what it is is it's basically
something that's not a specific chemical that's
not really addressed in SEM. And that's what the
IOM report had said they're not addressing
mixtures, in addition to which specific chemicals
that were probably related to a task wherever it was done have not been linked to that task at all the sites because there wasn't specific data that was there. So there are many ways in which the web of connections requires the addition of some expert judgement.

MEMBER REDLICH: But when you have so many different exposures over so many years, there may be some situations where fine-tuning this will create greater clarity. But I think there are probably a number of where it isn't necessarily more helpful.

MEMBER WELCH: Well, yes. I mean the problem would be if the SEM is considered the ultimate answer. But if the SEM is there as a useful tool the same way the Occupational History Questionnaire is there as a useful tool if it has something that helps, fine. If it doesn't answer the question, it's not the end of the inquiry.

MEMBER REDLICH: I guess also from my perspective how much time, effort and resources are being devoted to this activity to me would be
helpful in trying to decide how much added
benefit is there.

MEMBER WELCH: I don't think you need
to know that. I think at least our committee who
is working on this has already decided it's more
important to put effort to broadening the range
of assessments rather than trying to make SEM do
things that it may not be able to do. Is that a
fair statement do you think, John?

MEMBER DEMENT: I think so. The other
thing, a lot of cases, we started reviewing
specific cases in great detail. When it's a
survivor case and you look at the History
Questionnaire, it's usually pretty much blank
except for having worked at a site if you're
lucky to have a little bit about the job at the
site. But nothing in terms of potential
exposures in most cases and certainly nothing
about task.

Where do you go from there in terms of
assessing that potential exposure? And I think
the SEM does or could play a role in that given
that it could be expanded in many cases in terms
of these exposure disease links.

I think the SEM plays a role. It can
play a role in specifically some of those cases.

MEMBER SOKAS: It sounds like the Venn
diagram approach is one of the recommendations
that would come forward from the Committee
because I think it's pretty clear from the spot
review of some of these charts that it's really
being used as a filter right now. And you don't
get to the next step if you don't get through it
which is problematic.

MEMBER VLIEGER: Excuse me. A few
things that aren't being covered here, we didn't
discuss the EE3 which is a required document for
the claim and it's the work history. So even
when the worker put in what processes they worked
in because there's no link and there's no
database. No one has gone and looked at the
documents that even the unions have maintained.
Or building trades has a good database when they
interviewed the workers for their exposures. No
one has looked at acquiring those and linking
those on the SEM.

So the EE3 is a required document
under the claim process. But when the worker
says what they did, those comments are mostly not
developed. When we received our files, the EE3s
were not with the files. And I found in one of
the files the claims examiner said the person was
a laundry worker when in fact they had claimed --
and it was in an earlier document -- they were
actually a laborer and not a laundry worker.

By not including a lot of the context
from the EE3 in the documents, you lose what the
worker is trying to tell you they knew that they
did. So I think a lot of the development in the
EE3 could be improved. That form in itself could
be improved.

Another comment was, and Kirk can
speak to this, the unions by contract changed
their jobs at the sites. And that information
can be captured, but it hasn't been captured. I
think if we're going to try and figure out what
people did at different sites by varying processes and what they did in the overall complex of the program, we need to go back and capture that information from the unions for the site surveys and the definition documents they say for the site and what they did and what processing they did.

NIOSH has done a lot of that. They know what went on. That's how they're doing their process. We should be able to capture those documents from NIOSH about what work processes and thereby what exposures were going on.

And every site was slightly different. Or if a contract changed or a mission changed, but we should be capturing that somewhere. That's going to tell you what was going on and what they could have been exposed to.

MEMBER CASSANO: I think the point is that you need to look at the EE3 and see if you want to include that maybe in an updated form or better form in your Venn diagram of what needs to
be.

MEMBER WELCH: If you feel like what you have to say is reinforcing what somebody else has already said and we're discussing the same points, then hold your comments. I wasn't particularly looking at you, Les. You were the only one who flipped up your thing.

(Off microphone comment)

MEMBER WELCH: Thank you, thank you. Because Steve is not nudging me yet, but we have one more recommendation and we're supposed to move along. Now could I get a sense of the Board? Should we have people raise their hands? Are people in favor of the recommendation that OWCP establish a process whereby the industrial hygienist interviews the claimants directly when the hygienist thinks it is necessary to adjudicate the claim? Show of hands.

(Show of hands)

MEMBER WELCH: Okay, great. So I think the process we're going to use is that I think that one probably doesn't need additional
bullet points because that's pretty straightforward. And then I'll add we'll figure out how to do it. But by the end of the meeting or between now and whenever we need to do it we'll add rationale for that which I already have in that document, a rationale for it.

MEMBER BODEN: The CE is the gatekeeper. And so it can't be that the industrial hygienist decides when to do it. There has to be a way for the industrial hygienist to have a chance to decide when to do it. So we need to figure that out.

MEMBER WELCH: I guess I'm saying if we tell OWCP they need to establish a process then they should take the CE out of the line of fire or out of the gatekeeping role. As it is now, the hygienist can ask for more information. But instead of asking the worker, they ask the CE and the CE only uses the sources that they already have. So it doesn't seem like there's new information that comes in.

Carrie had hers up first.
MEMBER REDLICH: I guess this would be addressed with your initial Venn diagram. But the SEM seems to be I need to characterize all the exposures of this job. But depending on what the disease is, you have ideas about what would be relevant things that you would need to know or would be helpful to find. That SEM up front should do that.

But my concern is -- and maybe this is something the other group would discuss -- are you really going after fine-tuning this exposure where if you actually think for this particular disease these are the exposures I might care about versus a more extensive characterization.

MEMBER WELCH: Right. I think you're saying what you said before about the SEM and that the idea is that the SEM doesn't do the job. And if you're looking at a case or an industrial hygienist is looking at a case and somebody falls with silicosis, the question is were they exposed to silica. And if they weren't exposed to silica as a physician you would say were they exposed to
other things that cause the same change on the x-ray or do they have other medical conditions?
From the industrial hygiene question and claimant question, it would be whether they're exposed to silica.

So if that information is not in the SEM, the hygienist might have to interview the worker to figure out what task they did and how they could have been exposed. So the SEM I think --

MEMBER REDLICH: So maybe to re-ask the question is how much is the person doing the SEM directing their activity towards the specific disease. That's not --

MEMBER WELCH: No, the SEM is a collection -- people can correct me if I'm wrong -- of exposure data. It's not a way to identify we have claims for silicosis. Where was silica used? It's taking existing records and putting them in a system that links this Material Safety Data Sheet or this industrial hygiene to a location within the DOE complex and to a disease
if there's a link with that substance in a
disease.

So it's starting from the information
on substance use at the facility, however those
records exist. It doesn't do what you would like
it to do. And I think it would be hard to. It's
like saying we want the Occupational History
Questionnaire to gather everything going in.

And I think John made a really good
point that usually even if you have an extensive
one. Even our building trades one takes an hour
to interview. Got a lot of information. But I
often have to call the worker or have one of our
guys call the worker to clarify some things that
were there to really figure out if they had the
exposure that we think they might have had.

MR. RIOS: Just for clarification,
this is Tony Rios. The only recommendation that
the Board has voted on is the one outlined in
bullet number two. And I am asking for
clarification. Do you want it submitted to the
Department as it is written?
PARTICIPANT: Yes.

MR. RIOS: Okay. And the only reason I'm bringing that up is because Dr. Boden was talking about the CE being a gatekeeper and those additional conversations. So that's why I just wanted to make it clear that the recommendation is exactly how it's written on bullet two.

CHAIR MARKOWITZ: Do we have a comment down there?

MEMBER CASSANO: I think though I agree with what you're saying. I think a lot of these recommendations may be modified after we get through our discussion.

A lot of what is determined to go to the industrial hygienist and the CMC is by the CE. The industrial hygienist is only seeing what the CE determines to be relevant. And that makes a major impact on the process of him interviewing it.

Maybe he doesn't need to interview if they have all of the information. Maybe they still do. But I think maybe we can hold all of
the recommendations from all of the subcommittees because there's so many cross-cutting issues until after all the subcommittees report. And then we can develop more cross-cutting recommendations. So I don't want to have two contradictory recommendations.

CHAIR MARKOWITZ: I think it's a good point. And what we ought to do is as we go through the subcommittees develop provisional recommendations which reflect the sense of the group but aren't officially voted on. And then tomorrow we will revisit them, hopefully not revisit a lot of the discussion in relation to them. But we can formulate the specific language and then vote on the specific recommendations. I think that probably makes a lot of sense.

And I do have one last comment though about this recommendation. I do think we should generalize it and say that we believe the industrial hygienist should conduct personal interviews of claimants under some circumstances in order to obtain better information, but not
specify that it's when the IH thinks that the
information is insufficient. Then we're
inserting ourselves in the claims process in a
way that may not make sense.

MEMBER DOMINA: I just want to make
sure though when we're talking about industrial
hygienists and the SEM what SEM are we talking
about, the public one or the one that DOL keeps
behind closed doors that we don't have access to.
That could have for any given site 50 or 100
chemicals on it. We don't know because we
haven't seen it.

I brought this up several times. And
also the fact is like it was brought up on the
tour yesterday -- Mr. Whitley brought it up --
just because of somebody's job title does not
mean that they're not exposed to something like
janitors and somebody just brought up laundry
workers. Laundry workers are involved with a lot
of nasty stuff.

MEMBER BODEN: I just want to remind
everybody that they need to speak into the
microphone and that they need to put the
microphone as close as they can to their mouth.
The captioner as well as the transcriber have
informed us that the audio is poor.

MEMBER WELCH: Why don't we -- Kevin,
if you can move the slide. I don't remember what
our third recommendation is, but I know I had
one. Let's see. Is that the last slide? Go
back up then. Oh, yeah.

So we wanted to recommend that one way
to improve the Occupational History Questionnaire
is to have former workers administer the
questionnaire who have been trained in
questionnaire administration instead of having
staff who don't have any experience at the site
or have specific training in taking an
occupational history. That's how it's happening
now.

When the questionnaire is improved and
let's say it's asking something about task, it
would really be very valuable to have the
questionnaire administered by individuals who
have worked at the site and understand something
about task. And as representing the Building
Trades Medical Screening Program, we're happy to
work with DOL to implement the development and
quality assurance process that we've been using
to make sure the questionnaire captures as much
as we can. Do people have any comments on that
idea of having former workers administer the
questionnaire at the resource centers?

MEMBER POPE: I think that's a great
idea. The former workers are the ideal people to
put that input on that form. They would be the
ones that would know those different areas that
would be applicable to those different claimants.

CHAIR MARKOWITZ: In our Former Worker
Program which is at 14 DOE sites, most of them we
have former workers who are coordinators at those
sites and they assist. Gary Whitley is one of
them. There are two additional ones from Fernald
and Mound in the audience today. They are the
ones who assist at a local level workers, former
workers, claimants with filling out forms
including the EE3, whatever work history
information is provided. So they really are and
have been the collection of the repository of a
lot of the exposure information at those sites.

So it's been extremely useful in the
Former Worker Program. Therefore, it should be a
kind of approach that would be endorsed by
EEOICPA.

MEMBER TURNER: I'm a former worker
and I'm in that program. About 1998 there was a
group of -- There was a couple of women that came
-- It was a man and a woman that had come from
Washington into National Jewish. And they did a
video. Somewhere there is a video floating
around that I was in.

MEMBER WELCH: Sounds like there's the
absence of more comments. Do we have a general
sense of the group that people like this idea?
Okay. Good.

The other point that's on this slide
is that we had discussed what we refer to as the
1995 Memo which I think some of you are familiar
with. But not everyone is familiar with it.

We have it on the agenda for Wednesday I think. We can circle back, but it was -- It's after the break today?

CHAIR MARKOWITZ: We have it on the agenda for this morning.

MEMBER WELCH: So we'll talk about it then. Okay, because we think these things help with that particular issue.

I think I'll stop there. We discussed other things in the committee. But what I really wanted to present to you all was those three major concepts. We'll continue to work our way down the list in future calls. But I think these are going to be -- Sorry. I'm not close enough. We can move on.

CHAIR MARKOWITZ: Great. Thank you, Dr. Welch.

Dr. Redlich who is the chair of the subcommittee on looking at issues relating to Part B Lung Disease. If you could discuss the subcommittee's activities.
PART B LUNG DISEASE SUBCOMMITTEE

MEMBER REDLICH: I should first say
the other members of our committee did not have a
chance to review the conclusions we've come up to
date with. Please, others, chime in. These are
the members of our committee.

So I think we've introduced myself,
John Dement, Kirk Domina, Jim Turner next to me
and Laura Welch. And I appreciate everyone's
input.

Just to review, we had our initial
meeting and then we have had two teleconferences
that were open to the public since then, the end
of June and the end of September. This is a
summary of where we're up to so far.

At the initial June meeting -- and
I'll get into this further -- we tried to just
clarify our charge and areas where we overlap
with some of the other subcommittees and define
what data and information needs would help us
come up with recommendations. And then we did
receive data, did the initial review of the
analysis and then also a plan to review cases
that we had requested.

        Just to go over, I think we are
somewhat clear on our goals. But I would say if
there are other issues that we don't discuss
today that people feel belong under this
subcommittee let us know.

        And I'll go over -- We requested DOL
the information we got. Dr. Dement will present
some of the initial data analysis he did and then
what our initial conclusions are.

        We got a number of questions from the
DOL concerning the Part B conditions. And the
general areas that they fell under were specific
questions about sensitization, the BeLPT. Some
of them were a little bit more technical or is
there a better test for acts and a couple of
questions about clarification for diagnostic
criteria CBD, the question of what to do with the
sarcoid-CDB overlap and similar with silicosis
and then complications of disease.

        As far as the information needs, I
think we realized that we felt like we needed
more data on the Part B claims process. I think
some are more familiar with it than others. And
then we also felt that it would be helpful to
have cases to review.

We did ask is there any relevant
surveillance or other data from any of the sites
such as Hanford that might be useful and then
input from patients and also providers involved
and others in the process.

This was actually not meant to be able
to read. But it is available on the website.
This was data requests that we gave to the
Department of Labor in terms of specific data
about the claims process. Dr. Dement will go
into that. And then also specific cases to
review. I would say that the Department of Labor
was quite responsive to our requests and really
gave us the data or some of the data fields that
they gave us in response to our request. So that
was productive.

And probably next -- and
unfortunately, John, I had trouble putting them into a slide form -- this is from John's initial analysis of the data. And the whole group has not gone over this ourselves first. But we're presenting it to everybody.

John, do you want me to just quickly and you comment or the other way around? They're in the order of your --

MEMBER DEMENT: Whichever one is fine.

MEMBER REDLICH: It's probably best because I think John can also explain just some of the issues with the data that we got or not issues, but just what fields.

MEMBER DEMENT: First of all, we received an initial set of data and we requested some additional fields. The Department of Labor was responsive in coming back with what they could provide. We got an additional file that had the data fields.

There are still some questions. So we had a couple of telecons for me to basically understand how the information was extracted from
their system. So I could understand how to classify cases with regard to acceptance or denial by condition.

And I guess from the outset there's one point I want to make. The way the information is structured allowed some overall look at acceptance and denial by classification and by Part E and Part B.

But for many individuals that had multiple conditions that were filed, it's not possible to look at it with the way the data is structured over years. You can only look at specific cases in which there's only one condition filed by year. And you can only look at the reasons for denial for individuals that have one condition filed.

As I go through this information, keep that in mind. This represents overall information from all the cases. But as we drill down deeper into the information, it's not possible to look at it except individual classifications.
MEMBER REDLICH: And I should say that though our charge was B claims, we did ask for some information such as how many cases of sarcoidosis or interstitial lung disease, things that might should be a B but not be recognized as such as interstitial lung disease that could be chronic beryllium disease. That's why we have diseases that are non B diseases up there.

MEMBER DEMENT: Part E is Part E. I mean individuals -- For each individual there's a line item. And it shows what they filed in for Parts B and E. So they can actually file in both. Some of this will count as both. And I'll show you a slide that shows the overlap.

MEMBER BODEN: John, quick question. In some cases, you'll have one of the conditions accepted and another one denied. How are they counted here?

MEMBER DEMENT: There is a separate acceptance or denial by each part.

MEMBER BODEN: Okay. So this is actually conditions accepted or denied, not the
cases.

MEMBER DEMENT: Yes. Conditions. And these are conditions in this particular file.

Can you advance the slide?

MEMBER REDLICH: Just the other point is I think part of the rationale especially for someone like me who is less familiar with the whole process is trying to identify maybe where the biggest problems are and also currently more major concerns which is why we broke the data out by year.

MEMBER DEMENT: Right.

MEMBER WELCH: John, can I ask a small question?

MEMBER REDLICH: And so I'll let John.

MEMBER WELCH: That's okay. My question on the previous slide, there could be people who are reflected in those numbers. An individual could be reflected multiple times in those numbers on the first slide because it's by condition.

MEMBER DEMENT: On this slide, yes.
MEMBER WELCH: On this slide, yeah.

MEMBER DEMENT: Because it's a summary of approvals by condition.

MEMBER WELCH: Right. So when you look at interstitial lung disease where the percent approval is fairly low one of those people could have been approved for CBD.

MEMBER DEMENT: Yes.

MEMBER WELCH: They could have filed for both CBD and interstitial lung disease.

MEMBER DEMENT: Right.

MEMBER WELCH: And they were approved for CBD and essentially denied for interstitial lung disease. So I'm just pointing out that you can't just look at this and say "Wow. There are only 28 percent of the people with interstitial lung disease who had their claim approved." Many of them had a claim approved for a more specific diagnosis.

MEMBER DEMENT: Many of them had multiple approvals and multiple denials as well.

MEMBER WELCH: And there's just --
John will explain it, but anytime you look at a number that we're showing you and you draw a conclusion you have to then go back and say "What are the limitations on that particular line item maybe?"

MEMBER DEMENT: Right.

MEMBER WELCH: Thank you.

MEMBER VLIEGER: I just have one comment on that slide. Most of the overlap is going to be between beryllium sensitivity accepted and then CBD. That's where the majority of the overlap in my experience is going to be. In order to get CBD approved, you have to have the beryllium sensitivity approved first.


MEMBER VLIEGER: Right. And so when we're looking at a lot of those overlaps, my experience is more that those are the two that are going to be the overlaps.

MEMBER DEMENT: Yes.

MEMBER REDLICH: Okay. So this was broken out by year. Yes.
MEMBER DEMENT: Do you want me to talk about it?

MEMBER REDLICH: Yes.

MEMBER DEMENT: So what you have in this slide is for individuals who have a single condition that was filed that's where we can make this breakout. And this is the approval rates by year.

It's really taking a snapshot in each year saying which cases were approved and denied. It doesn't say anything about when the case was filed. This is looking at a specific year which approval or denial was made.

If you look, for example, under Part B -- I started all this in 2005 realizing that Part E was only in place in 2004; so looking at 2005 forward -- I guess for CBD it looks like there's a downward trend and probably worthy of some discussion about why that might be.

Is it because as we go forward in this program we are requiring the post-1993 for most cases? That is required sensitivity. Is that
the reason we're seeing a decline in the rate of approval?

Or is it early case finding? When we started the program, we had lots of individuals who actually had better medical information developed in the cases. When we go further down, we have more cases that have less information. I don't know the reason for that. But the others are a little more consistent with regard to the approval rates.

I don't have much more comments unless you have some more comments on it, Carrie.

MEMBER REDLICH: Yes, any other before we move onto the next slide?

CHAIR MARKOWITZ: I'm sorry. I don't understand the overall, the column to the right. That doesn't represent the total of across the rows, right?

MEMBER DEMENT: No, it represents a total for the whole program from the start of the program.

MEMBER REDLICH: This is the Part E.
John?

MEMBER DEMENT: Yes, this again if you look at the trends across time, there are some ups and downs. In some cases you're dealing with relatively smaller numbers. So there's a lot of variability about it.

But for CBD again it looks like over time we're seeing the downward trend in approval rates.

MEMBER REDLICH: And then this is the other Part E conditions.

MEMBER DOMINA: I just want to make a comment here. I think you also have to be aware of based on demographics the person's age, if they're currently working, if this is still the best program for them to be in. If you were one of my guys based on your age and whatever and now we have this under our Workers Compensation Program based on the benefits allowed by an individual, this may not be the best program for that person who is a current worker and who still has several years ahead of them in his career.
Or this could actually be the worst of the three programs that we would have to go under.

And I can't speak for anybody's state except for Washington because our Workers Compensation is better than others. And the program that we have set up through our current Chronic Beryllium Disease Prevention Program allows for a lot better benefits for the people than this program. And because you do have offsets in compensation, you need to be aware of that.

MEMBER REDLICH: This is the Part E Other Conditions.

MEMBER DEMENT: We see as you've outlined or highlighted in this slide some downward trends for the interstitial lung disease over time. And again, the reasons for that you can't call out of this data.

MEMBER REDLICH: I agree. And I think what struck me from it was as far as the low -- I mean the total number of sarcoidosis cases being relatively small. And I was -- Some of the
reasons some of those weren't accepted and then
I guess the interstitial lung disease was another
one that we were questioning.

MEMBER DEMENT: And again for the
cases where we had individual conditions filed
for, single conditions filed for, we were able to
look at the classification for reasons for
denial. This is not broken out by year. This is
overall for the entire program from the
inception. And these are the classifications
that were provided.

If you look at for example CBD 60
percent of the denials were for primarily lack of
medical information. And if you look down into
Part B that pretty much is a driver except the
chronic silicosis where we have a combination of
medical condition not covered or insufficient
medical information.

MEMBER WELCH: The one thing to
remember because maybe not everybody knows the
Part B rules but the medical condition not
covered could be because they worked at the site.
That's not specified. They have chronic silicosis, but they didn't work at the Nevada test site.

So Part B was very specific for that. That's why you probably see such a high percent not covered there. And those same people could go and apply under Part E and have their case accepted.

CHAIR MARKOWITZ: Just a quick question about what is meant by medical information insufficient. That doesn't really mean lack of information. That means whatever medical data or information that was provided that didn't meet the criteria established for those conditions. Is that right?

MEMBER DEMENT: Well, I can't answer that. The program will have to answer that. And I think we're starting to get a sense of it as we review individual cases for that. That's as it is provided to us.

MS. LEITON: This is Rachel.

MEMBER REDLICH: Rachel, this is Tony.
Can you place one of your phones on mute?

MS. LEITON: Yes, the other one is on mute.

MEMBER REDLICH: And if you can speak slowly.

MS. LEITON: Yes. So medical conditions usually are not covered if they don't meet the criteria. Or medical condition information is insufficient.

MEMBER BODEN: John, a question about first denial reason. So in the small number of cases that I've looked at there have often been multiple reasons for denial. And I'm wondering whether looking at the first denial condition necessarily gives you a full picture of what's going on.

MEMBER DEMENT: May I ask a question? We were only provided that. We weren't provided a whole chain of acceptance/denials. But I guess my review of the cases so far I don't think it's a bad ball park look-see of the reasons for acceptance or denial.
I think it's representative. Whether or not it's 66 percent or 56 percent, it still represents for sensitivity. And I think that may be the major reason.

MEMBER REDLICH: I feared the somewhat confusion between what these different categories actually meant. The medical condition not covered seemed more straightforward, but insufficient information that would partly depend on how high a bar or where your level of certainly you needed to make a decision. And that and the negative causation result, I'm assuming that was just a decision it was not related.

MEMBER DEMENT: That's my interpretation of that. As you look at Part E, you'll see that under Part B you don't see as much of that. But you see more of it under Part E.

MEMBER REDLICH: That's right. And then this is Part E and if John wants to comment. I think it's mainly the other conditions of Part
E.

MEMBER DEMENT: Yes.

MEMBER REDLICH: So we could --

MEMBER DEMENT: I think you move onto
the other conditions because those are the ones
that are primarily the COPD, asthma, ILD.

MEMBER REDLICH: That's right,
exactly.

MEMBER DEMENT: If you look at it, a
lot of these are negative causation result. And
again it is what it is in terms of what this
thing says.

But we need to drill down more into
why there's a negative causation. Is it lack of
exposure? Or is it a lack of an association
between an exposure and an outcome? I guess we
start to get some picture of that. We need more.

We need more information.

MEMBER REDLICH: And I realize I tried
to squish this onto one slide which may have made
it illegible to some people. But this was for
the COPD, asthma, ILD and sarcoid. The negative
causation result for all of them was the most common reason for denial.

And I would take into account the comment Laura made earlier. But to me this was striking.

MEMBER WELCH: Although if I understand what John said, these are people for whom this was the only claim that they made. So it wasn't like these people. These ILD claims got accepted for something else. Once you're drilling down to this level, they were claimants with a single disease.

MEMBER DEMENT: Single disease in the part that they filed under, yes.

MEMBER WELCH: Right. So I was talking about only the first slide.

MEMBER DEMENT: Yes, the first slide is we're able to look overall, but you just can't break it out by cause or year based on the way the structure of the information is. And it took me a while to realize that going back and forth with the folks at DOL. And we finally I think
have it calibrated.

MEMBER REDLICH: And one thing that this does not reflect is has there been a change in the pattern of acceptance over time. I think what we're most concerned with is trying to improve or fix how things are happening currently.

So whether these numbers reflect how things were seven or eight years ago versus the past several years you would have to look at the trends. My guess is that just from the cases that we've looked over as John has said that this seems to fit with the cases.

MEMBER DEMENT: I guess it's possible in this to restrict this type of output to the last five years based on the structure of the data we have. I just didn't do it yet.

MEMBER REDLICH: Sure.

CHAIR MARKOWITZ: Question. One of the ways in which this look is vulnerable is whether in fact these cases are representative of the larger number of cases. Many claimants do
submit claims for multiple conditions. And these
of course are only the claims which are for a
single condition.

John, do you have any sense of what
percentage of all the claims that these
represent? Is it 10 percent? Is it --

MEMBER DEMENT: No, no. It's much
greater than that. It's at least half and maybe
even more. I guess my sense of taking a look at
these reasons and looking back at the bigger
table that has it all in it the distributions
look pretty similar in terms of --

So I think it's probably a reasonable
representation of the reasons for acceptance or
denial for the conditions stated. But I think
the issue of beryllium disease and sensitivity
collectively may be an issue for discussion
because I think those two are so interjoined.

MEMBER REDLICH: I was just going back
to the original.

MEMBER BODEN: Okay. Thank you. So I
was trying to think about ways in which these two
groups, the single and the multiple, might be
different. And this is a question maybe for
people who have been more involved in the claims
processing.

I could imagine that people who had
some sort of representation might be more likely
to file multiple claims to try to cover different
possibilities. Whereas, people who were less
likely to be represented and who might therefore
not be as good in a way of pursuing the claims
might have single cases. And I wondered if
anybody who is more familiar with the process
might be able to answer that question.

MEMBER VLIEGER: In my experience, the
better way to get a lung condition accepted is
for everything they've been diagnosed with to be
applied for. What this comes down to is
ultimately under Part E for the benefits which is
once you apply for them and at least one lung
condition is accepted there's very little
variance depending on how chronically ill they
are with their condition under the Impairment
Rating Guidelines with the AMA Guide, 5th edition. Their benefits are going to be about the same whether they get one, two or three lung conditions accepted.

The difference with beryllium of course is there's a different benefit package for that. There's Part B benefit. But when it comes to wage loss and impairment rating with the impairment system we currently use under this program, as long as you get one of their lung conditions accepted they're going to be covered medically and they're going to be getting as much benefit.

So, yes, multiple conditions are claimed. Then as long as it's substantiated by medical evidence, we can get them accepted.

MEMBER REDLICH: The issue of this overlap -- and John could clarify -- because this was accepted by year. So you could still be included if in 2015 you had accepted one claim. But three years earlier there could have been a different condition. That was still there were
two claims, but that would be included because one was earlier. Am I correct about that or not?

MEMBER DEMENT: The way this information is structured I don't think that would happen because we have a line item per individual. And actually on the line item is both Part E and Part B. If they didn't file in one of the parts, it would just be blank in terms of medical conditions filed.

If they actually filed for multiple conditions, I think even if it filed in different time periods, it should appear on that line. And I'll speak to the DOL people for that. I think it should be there in terms of that information on that line that says medical conditions filed. I don't think that would necessarily be the case in our data.

MEMBER CASSANO: One of the things that I see and probably assume happens a lot is that a claimant either applies -- They've been diagnosed with multiple conditions. They apply for the wrong medical condition or they apply for
the wrong nexus of causation. And therefore it gets denied.

Part of a duty to assist which does not statutorily exist in this department is that if the CE or someone with the knowledge sees that they should say, "Oh no. This person actually was exposed to such and such and therefore, yes, there is a nexus and therefore we should accept the claim." And that does not happen I don't think.

MEMBER POPE: I just had a question about the insufficient information, that percentage. Could it possibly be some contributing factor that the claimant did not have an advocate or support when filing their case that that percentage is so much higher in terms of their claim being processed or being approved?

MEMBER DEMENT: Again, I think the information from just this data file won't provide the answer to your question. It's a great question, but I think we actually have to
look more at the collection of cases that we're
provided to review to see if that might be the
case.

In the ones I reviewed if there was a
representation for the individual, it's usually
stated in the letters that go back in terms of
the fact that it goes back to the representative
and they're copied on things. So we should get a
sense of that.

MEMBER REDLICH: But I think that
raises a very good question because I think for
certain things like beryllium sensitization if
there was no beryllium sensitization test result
anywhere in the packet one would consider that
reasonable. But that's insufficient evidence.

There are many other situations where
that person may feel "Gosh, I'd be more
comfortable with additional medical information."
And whether I could imagine some of the COPD,
ILD, asthma, how carefully has the person proven
asthma. And where one could potentially make a
decision based on imperfect information.
I think under certain circumstances it's very common as clinicians we want more medical information. And it turns out that either you can't really get much more or what you get in the end doesn't really change the decision you would have made with the information you have.

I think that's an area to look into further. With this additional information that someone feels they need, what's the likelihood that it would change your decision?

MEMBER WELCH: I was just going to say I feel like our board looking at these cases the classic story about like 12 wives, men they're blinded and they're trying to identify an elephant. So I got the toe and you got the trunk.

But I've seen cases for the medical information insufficient where, say, for COPD the claims examiners are being told to use certain criteria. And if the case doesn't meet those criteria, it doesn't move on. It will be turned
down at that point. Then the worker can come
back with more.

And at some point it gets to a CMC.
the claims examiner will say "Is the medical
information sufficient" sometimes. I mean I've
seen that. No, not always, but sometimes. And
then CMC will say yes or no.

But it's often when they're looking
for, say with COPD, a pulmonary function test
that supports COPD when there might be a CT scan
that says COPD or a chest x-ray that says
emphysema. But the structure of the way the
claims examiners are told to review the case,
they want pulmonary function testing.

So it doesn't get to the -- Once
medical insufficient is insufficient, there's not
a decision about causation. There's a hierarchy
that way.

Once you get to something where the
diagnosis is a little easier to make the way the
claims examiners are approving it, you then
switch. You see more negative causation and less
insufficient. And probably those relationships
between the two depend a lot on the specific
disease and how the claims examiners are being
instructed to identify the condition.

I just thought that might be helpful.

But that's again my little -- You know I got the
toe and maybe you have the trunk.

MEMBER REDLICH: I agree. I think
what we were hoping for was that this data would
not come up with any specific recommendations or
answers, but to more highlight where we maybe
want to look further or focus efforts.

MEMBER CASSANO: I think this data
shows that we also should look at a
recommendation for the CEs for when they're under
the weighing medical evidence portion of our
discussions. This is another point where the CE
just says no and then an unassisted claimant has
no recourse because they don't know the
difference between valid medical evidence and
invalid medical evidence. I think this is going
to be a recommendation area for CE guidance as
CHAIR MARKOWITZ: But we don't know the extent to which these particularly CBD claims stop at the CE or to what extent they move on to CMCs. But do we have any insight yet? I know you only looked at a limited number of CBD cases. But I think DOL has identified before us assistance with interpreting the vague language of the Act about how to define consistent with. Something is consistent with the finding of CBD or a characteristic of.

To what extent is medical information insufficient or medical criteria not satisfied? It really is about that. It's about how to define what consistent with is. Have we developed any insights into that? And if not, how can we?

MEMBER REDLICH: To just finish up, we did request cases. We requested 20.

(Off microphone comment)

MEMBER REDLICH: Yes, I was going to get to it. I just wanted to -- Exactly, that is
the bottom. I will. I just thought we should --
because there's a later slide that starts to. So
there were 20 beryllium sensitization CBD, 10 of
chronic silicosis. Of each one, there was half
accepted, half denied.

And we just got these cases a couple
weeks ago. We also developed a form to go over
as we reviewed them in terms of -- I realize that
these aren't legible up here, but the types of
things looking at the number of points we raised
as we went through the cases. The source of the
IH data, what conditions were claimed, what the
conclusion was, did we agree with it, yes and
why.

So we have been through or are going
through these cases. It's taken a little bit
longer both in terms of access in going through
them. But I think to address the conclusions to
date and as I said we have not all reviewed
these.

One of the questions that was I think
easier to address was the sarcoid CBD overlap.
And at least from both the data and the cases that I reviewed, there has been some confusion about this presumption. And there is a document that I've read several times. It's somewhat confusing about how to interpret and implement this. And part of it relates to whether it's pre or post 1993.

This is an area to me that seemed that this presumption -- the question was if someone has a history of beryllium exposure and a diagnosis of sarcoid and whether it is presumed that that is CBD. And I would recommend that it be presumed. And that would not need a proof of sensitization.

We could get into that discussion further for reasons for that, but I think that a lot of effort has been spent that probably could be simplified there.

And the other DOL questions that we were asked, the majority of them I think we have answers to. This is a draft. They were very specific sort of questions. And again this isn't
quite legible, but what pathologic characteristics or is there another test other than the BeLPT or are there reasons to do that differently than currently is being done?

And I think those questions, a number of them, hopefully we could more in the short run I think address in terms of really just using the most recent guidelines and the state-of-the-art for testing. I wasn't going to go through each of these. But I think the majority of them are addressable with the information we currently have. That was number two.

From these initial reviews of the cases, I'd say we all have been through different amounts. This is in process now. I think on a number of them we agree with the conclusions.

Where the issues so far I think have come up are there have been a few on the CBD, but more of the non-CBD cases, the ILD, COPD. A number of those come up with the use of the SEM and that's probably why I was making the earlier comments. The most noticeable were COPD and
silicosis with sort of a lack of recognition
sometimes of the multiple exposures.

And then I think a more minor question
that I saw raised and also in discussing with
colleagues is this question if you have an ILO
reading that shows something, but a CT scan that
may be disparate. And I think that's something
that could be addressed.

My opinion is that if an ILO is the
standard and what everyone has and if someone
also got a CT scan which the scenario could
happen that an ILO would find evidence of a
pneumoconiosis, but that a CT scan could be read
where that interpretation doesn't say that the
person has a pneumoconiosis, then the chest x-ray
reading gets discredited. I think that that's
something we could address sooner rather than
later.

I think the other thing that became
apparent with certain areas that I don't think we
may be able to fix but at least we could comment
that we thought there were some issues is this
limitations of the RECA eligibility. And I think others know more about this, but there seems to be a year cutoff and if your exposures were after that year in terms of the uranium miners.

MEMBER WELCH: Then they're not eligible for RECA.

MEMBER REDLICH: That is correct. And if they're not eligible for RECA, they're not eligible for this program. That's my understanding. I just put that there because there were a number of claims that did involve that.

I don't know if others on our committee because we didn't really discuss these amongst ourselves have other comments or conclusions that they feel stood out from the data so far and the cases.

MEMBER WELCH: Actually, mine is just to comment on your number one about the presumption about sarcoidosis. We can't say with demonstrated or known exposure to beryllium because at least none of our workers identified
the exposures that caused them to be sensitized
or developed CBD.

People are working in buildings where
beryllium has contaminated the building. They
get exposed after the fact. They're not
beryllium process workers.

However the presumption is expressed
what BTMed does for our screening programs is we
screen everybody at every site. And we've
identified sensitized workers at the majority of
the sites, a great majority of the sites we've
screened at. So we presume that beryllium
exposure occurred to workers at that site.

And it's something we're actually
talking about in terms of language that we've
written within our own program to try to be very
careful not to say they have to report a history
of a beryllium exposure or they have to have
documented beryllium exposure. None of those --
You could definitely have CBD without.

MEMBER REDLICH: I guess what I meant
was if you qualified to be in this program it
seems there was enough beryllium around and there aren't that many sarcoid cases. Being part of the program they would qualify. That's what I meant. That would be just be -- That was not worded correctly. You're correct. I did not --

MEMBER WELCH: When you described it before you said with known or documented or reported or something like. So let the record reflect.

MEMBER REDLICH: So the possible, correct.

MEMBER WELCH: And when we actually come up with the language we'll be sure to get that right. But I would agree.

MEMBER REDLICH: Yes, that was not worded as intended. Thank you.

MEMBER WELCH: And you haven't struggled with it quite as often as I might have.

MEMBER REDLICH: Well, I will say that I do think we come from this from the disparate perspectives. And so I have not been involved in the surveillance programs. What I see is workers
who have a diagnosis of sarcoid and then ten years later someone finds out that they had a history of metal work or even raised the question. And there are many reasons in that situation where it can be very difficult to get a BeLPT test done.

MEMBER BODEN: I need to go back to the reasons for not accepting claims slide. Okay. I just wanted to point out one thing when we're thinking about this slide that is actually something Laura brought up to me. These are not independent percentages because there's an order in which people make decisions. If the employee isn't covered, nobody bothers with the rest of the questions because they're irrelevant. And as you go down the list, really each of those things is if the medical condition isn't covered, then you're not going to look at the rest. And if the medical information is insufficient, you're not going to look at the rest. So that's just something to think about
when we're interpreting these things.

   Actually, in that case because we've already ruled out 25 percent of the cases before we get to the question of causation, that causation number is really like 90 percent and not like 67 percent. It's really an important number.

   MEMBER CASSANO: I just wanted to go back to the sarcoid versus berylliosis or chronic beryllium disease question. Something that came up in our discussion as well, we did not write it as a recommendation, but it certainly would have been one of our recommendations.

   MEMBER REDLICH: The point that you made earlier that at the end I think it would be reasonable for us to go back -- at the end of these three days -- and to restate our recommendations and see if we can get agreement on some of these and have wording that we're comfortable with.

   CHAIR MARKOWITZ: Can you go back to the slide, the last slide, the one at the end,
the conclusions? That's it. A question there on number one. The text "should be presumed to be CBD" that's not the policy of DOL. This is the recommendation or the ideas of the subcommittee, right?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay. So the question is in this second line "BeLPT not needed for diagnosis." So post 1993 a person has sarcoidosis. They have a negative beryllium lymphocyte proliferation test. The recommendation is that they be considered as having CBD.

MEMBER REDLICH: Yes.

(Off microphone comments)

CHAIR MARKOWITZ: Okay, right. But we're presuming people have beryllium exposure within the complex because of the problems of actually identifying exposure. How is it then that a negative BeLPT? How do you differentiate with sarcoid versus CBD with a negative BeLPT and sarcoidosis from those with BeLPT?
MEMBER REDLICH: The BeLPT for blood is not a perfect test. And there are many reasons why someone could have CBD and have a negative BeLPT test. It could be related to the medications they're on. It could be related to how that blood flew to Denver.

There's also the feeling that you recruit the sensitized lymphocytes to the lung to granulomas in your lung and you don't have many left circulating in your peripheral blood. And I think it's very reasonable whether the test doesn't need to be done. But just because not to require the test because it can be difficult to get it done if you're not a surveillance program. I have a lot of experience with this.

And also if it comes back negative and the person otherwise qualifies, I think it should be presumed. There's also data of a higher number of sarcoid cases in the Navy. I think there's data at Hanford to suggest that these work environments have an increased risk of a sarcoid like disease.
CHAIR MARKOWITZ: Just a follow-up question. This recommendation, how does this differ from what DOL is doing now when they address sarcoidosis, not how they're settling claims, but in the policy statement?

MEMBER REDLICH: The DOL may be the best person to answer, but my understanding is it was a somewhat confusing one-page, presumption document. But currently if it's pre 1993, that is a presumption because you don't need the BeLPT. I think then there were some other issues in those cases about how definitive of a pathology and things like that I think will be clarified.

The post 1993 my understanding is that you still need the criteria, meaning that you need a positive BeLPT test.

MEMBER VLIJEGER: Or a positive lavage.

MEMBER REDLICH: Yes, that's the other point that the BeLPT is not as sensitive as the lavage. And there are patients that you would not do a lavage on because it's too invasive and
dangerous a procedure.

MEMBER DEMENT: I have a question about nonpulmonary sarcoid. A couple of the cases that I reviewed appeared to be a nonpulmonary sarcoid involvement.

But some of the cases it wasn't entirely clear that that was true. There may have been a pulmonary component to it. And it's currently I think the criteria for acceptance, for example, on the CT scan. It might would help in that regard to establish the pulmonary component of a primarily nonpulmonary sarcoid.

MEMBER REDLICH: Yes, or I think one could also just look at the sarcoid literature since most cases of sarcoid have pulmonary involvement. Whether that was documented in the medical records or not, I think we could just assume that there is a diagnosis of sarcoid.

You might want to slightly clarify either biopsy proven or something. But I think someone may not have looked to characterize the pulmonary component versus there being no
pulmonary component. And I would say knowing
that that would be -- If you actually went and
looked carefully, you would find it in the
majority of people that could stop the process to
make the person go and have that done. That's
where I think a presumption would be helpful.

MEMBER FRIEDMAN-JIMENEZ: Just a quick
question, Dr. Redlich. Is there sensitivity and
specificity of the BeLPT known? Has anyone
measured that? And is there a good enough gold
standard to actually calculate it?

MEMBER REDLICH: Laura could probably
answer this question better than I can.

MEMBER WELCH: Yes, I mean there are a
couple of published papers on that, on
sensitivity and specificity. There's also inner
laboratory variation. So I think the programs,
the two screening programs, have developed an
algorithm that will try to address those
questions.

And then there's also the predictive
value of BeLPT for CBD. I mean I shouldn't say
predictive value. It's more than that because it's a biological assay. If you have two positive tests or a positive test and a borderline test the likelihood there's true sensitivity is thought to be higher.

DOL doesn't require high level sensitivity of the test to allow beryllium sensitivity. So beryllium sensitivity is accepted with one positive BeLPT which is sensitive and not as specific as if you had two positive tests.

So there's a combination of the meaning of each individual test. And in terms of reproducibility which then may relate to --

There's no other biological test for sensitivity other than the blood test. So you can't really test it against something else.

MEMBER FRIEDMAN-JIMENEZ: Lavage.

MEMBER WELCH: No, but not necessarily because lavage is not the gold standard. I mean you could have somebody who has a negative lavage and a clearly positive peripheral blood test. It
just kind of depends where those lymphocytes are at the time. You can be sensitive.

Now the lavage is obviously more predictive of having lymphocyte granulomas in your lung.

But one of the things we found in the Building Trades Program is we found a lower proportion of CBD cases upon our sensitized workers maybe because the sensitization is occurring by skin contact rather than through the lungs. So sensitivity in some workers may be less predictive or it may have to do with dose. So among Rocky Flats workers if you were sensitized and you worked there during a certain period of time, you're likely of having CBD was pretty high. That's about four times as high as sensitized construction workers.

The disease is rare enough that you can only speculate about those things. But each test has -- We can talk about it for a long time. But there are some good papers that talk about reproducibility which really has to do with
specificity of the test. Is it reproducible in
an individual? And then biological, how
meaningful it is by comparing it to additional
diagnostic evaluations.

But the thing is a sensitivity test is
not a diagnostic test for CBD. It's a diagnostic
test for sensitivity. And it is in itself the
answer. So it makes it really hard to do it the
way we're used to doing other tests where you can
take a test and measure it against a different
gold standard. Way too much information.

MEMBER FRIEDMAN-JIMENEZ: But that
just raises a question. If it is the gold
standard essentially, then eyebrows may go up if
you say that you want to accept a case in the
face of a negative beryllium sensitization test
if it's presumed to be the gold standard.

Carrie mentioned several reasonable
reasons why you might have false negatives. But
I think that needs to be clarified and justified.

MEMBER WELCH: It's not sufficiently
sensitive a test.
MEMBER REDLICH: Can I? And I know Gary had a comment. All of the studies that looked at the sensitivity and the use of the BeLPT have been done in the setting of surveillance of healthy workers. That is a different use of the test.

What we're talking about now is not that. We're talking about a person who has a diagnosis of sarcoid and who has been in this program in one of these facilities where beryllium has been used. And in that setting, do you need that test?

There's a lot of misunderstanding of the beryllium literature. Because in the setting of healthy workers, you don't want to start giving someone a diagnosis that they may not have or doing harm with a blood test in a healthy person. That's different than in a patient with a diagnosis of sarcoid in this setting.

I don't mean to blow off the BeLPT. Just we're talking in this narrow setting.

Gary, you've been patient.
MEMBER WHITLEY: Is there anything that says if you have six or eight inclusive BeLPT tests that it means anything in the program? You don't have a sensitive -- I mean you don't have a positive. So you don't ever get to be sensitive according to the program. But there are people who have six or eight inclusive tests.

MEMBER WELCH: It depends on the reason for being inconclusive. If it's borderline, it has more meaning than if it's uninterpretable. So you can get a test that's inconclusive because the cells died on the way. Nothing grew. So it's not a negative test. It's a nothing test.

But there are people for whom the uninterpretable occurs because there's cellular overgrowth. And that's a reaction between the individual's lymphocytes that you're putting into the assay and the medium that they're growing in.

ORISE and National Jewish have developed ways to do this. We've only used it a
couple of times. But if we have people who have repeated uninterpretables for that reason as opposed to the lack of cell growth, there are methods that they can use for that individual to develop a growth system for the cells that's much less likely to have that overgrowth problem.

As a general rule, if somebody has several uninterpretable tests you should just stop repeating it. It's going to continue to be uninterpretable. It has something to do with the reaction of their cells with the growth media. But there are solutions for it. The people at National Jewish and ORISE know how to do that, so that the surveillance programs can be in touch with those experts.

MEMBER REDLICH: But one of the cases that we reviewed was a situation like that. And then there was a letter that basically said from one of the labs "In our experience when you have four uninterpretable tests this means sensitization." And then there was resolution of the claim.
So if that is something that is happening more commonly, then that would be something that I think should probably be looked into. Someone should look at all of those and try and come up with a plan.

CHAIR MARKOWITZ: Before we continue the discussion, just a question for Dr. Redlich. How much more of the subcommittee report is there? We have 15 minutes.

MEMBER REDLICH: We're done.

CHAIR MARKOWITZ: Okay, fine. So we can continue the discussion. Ms. Vlieger.

MEMBER VLIEGER: Dr. Redlich mentioned that the procedure manual is difficult to follow in the way that it's written for the pre and post 1995 criteria. I would like us to consider a proposal for clarifying that section of the procedure manual.

The criteria for post '93 actually should be repeated in the post '93 section, but it's presumed that you understood it from the pre '93 section of the procedure manual. If we could
maybe look at that down the road for clarifying
that because that's a problem.

Then we also discussed at our previous
meeting the instructions given to the CMCs
regarding what is the criteria under this program
of acceptance of a CBD claim. And in the cases
we received it was clear that the doctors that
were being asked this question were wandering
away from the intent of the program and the law.

There again, I think that's something
that we can clarify through the procedure manual
making a recommendation for the wording and how
those questions go to the CMCs, so that it's per
the provisos of the program and not the case
registry criteria which is a much higher
standard.

MEMBER SOKAS: I wanted to basically
thank this conversation because I think it really
helped clarify the distinction between a
screening program, Dr. Redlich, and the
definition of illness.

So I guess one of the clarifying
pieces could be that if you're getting repeated beryllium sensitization tests done if it's part of a screening program and you have absolutely no lung disease, then that might be appropriate maybe or maybe not. I don't know. But it does seem fairly clear that if you actually have the diagnosis of lung disease that it shouldn't be part of the diagnostic process the way it seems to be used.

That I think is new information for me and helpful clarification for how to do this. I think it will probably save a lot of difficulty and expense to have that clarified.

CHAIR MARKOWITZ: Is there a response to Dr. Sokas?

MEMBER CASSANO: Having looked at this from the process part and what the CEs are doing, I think the easiest way to resolve this is to basically take away that 1993 differentiation. And if someone has sarcoidosis the LPT is not required regardless of whether it's pre 1993 or post 1993.
While people in the surveillance program can continue to get LPTs some person that is out on insurance and they say, "Well, you've got sarcoid" you don't know. What the heck. The insurance company is going "What the heck is a beryllium sensitivity test and why do you need it? And that sounds like Worker's Comp. And we're not going to cover it."

I think in order to make this equal for people that are either in or not in a surveillance program we just don't require it if there is a diagnosis of sarcoidosis.

MEMBER REDLICH: Agreed.

CHAIR MARKOWITZ: Additional comments or, Dr. Cassano, if you could put your -- Thank you. Otherwise I will be calling on you all day. Any other comments or questions? Anything else from this subcommittee? Dr. Welch.

MEMBER WELCH: I have a question and probably this is for Fay. I should understand this, but people applied. Not everyone applied for Part E if they had CBD. But it seems like
Part E provides additional benefits if your claim can be accepted in both parts. It's only Part E that's going to be providing treatment for consequential conditions.

MEMBER VLIJEGER: That's correct because it would fall under Part E. So under Part B for chronic beryllium disease there's the benefit compensation. Then it rolls into Part E benefits.

Part E benefits, the medical is not part of the lump sum. It's part of the compensation amount. The compensation amount would come under wage loss or impairment rating if they qualify for both.

But medical benefits are separate and not counted under the benefit. And it's under Part E for management. I'm looking at John Vance. Well, medical benefits come under Part E, but it's not part of the compensation. It's not calculated compensation.

Do you want to come up? This is a John section. But when you get accepted for Part
B your impairment rating and wage loss would come out of Part E.

MR. VANCE: Yes, this is John Vance. So the question is how are the medical benefits covered under Parts E and B. If your condition is accepted under Part B, we would cover the medical costs for the care and treatment of chronic beryllium disease and any consequential illness from that under Part B.

If you have a Part B and Part E case, your medical benefits are going to be paid. How it's paid, it doesn't matter whether it's under Part B and Part E. There's budgeting issues involved there.

But needless to say if you have a condition that is accepted under B or E your medical benefits will be paid. And in most cases where you have a chronic beryllium disease accepted for a DOE contractor or subcontractor that qualifies under Part E you're also going to have your chronic beryllium disease accepted under that aspect of the program and your
impairment and loss of wage benefits could flow from that Part E acceptance.

MEMBER WELCH: But is there a reason then that should every CBD case also be applied under Part E because that's not what we saw? Or is it just duplicative and it's unnecessary a process?

MR. VANCE: It's going to depend on the nature of the employment because you're going to be looking at individuals that are they even qualified to apply and be eligible for benefits under Part E. So if you have individuals that were working strictly for a beryllium vendor, they're not going to qualify under Part E because you have to be a DOE subcontractor or contractor employee.

When we look at the cases if there's any possibility that that employee could qualify under both Parts B and E, we will create the claim as a combined claim. But if we're looking at it and seeing this person only worked at an AWE or only worked at a beryllium vendor
facility, then we're not going to create that Part E component unless there's some reason on the claim that says they want that to occur.

Okay.

MEMBER REDLICH: There's one thing that I didn't add to the slide, but it was on the list. There was a question raised in terms of complications of treatment of disease.

And I think that it would be very -- It seems that there is not now a presumption. And that's something that I think we would -- Fortunately for pulmonary diseases you just treat them all about the same, steroids no matter what the disease is. In terms of complications of the treatment and the complications of the disease whatever it is, the end-stage disease and treatment tend to have the same complications.

So it's not that hard to come up with presumed complications if that would be helpful for that part of the process.

(Off microphone comment)

MEMBER REDLICH: Yes, that's right.
That was on that other list. Right.

MEMBER VLIEGER: This is an area that I have to compliment the Department of Labor on in the past year. Consequential conditions of lung conditions particularly after steroid use and multiple antibiotics and that type of situation were difficult to get accepted.

In the last year, I've seen a change in the way they look at them and they seem to have some presumptive list. There's some stuff coming up that is easier for claimants once they have an accepted lung condition and they've had years of treatment.

I want to compliment them on that. But I do believe that it could be better listed. I think we could actually add to their knowledge on what is considered presumptive after a lung condition with years of treatment.

CHAIR MARKOWITZ: If there are other comments or questions? So with that compliment from Ms. Vlieger for the Department of Labor, we will take a break and reconvene at 10:45 a.m.
(Whereupon, the above-entitled matter went off the record at 10:24 a.m. and resumed at 10:51 a.m.)

MEMBER WELCH: Since Steven has a sore throat, I'm going to call it to order so he doesn't have to yell. Now he's allowed to talk.

PRE AND POST 1995 EXPOSURES

CHAIR MARKOWITZ: Thank you, Dr. Welch. Our next topic we're going to be discussing is a set of communications from Department of Labor regarding how the claims examiner and claims process will regard exposures that occur before and after 1995. And what I wanted to start this conversation off with is -- This is an issue that cuts across various subcommittees. That's why we have taken it out of individual subcommittees to deal with it as a group.

But I just want to start off the conversation by actually going to the text of what DOL says so that we're on the same page so to speak or even literally. And I'm just going
to then read through excerpts. And I've highlight parts.

First, we'll look at the circular dated December 2014 about post '95 occupational toxic exposure guidance. Let me ask this. I know Mark Griffon wanted to participate in this, a Board member who may be available by phone. But do we know whether Mark Griffon is on the phone?

Anyway, while I'm reading if you could let me know, that would be great.

MEMBER WELCH: Do you want somebody else to read?

CHAIR MARKOWITZ: No, that's fine.

"After 1995 significant improvements in occupational safety and health programs, engineering controls and regulatory enforcement existed throughout the Department of Energy facilities. These measures would have served to limit employees' exposure to toxic materials. Therefore, in the absence of compelling data to the contrary, it is unlikely that covered Part E
employees working after 1995 would have been
significantly exposed to any toxic agents at a
covered DOE facility."

And then scrolling down, okay. That's
it. You can leave it there. "After 1995 it is
accepted that any potential exposures that they
might have received would have been maintained
within existing regulatory standards and/or
guidelines. If there is compelling, probative
evidence that documents exposures at any level
above this threshold or measurable exposures in
an unprotected environment the claims examiner is
to contact the DEEOIC Lead Industrial Hygienist
on guidance whether a formal IH referral is
required. Any findings of exposure including
infrequent, incidental exposure require review of
physician to opine on the possibility of
causation." And that's the end of this
particular circular.

This was followed by a memo a couple
of months later from the Division clarifying or
really giving the rationale for this. And I'm
not going to read through all of this. But basically it's worth looking at. It's available online. We have it in our briefing books here.

It explains the sequence of events that occurred over time within the Department of Energy whereby it was expected that 1995 and thereafter that toxic exposures would have been adequately controlled. And the number of those events included the use of Tiger Teams by DOE to do a health and safety audit at the facilities.

Other measures that were taken within the Department of Energy to improve safety and health in the '80s and into the early '90s, issuance of a DOE Order 440.1 -- I think that was in 1995. Correct me if I'm wrong -- about the need to keep exposures limited to below the regulatory levels.

And so at the end of this three-page memo, it says -- this is in the first full paragraph toward the third line -- "Further since DOE published the order with the goal of significantly mitigating employee exposure to
workplace hazards including exposure to chemical or biological toxins, DEEOIC finds that after 1995 any exposure to a toxic substance by an employee working in a covered DOE facility occurred within existing regulatory standards and/or guidelines."

Finally, more recently there was a third document, a note from DOL which Kevin is going to bring up. And I think we were sent this after our first meeting because we were interested in the background for the particular circular. And it was pointed out that the February 2015 memo which I just read part of is the rationale basically. But in addition they added "as to why we created the distinction between pre 1995 and post 1995 exposures we thought this would allow us to cut out the industrial hygiene referrals on certain cases which at that time were slowing down the process. This didn't mean that the cases would not undergo a medical review, but at least we could make the assumption that for cases in which employees
worked only after 1995 the exposures would have been within regulatory standards and guidelines. We could then send that statement directly to the treating physician for an opinion or on causation."

So that's the text from the various communications from DOL on this issue. Now I will open this up for discussion. Ms. Vlieger.

MEMBER VLIEGER: First of all, a number of the advocacy groups weighed in to the Department of Labor and questioned the Department of Energy when these two circulars came out. In particular, I had forwarded this to the Board. I don't know if it ever got up on anybody's website.

I received a response from Pat Worthington from the Department of Energy into a query as to what their participation in these circulars was because they would be the people that would know about the inspections, incidents, accidents, off-normal occurrences that would have happened at DOE facilities and injured workers in
all kinds of toxic situations.

And their response -- I can forward this email again -- was that "we are aware of the two circulars you reference, but we are not involved in the policy making process at the Department of Labor." I find it entirely curious that the regulatory department that would know where all of these inspections reports on accidents, incidents and off-normal occurrences would be did not participate in the logic of these two circulars.

Furthermore, the building trades and a number of other union members protested these and pointed out that there have been a number of inspections and management oversight done proving that the toxic exposure regulations were not being followed.

And I'd like to point out that 440.1 was actually published in September of 1995, not January 1st. So to say post '95 when the regulation didn't even come out until the last quarter of the year is kind of baffling to me,
too. That's just the start of my objections to these two.

MEMBER CASSANO: From a medical perspective and having dealt with many, many different industries and many, many different contractors, I think this whole presupposition is wrong-headed. And there are two reasons it's wrong-headed.

First of all just because there are regulations in place doesn't mean that everybody is following them. And to assume that because these are Federal contractors that they're sainted in some way and are doing everything perfectly correctly is number one not true.

Number two, regulations are regulations. And as we've seen from the continued reduction in lead standard over the years, a regulation isn't necessarily totally protective of a particular medical outcome. So I think from those two perspectives this presumption is -- presupposition, not presumption is wrong-headed.
MEMBER SOKAS: I want to basically second what both Ms. Vlieger and Dr. Cassano have said. I participated in an OSHA evaluation for a variety of purposes, but it was ostensibly in regard to DOE facilities applying for VBP statistic back sometime between '97 and '99.

At the time, there were clear indications that the subcontractors were being hired on the basis of their injury and illness rates. So there was clear evidence of pressure to reduce record-keeping and reporting at the time which was of concern. And there were also clear discussions on the part of the clinicians and others at these facilities about problems that had occurred or episodes of things that had happened. Again, the idea that instantaneously everything is under control is not supportable.

I did also want to check to see if Mark Griffon is on the line because this was an area -- Okay He in our subcommittee was investigating that in particular.

CHAIR MARKOWITZ: Dr. Boden.
MEMBER BODEN: Concurring with everything that's been said so far and also just thinking about what it means, it does say that a claim in this case post '95 could be sent for a medical opinion presumably saying that you have to assume that everything was within regulatory standards and guidelines. And as a consequence it seems pretty clear that that in most cases is going to make it very difficult for a physician to make a connection between a presumed, adequate occupational environment and illness.

MEMBER WELCH: As Ms. Vlieger mentioned, the building trades did send a multi-page memorandum to the Department of Labor on this question. There's a different issue for construction workers which represent a lot of the workers here. It's that the DOE regulations didn't apply to the subcontractors. For construction workers there was a DOE rule passed in 2006 that required the application of DOE site regulations to subcontractors.

And I might not have been listening
completely, but I think we all agree that there
are many substances that are known to be
hazardous for which there is no existing
regulation.

And the OSHA regulations clearly state
for some substances a residual risk. So they'll
say for asbestos exposure and mesothelioma for
example that at the current exposure level there
will still be a measurable 1 in a 1,000 rate of
mesothelioma.

And all their standards do say that
there's not one that's completely protective. It
just lowers the likelihood of the number of
people who will be affected, but it does not
prevent it. Even if all the standards were
followed if a case occurred and an individual
with benzene exposure got the classic disease, it
needs to be investigated what that person's
exposure was. Then an individual decision needs
to be made in that case. You couldn't assume
that that was a idiopathic case of leukemia that
occurred in the setting of a known hazard
exposure.

Even if the exposures were completely controlled to OSHA standards, we would still expect to see a lower level but cases. And I'm always explaining the difference between risk from exposure and causation after the disease occurs and it's a very different issue.

If the risk is lower, it means there will be fewer cases. But when the cases occur, they're still related to the hazardous exposure in many cases. So setting this rule is providing information that's misleading I think in many ways which we've talked about to medical providers who may not have the experience that all of us have in nuancing these exposure disease relationship.

That's one reason that our SEM committee wanted to allow individual assessment of individual cases. We think that would obviate. You could get rid of this memo if you were doing what we were suggesting.

CHAIR MARKOWITZ: Dr. Friedman-
MEMBER FRIEDMAN-JIMENEZ: I also want to concur. In 25 years of running an evidence-based occupational medical clinic, we've seen several dozen probably patients who we've been convinced have work-related diseases for which OSHA or NIOSH has done an inspection or a health hazard evaluation afterwards.

I cannot remember one case in which OSHA or NIOSH found a level of the toxin in question above the OSHA standard. And we've been very surprised by the results of the HHEs and the OSHA inspections that they've been so low.

Typically they've been done months or years after the patient has stopped working there. They've been done with due warning to the employer after the workplace has been cleaned up. And I do not think that these inspections are representative of the levels that are seen every day in the work process.

So either there are high levels that are being missed and not documented which I think
is very likely or the levels that are there are under OSHA standard, but OSHA standard is not adequately protective which is a likely possibility. In particular for carcinogens, the OSHA standards are frequently calculated to make the risk one in a million or one in a hundred thousand, low enough --

PARTICIPANT: One in a 1,000.

MEMBER FRIEDMAN-JIMENEZ: One in a 1,000. But the point is that these risks are way below a risk that would give you some probability of causation that would be greater more likely than not to be work related. So essentially it will rule out carcinogenic exposures causing cancer if you presume that they've always been under OSHA standard.

I think this is a non-evidence-based ruling that we should make a strong statement that it does not match with the level of science that we have.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: I guess a couple of
comments from an exposure perspective. A lot of the exposures that occur doing non-routine operations. And it's true at most facilities and I think probably even more true of DOE facilities.

Secondly, if protection programs rely on personal protective equipment and programs, they're prone to provide much less protection than the type of respiratory protection for example would predict because a failure is along the way in a program even in a program that's reasonably well designed and administered.

A presumption of no exposure or exposure within guidelines based on use of PPE would not be appropriate in most circumstances because actual field measurements of protection factors have been much lower than predicted by the device itself.

MEMBER REDLICH: I was just going to say this seems to be uniform agreement the problems with this statement. What is the process to undo it?
CHAIR MARKOWITZ: So I will formulate
a recommendation which we'll review tomorrow.
It's going to be pretty straightforward I think.

MEMBER REDLICH: I don't mean to limit
further discussion.

CHAIR MARKOWITZ: I understand.

MEMBER REDLICH: But it seems quite
clear that it should be undone.

CHAIR MARKOWITZ: That's fine.

Further comments, particularly if they address
new topics or new issues that haven't been so far
discussed? Mr. Domina.

MEMBER DOMINA: I guess some of this I
look at maybe a little bit different just because
I know initially they told us this had to do with
the Tiger Team stuff. Well, there was also a
Progress Assessment Team that came out in 1992
that said you still didn't do what you said the
Tiger Team was going to do. Then there was a
Safety Management Evaluation Team in 1996 that
said you still haven't done what you said you
were going to do in 1992.
And then you get into currently -- I don't know if a lot of you know this -- when a DOE site shuts down they move the retiree benefits to another DOE site. So out at Hanford, we administer the retiree benefits for the folks at Rocky Flats, Mound and Fernald. And so you have to look at what they did at Rocky Flats a few years ago when they changed the retiree medical benefits. They never would have shown up in this program because everything was being covered in the retiree medical.

And then I also look at if everything was being so safe Hanford Tank Farm folks wouldn't be in Federal Court right now with the State of Washington trying to sue DOE for adequately protecting the workers. And so it still continues today that people aren't adequately protected.

CHAIR MARKOWITZ: Ms. Vlieger, did you have something to add?

MEMBER VLIEGER: One other piece of evidence to consider when we make our
recommendation is that the advocates hold an
annual meeting in Denver. And in 2015 we asked
the Department of Energy because in the process
of the claims processing the claims examiner will
do what's called a document acquisition request
to the Department of Energy. That would include
exposure records, medical records, personnel
records and EJTA's, that sort of thing.

When we get those records back from
the Department of Energy there is no exposure
records. And these were mandated by regulation.
So we asked them if they're not in the DAR for
the claims examiner to look at, where are they?

And the response that came back on
July 20th of this year is that we don't have
those records to put into the individual
claimant's records. And I believe I forwarded
this communication as well. I can do it again.

But the response from the Department
of Energy was we do not have individual exposure
records for workers. When these go to the CE and
the CE limits the exposures, then the industrial
hygienist says, there's no evidence of exposure. It's because the records are not in the personnel files.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: It's disturbing to me that the Department of Labor seems to have caught an Atomic Energy Commission disease of believing that certain documents that say the way things ought to be, guidelines, regulations, orders, are the way they are.

People from DOE communities probably remember the old official line that the contaminants never went past the fence line. And DOE era of openness blew that away. I doubt that DOE chastened staff who issue these order of the way things ought to be are a good description of the way they are.

There are plenty more examples. The term fantasy documents was coined by an environmental sociologist, Lee Clarke, who is now at Rutgers who studies risk analysis. So I would place this in the category of fantasy documents.
CHAIR MARKOWITZ: Dr. Redlich, did you have something else?

MEMBER REDLICH: In addition to stating that we think this should be withdrawn or whatever, I think whatever process came up with this statement -- you know, we'd like to prevent something like this that clearly there is uniform opinion that this does not make sense.

It's very concerning how this passed through whatever review process. And I don't know that that is. But I think whatever process put this in place appears to be problematic in this case.

CHAIR MARKOWITZ: Okay. That's interesting. I have a final comment to say. I think actually this was Dr. Dement's idea on one of the phone calls which is in some ways -- I mean I do believe from what I've heard that in many situations within the complex the conditions did improve over time and that health and safety hazards were reduced over time through the '80s and into the '90s. Maybe it was not specifically
around a particular date or around a particular set of actions. But conditions did improve.

Actually those are the situations in which we actually need the industrial hygienist to weigh in to see whether there was a significant exposure or not. This is exactly when we don't want to bypass the investigation into the exposure because we won't need to understand whether there was excessive exposure or not.

I would say quite the opposite that as conditions improved it's where further investigation into the exposure of a particular alleging disease where we really need that additional information. And the physician who needs to opine -- express an opinion about causation really needs to know whether the significant exposure occurred or not.

It's actually the reverse. What I think should happen is actually the reverse of what this policy advocates. Dr. Cassano.

MEMBER CASSANO: Yes. And just
circling back to Laura's initial comment about the industrial hygienist interviewing the claimant, I think this is a perfect example of why that has to happen.

CHAIR MARKOWITZ: Okay. We need to move onto the next topic. Dr. Welch is going to lead a discussion on the different EEOICP policy involving solvents and hearing loss.

EEOICP MEMO/POLICY RE: SOLVENTS AND HEARING LOSS

MEMBER WELCH: And Kevin I hope is going to be able to bring up a slide presentation that I just emailed to him.

We discuss at the Board at our last meeting that there are limited number of presumptions that have been developed to help the claims examiners adjudicate cases. And this is one of the more recent ones that determines in which cases does organic solvent exposure be a contributory cause to hearing loss.

I mean it's really great that DOL decided to address this question because hearing loss is really quite prevalent in this former
worker community. And it generally has been attributed to noise. But there is --

Looking at the contribution of organic solvent exposure based on the literature that now exists is really an appropriate thing to do. Because there's this complicated relationship, many of the workers, the hearing loss could be considered noise-induced. I was explaining it's not a different pattern with organic solvents. It will be contributory.

So it makes sense to figure out a way to approach that. A presumption is a really good way to say, okay, in this circumstance even if somebody had noise exposure we can presume that solvent was a contributory cause.

This is my idea of how one would develop a presumption generally. And then I want to talk about the solvent one. There has to be an exposure-disease relationship already if we're going to presume that in this particular this particular exposure caused this particular disease.
And then you need some kind of dose or exposure needed for a presumption based on what we understand about the epidemiology or the biology of that disease. In this particular case, if somebody was using a magic marker -- they're a trainer and using a magic marker at work -- most of us probably wouldn't say that solvent exposure was sufficient to be contributory to their hearing loss if they also had noise exposure. Not every solvent exposure is contributory.

A presumption would -- And presumptions that have been used in many settings usually do have something that helps define the dose of the exposure. It could be latency. It could be occupation. It's not necessarily industrial hygiene.

And you also need to identify the criteria that's used for the diagnosis of the disease which is something DOL has done, OWCP has done, throughout the program. We see there are many cases that are denied because medical
evidence was insufficient. That's because they're comparing the medical criteria to some established criteria.

And then each presumption should -- and the ones I worked with before which are a lot in bankruptcy cases in asbestos companies where there's a trust fund for people to apply to. In every case, it specified how the workers who did not meet the presumption can meet alternative criteria. And Dr. Boden is really an expert on this and he helped me think through this a few months ago when we were talking about presumptions.

You can set a presumption to be quite strict which makes it very easy because then the likelihood the people who make that presumption have a very high likelihood of it being causal or contributory. But then there's a big pool of people who definitely have that exposure-disease relationship. They just haven't met the presumption.

If you wanted everybody who could get...
compensation to meet the presumption, you need to make it much more generous and include less strict criteria. Any organization of the Department of Labor can determine where that balance is. How many people come in with easy criteria and leave the remainder to prove their case in a more specific way. But there needs to be a way that you can demonstrate that you essentially meet the criteria for compensation even if you don't meet the specific presumption.

The Department of Labor criteria for solvent-induced hearing loss says the employee needs a diagnosis of sensorineural hearing loss in both ears which is a specific pattern of hearing loss. And the employee was exposed to one of a relatively short list of chemical solvents. And that he or she worked in one of the listed labor categories for a concurrent and unbroken 10-year period. Then the claim can be accepted for hearing loss.

Then in addition the presumption essentially says -- and I might not have put the
language in -- essentially, this is the only way you can get in. If you want to come in, you have to demonstrate not that you meet what's assumed in the presumption, but there's additional scientific research that applies to your specific circumstance. So it could be very high industrial hygiene exposures. It could be things, but it's a very high bar for a worker to come in and meet the presumption.

CHAIR MARKOWITZ: I'm sorry, Laura. I'm sorry to interrupt. But I believe the criteria include that the exposure has to occur before 1990.

MEMBER WELCH: Oh, sorry. Yes, you're right. So in addition the exposure has to occur before 1990.

Here are the solvents. This is a list of solvents that have been demonstrated in specific studies to be associated with solvent-induced hearing loss. It's not an unreasonable list. I don't think this is the part of the criteria that's significantly limiting people
from applying. But we could address that.

   So DOL made a decision. Instead of
saying exposure to organic solvents as a general
criteria, they limited it to the ones that have
been demonstrated in either animal experiments or
human epidemiology to be specifically associated.
Which is again making the presumption more
specific.

You might be able to see it better on
your screen. This is a list of the labor
categories. And again this is exclusive. If
you're not in this labor category, you don't have
the opportunity to say, well, although I was
classified as a laborer, I really worked as a
machinist. And therefore I should be considered
a machinist.

What's on this list are ones that if
you all were to make up a list you'd probably
come up with it. But you can also look at it and
say, well, where are -- there are some
construction trades, for example, that may have
used a lot of solvents that aren't on the list.
So in terms of the animal data,
there's really quite a bit of research.
Actually, I should back up a second. Just hold
that slide in your head for a minute.

One of the things that my committee
had recommended, the SEM subcommittee had
recommended that we talked a lot about yesterday,
was that something should be added to the disease
causation list if it's in Haz-Map but also EPA,
National Toxicology Program and other sources
that are listed in the Institute of Medicine
report. The relationship between organic
solvents and hearing loss has been accepted by
several of those agencies.

We could move forward if we meet the
criteria for something where we should add the
exposure-disease relationship. I don't really
need to show you all this. Because as we said
before, if EPA has reviewed it we don't really
need to and see that styrene and toluene do this
and do that.

But I just wanted to let you know that
there's a good amount of animal data that shows something about dose, although we can't go straight from animal data to human data and something about the biological mechanism. And the biological mechanism helps when we look at the fact that it's probably at least an additive and maybe synergistic with noise. Somebody who has solvent exposure and noise exposure may end up with more hearing loss than each one individually.

And then I just put in one epidemiologic study from 2008. But there are many more and there's been a good systematic review. The tables are so big because there are now so many studies I couldn't figure out how to get it into a slide in the time I had to put these together.

But I wanted to point out here was the air concentration for solvents were quite low in this particular study. Those are within the OSHA standards for some of those solvents.

But many of these studies don't
necessarily give you a number of years exposure. But in this particular one the workers were followed up for at least six years from after exposure began, but a minimum of four to six years.

From this study, we can't really see if the effect occurs in two years. But they were seeing an effect before ten years. In addition to which these were workers who were exposed after 1990. So this study alone helps with some of the presumptions that are set by OWCP.

And the big recent reviews, everybody agrees that animal and human studies clearly establish an effect of solvents on hearing. And then based on those, I think we would all conclude if you read what I read that compound-specific data has clear limitations.

Because when you do animal experiments, they're generally going to expose them to one agent at a time. And the industrial hygiene that's done is one agent at a time. But the biology lets us conclude that this isn't a
generalized effect of organic solvents. It's not specific. There are some solvent health effects that seem to be very specific to one solvent.

That's not the case here. Every time they test one in the animals it has the same effect. And I said consensus statements are available from NIOSH and EPA that date back two decades.

I know that if we ask for discussion around the table everybody is going to agree with me that --

(Laughter.)

PARTICIPANT: That's a presumption.

MEMBER WELCH: I'm presuming. I'm presuming that the people who've dealt with this in the past would say that the presumption that is set by OWCP is quite stringent and unnecessarily so.

The biggest problem we've had with the building trades is our construction workers may spend 30 years working at Savannah River. But it's never continuous. They're working one job
after another, but they might have a couple weeks off. We can't find anybody that has ten years of continuous work at one of these facilities.

    In addition to which, the evidence suggested should not be limited to specific solvents. Although the cases I've looked at for people who have solvent exposure, we don't have any trouble demonstrating that they had exposure to xylene or MEK because they were used everywhere. But there still would be people who unnecessarily would be excluded because their solvents are not on that list.

    One reason we talked about it and that Steven suggested we talk about it, Dr. Markowitz suggested we talk about it, is that we've talked about one thing that our SEM subcommittee could do is help DOL establish additional presumptions, particularly for diseases for which they're being reviewed. COPD is a very big -- there's a lot of claims for COPD and presumptions would help speed the analysis. They wouldn't necessarily have to go to industrial hygienist if we can build a
presumption. It could make the claims go through
greater, but also it would be much less time, much
less money for the adjudication of the claims.

Our committee hasn't gotten to that
topic yet, but we will. But there needs to be a
transparent process for establishing presumptions
with some clearly stated -- I don't know what the
right word is -- assumptions/presumptions about
those factors, particularly the dose that's
required before we set a presumption that if a
worker has this particular dose of whatever the
hazardous substance is, his disease can be
considered caused or contributed.

We're going to get into the discussion
tomorrow of what caused, contributed and
aggravated means. And that will help our
committee develop a process. But it should be
very clear when a presumption comes out why each
of those decisions was made in our opinion.

We can go back and once as a group
we've decided maybe how we establish those, our
subcommittee can come up with some additional
presumptions and help improve the ones that exist.

MEMBER SOKAS: I wanted to thank Dr. Welch and ask her to go back to her very first slide which kind of lays out that. And by way of discussion our subcommittee was given a list of 14 -- in response to some back and forth with Department of Labor -- given a list of 14 areas where they had challenges and were asking us to look into it. Solvents and hearing loss was one of them.

And I wanted to agree with everything you've said. There is a couple of additional pieces that I would just like to say we further support what you've outlined there. One of which is that there's a recent publication from Korea with 30,000 workers explored across a variety of different industries based on surveillance that took place in 2009. And at that point, they had clearly established the additional deficit in hearing beyond what's related to noise for workers who had solvent exposure. And it was at
least a two-fold increase in the decibel loss and then for workers who had heavy metal exposure. So there was an additional category.

In addition, there are as you mentioned new cases all the time. Sometimes and in fact there were several human case reports of exceptional amounts of solvent exposure that resulted in acute and transient hearing loss without noise exposure. So that's also been reported.

And the types of solvents, the more people look the more they add to it. It just really confirms the things that you've said.

Getting into your development of presumption, I think that list is really helpful. I would like to ask because we're going to get into that a little bit more with these 14 questions that only a handful of which did we actually try to do.

I would also put in there that there are some chemical disease associations that have been established, but it's not clear whether or
not these types of exposures could or have
occurred in Department of Energy sites. That's
probably a step in there. And that may be just
an amplification of it's not only establishing
the dose exposure needed, but whether that that
substance would be used in that concentration in
a DOE facility. So it's maybe a part A and part
B of your second point there.

CHAIR MARKOWITZ: I'm not sure of the
order here. Let's just continue. Dr. Boden.

MEMBER BODEN: This is really good I
think. One thing I think that we might want to
consider here in light of the contributing to or
aggravating piece of this is that it's likely
that people who are exposed to solvents are also
exposed to noise. And I understand that noise is
not one of the things that can under this law be
used to get somebody compensation.

However, a threshold that might
otherwise for a solvent alone apply appropriately
to a presumption might be higher than a threshold
that might apply to a solvent in combination with
somebody who already has noise-induced hearing
loss or also who has noise-induced hearing loss.

CHAIR MARKOWITZ: So is there a
comment specifically in response to that? Dr.
Sokas.

MEMBER SOKAS: Yes, I'm sorry. So one
of the toxicology studies, a recent one, says in
addition to the fact that the solvent poison the
hairs themselves, the direct neurotoxicity of
that, there is some suggestion in animal studies
that they may also relax reflex that the ear has
that prevents noise damage.

You could say that the solvent itself
is allowing the person to go home and mow the
lawn and perhaps have more hearing damage from
that. So the interaction is probably in a
variety of different ways. And that what you've
said makes really good sense.

CHAIR MARKOWITZ: Ms. Pope.

MEMBER POPE: This question might have
been already answered. But my question is when a
claimant files a claim in relation to the solvent
and the hearing loss, are those studies from
different organizations and different agencies
accepted as supporting documents accepted for the
claim?

MEMBER WELCH: My understanding is
that if the worker can't demonstrate through the
SEM that they're exposed to one of those specific
solvents and their employment history has to
demonstrate they worked for 10 consecutive years
prior to 1990 it doesn't matter what else they
submit.

MEMBER POPE: Got you.

MEMBER WELCH: And if they do meet
those --

MEMBER POPE: It's pretty restrictive
already.

MEMBER WELCH: If they do meet those --
they have high frequency hearing loss on the
audiograms. So they have sensorineural hearing
loss and it was 10 years before 1990 and you're
on the occupation list and you're on the solvent
list. You can have your claim accepted.
Otherwise, if you send in more studies, it's not going to help you.

 MEMBER POPE: Thank you.

 MEMBER WELCH: I actually haven't reviewed any of those cases to see how it -- And that's something we can look at when we're looking at disease-specific cases. And it may be that Dr. Sokas' committee already has. But that's my understanding of how the presumption is. That's the way it's written.

 CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

 MEMBER FRIEDMAN-JIMENEZ: Yes, just real quick. Sliwinska-Kowalska has a nice review in 2015 that's updated in the Textbook of Occupational Neurology. It won't come up in the MedLine search. I suggest you look at that. It's basically agree with above. But it may have some new references.

 MEMBER WELCH: Yes, they're responsible for most of this data. That's good.

 MEMBER FRIEDMAN-JIMENEZ: Yes, she's
done some great work.

CHAIR MARKOWITZ: Mr. Whitley.

MEMBER WHITLEY: What's really happening in reality is the CE uses this document as a bible. And if you've got nine years and 11 months before 1990 but don't have the other you're denied because of you don't have enough time.

If you worked in two of the categories that are both on there or three and you never had a break in service, you'll still be denied most of the time. Very seldom do we ever see one go through unless it is 10 years in one of these exact categories. Some of them have worked in all the categories that are listed, but they've split up and never had a break in service. You'll still be denied saying you don't meet the criteria.

The list has some holes in it. A good example is carpenters and everybody knows all the chemicals when they're laying tiles. That's not on there. Welders are not on there.
But basically the CE use the document as the bible. If you don't meet exactly what's in the document -- I don't care if it's one week and you don't have ten years -- you're denied and you're denied because you don't meet the criteria. You'll get a letter in 30 days that says that.

CHAIR MARKOWITZ: Dr. Cassano.

MEMBER CASSANO: Yes. Since I have lots of experience both establishing presumptions for agencies as well as getting people granted compensation when they don't necessarily meet the criteria of a presumption, I have a couple of things to say about this process. And it's not specifically about the other toxicity issue, but in general.

This, as everybody else concurs, this is an extremely stringent and narrow presumption. And the presumptions that I see while they may be very strict as far as who it qualifies they are usually very broad in terms of how much exposure qualifies you for the presumption.
For instance, the Vietnam thing is foot on the ground which is ridiculous to the other extreme. But when you look at Camp Lejeune presumptions they are I believe -- our recommendation, the scientific recommendation, was six months. They went to three months of exposure. Now that is obviously very generous, but it also depended upon the fact that these guys were Marines and they were drinking maybe five to six to eight liters of water. So the EPA referenced dose didn't actually apply to these guys.

And so I think we can help in making these very fair but also very -- so that OMB when they look at these things is not going to sit there and say, you're giving away the farm.

I also think that these need to be subjective to the entire rulemaking process as they are in VA. Then they are set in statute and they cannot be changed at the whim of administration. Right now because these are procedures, they can be changed just as we've
seen with the 1993 and 1995 criteria.

As far as if you don't meet the presumption, at VA everybody has the right to present additional evidence and have it considered valid for evaluation purposes. At VA, if the presumptive criteria are not met, then it automatically goes to a medical examiner to look at the evidence. In this case, I think at DOL it should go to the industrial hygienist first and then to the CMC. But it should not definitively stop just because you don't meet the presumption.

CHAIR MARKOWITZ: Ms. Vlieger.

MEMBER VLIEGER: I have a question in a claim that I'm familiar with. It was a painter. And because he was exposed to mixtures, they were saying it was not an exposure to the chemicals on the list. Even though he met the presumption as under the labor criteria, they were saying, show us that he was actually exposed to enough because in a mixture it would be a lower dose than the pure chemical.

And I realize that all of you are
shaking your head and going, this is ludicrous.
I agree with you. However, we had to go to the
extent because he's a current worker where he
took photographs of the content labels of the
materials he used. We had to provide those to
the Department of Labor to show that those
materials were in a significant quantity in the
things he was applying high enough up on the
label to show that he was getting enough exposure
of the pure chemical from these mixtures that he
was applying as a painter.

  I would like something about the
synergistic effect of the number of things that
are in a product or that the mixtures are
considered as well versus just these straight
chemicals. Because we run into this problem
where someone is trying to do their job and they
don't have that guidance that mixtures count too.

  CHAIR MARKOWITZ: I'd like to make a
comment. I take it there's significant
disagreement with the elements of the
presumptions here. But I would say that the set
of presumptions on this issue would be extremely useful to have. If you think about it if we were to recommend eliminating these presumptions and leaving it up to the claims examiner, the industrial hygienist and the physician, that would be very problematic.

The industrial hygienist is going to have a very hard time trying to figure out what the dose of solvents is. And the physician is -- most of the physicians will be clueless on this particular issue.

This is a very specialized issue and they won't be able to make an informed judgment about the relationship because they won't know about this. Even your standard occupational medicine physician isn't going to be informed about this issue.

I would say that it would be extremely useful to come up with an alternative set of presumptions that would facilitate the process.

MEMBER WELCH: I just want to mention one thing that Fay made me think of which is that
the construction trades are not really addressed by the SEM. The construction trades have a general -- it makes sense. The exposures are more similar across sites than they are different.

But when you need to identify a specific chemical, that's in the SEM. So it's hard to place a construction worker using the SEM database. So we would see for construction workers -- what Ms. Vlieger was talking about that painters know they're exposed to a lot of solvents. And the presumptions suggest they do.

But their ability to demonstrate that they were exposed to those specific solvents can't come out of the SEM because you can't put a construction painter into the SEM. A production painter you could. It's another reason that there needs to be more flexibility in the presumption to be able to accommodate all the workers at the sites.

CHAIR MARKOWITZ: My question is initially for Dr. Welch but also others whether
there's enough scientific knowledge to enable us to make a recommendation to DOL about changing the number of years of solvent exposure, changing the issue of 1990, changing the set of job titles that predictably had solvent exposure. Do we know enough that we can provide a rationale for an alternative formulation of presumptions?

Dr. Sokas.

MEMBER SOKAS: I think the answer is yes, but. I mean I would feel comfortable. I think, Laura, we could probably sit down and do it based on what we've looked up.

The problem is I think if you want to do this in a really rigorous, really in-depth way where you've got some evidence that you've actually done a complete review and come up with something that the program can actually point to and use, I honestly think what we may be suggesting is there needs to be some subcontracting done here where that kind of work gets done.

I mean it wouldn't take a huge amount.
It would take a relatively small amount. But I put in a Saturday afternoon basically doing this. I don't think that's necessarily got all the information we're going to need.

So I would say what we as a Board might be able to do is to propose where we think those issues are that could benefit from a little bit more thorough. Then we would offer to review the results of that. Again I may be not recognizing my full responsibility as a Board member. But I don't think we can say, yes, we can handle all of that.

MEMBER WELCH: I agree with you and we could probably, the Board could probably, do a couple. But if your committee comes up with 15 for which you want to make a presumption, I think that for us to try to get it done is going to be violating what we're generally recommending that things be thorough and transparent.

But I agree. Probably if one of us spent an additional day we'd find all the literature and be able to read it all and
summarize it. But it shouldn't just be one person because we all have implicit biases in some way or another. So I think having a process where you have a subcontractor do it and then it's reviewed by the Board makes more sense or some interaction between the expertise and the Board and some technical assistance makes more sense than having the Board do it.

I want to add one thing to your question. I think that the law itself that says the claim is accepted if it's determined that an exposure cause, contributor, aggravated is what we would say claimant-friendly because contributed to there's no real definition of contributed to.

I've spent time in court testifying as an expert on behalf of injured workers and give an opinion that this particular exposure was a substantial contributing cause to the individual's disease because most diseases have multiple causes, some of which are smoking or noise in this case. So I give an opinion and
I've had a thousand lawyers ask me what do you mean? What's substantial?

And I say, well, in my eyes it's substantial. I just kind of wiggle out of that as quickly as I can.

It depends on the individual case what's substantial. It depends on the amount and degree of other exposures the individual has and characteristics of the individual's susceptibility. So it's not like there's a number. But to develop a presumption and say that if someone has this level of exposure they're presumed to have the disease, we're going to have to talk about what contributed means.

Cause won't be that hard. We'd probably disagree, but I think we could come closer. But contributed, there's a lot of flexibility in contributed. I think that the science is there once we decide what contributed means. The science is there to set a presumption that complies with the program standard.

CHAIR MARKOWITZ: Ms. Vlieger.
MEMBER VLIEGER: I just have an administrative point that Dr. Cassano brought up. I'm wondering after we do all of this work and we provide our input at what level it's going to be maintained because I'm not sure where our recommendations fall under policy, procedure, manuals, regulations. And so perhaps we could get a briefing from the Department of Labor about once we make these recommendations how sturdy they're going to be, how long lasting the review process.

My concern is we do all of this work and then we get an administration change and the baby goes out with the bathwater. So I believe we need clarification so that when we write these we know where we fall into that whole process. And I'm looking at John Vance right now. Do we have the capability of doing that?

CHAIR MARKOWITZ: Mr. Rios wants to respond.

MR. RIOS: You provide your recommendations to the Department through this
process. And the Department then determines
where they are in terms of existing priorities
that they have. Generally after about four or
five months after you submit your
recommendations, such a report can be requested.

However, to apply a broad brush and
say when you give us a report this is how long
it's going to take for us to process it is
unrealistic.

MEMBER VLIEGER: I'm sorry. I don't
understand what process means and I don't
understand what priorities mean.

MR. RIOS: It's dependent on the
recommendation that you provide. If you're going
to recommend that they add a sentence, for
example, to the procedure manual, that process
can take a very small amount of time. If you
recommend that they update the SEM and invest a
lot of resources into that, then obviously that's
going to require a significant amount of time.

It's all dependent on the
recommendations that you make. That's why I'm
saying for us to apply a broad brush and tell you that it's going to be implemented in x, y, or z number of months it's not realistic.

MEMBER VLIeger: In order to be expeditious about what we're doing and try and fulfill what the Board's priorities are, could we know where we are on the menu of the things? So when we make recommendations, we can try and fit them in an expeditious manner.

MR. RIOS: Like I said, you can certainly pose that question to the Department and we can get back to you on that. But first we need to receive the recommendations.

CHAIR MARKowitz: Dr. Cassano.

MEMBER CASSANO: One additional comment to get back to what I said about rulemaking. These little circulars are guidance. They're not mandated. You can follow them. You don't necessarily have to follow them.

Even the procedure manual tells people what to do, when to do it, but not how to do it.

Therefore, Fay is right in that an administration
change or even somebody in the hierarchy can
change this or say ignore it just like we saw
with the 1993 and 1995 menus.

The only way to get these set in stone
is to have them developed in a rulemaking
process. Otherwise they can go away. They can
be superseded or go away within six months of
being promulgated.

CHAIR MARKOWITZ: Any other comments?
We're approaching lunchtime. Dr. Welch is going
to not now but for tomorrow formulate a
recommendation regarding this issue which will
reflect I think the level which we discussed it
so far.

We will adjourn now. Any comments?
So we will reconvene at 1:00 p.m. Thank you.

(Whereupon, at 11:54 a.m., the above-
entitled matter went off the record and resumed
at 1:05 p.m.)

CHAIR MARKOWITZ: Okay. We're going
to get started. We're missing three Board
Members. But I think they will be here shortly,
because I just left them.

So, we're now going to hear from Dr. Sokas, from the Industrial Hygiene and CMC Subcommittee. This is the task of the board that addresses the work of the industrial hygienists and the physicians who assist the program. And to take a look at the quality and consistency of that work. So, Dr. Sokas.

IH & CMC SUBCOMMITTEE

MEMBER SOKAS: Thank you. And Dr. Markowitz already explained what the committee's about. The members of the committee are listed up there, Mr. Domina, Mr. Griffon -- Dr. Griffon, Dr. Friedman-Jimenez. Dr. Markowitz is also on that, Ms. Vlieger, and Mr. Whitley. So, all of whom will be participating in this update.

We had shared a number of the Board Member's concerns that I think we heard at this meeting, and at the previous meeting, about the information that goes forward to the industrial hygienists, and to the contract medical clinicians. And I'll get to that in a minute.
We had our one teleconference Board Meeting on July 18th. And at that time we attempted to go through the original list of questions from DOL to see what we could do, what others were attempting to do.

And we nevertheless had a ton of overlap, since several of the circulars, including the post 1995, the asbestos circular, and the information about solvents and autotoxicity were all kind of, you know, shared by our committee, as well as others.

So, we were not completely successful with that. But we did then subsequently have some additional information that we requested, communication by email among the subcommittee, and with the Department of Labor.

And I did want to share a little bit of that first, before we get into our report. We had a question about, do the claimants see, and/or have input into the process of the CEs, referring cases to the IH or to the CMC, and to the IH/CMC response? This includes how the CEs
frame the question. Do the claimants automatically get copies of the reports?

That was just sort of a general question that we asked going forward. And I think it's been a topic of conversation, as I said at both of these face to face full Board Meetings. The response was interesting. And I'll read just the first sentence really, or two.

The type of claimant input the referral process described in the question resembles a method used by opposing parties in litigation to agree upon the wording of a question that are then submitted to an outside independent expert are not appropriate for use in the non-adversarial claim adjudication process used by the program for several reasons.

And then they go through the reasons. And I think that kind of illustrates. I didn't think the question going forward had that context to it. But clearly I think there is that set of concerns. And what we did then review was, we reviewed, there's a memo that is public that was
an informal review of the IH and CMC reports.

It turns out that that's much more of
a process memo than a quality memo. And
basically the concerns that were raised were ones
I think profoundly of communication, where there
were questions given that were not directly
responded to.

There were even comments by some of
the claims examiners that the clinician was
providing too much information, but not the
information that they really needed.

And so, there's a clear communications
gap that I think has again been highlighted over
and over and over again.

We also asked whether there were
referral opinions, which are really third
opinions that are supposed to break a tie vote,
both between either the CMC and what the treating
clinician says. And we were told that there were
zero referrals made in the preceding year.

So, I don't know if we had gone back
further there would have been more. But clearly,
there's no content evaluation for quality,
because there's really nobody to do that, you
know, for the CMC. So, that was something that
we were interested in finding out more about.

We received some CMC and IH
information in records. We didn't necessarily
have the -- how those were used in the results.
So, those are still a little bit of a question.

And then we were just given a new disk
with more information, more examples, and more
charts, that only arrived on Friday. So, we
haven't had a chance to really look at that and
talk about it.

We did, as I said, review the cases
that we were given, as well as very interesting
policy teleconference information, which I think
had an enormous amount of information in it.

We were also -- we also clarified with
the program the areas where they get most of the
questions about. And they gave us a list of 14.
I am going to read through them, because I think
there may be Members of the Board who have done
some in depth work on one or the other of these.

We will just kind of briefly highlight
six that we assigned to Board Members to go
through. And we'll do that in a moment. But the
14 were cadmium, arsenic, TCE relationship to
prostate cancer, occupational toxins related to
Parkinson's disease. There is a guidance on
this, but Board review was thought to be
additionally helpful.

The question about the hearing lost
and solvents, diabetic relationship to
occupational toxic substances, radiation
connection to glioblastoma/meningioma, non-
Hodgkin's lymphoma, and trichloroethylene or
benzene, hyper/hypothyroidism, goiter nodules and
ionizing radiation, breast cancer with different
exposures, immune system disorders, lupus and
others, and again, different exposures,
colorectal cancer and asbestos, and other
exposures, melanoma and other skin cancers,
kidney cancer, TCE, benzene, cadmium and
asbestos, bladder cancer, many exposures, and low
level radiation related to heart disease.

So, this is what the program is asking for help with.

CHAIR MARKOWITZ: So, Kevin, could you just advance, move up the slide a little bit?
The list, the end of the list that Dr. Sokas just read isn't visible.

MEMBER SOKAS: Oh, I'm sorry. That total, that list isn't all included in there.

CHAIR MARKOWITZ: Oh.

MEMBER SOKAS: So, I'm sorry. We only took the first six to work on. So, I think with that I'll turn it over. So, what we did was, we asked Mr. Domina, Mr. Whitley, and Ms. Vlieger to identify problems raised in the cases that were reviewed. And we'll have that report out first.

After which we'll have the specific toxic substances, questions that were raised. And Dr. Friedman-Jimenez is going to lead off that discussion. And then we have a number of other items that we'll get to as time permits.

So, I'll turn it over to our first discussion.
MEMBER VLIEGER: Okay. So, we were
sent disks of information to use for our basis of
this analysis. And Kirk and I spent four and a
half hours last Tuesday together, just cursory
going through them, besides what we were doing on
the individual cases that we were assigned.

So, what we found is that the
information we were sent was incomplete in order
to follow the logic pattern of what was going on
in the claim. And essential things were missing.
The EE1, the EE3, and OHQ were all missing.

And then, because of the way the data
was separated in by the different subcommittees,
some of the claims were parsed. And so, I did a
quick data check on that last night. And of the
total number of cases they sent us they parsed a
number of them.

And, just a second, let me bring up my
Word document. So, after, what we did is a
cursory review, because we couldn't find all the
information in order to do our analysis. So, I
need to preface what I'm going to tell you with
And of the approximately 77 claims, because there was one claim that was not actually included. Its file was a duplicate under a different number.

Nine of the claims were used in more than one of the four sections. So we had, it parsed, a section of the claim was taken out and moved under a different subcommittee. And so, in order to find some of the information you had to go into more than one file on the disk. So that was part of the problem.

And then, we just found that the documents that were provided seemed like they had been, they're incomplete to make a logical decision about what's going on. So, that being said, from my experience what we have on those disks is a very incomplete file, compared to what you get when you request a file as a claimant.

The process on the claim that I individually had to look at started, and repeated through no less than four recommended decisions,
because of inadequate instructions to the
claimant of what was required to go through the
next process.

And so, this was a claim where it
falls under the CBD criteria in sarcoidosis.
This particular claim, multiple times through.
And the CMC was sent documents. And he said,
well, you said you're sending me a biopsy. But
there's no biopsy in the records you sent me.
And this kind of thing happened over and over.

Now, my particular claim may be an
outlier. But I, because I can't speak for the
other ones that everybody reviewed. But on my
review of my claim it started in early 2014, and
was finally resolved --

Actually, the initial biopsy that
happened was in 2010. And the claim was resolved
at the impairment ratings. They had already
gotten a final decision under Part B, and they'd
moved to Part E benefits in July of 2016, after
multiple reviews through CMCs.

But I didn't see all those CMC
reports. Multiple recommended decisions, and multiple remand orders, because the evidence wasn't properly considered. And everybody's looking at me like --

MEMBER SOKAS: No, no. I just, is that the conclusion of your portion of it? Or did you want to --

MEMBER VLIEGER: That's the conclusion of what I did.

MEMBER SOKAS: Okay.

MEMBER VLIEGER: Kirk can speak more of what we found in our cursory review. But the files that were sent were not what I would expect of a claim file.

MEMBER DOMINA: Yes. Some of them were extremely difficult to do, because some of them only had three pieces of paper in them. We found some where there were autopsies, death certificates where it disagreed with the CMC on the cause of death.

And then, that was it. They went with what the CMC did. Where me, because I'm not a
medical person at all, is that, you know, why
didn't it go to a referee?

And a lot of them they used the SEM
against the person. They said, well, we didn't
find anything in the SEM, so this is why we're
saying no.

Some of the uranium miners, we found
that several, like 15 to 18, all went to a
certain CMC on the East Coast, which to me seems
a little odd when your uranium mines are in the
west.

I guess I just assumed that they
should have went to Dr. Sood, or somebody who has
more experience. Just my opinion.

And there was just, it was so
incomplete. Because, like, when I went through
this I didn't assume anything. I wasn't going to
say, well, they must have thought this or that.

Because I wanted to go with just the
evidence that's in front of me. And there's too
much of it that's missing by the way the claims
were parsed out. Because I didn't know that
initially going through, until Faye and I started
going through them, that we found some duplicate
numbers.

And then there would be a lot bigger
file for a different illness that they were
claiming. And so, it was extremely difficult
with the information that we were given, to try
and come to any conclusion on almost all of them.

And then, some of them were missing
the basic information on what their job title
was. Or a couple of them, and not even, it
didn't even say where they were.

MEMBER SOKAS: So, I don't know,
Garry, if you had anything to add to that, Mr.
Whitley, or -- So, one of the issues possibly,
and I just want to clarify that.

When we asked for files, we were told
that it was kind of in the midst of all the
different subcommittee asking for files. And
that maybe we could use some of the same records
that had been pulled for other purposes.

So, it's possible -- And the other
piece is that some of the files that we got, all we got really was the information that went to the CMC or, you know, that came back.

And so, it might have been the way in which the request was made or processed. So, I did want to clarify that. That this, that in retrospect it would have been helpful for us to have specified that we wanted every single piece of the file. Because I think in a way we may have inadvertently restricted the amount of information.

I would like to say that even with that restriction one of the things that, there were a couple of points that I think were made very clear, just from the few files that I reviewed.

One is that, in fact, there are enormous communication issues that take place routinely. That there's also a serious need to simplify.

So I think the conversations around presumptions become more and more and more
important. And that as I think we've all
discussed, that transparency is probably very
helpful.

But, for example, there was a case
that we reviewed where the, clearly the treating
physician -- I mean, it gets back to the
fundamental expectations of the program, which
may have been inadvertently presented as, this
program will make injured individuals whole, when
in fact, no program is able to do that, right.

So, there's this, there may well be an
expectation there that's beyond the ability of
any program to fulfill. I say that because the
one case we had, a primary care treating
physician, clearly very engaged with a worker and
the worker's spouse, who are both failing in
health.

But writing a requirement for 24 hour
RN care, seven days a week, which would imply the
need for intensive care unit care basically,
which was clearly not, in fact, what was the
needs of the individual.
That somehow or another the CE, the claims examiner managed to come up with what objectively seemed to be a fairly realistic kind of compromise about the level of home care that would be useful for that individual.

And then, when they went to the CMC for evaluation, the CMC did an incredibly thorough, very complete evaluation. But almost in reaction to the over the top recommendation from the treating physician.

Then pulled back and said, but none of these impairments are really related, I mean, kind of, almost that adversarial, it wasn't due to that anyway. So, they really don't, you know, so the program itself shouldn't be on the hook for this at all.

So, you wound up with these kind of, on the one hand, on the other hand, communication debates almost that clearly had an advocacy/anti advocacy position when the CE was trying to thread the needle in the middle. And it was challenging.
So, there are clear examples of that I think in almost every case. What I would like to mention is that the, and ask if anybody on the team has a different or additional comment on it.

The policy teleconference information was incredibly helpful in a variety of ways. It's a periodic phone conversation, as I understand it, among, I don't know to what level every CE can dial into it. And maybe Mr. Vance can kind of let us know about, some of the details of it.

But the logs that we were given to review had important questions that were reviewed, and that had major implications for determinations in general. And some of which seemed to be very clear cut, and some of which seemed to be very problematic.

I mean, there's one whole conversation about suicide, whether if it's just suicide, it's not considered a follow on condition. But if it's physician assisted suicide, somehow it takes it outside of that. And then becomes, you know,
kind of okay.

And so, some of it would be helpful to have real kind of in depth clarification, in addition to that. So, that was a very useful, and looked to be a very rich source of information, especially around interpretation and how things are done.

I think there was a conversation around solvent induced hearing loss. There were a number of conversations that looked as if they would be very, that they would illuminate some of the questions that come up repeatedly. Faye, you wanted to --

MEMBER VLIEGER: On the claim that I was asked to look at in particular, the claims examiner early on put in a notation that the person was a laundry worker. Yet, their EE3 said that for five years they machined beryllium parts.

And so, the laundry worker context went to the CMC, where the claims examiner was never challenged when they made the statement, in
the statement to the CMC for their opinion that
said, well, this is a laundry worker that claims
he did five years of beryllium work. And I don't
see how that could be true.

And then, when I read back, now, I
don't have the EE3, and I don't have the
occupational history questionnaire in front of
me. The CE do. When I went through, back to the
very beginning of the claim, they claimed as a
laborer. But it got transcribed as a laundry
person.

And so, the CMC was given the wrong
context for their exposures. So, I mean, this
kind of thing was kind of problematic. I don't
know. It's human error. It's going to happen no
matter what you do.

But in this particular claim it
confounded it very early. And it took another
two years to untie that knot.

MEMBER SOKAS: All right. Any other -
-

MR. RIOS: Dr. Sokas?
MEMBER SOKAS: Yes.

MR. RIOS: This is Tony Rios. I just want to comment, I guess, on the completeness of the file reviews that you, that Ms. Vlieger and Mr. Domina were discussing.

First, I want to thank you for clarifying that the nature of the request is certainly going to affect the content of the file that were provided.

I think Dr. Redlich, Dr. Welch, and Dr. Markowitz have experienced that whenever a file or data request was submitted, and that there were any questions that, or subsequently provided to the Department by the originator, the Department has made themselves available to try to provide clarification, or try to provide any data that perhaps wasn't submitted initially.

As was the case with them, the Department is more than happy to provide you additional contents for any files that you believe are incomplete.

MEMBER SOKAS: And again, these were
not the files we would have picked. They just
happened to be the ones that were being collected
for other people. So, I think this new,
hopefully the information that arrived, the disks
that we got this past week --

We were asking for other than, you
know, we were asking for both acceptances and
denials for these other commonly encountered
conditions, other than the lung conditions.

And as we move forward we'll be able
to look at those. And if we do have any
questions about completeness of the files, we'll
definitely get back through Garry to you.

CHAIR MARKOWITZ: Dr. Welch. I think
Dr. Welch has a comment.

MEMBER WELCH: Yes. Just, because we
went through that same exercise, trying to figure
out how we could request cases where, say for
example, where exposure assessment was an
important part of the denial.

And the, what I've learned is that
it's, you know, you kind of have to, we have to
get different levels of understanding about how
the cases are constructed, and how to find them.

But I think in a way what John and
Carrie did with the beryllium cases is most
useful. Because they were starting with a
smaller subset of diagnoses.

But the ICD-9 classification is added
for accepted claims, but not for claims that are
denied. And so, an individual could have had
multiple conditions that they claimed for. And,
you know, so two are accepted and eight were
denied.

It's hard to, it's much easier to
follow the stream of records and find that
information on claims. We started by asking for
ICD-9 or ICD-10 kind of reports. And then
realized, well that would get us a very small
subset of the claims.

And the folks at DOL had to do quite a
bit of work to try to create what looked like a
comprehensive review of all claims accepted and
denied. Because the denied ones are going to be
found with the text description in normal cases.
And John can explain that a little bit more in
one of the beryllium.

So, I think that we might want to
even, you know, try to, so that not each of the
four committees has to learn --

MEMBER SOKAS: It does the same thing,
yes.

MEMBER WELCH: -- what we've learned.
And our SEM Subcommittee has not yet gotten back
to the point to get back to the Department of
Labor, to say, here's, give us some actual claims
that we think are going to get us what we want to
look at.

Because, but now I understand what the
reasons for denials are, you know. So, we want
to focus in on the causation result, not the
medical. And so, we may, because if you get, you
know, 100 claims, but we want to look at a
specific issue, it may turn out that none of them
illustrate that issue.

So, it's how to request a subset that
fit within what we want to know, but also what
DOL can with assurity give us out of their data
system.

MEMBER SOKAS: Right. And what we're
trying to find out is the adequacy of the CMC and
the IH evaluations. And some of that I think, so
I think it's already, some of it's come through
where, you know, if they don't get the
appropriate information, they're not going to be
able to do that.

But it did look from Carrie, from Dr. Redlich's slides that in fact there may be a
number of opportunities to see whether or not
perhaps there should have been, you know, an
additional referee opinion obtained, if some of
those either lack of causality or lack of medical
information include a CMC and a primary care,
treating physician's lack of agreement.

So, that would be interesting to find
out. And then maybe we could go and pull those.

MEMBER WELCH: You're not going to be
able to, I don't think you're going to be able to
get that. You're not going to ask, you're not
going to be able to get, give me cases where the
denial was for insufficient medical evidence, and
there was a CMC report.

MEMBER SOKAS: So, I'm not trying to
do it on a large data set. I mean, I think if,
as we look through these cases we see a sample,
or an example of that, that's what we're looking
for, yes.

CHAIR MARKOWITZ: Dr. Boden, did you
have a comment?

MEMBER BODEN: Yes. I'm still, it's
actually a question for people on this
subcommittee. I'm trying to understand what one
would need to request in order to get sort of a
full reading.

And my question is, does it seem like
one would need to request all the information
with respect to a person, rather than with
respect to a claim, in order to make sure that
you've got all the relevant information actually
for a particular claim?
MEMBER VLIEGER: My experience is that you have to request the entire claim file. Because you don't know what bit they took from where, and whether it's the correct assumption of what they're reading.

So, as with the labor category, or with an area that they worked in, and because of the multiple use of jargon in the documents, it can be misconstrued. Because plain English words mean something completely different on a Department of Energy site.

Because when you went home at night they didn't want you to alarm the public with the actual facts. So, the jargon and the use of terms. And the only way to check it is to have the whole file.

And the same thing with all the doctor records. You don't know where they pulled it from.

MEMBER BODEN: So, my question was actually a little broader than that. So, an individual might have more than one claim,
correct?

MEMBER VLIEGER: It's all the same file.

MEMBER BODEN: It will all be in the same file?

MEMBER VLIEGER: Right.

MEMBER BODEN: Okay.

MEMBER VLIEGER: And it's a perpetuity type of file. So, once you start it, everything is in there, from the beginning to the end.

MEMBER SOKAS: And we did not specify we wanted the entire claims file. So, I think that was the problem at the beginning. So, that pretty much explains it. So then, thank you.

The next set of brief reports are going to be about the topic areas that DOL specifically asked for. And I would ask us to kind of keep in mind Dr. Welch's slide about what you would need to create presumptive categories.

The first two are going to be presented by Dr. Friedman-Jimenez. And then, as time permits we'll have, you know, just brief
mentions of the other four.

MEMBER FRIEDMAN-JIMENEZ: All right.

Thank you. I thought I would go through the process by which I do one of these searches. I'm going to talk about four different associations. And three of them are cancer.

So, typically what I do, I start out with a cancer textbook, D'Adamo, Scheinfeld, Nasca, or 2008, 2006, see if I find anything in the textbook. I do a Google search to see if I, what's out there in general.

But then I usually start with the IARC, the International Agency for Research on Cancer, which does very thorough reviews by panels of real experts on cancer epidemiology, and is really one of the two authoritative organizations in the world that judge carcinogenicity in chemicals.

I then look at the National Toxicology Program review on carcinogens, which is the other authoritative body that does these reviews.

There are other bodies. But these are the two
that do the most, and the most comprehensive
reviews.

Then I'll do a Medline search, review
abstracts, pull together the pdf files of what I
find that looks interesting, maybe critically
review a few of the articles as needed, and get
more references as I feel I need them. Then I
write up a review.

Typically it takes between one and six
hours to do one of these reviews for me. I do
occupational medicine. I also have training in
epidemiology. And it's quite labor intensive to
do a thorough review.

So, I'm going to start off with
trichloroethylene and prostate cancer. I didn't
find anything on that in either, any of the three
cancer epidemiology textbooks.

In Google I found one article from
2000 by Wartenberg, that was a pooled analysis
that reported a standardized incidence ratio of
1.3, 95 percent confidence from one to 1.6 for a
subset of the cohort studies that had the best
trichloroethylene, TCE exposures.

And they said that this suggested some increased risk of prostate cancer in TCE exposed working populations.

The next thing I looked at was the IARC 2014 monograph on TCE, which really reviewed cancer and TCE. They explicitly stated that TCE causes kidney cancer. And they mentioned positive associations with non-Hodgkin's lymphoma and liver cancer.

They did not mention prostate cancer, which is significant for an IARC review not to mention prostate cancer in their overall evaluation.

They did mention one study of prostate cancer that had a positive association with an odds ratio of 1.3, with 95 percent confidence, from .7 to 2.6. Not even close to statistically significant.

So, then they went through a lot of mechanistic, in other words the biological science on the mechanisms of cancer. And said
that it's plausible, that there is a plausible mechanism for prostate cancer and TCE.

However, they, I'm sorry. There's a plausible mechanism. But it was done only in kidney cells, not in prostate cells. I misspoke. So, their mechanism was really only applicable to kidney.

And so, their bottom line is that TCE is a known human carcinogen. However, some of the mechanistic evidence suggests that this may be specific to kidney.

So, bottom line for me is that I would say that this is a fairly clear negative, trichloroethylene, and prostate cancer. This is what I would consider not much evidence in favor of an association.

Typically, there may be one or several positive studies, often with no statistical significance of the result. But then other negative studies, or null studies on the other side.

So, this is an example I think of a
fairly clear negative. Although nothing is absolute in this business.

The second association that I looked at is cadmium and prostate cancer. And I'm going to go into some detail here. Because I think this is a complex and interesting evaluation.

I'm jumping straight to IARC. They did a monograph in 2012 on cadmium, and concluded that there was significant, sufficient evidence that cadmium and cadmium compounds were human carcinogens.

The did review prostate cancer studies, and concluded that after a 1965 study that reported increased prostate cancer in workers in a nickel cadmium battery factory in the U.K., nine additional studies up through 2004 did not confirm that finding.

There were several cohort studies reported insignificantly elevated risks among cadmium exposed workers. But the results were inconsistent, and based on small numbers of cases.
A small pooled standardized mortality ratio study from four cohort studies that overlapped, they were not all different populations, reported a summary standardized mortality ratio, SMR, of 1.26 that was not statistically significant. There was a total of 27 total deaths.

There were several case control studies that reported slight increases in odds ratios, which is similar to a relative risk. But the findings in a 1985 study that was positive were not replicated in a 2002 study that used toenail cadmium as an individual level exposure measure.

We like to see individual level exposure measurements. But it's not always done. And it's not always clear what it means.

In this case they thought that maybe the toenail cadmium reflected something that happened after the tumor started, that reflected a long term, an increase due to the tumor, and not necessarily a good measure of exposure. They
didn’t present the data on which they based that conjecture.

A 2007 hospital based case control study reported an elevated odds ratio in the highest exposure group. A Japanese study in Nagasaki reported elevated mortality risk, with relative risk of 2.6 that was statistically significant, and an increased incidence risk that was not, in those with elevated urinary excretion of microglobulin beta-2, which this is a test, a sign of cadmium toxicity, and is somewhat of an indicator of cadmium exposure. Although there are other causes of elevation in beta-2 microglobulin.

IARC noted that the numbers were too small for detailed analysis. And they characterized the evidence for cadmium and prostate cancer as suggestive of an association, but inconsistent.

They also concluded sufficient evidence in one, not species, one, a subtype of rats, Wistar rats, for proliferative prostate cancer.
lesions and prostate cancer after oral ingestion
of cadmium chloride. But did not find in mice,
hamsters, or other rats a similar finding after
injection or inhalation.

They concluded there was limited
evidence in rats for cadmium metal and cancer.
Mechanistic evidence suggested disturbances of
DNA repair or tumor suppressor proteins leading
to chromosomal damage. So, they also mentioned
some DNA methylation patterns that may happen
epigenetically after the initiation of cancer.

So, their overall conclusion was that
evidence is sufficient that cadmium and cadmium
compounds are human carcinogens. Group 1 is how
they classify it. And noted lung cancer
specifically. But they did mention there were
positive associations for prostate and kidney
cancers.

IARC typically does not limit their
evaluation to a specific type of cancer. And
they don't generalize to all types of cancer
either. So, they do provide some guidance to
follow-up on this.

The NTP review of carcinogens in 2014 agreed with IARC. I'm going to speed this up a little bit. They did mention that there was no evidence that had been found that mechanisms of carcinogenesis in animals would also not operate in humans. So, they gave some basis for generalizing from animals.

But since IARC and NTP there was an important systematic review that was published in 2016 by Song, et al. Reviewed 478 articles, and included 22 that met their criteria. They calculated a pooled SMR of 1.66, 95 percent confidence interval from 1.1 to 2.5 for occupational cadmium exposure and prostate cancer.

But there was evidence of heterogeneity. In other words, the studies they reviewed were quite different. And that showed up statistically. They used a random effects model, which seemed to be the right choice.

And they also looked at dietary
cadmium and environmental cadmium, and did not find a strong association. So they concluded overall that their meta-analysis added --

They said that their meta-analysis found that high exposure to cadmium is a potential risk factor for prostate cancer in occupationally exposed populations, but not in non-occupationally exposed populations.

They tempered their conclusion, and urged caution because of the heterogeneity, the differences among studies.

Overall their meta-analysis I think added some evidence to the IARC and NTP. And it's a good example of where IARC and NTP are not the final word.

And you do need to do a literature review after reviewing these definitive reviews. Because usually they're several years old, and there may be new studies. So, in this case it paid off to do a follow-up Medline search.

All right. So that I think illustrates a fairly middle of the road finding.
It's not definitive causation. But there are enough suggestive studies that in a highly exposed occupational group I think it's reasonable to look at the case on a case by case basis, and in some situations maybe conclude that there is a causal relationship.

I don't think that the data preclude causal relationships in this case. So, I thought that was an interesting case to present in detail. And I'm going to finish up with the last two, which are fairly quick.

Arsenic and prostate cancer. IARC in 2012 said there's sufficient evidence in humans and experimental animals that arsenic and arsenic compounds are carcinogenic.

They specifically, explicitly list lung, bladder, and skin cancers. They mentioned positive associations for kidney, liver, and prostate.

For prostate cancer, however, the studies, mortality studies from China show elevation with some dose response. But the study
from Chile in South America did not support this. They concluded that for prostate cancer, although the evidence suggests the possibility of a causal association, the working group could not rule out the possibility of chance or bias.

They also made an interesting statement that all of the different inorganic and organic arsenic species shared the same common metabolic pathway of arsenate to arsenite, to methyl arsenate to dimethyl arsenite. So, they say that carcinogenicity can be generalized among the different inorganic arsenic species.

And there were a variety that were looked at in different studies. And typically this divide and conquer method is used. And interestingly, in this case you can generalize. And they looked at the mechanism, and it was helpful.

So, the last one I'm going to do is Parkinson's disease and occupational exposures. There's no IARC for this. You have to do a
literature search. I don't have a general method I could present.

But I did a Medline search. And I found eight studies that reviewed pesticides. And many of them were positive, either statistically significant or not statistically significant, but with an elevated risk in the pesticide group.

Overall it looks like there's a suggestion of an association of Parkinson's disease with pesticide exposure. However, the studies were not that well done that you could rule out bias or confounding as explanations for this.

So, if I were on an IARC like panel I would have to say, well, it looks suggestive, but it's not definitive for pesticides. And that was the most strong relationship.

There was actually one particular pesticide that came out statistically significant elevation in one study, which is benomyl, which is a benzimidazole fungicide.
And it was positive in a Netherlands study that was null, negative for everything else, including high dose insecticides, herbicides, which were suggestive, as well as endotoxin, which was strongly null.

Overall it looks like, well -- The other things that I looked at were welding fumes. The studies are mostly negative. Meta-analysis by a guy named Mortimer.

And then when you read down at the bottom of the study after this long negative meta-analysis, you see that Mortimer was funded by the Welding Industry Defense Group.

And he ends his analysis, his paper, by saying, the absence of an association of welding or manganese exposure with increased risk for Parkinson's disease is consistent with conclusions reached in previously published reviews.

This finding does not preclude the possibility that high manganese exposure, as occurs in some miners and workers at manganese
processing facilities can lead to a form of parkinsonism, not Parkinson's diseases, parkinsonism, called manganism.

And he's correct in distinguishing manganism from Parkinson's disease. However, he does not make this at all clear in the article. The article is written with minimal discussion of manganism.

And in fact, there's a renewal of research interest in manganism now. And it's distinct from parkinsonism. If you look at the MRI findings in parkinsonism, a part of the brain called the substantia nigra is damaged. Whereas, in manganism it's the globus pallidus, which is a different part of the brain.

So, there is some technical difference, although the symptoms are quite similar between manganism and parkinsonism.

There was a conference several weeks ago at Mt. Sinai, a three day conference on manganese. I unfortunately couldn't go. But there's a lot of research interest now on
manganism.

And I think that the problem for us is, the disease is actually now called manganism. But there's no ICD code for it. You're not going to find it in, you know, in lists of diagnoses. And Parkinson's disease is not really the appropriate thing that we're looking for. It's parkinsonism.

And so, the terminology makes it very difficult for us to say, yes, this person has manganese exposure, and a movement disorder related to that, which there's fairly good evidence supporting it.

So, I conclude by saying that it's a tricky business trying to do these reviews. And you really have to do it carefully sometimes. And I think the idea of a claims examiner doing this level of evaluation and critical reading of the literature, it's not going to happen in most cases.

And I think there needs to be some structure for us to have difficult questions like
this triaged to a group, probably a group of
reviewers that have the skill set to do these
kinds of critical evaluations.

MEMBER SOKAS: Any questions or
comments? Okay. Dr. Cassano.

MEMBER CASSANO: Yes. A couple of
comments. On the TCE and kidney cancer I just
went down the exact same rabbit hole. Because I
was asked to look at it, and exactly the same
conclusions.

And I actually looked at exactly the
same sources of information that you did. But
also including the 2006 National Research Council
report on the health effects of
trichloroethylene.

On the arsenic and prostate, it's
interesting, because VA presumptively service
connects prostate cancer to Agent Orange. But in
actuality it is due to cacodylic acid, which is
an organic arsenical that veterans were also
exposed to.

I'm going, on the Parkinson's disease,
I'm going to disagree. Everything else, yes, I agree with. But the Parkinson's disease I, well, the manganese and Parkinson's like syndrome, yes, it's not Parkinson's disease. It's very similar. So, you may not be able to say Parkinson's disease.

But on TCE and Parkinson's disease, I think there is enough literature. Because VA just presumptively service connected, is going to presumptively service connect Parkinson's disease or Parkinson like syndrome to TCE exposure at Camp Lejeune.

And I just did another case on straight TCE exposure. And there were at least six or seven references on TCE and development of Parkinson's disease, that I think give you enough information to say there is maybe, not what IARC would consider 1A, but at least a 2A level of risk. So, that's, and I can give you those references if you want.

MEMBER SOKAS: And tying this back to our conversation this morning, I mean, I think
there's kind of a go/no go. So, it sounds to me as if TCE and prostate cancer are probably not high on the list. We throw that away.

But the other relationships might move forward, based on a preliminary Board Member evaluation, to go to this subcontractor to develop, you know, whether or not there might be something there. And then it gets reviewed again by the Board.

And it may well be that some of the presumptions made at the VA might be a useful starting point, depending on the types of exposure.

I'd like to just briefly mention, we've already talked about solvents and noise, which the more you read, the more you're convinced. I mean, there's no real discussion there, I don't think, except for how to frame, you know, what the requirements are.

Diabetes mellitus, especially Type 2 diabetes is a huge issue obviously. And toxic exposures. And there are, again, VA presumptions
based on Agent Orange exposure, and also
arsenicals, where the chlorophenoxy herbicides
and the, and arsenic in different types of
studies, in epidemiologic as well toxicologic
studies, have been demonstrated.

The question really would be, I think,
that second layer bullet for the Board here. And
I think that gets into, and what's the
plausibility of exposure for people on DOE sites?

Would there have been high levels of
persistent organic pollutant exposures that might
be, you know, worth developing further? If not,
then we let it go until we find some of these
other exposures.

The trouble with diabetes, and I just
want to make this really clear. There's a
British epidemiologist who once said, if
everybody smoked we'd think lung cancer was a
genetic disease.

And what's happening with diabetes
right now is, in addition to the genetic, and
behavioral, and dietary, and all these other
concerns, there are huge concerns about a whole
laundry list of persistent organic pollutants.

The research, a lot of it is looking
at environmental exposures that take place in
utero, for example. I mean, so it's not just,
you know, occupational exposures.

And, in point of fact, some of these
things, like bisphenols and phthalates, and that
are in cosmetics. They're in all kinds of
consumer products. So, in fact, it really is
ture that there are very few, if any, unexposed
populations to evaluate those.

So, it's an enormous epidemiologic
challenge. None of which seem to really give
enough information to move forward within the
context of this program.

And I would again defer to industrial
hygiene assessment of what is the likelihood that
the few items that have been associated with
occupational exposures might be relevant
exposures in DOE facilities.

And so, that's a question back to the
program, back to the industrial hygiene people.
And that would determine whether or not there
would be any further look at diabetes mellitus at
this point.

I don't, oh, Victoria, you have a
question? I'm sorry.

MEMBER CASSANO: Yes. I just wanted
to make one comment, which may or may not be
relevant in the end process. But especially, you
know, when you're using Agent Orange or
chlorophenoxy herbicides, there are two issues
there.

Chlorophenoxy herbicides are cancer
promoters. They're not initiators. And
therefore, if you are exposed to something known
to initiate a cancer, it's going to basically
potentiate the development.

So, a lot of stuff over in Vietnam was
attributed to Agent Orange, that actually,
probably had a different causation. Because
Agent Orange became the scapegoat for everything
bad over there.
And those are the only two comments I wanted to make. Because you can't, you have to be able to equate similar things.

MEMBER SOKAS: So getting back to diabetes. There are tons of tox studies that look at everything from insulin resistance to being able to produce insulin, to cellular mechanisms.

So, all of these things have been studied fairly substantive -- I mean, again, it's such a huge epidemic these days that there's been a ton of programmatic reports and interest, and meta-analyses, or review papers, rather. There's a need for meta-analysis. But there are review papers.

But the challenges, the epidemiologic challenges are also huge. And so, right now we're kind of, we're starting to recognize I think that there are chemical associations. But for the purposes of occupational health, again, the, probably the VA is the only place where that's been recognized and compensated.
MEMBER SOKAS: Yes.

MEMBER REDLICH: So, these are the questions that the DOL raised. But are they asking the right question? Because just stepping back they're, you know, so arsenic -- asenic, TCE related to Parkinson's disease and prostate cancer. So, my guess is that there are probably increasing number of claims related to those diseases.

MEMBER SOKAS: It's on the claims base.

MEMBER REDLICH: So, the question that comes to me first is, what are the major exposures that these workers have that, you know, could these workers be at risk, increased risk of these diseases?

So, they've, the DOL has picked out, you know, one or two. But, you know, what about mercury? So, it seems to me the question is, let's start with the, you know, starting with this disease, do we think these workers, given what we know about their exposures, have an
increased risk?

MEMBER SOKAS: Got it.

MEMBER REDLICH: Or the second thing, let's say non-Hodgkin's lymphoma, TCE and benzene, okay. But the number of workers exposed to mixed solvents is way greater than benzene.

And so, that's really the more important question to answer. Because, you know, there are just many more people exposed to solvents. So, I feel that --

MEMBER SOKAS: Right.

MEMBER REDLICH: -- that's the question they're asking. But I'm not sure it's the most important question to answer.

MEMBER SOKAS: That's a great point. That is a great point. And so because really what's happening is they're getting these, it's all claims driven. So the claims for the conditions are what we should be paying attention to, and then the associations we could independently look at.

MEMBER REDLICH: And to me, maybe we
need an expert panel that takes the data and says okay, these are the claims we're seeing, what do we know about the risks of these workers.

MEMBER SOKAS: Right.

MEMBER REDLICH: And do we need some presumptions --

MEMBER SOKAS: Yes, yes, yes.

MEMBER REDLICH: -- that if you worked at this place and were exposed to mixed solvent or mercury, then these would be accepted conditions type of approach.

MEMBER SOKAS: Yes.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: I think there's two thoughts I have, one of which is historically the resource centers encouraged individuals to include every medical condition they had on the claim form.

So it was with the concept that this was, the program was established to allow individuals to have their conditions reviewed for work relatedness within the Department of Labor
program without having to get an expert report
from an outside expert saying your, and laying
out why their Parkinson's disease was related to
cadmium exposure.

So what you'll be seeing when you look
at the pattern of claims is the diseases
prevalent in the general population for the
socioeconomic status and age of people that we're
seeing.

It is reasonable to say are those
conditions potentially caused by work, but you
don't have to, I think you can skip looking at
the pattern of claims because it would represent
what these workers have in terms of disease.

And as the population ages you're
going to see, I mean, at least among our
population of workers it's overwhelmingly men.
So you're going to see more questions about is
prostate cancer related, just a very common
condition.

But it is worth to say what agents do
we know cause prostate cancer because people will
be asking that question. Probably it's the case that claims have come in identifying agents for which there is some support already in the literature, so somebody's done a basic review.

So I had another idea but I forgot it.

CHAIR MARKOWITZ: So can I just make a comment? A large thing about that, we're responding to particular requests from DOL for assistance really on selected issues which is great. And happy to do that.

To broaden that however into for instance looking at all potentially toxic causes of prostate cancer, is it enormous task multiplied many times and essentially involves perfecting the Haz-Map system.

And this committee doesn't have the resources, doesn't have the charge to do that. I think this morning we elaborated on the recommendation around use of certain authoritative materials in order to enhance the SEM and the Haz-Map system, we'll continue to think of ways to do that.
But in answering specific claims
driven questions of DOL, I would hesitate to
broaden the scope of what we're supposed to look
at because it will go on and on and on.

MEMBER SOKAS: Which is true. But I
think if we could come up with a presumption for
one or two that makes, and tell them not to worry
about some of the others.

So again, if there's no evidence that
there's a lot of chlorophenoxy herbicide use in,
or arsenicals use in DOE facilities, then don't
worry about diabetes mellitus for this coming
couple of years.

I did want to make sure that Mark
Griffin was not on the phone yet.

MEMBER SOKAS: Okay. So Dr. Cassano?

MEMBER CASSANO: I just forgot what
was going to say.

MEMBER SOKAS: Okay, that's great.

That's perfect. We can keep going. Sorry. No,
okay. Dr. Redlich?

MEMBER REDLICH: Well, I feel that our
mission is not necessarily to, I mean part of it is yes, to address specific items that DOL raised.

But hopefully we could make suggestions to put in place a structure that would improve this system and with future issues come up, such as a suggestion of, you know, an expert panel that made presumptions because I sort of feel that we may not be, the question they're answering really may not be the fundamental problem.

So I don't want suggesting we address the whole literature of prostate cancer and, you know, causation. But one could say okay, knowing what we know about the most common exposures these workers have had, can we come up with a presumption.

Or not we come up with it, but at least suggest this is a way to approach this different than what is currently being done.

CHAIR MARKOWITZ: I would agree with that, that we ought to recommend the structure
for them to deal with that on an ongoing basis.

MEMBER SOKAS: Okay. And Dr. Cassano?

MEMBER CASSANO: I did remember what I was going to say now. I agree with the idea of doing a -- I think where something is patently obvious or where there is a exposure of concern at DOE facilities and a presumption has been established by another agency that we should at least list that as a possibly presumption to be evaluated further.

So I think there is a happy medium between going through everything and just saying we're not going to establish anything.

MEMBER SOKAS: Right. And I think we're in agreement on that. I did want to kind of move on since Mark's not on the phone. We can deal with the radiation questions later.

We had another question that came up on the telephone, policy telephone which we asked yesterday to see if DOL may be able to get us back some information.

There was a considerable amount of
discussion in those meetings, in the policy
teleconference meetings about interactions with
NCI I believe around prostate cancer. I may be
wrong on what the topic was.

But it was interactions with NCI that
seem to be helpful to the program personnel and
then something happened that the SOL put a stop
to it.

And I did want to ask for
clarification on that because I'm a little
concerned that we may be following NCI down the
rabbit hole if in fact there are legal reasons
why some of these, some of the recommendations
because honestly I don't see us coming up with
something radically different than what NCI would
come up with and I just want a clarification. I
don't know if there's been a chance to get that
or not.

CHAIR MARKOWITZ: No. I mean, we've
put that question to Department of Labor and we
expect a formal response, not an ad hoc response
at this meeting.
MEMBER SOKAS: Okay.

CHAIR MARKOWITZ: So we will get it and we will circulate it.

MEMBER SOKAS: Okay, great.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: Well, I think that the decision of causation and where we draw that bar, I think you do take into account information in addition to, you know, what the NCI and other people because I think this, in the setting of some sort of compensation system, you might say okay, how common is this cancer, what are the most total number of this sorts of cancer.

So how much effort are we going to spend for X type of cancer, teasing out, you know, the cases that we think are related or are not. So I think that the decision making about presumption, one piece of information is what the science shows but then there's also where you draw that bar.

And I think, you know, different systems I think do look at other pieces of
information to add to that decision making
because you do look at what the cost benefit
ratio is of implementing a presumption.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: I think that's not the
job of this committee though.

CHAIR MARKOWITZ: Very succinctly
said. Well I mean, where you place the bar is
essentially a policy issue. I mean, science
supports the facts about the spectrum of where
the bar could be, but ultimately where you set
the bar is ultimately a policy issue and we may
veer into that somewhat but it's probably not our
primary task.

MEMBER REDLICH: Just to clarify, I'm
not suggesting we come up with presumptions for
all these things. But I'm not actually clear if,
you know, it is a policy decision. But I'm not
actually clear where that is for this program.

MEMBER SOKAS: So that's what the
question really is to DOL that they'll get back
to us then because there was an example where
there was a scientific body part of the federal government who had some interaction with the program and was pretty much shut down based on that. And so my question really is where is that line, and that's what we'll find out.

We've got a couple of other items. I want to mention that the asbestos memo 1505 is going to be deferred until tomorrow's conversation if there's time for it.

I did want to highlight a little bit before that the question about medical expertise in these policies, and that includes a number of questions about terminology and language.

I personally feel like I'm listening to chalk being scraped on a chalkboard every time I hear the term alias for another word for a disease. So when you talk about asbestos aliases or asbestos' aliases, that just kind of grates.

I'm also not a big fan of opine because a variety of reasons. So I do think that there is an enormous need for the personnel in this program to have a translator and that
translator should be a physician in the program.

I understand that there has been a successful higher recently and that there is someone there. And hopefully at our next meeting in DC we'll have a chance to interact a little bit.

But it would be very helpful to have all of these issues engage internal medical expertise as well, in particular if the memos that are created are not coming through us for approval. It would be useful to know that they've had some level of oversight or input at least at the program level.

So I'm just making that observation and pleading again for just kind of an attention to the way that words matter and the way that physicians in particular but also other healthcare professionals are trained through a fairly long period to express themselves.

And so the fact that there are disconnects in terms of whether a physician is comfortable saying with a reasonable degree of
medical certainty, et cetera, you know, versus
the way that most clinicians would say things
which is that it's probably contributory. Right?
I mean, so again, these kind of
language differences, there may be other ways
than training the entire field of primary care
clinicians out there in order to address them.
I would like to then turn it over to
Faye -- oops, sorry.

(Off microphone comments)

MEMBER SOKAS: Oh, sorry.
MEMBER FRIEDMAN-JIMENEZ: I just,
going back a couple minutes. I want to agree
with Les that given our ever increasing
responsibilities as a committee, I agree that
it's probably not our best role, best use of time
to try and set these bars.
But rather I think it would be a good
use of our resources to develop and recommend
improvements on the triaging system so that we
don't see so many people getting blocked at early
stages of the system because of inadequate
information availability, so that we have a more effective triage system that will really pick up most or all of the cases of real occupational disease and move them down the line so they can be evaluated by people with the appropriate level of expertise rather than have them be blocked early on by an inappropriate triage system.

So I think that we could refocus maybe our work to look at that rather than trying to micro manage the individual bars that are being set.

MEMBER SOKAS: I did want to turn it over to Faye, but to note that we do have three recommendations at the end that would like to at least touch on before -- so we --

CHAIR MARKOWITZ: Okay, so just a time check. We have about 20 minutes for this subcommittee. So just if you want to get to recommendations, let's just be cognizant of time, that's all.

MEMBER VLIEGER: We had discussed these earlier during our subcommittee that I
wanted to bring them to everyone's attention because we seem to all be going around the same bush over and over again.

And that is the vetting of the CMCs for the actual experience in the field of what they're opining. And I've found in my CV searches and through final adjudication branch hearings is that they truly don't have the experience level we're looking for.

They may have a certificate but they really don't know what they're looking at, yet they're being used as an expert level opinion. So in the CMC contract that was just let, I think it's important that they do look at how many hours of clinic they're still doing so that they're staying current in what's going on because a number of the doctors they use are retired and no longer stay active in any type of clinic work.

And so, and that's something that I always look at when I'm looking at who made the opinion for a client.
Along with that, when you're looking at the vetting of the CMCs, in all of the state labor and industry vetting of doctors to do independent medical exams, they're supposed to sign an affidavit about how much of their work is strictly done in these type of programs, and I haven't seen that yet in anything that the Department does.

So when Kirk and I reviewed the claims and we found that no it doesn't add up because there were multiple times claims were sent to CMCs and sometimes twice to the same CMC. But in the 77 cases we reviewed, 18 of the referrals were to one doctor specifically for CBD, sarcoidosis, and the silica claims.

One doctor got the majority of those. The rest were onesies, twosies, and threesies of the 26 doctors that were on the list. And that was significant to us.

So we also would like to see instead of going to a doctor who typically has been saying no, at least keep track of how many times
he said no and maybe seek out someone else who is equally qualified if there seems to be a pattern occurring.

Then the other thing that we noticed in the case review, and it's important in this area, is that when the queries go from the CEs to the CMCs that they're not adversarial queries like we had mentioned earlier.

That they're an open question that deserves an open and complete answer, not a one word yea I agree with you or no I don't because you've limited the information in front of me.

And then it appears, and we've all run around this bush a few times with the references that we used to substantiate our opinions is that, we've talked about it yesterday, the library of accepted materials needs to be, we need to at least make a recommendation of what that library includes.

So that was it, and it was what we had talked about in our subcommittee.

MEMBER SOKAS: If we could move on --
thanks to Faye and also ask if we could move on
to the recommendations. Kevin, if you could
scroll down a little bit.

Okay, so there's the first
recommendation, I'll just, it's up there for
everybody to see. But that the policy
teleconference notes could be, should be
redacted, made searchable by topic and publically
posted that in fact there's a tremendous amount
of information that's provided in those. That's
very helpful to people.

And if there are concerns about some
of the way that some of the determinations are
made, having it publically available would also
be helpful to just in the interest of
transparency.

I don't know if there's any comments,
questions from the Board, any disagreements or
concerns?

CHAIR MARKOWITZ: Well, my only
concern is that would it change the nature of
those policy calls? In other words, if there's a
different sense of how that information would be
used and perhaps generalized, whether DOL is then
going to change the way they approach the policy
calls in such a way that they become less useful.

Now that's not a strong argument
against making them public, but it, I wonder what
actually is going to happen.

MEMBER SOKAS: Which is a good
question. I mean, obviously you don't want to do
anything that would inhibit communications
internally. I mean, I think that's really
important.

One approach would be that the person
who's most concerned about that would be the one
doing the redaction. So you could get rid of a
whole bunch of stuff if you thought that it was
not appropriate.

But it might then make people think
about what they're telling the claims examiners
about ways to proceed if in fact you're not
willing to have that information made public.

And the example I'm thinking of is the
suicide case. But there may be other questions
that it would make people think twice about and
then go back and maybe get a little bit more, you
know, of a response, at the worst. At the best,
it's incredibly useful information that everybody
would want to have.

MEMBER WELCH: So I would think that
some of the things that are discussed on those
calls would then become written guidance, and
there are periodically guidance issued in
circulars and, I forget, there are two terms,
bulletins and circulars.

And because you couldn't, you
shouldn't assume that everybody who's on the
call, everybody who needs to know the information
if a decision is made on the call, that everybody
that needs to know the decision would be on the
call and that they're taking appropriate notes.

So there should be some way in which a
policy decision that's brought up on that call
should be resolved and put into circulation. And
I don't know if you were able to see that
process. That makes more sense to me than necessarily posting the results of the calls.

But some assurance that the decisions, because if decisions are made on the calls and half the claims examiners hear and half don't and the second half never hear about it, you're going to start to see the disparity in handling cases that we're concerned about.

The part that seemed to be useful on these calls was that it's how you actually apply. So some of them did have written guidance already available. It wasn't as if they were developing the written guidance, but it was what does it actually mean to apply this in a concrete circumstance.

And again, you have to be careful that the concrete circumstance isn't presented clearly enough that you could figure out who the person was obviously. So there's a lot of confidentiality of the claims, for the examiner, for the client, for everybody involved that needs to probably redact location and site and things
like that.

But the way in which existing guidance is implemented as well as these are problems that are coming up for which there isn't current guidance. You know, is some in the pipeline? It just looked incredibly rich as a potential area for communique.

PARTICIPANT: So there's no more comment on that one. I mean, if people are concerned about, think about it and discuss it tomorrow. So the next one was that --

PARTICIPANT: Microphone.

MEMBER SOKAS: Sorry. So the next recommendation really grows out of what we've been discussing and may need to be tweaked. But that case file should be handled in the same fashion that large medical practices currently handle electronic patient records which is to grant password protected access to the entire file through an electronic portal.

And the goal there obviously is to allow the claimant to look and see well, I'm
really a laborer, I'm not a launderer. So for clarification where necessary, and also just in the interest of transparency.

So I know, and I did have a question for Faye. I know that files are available. I don't know what the process is for that. If you could?

MEMBER VLIEGER: They've always been available. Most claimants don't know that it's available to them. They have, you just do a simple file request. DOL does the best they can to get them to you.

We've had some long delays on retrieving some of the files. Some have taken as long as a year to get. That's not the requirement. The regulatory requirement is much shorter than that.

And they used to not provide them on disks at all. The Seattle District Office is starting to actually provide them on a searchable disk which is much better.

But an average small file is still
1,000 pages. A new file is maybe 200 pages. But a file that's gone on for five or six years, my particular file, five years, was three banker's boxes at the time.

So disks weren't available then. So you can request them. They're totally requestable. First copy is free, and then if you want to supplement what you have over time, you just ask for whatever's been added to the file since the last request to date.

MEMBER SOKAS: So the question is would it be, I mean there's two parts to this question. One is would it be technologically feasible and not all that expensive to make this something that could be accessed through a portal, and would there be any benefit to the claimants for that to happen?

MEMBER VLIEGER: I'm speaking from experience, and I'm sure someone out here from the Department may have something to add. However, not all the files are electronic at this time.
Some are still paper or they're what are called the hybrid file which is paper file and electronic because the electronic system has not been in effect for that long. So making everything on a portal right now could be cost prohibitive.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: In principle I agree with this, however in real life, sometimes it takes a lot of time to explain to patients what you mean by something in your medical note.

And we write things as physicians that are short hand, that are abbreviations, that are, you know, and we're under time pressure when we're writing these notes.

And so sometimes we have to go back and if they see it, explain to them what we meant by this and sometimes it doesn't sound very good. And to write a note that is user friendly for the patient takes more time.
So I think you have to build that into the process and have someone be there who will be able to answer questions from the patients. I think that it's useful to see what job title they were assigned, et cetera.

And I would also say I think it's useful for them to see the SEM for their particular job to make sure that they agree with their exposures. And if they have an issue, then that can be discussed.

I think that could be included as part of the process. But I agree that patients should be, individual claimants should be involved with their medical record. It's just that you're going to have to budget some time and resources to explaining some of the terminology.

MEMBER SOKAS: Well, and if what Faye is saying is it's not necessary because it's already available. Right? Okay, it may not be necessary. Okay, so that -- yes, okay.

MEMBER WELCH: I mean, the advantage of having it electronically available is as it is
now, if somebody gets three banker boxes it's a
little overwhelming to go through it.

If it were structured so that, you
know, the work history, the specific documents
were files that you could find, it's a big
project but it could be something if this program
is going on for a long time to build it in going
forward.

Then it would be possible for a worker
or someone acting on their behalf who could be
granted access, either an advocate or an attorney
or a physician could then look at points of
importance for the claim at that time.

It's like well I want to know how, I
know how this worker was characterized in our
database, but how is DOL doing that. And it
would be much easier to be able to go to an
electronic database than to have to request the
whole file.

MEMBER SOKAS: So maybe what we could
start with is to consider doing this for new
cases being filed moving forward. Okay.
MEMBER VLIEGER: So just so you're aware, since they started the electronic processing, they have a portal that has a security code on it. A letter goes to the claimant and says this is where you can check the status of your claim.

I don't know that the age range of people we're dealing with is really equipped to be doing that, in many cases. But it is available. And as the representative, I don't get that letter. It goes strictly to the claimant which is difficult because many times the reason they're using someone to help them is because they can't navigate computer systems.

So that is available for status checking or, like, what's happened. And it's bulleted type things, it's not full access to the file. So that's a separate thing we've not talked about that's available to the claimant.

And they get a letter. It has a particular code on it that doesn't match anything else in their file. And they get that letter
once at the beginning of a new claim that's in
the electronic system.

MEMBER SOKAS: So it may be that the
infrastructure is capable of doing something.

MEMBER POPE: Is there a process
within that electronic copy that the claimant has
the ability to edit that information?

MEMBER VLIEGER: No, no. They
wouldn't have access to that. What you can do,
they have an electronic portal for submission
now. And it has taken two to three weeks out of
the mail system that they used and a week out of
the system of using the resource center where
they would send things for you where I can hit
transmit, be talking to the representative with
the Department of Labor and within two to three
minutes they have the security cleared document
up on their screen.

And that's very helpful in the
terminal claims. So they can't access DOL's
file. And I think for security reasons, I'm
putting my old military security hat on, I doubt
that that would ever happen. But they do have
that status checking portal they're given for
each claim.

So like I said, I'm not aware of many
people that are actually using that system, and
maybe John has numbers on the use rate for that
system.

MEMBER SOKAS: Okay. So moving on to
the last item, this is kind of in response to
Steve's mention of explaining what occupational
medicine was to the Secretary yesterday.

But that it might be helpful in terms
of some of these communication issues that the
Department of Labor consider reorganizing its
occupational physicians into an office comparable
to the structure of the Solicitor of Labor so
that you would have physicians organized in
groups that support OSHA, that support MSHA, that
support OWCP and as well as providing, you know,
as needed support to others within the Department
of Labor who currently have no access to
occupational health.
And the rationale is that there is a pretty good model already in place that as a group, physicians can have residents going through and assisting them and other ways of helping.

And if for example there is a gap when they don't have a physician in OWCP or in this dedicated to this program particularly, that there could be backfilling, you know, that somebody else could kind of help out for a while.

And it just would enhance the overall ability to recruit and retain because of the concerns around professionalism.

MEMBER WELCH: That's a brilliant idea.

MEMBER SOKAS: Thank you.

CHAIR MARKOWITZ: Other comments?


CHAIR MARKOWITZ: Okay, so we're finished this subcommittee report. Thank you very much, Dr. Sokas. Since you started three minutes late, you're two minutes ahead of time.
Next we have Greg Lewis from Department of Energy, the Office of Occupational Safety and Health who is going to be discussing the use access of DOE records for the EEOICP. Welcome, Greg.

I want to also thank, while he's doing that, thank Greg for arranging for our tour yesterday. We had a terrific, short but terrific tour of parts of Y-12 and X-10, ORNL to enhance what we know about the DOE. So welcome.

PROVIDING DOW RECORDS FOR EEOICP

MR. LEWIS: All right, good afternoon, Dr. Markowitz and Members of the Board. Thank you for allowing me to speak with you today.

So last time you heard from my boss, Dr. Pat Worthington. And she's the Director of the Office of Health and Safety within DOE. So I'm the Director of the Office of Worker Screening and Compensation Support within her office.

And I'm going to talk to you about how we provide Department of Labor records and give
you a little bit of stats. If you remember from
Dr. Worthington's presentation, she kind of kept
it at a high level of in general what we do and
talked about our commitment to the program, our
commitment to the workforce.

And I'm going to try to take it down a
little bit and give you a little bit more detail
and again some stats. So let's see here.

All right, so you know, again, what we
do, what my office does is only work with former
worker programs. That's all we do. We support
this program, the EEOICPA and also the former
worker medical screening program. So former
workers are extremely important. That's what we
do, that's all we do at my office.

We work on behalf of program claimants
to ensure that all available worker and facility
records and data provided to DOL, NIOSH, and the
different advisory boards. So we provide
records.

And we do that in primarily three
ways. For individual claims, which is the bulk
of what we do is respond to individual claims,
provide records for those cases, is we respond
with the, via the SERT system to request from DOL
and NIOSH.

The SERT system stands for Secure
Electronic Records Transfer system, and this is
something we put in place a few years ago to do
two things, basically. One, to ease the
transition of records from us to DOL and NIOSH,
and two to protect those records.

Because of issues these days with PII
and people's information, before we were, you
know, originally we started mailing paper way
back when and then we got a little smarter and
we're mailing CDs back and forth and then we
password protected our CDs. And then we started
using encrypted thumb drives, but all of this was
going back and forth with the mail.

So in addition to being slow and
confusing to track, it was also not the most
secure method. So a few years ago we set up the
SERT system. And as soon as the Department of
Labor uploads a request for, you know, John Doe's records into the system and selects a DOE site like Y-12 or wherever, multiple sites and hit send, it immediately shows up on our screen and we're both responsible for it and our clock is ticking in terms of 60 days.

So it's a very transparent system. Everyone knows who has the ball and what the timeframes are. So again, that's the bulk of what we do is respond to individual claims.

However, we also provide support for the large scale, you know, records projects. So things like the site exposure matrix, we were involved initially in helping Department of Labor gather the records to put that together.

We've been involved since in, you know, both providing records and validating the questions that they have for us about the SEM. We also work with NIOSH on a large scale with special exposure cohort research projects, you know, and do other projects at our sites to enhance and improve the records.
The third responsibility is much smaller. It's important but it's much, much smaller in terms of level of effort, and that's to conduct research into facility coverage.

You know, with the large sites, that's really a non-issue. It's well defined, you know, in general what they did and when they did it. But for some of the smaller atomic weapons and players, they may only have done work for DOE for a couple years and that at the time would have been AEC back in the, you know, '40s, '50s, or '60s.

And even there's some facilities covered on the list that did work for, you know, ten days even for a very small project. So because it was smaller work, it was a long time ago, there may be questions, well do we have the right time period or do we have the right work covered. And so we'll do research into that.

So for individual claims, we respond to three types of record requests, employment verifications, NIOSH requests for dose records,
and what we call the DAR, the document acquisition request which is more or less everything else, everything that we have with that individual's name on it.

And before I talk to you a little bit more about that process, I'll just say at each DOE site, or DOE location I should say, we have a site POC responsible for the oversight of the EEOICPA work.

So we send out funding to all of the sites and those folks are the ones who manage that funding and, you know, make sure the process is complete and responses are getting in on time and that sort of thing with a little bit of oversight from us.

So they coordinate the research activities like the SEM and the SEC projects. They send us on tours like yesterday. And they, you know, if there are specific questions from DOE or NIOSH, they'll try to identify the right people to talk to, site subject matter experts or even retirees who they know who could be brought
back on site for interviews, things like that.

So these folks are, you know, they're really the people out there that are making this program happen at a site level. A lot of these folks have been on site. We really try to get folks in these positions that have been on site for years, some of the people have been there for 20 or 30 years.

And that's important both for their knowledge of the site and history, but also for their knowledge of how the site operated and where the records might be, and also their contacts within the site. You know, if we have an issue here, who can I talk to that's going to make this happen. So they're extremely important people for our program.

So for individual claims, I'll take you through the process. And again, every site is a little bit different. You know, we have closure sites, we have smaller sites, larger sites, labs, production facilities.

So it's always a little bit different.
But in general, our search process more or less follows these steps. So I'll take you through it.

So our EEOICPA POC is going to receive the claim through the SERT system. Typically some type of initial development is done on the claim. A lot of sites had a site ID number because they didn't want to use, you know, whether it's birthday because that's duplicative, or social security number or something like that.

They would have site ID. So you know, our folks will take the information that's in the claim from DOL and NIOSH and cross reference that against something on site to see what was their site ID number.

Or if there's missing information in the claim like the social's incomplete or there's no date of birth, we'll try to see if they can find that in their records to help enable the search.

So then for active site, for closure sites, you know, everything may be in one records
archive location so the search may be a little bit easier. But for a site that's still operating, typically the EEOICOA POC will have to send it out to a number of responsive locations, human resources, medical, industrial hygiene, radiation control, dosimetry, incident or accident, or the records archive.

And again, sometimes that doesn't go to all those. You know, some places the incident or accident reports are in the medical file or somewhere else. In some cases it goes to the divisions like medical and HR and then they sort of "own" the records in the records archive, so each of them may be going to the records archive to pull their record. You know, but essentially those are the primary groups involved.

And then each of those areas will conduct a search of their holdings. Sometimes this can be pretty simple. In my experience, typically medical is the most straightforward. There is one medical file for one individual and it just grows by the years. So it's pretty
straightforward in terms of finding that.

Although then again medical is
difficult because in the end you have to, many
times they're in paper so to scan them and to
process them you have to pull out all the staples
and all the different size pieces of paper and
writing in the margins. So there's challenges
everywhere.

But we'll go to those different groups
and they'll pull the records. So what I have
here, and I know you can't read this, I can't
read it either which is why I brought up my iPad.
So what I'll have, and I'll skip to the second
page, this is the first page and this is the
second page.

This is just a sample chart I picked.
It happens to be in the Nevada test site. And I
like this one because the way they put it
together it's more concise. It's two pages with
a lot of information jammed in it.

Most sites have it where each record
sources its own row so they can be 20 pages long.
And essentially this is a table of the possible places that they might go to pull records. This doesn't have a --

I don't want to blind anyone, I'll use the pointer. So I'll skip to the, yes the second page here. So if you look on the top left, it's hard to read but it says industrial hygiene records. I'll use that as an example.

That's the general type of record.

And if you move two columns to the right of that, sort of the middle column there, it gives the different databases that could have industrial hygiene records.

And so just to sort of read down and give you an idea, you know, you've got the LRC/FRC, I assume that's the Local Records Center, Federal Records Center. That contains records, if you move one column over, from 1945 to 2014. They're paper files, and there's 850 boxes.

And so for each source, we've kind of detailed, you know, the years that that source
covers, if possible. It's not always possible, the type of records, you know, whether it's electronic, microfilm, microfiche, paper, or all three and then sort of a rough idea of the volume.

So moving down, there's the ERS database, that's 1945 to 2005 electronic files and it has over a million records in it. Skipping down, you've got microfilm index and HRC, that's 1961 to 1992. And it's microfilm and that's also over a million records.

So every single entry in that third column over going down, and of course back to that as well, that third column, that's a record source that we may go to. So again, it could be boxes, it could be a database.

For your typical individual you certainly, you would never have to go to all of those sources. But for each one of those items on the left, you know, it's HR, on the left medical, you probably can't read it. And skipping down, IH accident and incident,
dosimetry and other information.

For each of those you probably have to
go to at least one source and probably multiple
sources for each individual depending on, you
know, what time period and how long they worked.
So if you're a 30 year employee, you know, we're
probably having to go to 15 to 20 different
sources for your records at least.

And skipping ahead. Actually, you
know what, I'll go back to that one. But
skipping ahead, so this is what we find. On
average on individuals, this is across the
complex, so averages are always, you know, a
little bit misleading.

But typically for an employment
verification, our average response is about 14
pages. You know, and again, that's the shortest,
that's the easiest, that's just what do we have
at HR saying yes, this person worked here and
here were their start date and term date or
multiple start and term dates.

And then the average number of
patients for a NIOSH request is about 50. So
NIOSH is typically dosimetry records, you know,
or the RadCon record. Sometimes there might be
some medical in there because at some sites,
particularly back in the old days there might be
dosimetry records in medical.

But that's about 50 pages, and then
the average number of pages for a DAR is 150.
And that's somewhat duplicative because the DAR
would typically have some of the dosimetry stuff.
So you know, part of that 50 or maybe all of that
50 at some sites are included in the 150.

And even within that, that's across
all of our sites. So some sites may have more,
some less depending on, you know, their record
keeping, how long they've been in existence, what
they do, that kind of thing.

And it also runs the gamut. You know,
for a subcontractor that we don't have much on, a
DAR might, we might not be able to find anything.
It might be not much, it might be literally
nothing. And then for some other folks, you
know, I've seen responses that are over 3,000 pages for a single individual.

So it really runs the gamut. And I know, Faye, you mentioned earlier that many times we don't have the records. And I will say sometimes we don't have the records. Many times we do. We certainly don't always have all the records and we certainly don't know in any given case that we have all the records. There may be some missing.

MEMBER VLIEGER: I noticed on your search list that list that you look for IH records.

MR. LEWIS: Yes.

MEMBER VLIEGER: But where do you look for them? They aren't appearing. So I guess my question is where is that database?

MR. LEWIS: I mean, it's funny. I picked IH, so at Nevada, you know, we did search any of those different databases for records. Now again, on any given case, there may not be industrial hygiene records for an individual.
You know, maybe there should have been or maybe they either should have been kept or should have been saved and weren't. But all we can do is go to sources where IH records are kept and do as exhaustive a search as possible.

And we don't know what we don't know, so it's hard to tell if something's missing or whether something should be there. But we try to do as thorough a search as possible in the databases that we have that contain IH records.

So I'll skip back for a second to give you an idea of volume. Last year, according to the SERT system, we did 18,621 records responses to DOL and NIOSH. Now that's of the three different types, employment verification, NIOSH, and DAR.

So one individual could have three separate types, you know, different requests. So 18,600 is not individuals, the individuals is less, but that's the type of request and that's for over 25 different DOE locations and some with sub-sites. Not too many with sub-sites.
So that's, so I talked about kind of how many we do, what we typically find from a very general sense, and then timeliness. We work with Department of Labor and NIOSH under a 60 day timeframe.

So we're trying to get every request, EV, NIOSH, and DAR back within 60 days. And last year, last fiscal year, so October 1 to September 30 we responded to 17,600 out of 18,600 which was 95 percent under 60 day response rate.

And actually typically, that's not really an average. Most sites are either, you know, very close to perfect and then there's some sites that we struggle with.

And the sites that we struggle with always kind of rotate around based on, you know, staffing issues or something going on at the site and you kind of work with them to get it back up, and it's a little bit of whack-a-mole. But again, we have a pretty good response rate across the board.

And just to highlight a few sites, you
know, at K-25 they had in the last year six late
out of 2,112. Richland had six late out of 1,564. And Savannah River was the all-star with zero late out of 1,316. So they worked very hard to stay under that 60 day timeframe. With some pushing and prodding from the folks in my office.

Sam, I'll kind of skip over this.
This slide was in there last time, you know, you guys are very familiar with SEM, but I will say we did help Department of Labor gather the information and do work with them on ongoing data requests.

And then we also work together with Department of Labor and NIOSH on outreaching issues. We were part of what we call the Joint Outreach Task Group which is NIOSH, DOL, my office, the DOL Ombudsman, NIOSH Ombudsman, and the members of the Former Worker Medical Screening Programs all get together to join forces and outreach.

We're all essentially trying to reach the same folks. And by, you know, working
together we can both be more efficient with our
dollars and also, you know, be all in the same
place at the same time to answer all the
questions because invariably when you go, you
know, if we were to go somewhere, half of our
questions would really should have been answered
by DOL. So we can make sure that the right
person is answering the right question.

And then of course I also mentioned
the other thing that my office does is fund and
support the Former Worker Medical Screening
Programs, and I don't need to tell some of you
that. But you know, it's a program that provides
free medical screens to all former workers from a
federal contractor and subcontractor workers from
all DOE sites.

You know, wonderful program, and
anyone in the audience that is not familiar
should certainly talk to me or look it up online.
It's a wonderful program you can take advantage
of. Here's some information, the website and a
brochure about the program.
And then I would be happy to take questions on anything that we do, whether I've talked about it or not.

CHAIR MARKOWITZ: Thank you, Mr. Lewis. We especially appreciate the plug for the Former Worker Programs. How many people, how much effort is used in retrieving these records at each site? I just want to get a sense of because the volume is amazing and the record of timeliness is incredible. Just wondering what kind of resources it takes to do this.

MR. LEWIS: I'm trying to think of how, I mean, that really depends on the site and on the claim. Like for example, the Office of Legacy Management is the group that, they handle most of the closure sites.

So they built one single database that at least has a finding aid for all of the records in its one database, and the records are at three different places. But really, you know, Mound and Fernald are in one place, Rocky is in another, and then a lot of the food scrap sites
are handled in Grand Junction.

So they have one search tool that will
tell them where to go for, you know, an
individual, x number of boxes. And they can go
pull it, so that's a fairly simple, you know, at
least they put in the name, they get the we need
to go to these 20 boxes or someone's going to go
pull it.

Most places, you know, each of those
organizations like medical, IH, and RAD, they'll
have a few people at least working on this
program. And where and how deep they have to go
for a claim, you know, is going to depend on when
the individual worked and for how long.

You know, at certain sites the, at
most sites the recent records, a lot of them are
both n electronic index and an electronic record.
So they can kind of find the different things,
drag and drop them into a folder, and then upload
them into SERT. Very easy.

For going back to the '90s, '80s and
before, a lot of that stuff hasn't been scanned
in, so you know, you're going to have to use from
15 to 20 search tools on the front end and there
might be five or six people actually using those
search tools.

And then that will lead you to boxes
of records. Sometimes it will lead you to some
scanned electronic records, you know, woo-hoo,
that's great. But then a lot of times it will
lead you to, you know, you've got to go to our
record center and aisle 27 row 52 box 5. And it
will be, you know, about 20 boxes like that.

So we'll have the record center staff,
you know, pull them all out and we'll bring a
cart over and someone will go through them all to
pull the folder.

And then of course on the back end,
you've got to scan those. So depending on, you
know, if it's a few pages, great. Again, if it's
a big medical file, those are a nightmare
typically because it's different size pages and
onion skin and you have to work to get the copy
correct and you're messing with the dark and the
light and trying to get the right contrast
because it's old records.

So it's a labor intensive, it can be a
labor intensive process. And sometimes we have
to go offsite for records, so we'll have to
request something from the Federal Records Center
and they'll pull it, but then they'll have to
ship it back to site.

And we'll go through and, you know,
pull those records and get it all scanned. I
mean, I don't know if that answered your
question, but it's really --

CHAIR MARKOWITZ: No, no. That's
fine. That's fine.

Dr. Cassano?

MEMBER CASSANO: I have a question as
to in what form does this go into the claims file
at DOL? Do you synthesize the 150 pages at all,
or does it just get sent as raw information to
the claims holder and therefore the CE has to
figure out what's relevant and what isn't?

MR. LEWIS: The only thing that gets
synthesized is the employment verification, when we can do it because that we're required to say okay, yes they worked here and here's their start date and here's their term date.

And that gets a little tricky too because for subcontractors and some employees that were, you know, employees with the prime and then they were there with the sub or multiple subs, you know, we may verify employment for a certain set of time, but then when we go do the DAR, we'll find evidence of site presence outside the time of that employment verification.

When we know that's going to happen at the onset it's clear that yes, this person is a subcontractor, we'll just go start pulling the DAR records right away because we know that an employment verification is essentially use, you know, the HR office is not going to have a formal file on this person.

But we may be able to provide many different records that show they're on site, or unfortunately none, but we'll go to that right
away. But sometimes when they were a prime contractor we'll pull the employment verification, think it's pretty straight forward, send it back.

And when we start working on the DR we realize oh, you know, we've got records from outside that time period. But you know, sorry to get back to the question, the rest of the stuff that DAR, whatever we find, that 150 pages, I mean, it's usually, it's organized by the different, you know, here's the medical, here's the RAD.

We just send that back. We don't get into interpretation of the record. We let Department of Labor do the interpretation.

MEMBER VLIEGER: I had a question. Listed on your list of things that you look for, that incident, accident, occurrences. When those reports were generated in the heyday at Hanford, there's only one page that actually lists the workers involved by name. And that one page seldom ends up in their personnel folder.
So how, do you have a database with
the names associated to those incident reports?

MR. LEWIS: I mean, I can't answer
that question for the whole complex. At some
sites they will have a database where they can,
you know, type in a name and see what comes up
for incident and accident reports.

At others they don't. They may have
the incident and accident reports listed
chronologically. So if we don't have anything in
the file or anything that suggests that a person
was involved in an accident, in this specific
incident and this specific time, there may not be
a way for us to search those records in any
logical fashion.

But when we can search based on a
name, we absolutely do. Or if it was included in
the medical file.

MEMBER VLIEGER: And then I had one
follow-on to that. There's a system called
CAIRS, C-A-I-R-S. Is that system searched when
you're looking for accident type reports?
MR. LEWIS: You know, I may have to get back to you. My impression of CAIRS was it was a de-identified database. But if it has a name in it, we would certainly search that.

MEMBER VLIEGER: The copy of the file that I got at one point for my particular claim had all the names on it, and they hadn't redacted any of the ones, my name and then a number of other names were on it.

So it can be hand redacted, but it's my understanding when the report goes to headquarters, DOE, it's fully listed.

MR. LEWIS: Okay. And actually, you know what, now that you mention it, for CAIRS I don't think a lot of them check CAIRS because the sites submit to CAIRS in the first place.

So theoretically each site should have that record in the first place because they were the ones who submitted it. So a lot of times they would search their own database first and then CAIRS if necessary.

MEMBER VLIEGER: Okay. In my case it
was omitted. I had to make a special request for it.

MR. LEWIS: And if there are issues like that, I mean, I could certainly look into it. We do try to adjust our process as necessary. We've certainly gotten a lot smarter in the last, you know, 10 to 15 years in terms of how we do record searches. But there's, we could certainly improve.

CHAIR MARKOWITZ: One last, we have time for one last question or comment. Dr. Silver?

MEMBER SILVER: Do you in DOL have a way of closing the loop so that ultimately you get some feedback on the value of the information that you've taken a deep dive to retrieve and whether it's determinative in winning claims or is that just something you've figured out intuitively over the years?

I'm thinking of the Los Alamos County Warehouse that we prevailed upon DOE to come up with a few million dollars to put in order.
MR. LEWIS: Well yes, I mean, that's a good example. There's not really a formal feedback mechanism because typically what we find is what we find.

You know, when we realized that there are additional sources of records like that warehouse, and warehouse is kind of putting it, it was sort of a tumbled down shack. I mean, those records were rescued.

But when we find additional records, whether it be in an offsite warehouse, whether it's we found them under staircases in people's offices when they retire, or even actually what's most typical is we open a box, you know, for the program we open a box either for NIOSH or on a claim and it's labeled as something and it turns out to be maybe that something and something else or just something totally different.

And you know, when we find that we'll pull the thread. Well, what is this box labeled, what collection is it part of. So we'll kind of look at the rest of that collection and see is
this something we need to index.

And actually the most recent example of that, there was, I'm a little fuzzy on the details but it was basically a collection of remediation records that were, and the remediation was done by Bechtel National.

And the Office of Legacy Management was looking for something else in response to a NIOSH request. This was about a year ago. And they realized that oh, you know, wow. Here are a lot of Bechtel National records, we didn't realize we had these, we had thought the company had them and the company said they didn't have them.

So again, it was sort of some confusion. We found them. We did about a six months, might have been nine, it was a fairly significant effort on LM's part to index all of those records and get sort of an organized list of what we have, including names of individuals that were in there.

And right now, we're just starting to
work with DOL to both make sure they know those
are available for future claims, but then we'll
ask for, we let DOL assemble the list but I think
it's typically previously denied claims that
would be relevant to that records collection.

And they'll send us over a list of
past claims and we'll run that list to see if we
have anything that might impact old claims, and
they may reopen if necessary.

And that's what we did with the Los
Alamos records collection, went through them for
past claims and now we're also using that for new
claims. And actually in that collection we found
the medical records of the gentleman mentioned on
the tour yesterday. So his records were in
there.

CHAIR MARKOWITZ: Well, thank you very
much, Mr. Lewis. And we will take a break and
reconvene at 3:30 in a half hour.

(Whereupon, the above-entitled matter
went off the record at 3:01 p.m. and resumed at
3:32 p.m.)
CHAIR MARKOWITZ: Okay. While they're doing the phone, I do have something to say to people who are present here. At 5:00 we're going to have a public comment session. There are seven people who have requested, in advance, for time to speak.

We, I think, previously communicated it would be a maximum of seven minutes per person. Happy to say that the number of people here have also decided that they would like to speak. So we're going to ask the people who made an advance request who believe that they have seven minutes, if you could shrink your comments to five minutes because we want to make sure we have time for everybody else to speak.

So just for the next hour and a half, as you rework your comments and shrink it from seven to five minutes that would be great.

A couple of announcements before we begin the session. First, the Advisory Board received two letters from ANWAG, the Alliance of Nuclear Worker Advocacy Groups, over the last
several months. They were addressed to me, and I
belatedly distributed them to the Advisory Board
last Friday. You received them by email.

They are on topics mostly familiar to
us, in part, because we've discussed part of
them. But we will explicitly discuss those
letters tomorrow morning. So for the Advisory
Board Members, take a look at your email last
Friday. You'll see two letters, relatively short
letters, addressing the specific topics.

As far as tomorrow, we will start
tomorrow by discussing the recommendations that
have come out of the discussions over the past
day. So we're going to reconfigure our schedule
tomorrow to accommodate that.

Dr. Cassano, this next Subcommittee is
the Weighing Medical Evidence Subcommittee. This
is one of the tasks assigned to the Board to
evaluate how claims examiners look at medical
evidence, and see whether we can make some
recommendations around that.

Dr. Cassano?
WEIGHING MEDICAL EVIDENCE SUBCOMMITTEE

DR. CASSANO: Good afternoon, everybody, and thank you for attending. Our subcommittee was charge with the task of looking at how the claims examiner develops claims then determines what medical evidence is relevant, and then how they decide a claim based on the medical evidence that they get.

Subcommittee members were myself, Dr. Boden, though Dr. Markowitz was on all of the Subcommittees as an ex officio member. I actually impressed him into service on my subcommittee, Duronda Pope, Dr. Silver, and Fay Vlieger. As we go along I'll explain why we really -- we broke up into work groups to look at some stuff, and I wanted one doc, one industrial hygienist and one member of the community on each work group, so that's why Dr. Markowitz got a little bit of extra work to do.

What we looked at were the materials that were available to assist the CEs in
determining the development and adjudication of medical claims, the logic processes. This is where we want to look at the logic process used from getting from what the claimant submitted to what goes to the industrial hygienist, what goes to the CMC, and then, finally, their final decision based on all this information.

And then what training materials are available on specific toxicants outside of the SEM and to make recommendations for some of them. A lot of these points have actually been discussed, in part, by all of the other subcommittees, so I'm hoping that when I finish a lot of this will get tied together a little better.

So on our first meeting on the 12th of July we were asked by Dr. Markowitz to define the issues and scope of the area, to find the data and information need, and draft an initial work plan. I think we got bogged down a little bit in what information and data we needed, but I think everybody did.
Then what we did at that first meeting was we reviewed the procedural manual in pretty
detail, especially Chapter 2, and this is what we found. In general, the procedural manual tells
the CE what to do and when to do it, but it doesn't tell them how to do it. It doesn't give
them any information on, gee, how do you parse between this piece of medical information and
another piece of medical information. So we found that was missing.

In cases going to the CMC, all submitted medical evidence should go to the CMC,
not just that which the CE determines to be valid or relevant. Because we were not sure how the CE actually determines what is considered relevant or whether there is actually enough medical expertise at the CE level to say, gee, this piece of medical evidence is not relevant, but this one is.

So we were a little leery of allowing the CE to make that decision, and the same thing goes for what goes to the industrial hygienist.
This is something that was brought up and I'm just -- there are publications and consensus documents available which provide better information on causation and outcome, but that it's not the CE's place to parse this information. These are the IARC and the National Toxicology Program. They need some kind of document or guidance that parses it.

Then there were problems with the type of medical evidence utilized to determine a diagnosis. Again, that's already been discussed. Whether it's a death certificate or in a death case versus the CT scan versus a treating physician's opinion, and a CMC's opinion.

Then, affirmative assistance. That basically says that the CE may not be aware of the necessary medical information needed to adequately adjudicate the claim, and therefore, they can't tell the claimant what's needed. And the issue is with the restrictive reasons for sending a case to IH or CMC.

Because the procedure manual tells
them it should be sent to a CMC when this occurs or when that occurs, but it's, as far as we were concerned, it was pretty restrictive. Please, anybody on my subcommittee that wants to chime in on any of this, feel free to do so.

What we did was we then set a request for information, just like everybody else, to Department of Labor. We had questions that we needed answered, and also we had some specific information and data calls that we wanted. So we talked about, again, the consensus document from IARC that they should be available to the CE in some form, but not as raw documents because they were not be able to parse them.

The expertise to review these and they may be ignored if submitted, and I think they, basically, affirmed that a lot of these are not even sent to the CMC because the CE determines that they're not relevant. Again, we went through that same problem.

Deficient evidence referring to wage loss. We don't believe that the treating
1 physician can make this determination at all and
2 that there has to be some other way to make that
decision.
3
4 We really wanted to know how the CE is
5 trained to weigh medical evidence. We found that
6 most of the training is basically done on the
7 job, and that a senior claims examiner sits down
8 with a new person and says, oh, this is how you
9 do this and this is how you do that. There's no
10 real standardization, from at least what we saw,
11 on how that is done. When we looked at cases it
12 was very obvious that very, very similar cases
13 were adjudicated very differently based on where
14 they were adjudicated from and who was looking at
15 them.

16 Therefore, what we did was we
17 requested to form a focus group of CEs that we
18 could sit with, at least parts of our work group
19 could actually sit with, go through claims with
20 them, and say, okay, how do you -- this is what
21 you get on this required form. How do you use
22 that? Do you use it? Do you dismiss it or what
happens with this information? And so we think
the only way we can do that is with a smaller
working group sitting down with CEs and actually
talking to them about that.

Then we requested the training
materials that are available to CEs besides the
procedure manual. Then we also requested the
Part E claims to review, specifically from the 14
priority areas, but there may be others as well
that we would want to look at.

So when we reviewed the cases, what we
did was we actually -- I was asked to develop a
template so we could review these cases in some
side of standardized format. So we asked for,
and this is where we found out, why Rosie found
out that the claim -- the information that we got
as the claim was not complete. We wanted to know
what was the original contention or contentions
of the claimant, and was it available -- and the
first question was, was it available to review?

The answer was no because the EE1 or
in a death case the EE2 was not in the claim
folder that we got. Was the occupational history questionnaire available? Many times it was not, and in sometimes the occupational history questionnaire we saw one case where it was actually completed after the initial decision was made, went to final decision, and we don't even know whether the occupational history questionnaire was looked at before the final decision.

Is there a definitive diagnosis and are there alternative diagnosis possible? Most of the time there was some definitive diagnosis, but in a lot of cases, especially because we were only looking at Part B cases the only thing that we really honed in on, which is what everybody else honed in on was the sarcoidosis versus the CBD. But, again, the claim only went forward as a sarcoidosis claim, and if there wasn't an LPT it was denied and never got to a CMC.

Was the diagnosis accepted by the claims examiner? I think most of the time it was. We really didn't get a lot of information
on that because, again, we don't have access to
their thought process.

Were all exposures that might have
called the claim condition evaluated? We
couldn't evaluate that because we didn't have the
EE3 which is the work history or the occupational
health questionnaire. So we really couldn't and
we didn't get any of the industrial hygiene
information that DOE so nicely provides to DOL.
So we really couldn't do a very good job in
evaluating these cases.

Then, was it referred to a contracted
medical consultant? We found that if the claim
that was submitted had relatively good medical
causation information -- there were a couple that
were done by some occupational medicine
physicians who had been involved in either the
Former Worker Program or some residence in
occupational medicine where they submitted a very
good evaluation.

At which point the claim was usually
accepted, but if that wasn't there and it was
left to the CE to determine whether or not it
should go to a CMC for an opinion. A lot of times
it was not, sometimes it was, sometimes it
wasn't. But again, when it's sent to the CMC
there are very specific questions that the CE
asks and it's not just, hey, look at this case
and see if there is a nexus between any exposure
and disease.

I think sometimes the CE when in
asking those very specific questions misdirects
the CMC, and the CMC doesn't look at the whole
picture which I think is probably more
appropriate. The same thing with the industrial
hygienist.

Again, we really couldn't do much of
this because we didn't see a lot of what the
source documents were that went to the CMC. A
lot of times we felt that the denials were not
necessarily appropriate. But, again, without
having all the information there it's hard to say
that all of them were appropriate or not.

So we can go back to the PowerPoint
now. So claims folder was incomplete, all we had was medical information and probably not all of it, and statement of case by CE. Did not have EE1, did not have EE2, did not have EE3. Did not have occupational health questionnaire.

I guess, pretty much I already sort of went through my results as I was going through the template, claims denied simply on lack of radiological evidence regardless of treating physician's diagnosis, and maybe a myriad of other medical information. But the CE decision was based on a requirement for some radiological diagnosis.

What we are going to try to do in the future is to do a CE form and discuss how they develop claims. We want to do a more complete review of Part E claims. If our data call was not clarified, I'm going to clarify it now. I want the whole claims folder. I want every piece of information in the claims folder because that's the only way we can do this.

Yes?
CHAIR MARKOWITZ: When we make a new request we're going to formulate it in detail and we're going to discuss it with DOL after we formulate it to make sure that we're communicating what it is that we want. Also, from their end, what they're able to deliver. So we will do it in writing and be quite specific.

MEMBER CASSANO: Okay. Thank you.

Then finally, this whole question which we've talked about already. How to operationalize causation, contribution, and aggravation really needs to be somehow defined, determined, and there has to be some structure for how that is parsed as far as a medical opinion or a denial is determined.

Certainly, the recommendation's develop better training materials that provide some standardization across the process, initially, for those 14 priority areas. There may be others. Next recommendation is that all medical evidence needs to be submitted to the CMC and all of the exposure information needs to be
submitted to the industrial hygienist, I might
add. Not just that which is determined to be
relevant by the CE.

Quite frankly, the two other agencies
that I've been involved in, in doing this, the CE
does not decide what the doctor gets to see or
what the industrial hygienist gets to see. And
other evidence of exposure must be utilized other
than the SEM for determining work relatedness.

In some cases, the IH should evaluate
on a case by case basis. Again, this is
something that everybody else is already
determined and, again, consider presumptions.

With the little bit of time I have
left I want to go to -- and, you know, I'm not --

CHAIR MARKOWITZ: So, Dr. Cassano?

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: This committee has
until 5:00.

MEMBER CASSANO: So I've got time.

Well, you told me to go quickly.

CHAIR MARKOWITZ: No. Just to clarify
though, you have over an hour so you can, you know.

MEMBER CASSANO: Okay. If we can skip down to where you can find exposure to asbestos because I think that's very relevant. Keep going down the document. Sorry, I couldn't extract all of this. Go past the ionizing radiation. It's going to be several pages down.

So basically, this is -- and, you know, I'm not a real apologist for VA, but I think in some of these areas I think DOL can learn a little bit from what VA does. So this is a document that does not go to doctors. This goes to the claims examiners on asbestos exposure.

Just scroll down a little bit for me. This I something that a CE can't understand. It talks about fibrosis and tumors and cancer of the lung. It talks about all the potential cancers that can be related to asbestos exposure: lung, bronchus, gastrointestinal, larynx, pharynx and interestingly enough, urogenital system except
for the prostate.

We can skip the rest of this and just
go to the next page. So they tell you,
specifically, lung cancer that originates in the
parenchyma rather than bronchi. It talks about
how it's -- and then they talk about cor
pulmonale and significant asbestosis. I'm not
sure, you know, we would agree with all that.

But then it does talk about the
synergy between smoking and asbestos exposure
which basically says just because somebody smokes
you don't discount their asbestos exposure in
determining a claim. And then it talks about a
latency period.

A clinical diagnosis requires this.

But, again, this is guidance. This isn't policy.
Then a whole list of the tasks and occupations
that could possibly be exposed.

MEMBER FRIEDMAN-JIMENEZ: Sorry, could
you go back up to the definition of asbestosis?

MEMBER CASSANO: No, it doesn't say it
requires cor pulmonale. It says that in late
stages if they don't die of asbestos they may die of cor pulmonale. It doesn't require it.

But it doesn't say a history of exposure and radiographic evidence of parenchyma lung disease symptoms and signs may include. But that doesn't mean they are required for the diagnosis. Only the history of exposure and radiologic evidence of parenchyma lung disease.

It's not perfect, but it's better than what DOL has now.

MEMBER FRIEDMAN-JIMENEZ: So it doesn't include pleural plaques?

MEMBER CASSANO: Well, because asbestosis is the disease. Pleural plaques is just a marker for exposure.

Again, this is more military specific, and it talks about some of the other things. So I just wanted to give you an idea of what could be done. I don't know if we want to go all the way to the end of the document because that does talk about mixed solvent exposure at Camp Lejeune.
I will stop doing this if you don't want to look at it. You do? Okay. Thank you.

If we go down to the end of the document and then scroll up. I think it's Page 52. Go up a couple of slides.

So this is a basically a mixed solvent exposure. What they did here, even though they don't know about it was this was based on IOM report and these are all, the following is a non-exclusive list of diseases potentially associated with containments present at Camp Lejeune.

The exposures were benzene, vinyl chloride, TCE, PCE, some heavy metals, and several other organic solvents. So basically they did a presumption on mixed solvent exposure. They had esophageal cancer, lung cancer, breast cancer, bladder cancer, kidney cancer, multiple myeloma, neurobehavioral effects, and then they have since added, believe it or not, Parkinson's Disease.

So this, again, this is not a presumption, but a lot of these are going into
the VA presumption. But it also talks about when it's manifested, how it's manifested, how the diagnosis is made, et cetera, et cetera. So, again, these, I think, we don't need to copy them verbatim, but I think documents like these that are developed by good medical personnel.

This was, by the way, not developed by medical personnel. This was developed by VBA personnel. Sometimes with medical input, but I think more documents like this are necessary.

I do have one other document, but we can take questions now.

MEMBER SOKAS: Just a quick question. The claims examiners at the VA what is their background and what kind of training do they get? Do you know?

MEMBER CASSANO: Basically, I think their backgrounds are very similar to the claims examiners at DOL. They are anywhere from GS-7s to GS-10s or, very rarely, they are supervisory if they are 12s. So this is not somebody with a -- I mean, I believe they all have college
degrees, but they're not, you know, they don't have graduate degrees. They don't have MPHs. They don't have toxicology degrees or anything like that.

But, you know, since 1945 the VA has been building a body of evidence for these people. The Central Office is very good at developing, when there is a new exposure of concern, of developing some kind of guidance based on that exposure to tell their CEs how they should start to evaluate it.

So, essentially, a CE looks at or should look at that list of potential cancers from asbestos, and if it matches up it will automatically, and the person has exposure, it will automatically go to a medical examiner for either a disability exam or for what's called a medical opinion. A determination of whether or not they consider the disease service-connected to asbestos exposure, whatever exposure the contention is in.

They have to give, the CMC has to --
not CMC, the claims examiner, the C&P examiner in this particular instance has to give a rationalized opinion for why that is, including references that they've used to make that decision. Even if those references are not included in the training document.

I think at the end of some of these there are references in the training document, and the examiner is free to use whatever other information they can glean. So it becomes, you know, it becomes a more inclusive process rather than a restrictive process.

Any other questions? Yes, sir?

CHAIR MARKOWITZ: So if there are exposure criteria that the claimant needs to meet that are specific, and if the diseases are specified by the VA as to what may be related to that exposure then why is a medical opinion even needed? Because if a person meets the exposure criteria and if they have a disease that's linked what is the role of the physician in actually reviewing this information on that specific case?
MEMBER CASSANO: Because it's not a presumption. Again, they recognize the fact that the CE can't say with medical certainty that, gee, in this case the disease was caused by the exposure in the military.

Let's say a guy is an aircraft mechanic in the military and then he spent another 20 years as an aircraft mechanic, you know, working for Pratt & Whitney, or somebody like that. The CE can't say, gee, you know, they don't rely on the CE's expertise to say, oh, the 20 years at Pratt & Whitney was way more injurious than the seven years in the military.

That would be left to a C&P examiner. Also, but what is more interesting is the claims examiner, if they cannot rule on a claim based on a presumption it is supposed to go to a medical examiner to get a medical opinion. That's final. A lot of times it doesn't happen, but every case that I've seen that comes back on appeal the board or the court will sit there and say it's remanded because there is no medical opinion.
MEMBER BODEN: Just one quick question about the VA system. Does that person see a doctor rather than the doctor seeing their records, which is the case here?

MEMBER CASSANO: It depends on what's needed. If there is, again, sufficient evidence to determine disability by the treating physician, and I can bring up another document that would help with that, it goes for medical opinion.

Because, remember, the VA has its own schedule of rating disabilities that has nothing to do with AMA guides at all. It's arcane. It's old. So what they will do is they send them for a C&P exam. That confirms the diagnosis. It confirms the exposure.

Then, based on their disability rating there are specific questions asked as to -- for instance, for heart disease. You know, is there a stress test? What METS was the person able to accomplish on a stress test? Is there angina with walking upstairs? Is there angina, you
know, walking down the street? Is there rest? I mean, all those kind of questions which will help determine disability.

So it might be very easy in this, not easy, but at least theoretically easy, with a lot of work, to look at the conditions, look at the AMA five and basically for each condition say, okay, these are the criteria for impairment and certain levels of impairment. We need to be making sure the treating physician answers all of these questions.

Any other questions? Any members of my committee that wish to talk about some of the cases they reviewed? I know this was sort of quick and dirty, but we didn't really have a lot of information to go on in order to do a deep dive into any of this.


MEMBER BODEN: Just a question for the committee as a whole. So we've been on several subcommittees talking about the possibility of
developing presumptions, which I think to the 
extent that we can do something like that will be 
quite helpful to DOL.

Have we talked about who and how we 
would do that? Which subcommittee or which group 
of people who might be on different subcommittees 
might take on specific covered diseases to see 
how far we could get or whether that should be 
something that we might start the process, but 
might end up being developed outside this 
advisory committee?

MEMBER WELCH: I think our committee 
thought it might help to also start with an 
understanding of the major diseases that are 
being claimed. You know, some presumptions will 
be easier to write, but there may not be that 
many claims for them, so it might not ever be 
helpful.

So one of the things we're going to 
request is a list that gets us an idea, just to 
start with by very broad categories, and see if 
we can kind of over some iterative process drill
down to better understand the major kinds of
claims that are coming in at the present time.
And there are, I don't know how many presumptions
exist.

I mean, there's one for asbestos
related disease. There's one for COPD. There's
the legislative ones for beryllium disease. Then
we talked about the solvent hearing loss. There
are probably others that I'm not familiar with.
So we may end up deciding, one of the first
things would be to improve the ones.

If COPD's a major number of claims --
that doesn't really answer your question of who's
going to do it. I think when we were talking
about the hearing loss one, Dr. Sokas had raised
the question earlier when we were talking also
about adding new data sources to the SEM that
either this committee or EEOICPA needs a
subcontractor to do some of the technical --
gathering papers, doing assessment.

But that's more than this board can
take on. We'd need that for development of
presumption. So I'm assuming it would be some combination of the board's expertise with oversight, review, and a contractor. That was my thought.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: I would just suggest before we decide who does what if we came up with what we thought would be a better system to address these issues, and let's say, come up with presumptions, and to then reevaluate them going forward. If we came up with that then the next step would be, you know, how one would implement that.

Because I think, realistically, if you do come up with presumptions then there's also the education, the implementation. There has to be a feedback on how all of that is working, a re-evaluation as more data comes in. It's not that I want to pass this off to another body, but I think we should first think about how this would be better working and then what sort of manpower would be needed to do that.
Because it's clearly a lot of manpower that's being spent on SEM and other activities. So I think if we came up with a plan there should be, then, resources to implement that.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I do have one other document. It actually pertains to multiple sclerosis.

CHAIR MARKOWITZ: I'm sorry, let me just say, is this about presumptions or this about the committee?

MEMBER CASSANO: It's about the committee. It's about the subcommittee and another document that might be useful for the CPs to use or for DOL to use to get information from treating physicians.

CHAIR MARKOWITZ: I'm wondering whether we should just hold off for a couple minutes on that and just continue the presumptions discussion?

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: I mean, if you think
it's highly relevant.

MEMBER CASSANO: No, it's not highly relevant right now.

CHAIR MARKOWITZ: Okay. Then we'll get back to it, for sure, today.

So, you know what? Presumptions can be useful or not useful. They can be good or bad. We discussed the post-1995 exposure memo. That was a presumption. Presumption was that exposure was controlled after 1995, unless proven otherwise, and we disagreed with that presumption.

So presumptions aren't inherently good or bad. That's one of the things I've learns from Dr. Boden. So I thought it would be useful to look at the way DOL has used presumptions. So when we think about presumptions we think about a way of efficiently characterizing claimants and their exposures and diseases in a way that will facilitate arrival at the proper claims' decision.

That can be a tricky process, and I
think it would be useful if we look at the specific ways in which presumptions have been used and I think, to some extent, not used properly. The intention was to continue to discuss some of that tomorrow morning by looking at some of the instances of presumptions, which we could begin to do this afternoon if there's time. We'll see.

Dr. Redlich, did you want to say something?

MEMBER REDLICH: No.

MEMBER CASSANO: I wanted to bring the one up for pulmonary diseases, but somehow, and maybe it's better that it's multiple sclerosis that I'm bringing up because you won't have objections to some of the content.

But, again, the concept, and this is a disability benefits questionnaire, and I never thought I would be advocating these because I fought vehemently against them. But they basically go through what is required for the treating physician, to the treating physician, or
it could be to the C&P examiner as well, exactly what is required to meet the criteria for service connection for a certain disability.

So, unfortunately, I brought up -- and remember, they're relating this to a document, a schedule of rating decisions that was originally written in 1942, and therefore, has not kept up with modern medicine much. But, again, the concept.

So this is the name of the patient. All of the diagnoses that the patient is going to claim. The ICD-9 code for all of them and the date of diagnosis. So is there additional diagnoses related to MS? List and use the above format. So any secondary conditions would be listed here.

Then they ask, because this is important for determining disability, are they right-handed or left-handed. Then all of the conditions, signs, and symptoms that the patient has that are due to MS. And so you can see how this is walking down to get to a particular line
on a rating disability scale so that you can go across and say, okay, this person has this. They have this. They have the other thing.

Even in the AMA guides, when you look at that, again, they talk about disability. This is really rating impairment, as we all know, those of us in this profession, impairment and disability are two different things. So this is really rating impairment, but they say it's rating disability because there is a direct link in VA between impairment and disability.

Are there any respiratory conditions? And so, again, we don't need to belabor this, but I want to get down to where the medical opinion is and where the person that actually opines as to what -- I know you hate that word, but opines as to the causation.

So are there sleep disturbances? Are there bowel functional impairments due to MS? Voiding dysfunction? History of recurrent symptomatic urinary tract infections? Then, I mean, this is how specific this is, it goes
through strength and range of motion, et cetera.

So the treating physician, when they get this, knows exactly what they have to write to get somebody's claim denied and get reasonable disability from them. Then they talk about financial responsibility. They always ask this question. Then any remakes and I think that's the end of it.

So that's just, again, not specifics, but a concept for what could be utilized to tease the appropriate information out rather than phone calls back and forth, and did you do this? And did you do that? It says exactly what diagnostic tests, obviously, in MS there aren't a whole lot, but diagnostics tests.

You need to say whether they were done and what the results were. Just a thought. Any comments or questions or suggestions?

MEMBER WELCH: The only comment I have is that, you know, when people apply for disability, which is usually managed by a state program there are similar forms that are
completed by the examining physician in terms of impairments. It's not as disease specific.

So, I mean, this is great, but then you'd need one for each disease. But to make it a little bit easier one could use the, you know, Medicaid disability form. Then the Social Security examiners use that to determine impairment directly from the form.

MEMBER CASSANO: What's nice about this thought is that it's -- well, it's not always disease specific. Sometimes it's organ system specific, so it will be peripheral neuropathy or, you know, pulmonary diseases all lumped into on.

So the Medicaid one you have to go through a whole bunch of things that aren't relevant to that disease. So when you're looking at the claim it becomes very complicated to see what's relevant and what isn't.

MEMBER REDLICH: I just wanted to make a correction to something I said earlier, because I said that I thought coming up with presumptions was beyond, potentially, the scope of what we
could do while I also proposed a presumption relating to sarcoidosis and CBD. Those are contradictory statements. So I think that there may be certain areas where we could come up with presumptions, but I do think that the process could become quite extensive.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So the idea of a form that directs treating physicians is always a good one I think because, especially because most of the treating physicians are not going to be occupational physicians. They're not going to have the kind of experiencing and understanding that occupational physicians would have.

It could also be, if we end up thinking that specific presumptions are a good way to go, a way to direct physicians to make sure that they do the tests that are called for in the presumption, and would short circuit a little bit the back and forth, and back and forth that I gather.

CHAIR MARKOWITZ: Any other comments at
this point? Because we do have a little bit of
time, and I'll go onto Dr. Silver in minute. We
could actually move on to begin the discussion
about causation which we won't be able to
complete, necessarily, but then come back to it
tomorrow. We can entertain any additional final
comments here.

   Dr. Silver, did you want to say

something?

   MEMBER SILVER: Maybe I shouldn't admit
this, but in early 2000 an Atomic Veterans
Advocate contacted those of us who were working
closely with Senator Bingaman, people refer to
EEOICPA as his baby. He said, stay away from
that radiation dose reconstruction. It's
horrible. He was right. We didn't really have
that much pull with the senator who was
straddling a line.

   Anyway, if we had a room full of Camp
Lejeune people and Vietnam dioxin exposed
individuals, and others covered by this VA
program, and a stack of GAO reports, and a stack
of Congressional hearings what would be the flaws
with the VA's use of presumption that all of them
would be pointing out to us?

MEMBER CASSANO: I'm not sure I
understand the question.

MEMBER SILVER: The VA has, evidently,
a much longer track record of developing what
appear to be fairly permissive or flexibly --

MEMBER CASSANO: Generous.

MEMBER SILVER: -- written
presumptions. We have EEOICPA, the devil we
know. Tell me more about the devil we don't
know.

MEMBER CASSANO: Okay. I think what
happens in VA is a lot of times VA will drag its
feet to that point that they are forced to do
something. Therefore, what happens is they come
up with these overly generous presumptions
because they didn't do all of the appropriate
scientific analysis early on enough to be able to
get good epidemiology and/or good toxicology.
Agent Orange is a perfect example of that.
So what happens is their hand is forced and they get into this overly generous process because they don't want to waste anymore time trying to figure out what really is reasonable and what isn't. In the Camp Lejeune case, this has been going on, they knew about this in 1987, 1988. It took them 30 years to get to this point.

It was only in the late 1990s, early 2000s that they actually asked ATSDR and IOM to look at it. By that time, you can't get very good information. So you're looking at other cohorts, and then you have to somehow extrapolate the information you get, primarily from occupational cohorts to an environment -- this was an environmental exposure.

What happens is nobody could really do it to any extent that would, basically, satisfy the people that are looking at the pot of money that there is to spend and the claimant community. And so what happens is we had recommended in my task force on Camp Lejeune that
the time period should be a minimum of six
months. We thought maybe a year would be better.

But then, even at six months, if you
weren't doing a presumption that you need to
figure out, you know, what this person was doing.
Six months at Camp Lejeune if you're a grunt
running around out in the field in the middle of
the summer where it's 110 degrees and you're
drinking six liters of water is very different
than the legalman sitting in an air conditioned
office, you know, drinking a cup of tea.

But they don't want to -- they don't
have the capacity to deal with that. So
therefore, they end up making these overly
generous presumptions. But what I was showing
you on asbestos is not a presumption. That is
not a presumption. If it was a presumption
they'd say, basically, you show you have asbestos
exposure or you were on a ship whose keel was
laid before 1978, and you have pulmonary fibrosis
or you have mesothelioma, or you have lung cancer
you are compensated.
There's none of that logic process.

This is for somebody that does not fall under a presumption, that training document that I showed. So, again, it helps the CE to figure out, gee, do I have all the information I need to send to the medical examiner.

Did I answer that?

MEMBER SILVER: What about the cost of program administration when card-carrying MDs are more extensively involved in each claim?

CHAIR MARKOWITZ: If you could give a brief answer to that.

MEMBER CASSANO: You want a brief answer to that? I think because some of the card-carrying MDs actually were employed by VA they're doing other things besides this. So your neurologist is doing the neurology stuff, but now that they're going more to contracts, and again, people that may not know all this I think you're going to see a less efficient process.

Was that short enough?

CHAIR MARKOWITZ: Yes, thank you. So
we're going to spend -- we've got about 35
minutes, so we're going to entertain a new topic.

    I'm sorry, Duronda, go ahead.

    MEMBER POPE: I just wanted to comment
on the responsibility that our team was charged
to do. I think if we start to address the
responsibility of the CE and them collecting all
this information from the claimant, and their
responsibility of determining whether this goes
to the CMC or not. If we remove that
responsibility from them I think that that would
move the process of this claim being moved
forward. I just wanted to comment on that.

    CHAIR MARKOWITZ: Okay. Thank you. So
I prepared a few slides to begin the discussion,
really, about causation. It's a little bit of an
orientation to how we think about causation.
Some of you may disagree with some of these
things. That's great. That's the purpose of
having a discussion.

    Is this PowerPoint meant to resolve
this problem or really just to raise the issues
as points for discussion? I wanted to start
with, actually, looking at the language from the
act that is used to link exposures that DOE
workers have had with illnesses. At least as
likely as not that an exposure to a toxic
substance at a DOE facility was a significant
factor in aggravating, contributing to, or
causing an illness.

Actually, there are three points in
this phrasing that could have been different. At
least as likely as not is as generous as standard
as you will see. It could have been more likely
than not which would make it above 50 percent.
By the way, numbers aren't used in this standard.
It's really qualitative language which is fine or
it could have been highly likely or most probably
or something like that. But instead Congress
used at least as likely as not.

A significant factor. That's somewhat
in the eye of the beholder, but normally we would
think of that as a non-trivial factor, right?
And significant can be 10 percent, can be 90
percent. It's not quantified. But it's important that that language is in here.

Then, finally, it's not just causing, but it's also aggravating or contributing. We normally think of contributing as being somewhat less rigorous as causing something, although I would disagree with that for reasons I'll show you in a minute.

So it's useful to think about the problems the DOE workers have in terms of the timeline, this horizontal line as a timeline in which a person in the middle of a timeline develops the disease, is diagnosed with the disease, and before that time the disease is incubating, right?

In that incubation period a toxin may act to cause that disease's onset. There may be other factors as well that are active during that incubation period. Then after the person has the disease, that's the period of onset, there's the course of the illness, what happens, how that illness develops, arrests, or not. How it's
treated or not.

The toxin can influence then that course of illness. There, I think, we talk about how a toxin affects the course of illness or really kind of into aggravation of disease. Before the disease onset we're onto causation of disease. I would say that contribute to disease can occur, actually, before or after disease onset. It could be during the incubation period or it can be throughout the course of the illness.

So we talk about cause and effect and I want to introduce the idea of a complete cause producing a certain effect. This would be an instance in which there is an exposure, a risk factor, however you want to think about, but an exposure in which in and of itself it will cause the health problem. Nothing else is needed for that person to develop a health problem from that exposure, from that toxin.

In fact, we would expect 100 percent of people who are expose to that cause, to that
toxin, to develop the effect. That's what we would say would be a complete effect. An example of that is acute inhalation of chlorine.

So chlorine's a toxic gas and everybody exposed to enough chlorine will develop respiratory irritation. There won't be any exceptions, and they all show particular outcome which is the respiratory irritation. No other co-factors are needed. They don't have to be genetically susceptible to that. They don't have to have emphysema or anything like that. They merely need to be exposed to enough chlorine gas. So chlorine gas would be a complete cause.

But there's another type of cause, and I think it's much more common, which is a partial cause which is a risk factor, toxin, or however you want to think about it which causes a health problem, but it only does so in concert with other causes, with other risk factors. Meaning that in and of itself it won't produce the outcome, but it is active when there are other causes, even when those other risk factors
aren't, necessarily, identified.

A common example of that is smoking and lung cancer. So when a person develops lung cancer and they smoke you say that smoking caused their lung cancer. But, in fact, you know, of course that majority of people who smoke don't develop lung cancer. Right? Only 10 percent do. So, clearly, there has to be something else going on with those people who have lung cancer from smoking such that they develop the lung cancer.

So smoking played a role. It was a cause. But it wasn't the complete cause because there is something else going on for that 10 percent that the 90 percent who smoked who didn't develop lung cancer didn't have. This, actually, is what Dr. Sokas said before when if everybody was a smoker we would blame it on genetics.

Because that 10 percent probably has some genetic predisposition. That's probably the most commonly other cause that's unspecified. We don't know exactly what those genes are yet. So it's an unknown cause, but nonetheless, those
genes represent a partial cause in addition to the partial cause of smoking.

The reason why I make that distinction is because partial cause, another way, in my view, is to simply call that a contributing cause. So that risk factor contributed to that cancer. So in this way of thinking a contributing cause is no less than what we would normally consider a cause.

So in the standard where it says, caused, aggravated, or contributed, most of that causing is actually contributing. It, in my view, elevates contributing where it's not secondary to cause it is. It is a cause. In fact, an equal case to ways in which we think about other causes. So contributing factors are causal factors.

Now, talking about partial causes, let's discuss a familiar example. This isn't really a DOE condition, though it could be if I changed the risk factors to, say, carbon monoxide exposure. But here are four common risk factors
for heart attacks: high blood pressure, smoking, elevated cholesterol, and a family history of coronary artery disease.

This represents the norm which is that most diseases are multi-factorial. Most of them have multiple causes, and multiple causes are active in any given persons' particular illness. So if a person has a heart attack, chances are they have two, or three, or maybe all of these risk factors, and each of these would be a contributing cause to their heart disease.

We don't normally say how much they contribute. We would say if a person had hypertension and had a heart attack, if they had a history of untreated elevated serum cholesterol, if they had a family history of early heart disease we would say they were all contributing factors.

But we wouldn't say the smoking was 20 percent and the cholesterol was 30 percent. In fact, I would maintain we would have a hard time actually putting a number on that, and for
complicated reasons. Even for the most researched and common health outcome which is coronary artery disease we'd probably have a hard time putting a number on the contribution in any particular case for these risk factors.

Think about it, an individual may have hypertension, but it was treated for five years, maybe untreated for another five years. A person had mild elevation in cholesterol as opposed to a very high elevation. They had a family history, but it wasn't so strong. You'd have to quantify each of those risk factors, figure out how they relate to each other, do they interact with each other in order to put a number on that.

We don't do that. There's no need to do that. We simplify the situation. We say those are contributing causes to this person's heart attack, and we'd be right by characterizing it as such.

And so those risk factors would be, at least as likely as not, to be significant factors in contributing to that person's illness. That
would meet this standard set up under EEOICPA.

I would maintain that, in fact, most contributing causes probably contribute less than 50 percent of the causation. Now, mind you, unlike on the radiation side of EEOICPA no one's putting a percentage on the contribution. We don't have to add up the radiation dose and calculate a Probability of Causation. We can't do that, actually, on the toxic substances side. That's one of the reasons we don't do that.

But in thinking about it, most of these contributing causes would probably be less than 50 percent of the contribution towards causation. Nonetheless, we would recognize them as contributing factors and accept them as contributing factors.

So I want to make a distinction then between the level of certainty that a toxin is a cause of disease. Does benzine, in general, cause leukemia as opposed to the degree to which a toxin contributes to an illness which I just said is routinely less than 50 percent. Right?
So the level of certainty that a toxin is a cause of an illness, and that's really what, for instance, Dr. Friedman-Jimenez was reviewing when he was talking about different exposures and are they related to prostate cancer or the like. And so the way IARC approaches this issue of level of certainty, and this is for cancer. Carcinogens are the cancer producing agents they look at, and they have a classification system.

They said Group 1, which is after they review all the relevant studies that say it's carcinogenic to humans. That's definite. Group 2A is probable. Group 2B is possible, and Group 3 is we don't really know enough to be able to say, and Group 4 is we've looked at all the data and it's pretty conclusive that it doesn't cause cancer.

You can actually see how many agents they've reviewed that fall into these different categories. So if we're thinking about level of certainty that a toxin produces a disease we would think normally that Group 1 and 2A are the
level of certainty that we would accept. It was
definite or it was probable.

If it was only possible we probably
wouldn't accept that level of certainty as
causing the disease. And so level of certainty
is more likely than not, and that's where the
definite or probable comes in. Whereas, possible
doesn't meet that standard of more likely than
not.

So the second issue was the degree to
which a toxin contributes to an illness. Here,
routinely I just said that most contributing
factors do contribute less than 50 percent and
that's perfectly fine with us. That's
acceptable. That's the way we recognize things.

So I want to give you an example then
of, we're all familiar with, which is second-hand
smoke. And is it more likely -- again, this is
not a DOE exposure, per se, not now, maybe it was
in the past. But not necessarily subject to
EEOICPA, I don't really know. But it's an
example to begin just to understand causation.
Is second-hand smoke more likely than not in aggravating, contributing, or causal factor to lung cancer? So what's the answer to that? Well, the answer is, sure. We recognize second-hand smoke causes lung cancer.

So let's look at the kind of numbers that Dr. Friedman-Jimenez was discussing a little bit before, and understand what's that based on. Well, the Surgeon General in 2006 reviewed this. They had reviewed it in 1986, but they re-reviewed it in 2006 and they looked at over 75 studies, so a lot of studies of second-hand smoke and lung cancer.

They determined the best estimate of all those studies was that there was a relative risk of lung cancer due to second-hand smoke of 1.2. So what that means is that people subject to second-hand smoke had a 20 percent increase in risk of lung cancer. Okay? The risk in the people exposed to second-hand smoke relative to the risk of people who are not exposed to second-hand smoke.
If that relative risk were two-fold
then that meant there would be a doubling of risk
among people exposed to relative risk. By the
way, relative risk of 1.2, a 20 percent increase
in risk is what we would consider to be a very
modest increase of risk by way of looking at
toxins or risk factors or the like. Or
cigarettes, for instance, the relative risk of a
moderate amount of cigarette smoking is probably
10, relative risk would equal 10. It would be 10
fold that of the never smoker.

So to express this slightly
differently, if there were a population of 100
people and ten of them who never smoked and
weren't exposed to second-hand smoke, let's say
10 would develop lung cancer, which is a little
high, but let's just use that to make the numbers
easier. If 10 out of 100 would develop lung
cancer, among the group exposed to second-hand
smoke there would be 12, right? A 20 percent
increase, 12 out of 100 who would develop lung
cancer.
Note that of those 12 that's only two higher than 10, right? Most of those lung cancers in the people exposed to second-hand smoke would have occurred anyway, even without the second-hand smoke. Right? They would be in the base 10 that went up 12. Nonetheless, they would say among those 12 that second-hand smoke contributed to their lung cancer risk.

So there's a question that is current in medical/legal circles and I need to raise it because it's sort of in the back of some of our minds which is does a toxin have to have a two-fold increase in risk for a disease to be a contributing factor. The answer, I think we just agreed upon from second-hand smoke is no.

It doesn't have need to a relative risk of two because we just acknowledged that second-hand smoke, which has a relative risk of 1.2, we recognize as a contributing factor. So we can reject the two-fold increase in risk as being a threshold which is important.

Now, EEOICPA doesn't specify a level
of contribution. It doesn't say 10 percent contribution, 90 percent contribution or the like. I raise the question, is it even possible in most multi-factorial diseases to quantify the contribution? The answer is no. We really can't do that. We can't quantify it.

    But, fortunately, EEOICPA doesn't require that we do that. It simply sets the standard of it is a contributing factor? Is it an aggravating factor or a causal factor?

    That's all for my comments on causation. I don't think I've solved our problem, but at least I've been able to, I hope, to kick off a discussion.

    Dr. Welch?

    MEMBER WELCH: I would say, of course I've got a comment. Because the other thing that you add to that is the word significant. So if you have someone who, let's use second-hand smoke for example. If you have someone whose only exposure to second-hand smoke was as a lifelong career as a bartender.
When you look at all those studies that were included in the Surgeon General report a lot of the studies, the occupational studies, were people who had -- that's much higher exposure than the second-hand smoke you get being in an office environment, so there's some relative -- but if they were not a cigarette smoker themselves, but were a bartender then that relative risk of 20 percent was really their only identified risk factor. Because they didn't have other identified risk factors, except maybe the genetics that we don't know. So it's easy to say that second-hand smoke was a significant factor in contributing to their lung cancer.

But if they, themselves, had been a -- smoked one pack a day for 30 years which then gave them a 20 fold increase risk or how do I put that in a relative risk? It's 20, so then it goes to 20.2 when you add in the second-hand smoke. It would be hard for me to say that .2 is a significant factor.

So it's looking at the relationship.
You know, by itself, second-hand smoke is a causal factor. But then in an individual case it has to be a significant factor in contributing. So it's balancing what we know about the risks for that other individual, and this is a statement on an individual person.

So it's not going to come up with that, but it would come up with, for example, we talked about solvents and hearing loss. I have no idea where I would put the concept of significant. You know, how much solvent exposure it would take for me to say that -- because I don't really know the literature well enough, but there's probably a place where you could say, okay, reasonable scientists who understand it would say a year of exposure to solvents or ten years of exposure to solvents is a good level to say it's a significant factor.

There's literature that would let you do that. So I think -- I loved your talk, actually, I shouldn't have started out by jumping in because I thought it was really good. You
kind of say is that substance known to cause,
including the contributing, the illness, and then
how do you move forward to say it was a
significant factor in the cause of that
individual? So those are two different steps.

But I think all the points you made
are really, really good. That it's at least as
likely as not is applied to the opinion that it
was a significant factor. It's not the definite
of significant. It's not the definition of
contribute or cause. It means if I'm expressing
an opinion I'm expressing it with a certain level
of probability, but not certainty that the
exposure was a significant factor.

So that anything that has to do with
saying 50 percent becomes kind of irrelevant to
this statement. Really it's once you know that
toxic substance cause that illness how you define
it as significant contribution. Thanks.

MEMBER CASSANO: Two comments. I
liked your presentation and I think it was right
on as far as level of contribution and level of
significance. Let's throw diesel exhaust into
the smoking. You know? Somebody smokes and
they're also a diesel mechanic and they're
exposed to diesel exhaust for, you know, 20 years
you're not going to be able to parse the
contribution of those two things.

So I think the legal term that we see
and should be used is that it does not have to be
necessary and sufficient in and of itself to
cause the disease. And that the other part of it
that we don't understand a lot, at all about,
except for in the case of asbestos and smoking is
the synergy between two causes.

I think if we were thinking about
going to the more than likely bar I think people
when they see that, especially legal folks, when
they say more than likely they want definitive
statement that in every single solitary case if
you are exposed you will develop the disease. So
I would stay at, you know, for this type of thing
I would stay at the at least is likely is not
level. Because that is equipoise and that, you
know, allows a little bit more wiggle room.

MEMBER WELCH: The law says that actually. So Dr. Boden and Dr. Friedman-Jimenez?

MEMBER BODEN: So just a short side comment. I mean, there is also, which is maybe marginally important for us, the concept of a necessary cause. So you're not going to beryllium disease without beryllium exposure or asbestos or mesothelioma. And those, I think, are important, probably, concepts although not central to the argument that you make which I think is really very good.

I do think in terms of trying to communicate to claims examiners that the most difficult thing to communicate is going to be the significance. Because I think they would probably appreciate some magical number which we can't give them, as you pointed out. It might be worth our thinking a little bit about how to help people decide whether something is significant or not significant. I think is an issue.

CHAIR MARKOWITZ: Let me just respond
to that. But if it's really a question of judging the significance that shouldn't be in the hands of the claims examiner. That really needs to go to the physician with the help of the industrial hygienist.

Because if there's a question about the significance, if it's a clear cut case, I mean, hopefully it can meet a presumption and not have to go to the expert. But if it's a question of is this significant or not I don't think the CE has the knowledge expertise to make that.

MEMBER BODEN: Oh good. That's actually a very helpful comment which suggests, and I don't know if this is part of the manual that the claims examiners use, that should be clearly stated. That if there's a question at all about whether something is significant that question should be referred.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: The terminology of as least as likely as not is problematic mathematically. And there have been
papers written and criticisms of it for 40 years.
The problems are well-understood. Nobody has figured out a way around it in the last 15 years since the last papers have been written on this.

My question is, is there a possibility of changing the causal standard? For example, like in New York State the Workers Comp law says within a reasonable degree of medical certainty which gives the physician some leeway and is not a fundamentally quantitative statement. At least as likely as not can be translated into probability of causation greater than 50 percent or greater than equal to 50 percent.

But there's no way to calculate the probability of causation. That's the problem. It's a theoretical thing that cannot be calculated from epidemiologic data. Even if you add aggravating or contributing to there's no epidemiologic data that you can use to calculate this newly defined probability of causation or aggravation or contribution.

So my question is, should we be
thinking about changing the standard to something like, with a reasonable degree of medical certainty. That gives the physician some leeway to make a decision. One example I would give you, physicians prescribe hormone replacement therapy which can cause cancer, uterine cancer and other cancers.

The relative risk is about 1.3. There's no way that you can calculate a probability of causation of greater than .5. It's a reasonable degree of medical certainty, enough to keep the vast majority of physicians prescribing hormone replacement therapy even though the relative risk is below 2 which is the magic cutoff that has been evolved in the courts.

So my question is, is this something that is on the table or is this carved in stone as the causal standard?

CHAIR MARKOWITZ: So the short answer is it's in the 2000 Energy Employees Occupational Illness Compensation Act. It's unlikely to change. But, also, you know, they were not
concerned about the mathematics. They were
trying to communicate something which is to be as
claimant friendly as possible in the decision
making process.

    I think that's what this was meant to
communicate, even as complicated as it is. But
it would take a Congressional -- it would take an
act of Congress.

    MEMBER WELCH: Can I add something?

    CHAIR MARKOWITZ: Sure.

    MEMBER WELCH: I just want to add
something too because I think you're saying it's
a 50 percent probability of causation would be
true if you left out significant factor. But here
you have at least as likely as not that exposure
was a significant factor in aggravating or
causing. Not that at least is likely not
exposure was a cause. So when you have
significant factor in causing it's another fudge
factor.

    MEMBER FRIEDMAN-JIMENEZ: It makes it
even harder to estimate a probability of
causation. It makes it even --

MEMBER WELCH: Fine. Because the law doesn't require a probability of causation. That statement does require a probability of causation.

MEMBER FRIEDMAN-JIMENEZ: But that's a probabilistic statement.

MEMBER WELCH: Yes. But there's no --

MEMBER BODEN: But significant factor is not a probabilistic statement.

MEMBER WELCH: Right.

MEMBER BODEN: So you can't multiple a probability by something that is not a probability and come out with something.

MEMBER VLIEGER: Getting back to the nuts and bolts of administering this program and what the claimants deal with. If we remove this decision making piece from the claims examiner it will streamline the process enormously. Be a number of our claims examiners, god bless them, are attorneys.

They like numbers. They think in
definitions that we don't think in. So when we
don't give them something to hang onto they still
want something tangible to say, well this is as
likely as not, and when they throw in
significant, many times I've been told, well that
means it's higher.

I understand what you just tried to
explain from a statistics point of view. But
they're not doing statistics. They're doing
definitions that they can write into a decision.
So this definition, while it is in the law, is
still problematic in claims adjudication because
everybody wants to say, well, I've got a good 50
percent handle on this. Then they throw in
significant and then is goes above.

MEMBER VLIEGER: Well, maybe that's an
education job that we could help with Department
with. It is really difficult.

PUBLIC COMMENT SESSION

CHAIR MARKOWITZ: So I just want to
interrupt this. We can continue to tomorrow.
The reason I say that, in five minutes the public
comment period begins. I just want to give
people a moment to stand up and stretch if they
want to.

Also, just for the public commenters
we're going to start with Deb Jerison and then go
to Terrie Barrie. Then Paige Gibson. Then the
fourth is Glen Bridges. Then Tim Lerew, Ti Le
Ong, and finally Walt Schuman. Then we'll go
into additional people who have signed up.

If there's anybody who decided they
would like to make a comment please let Carrie
Rhoads know over by the table.

MEMBER REDLICH: And for those folks on
the phone you want to hang up and call 1-800-369-
1712 and enter code 5522817. This information is
located on our website. Thank you.

(Whereupon, the above-entitle matter
went off the record at 4:56 p.m. and resumed at
5:02 p.m.)

CHAIR MARKOWITZ: So each of the next
seven speakers gets five minutes, and then we'll
call others. At four minutes we'll give you
notice, but please then stop speaking at five minutes.

First is Deb Jerison.

MS. JERISON: Dr. Markowitz and members of the Board thanks very much for this opportunity to speak. I'll make this brief because I know we have a lot of people.

Last week DEEOIC reversed 14 years of proving claims under special disclosure cohorts for people with uterine cancer, fallopian tube cancer, and chondrosarcoma of the cricoid cartilage of the larynx by rescinding final bulletins in circulation from 2002 to 2012.

This means that workers with these cancers with an SEC period, before last week, were paid while those with the same cancers after last week will not be paid. This is inequitable and unfair. Making these changes in the policy and procedure manual may also be improper. Changes like this need to go through the rule making process since they reduce workers' benefits.
Speaking of rules, I strongly encourage DOL to withdraw the proposed rule changes. These changes are detrimental to the workers for all the reasons I stated at the last meeting.

Medical reimbursement issues remain very difficult. Claimants who don't have or are not comfortable with the internet cannot see which charges have been paid. Another huge problem is that submitted claims are sometimes ignored by ACS rather than being paid or denied. One claimant had over $30,000 of medical reimbursement charges at ACS just ignored.

This month EECAP developed a survey on medical benefits for claimants. With Cold War Patriots we were able to get 1,700 respondents already, with 450 of those reporting on the medical benefits. That survey will be open until the end of October.

The report's divided into five parts. I did a put down and dirty thing for the Board, just so you could see what I was coming up with.
so far. Part 1 is on the claimants' experience with medical benefits. This shows that 21 percent of all respondents have had problems with medical billing, 13 percent have had problems finding providers who will take the EEOIC medical card, commonly known as the white card.

Part 2 is on the claimants' doctor's experience. Respondents report that their doctors have asked them to use a different insurance 35 percent of the time. The doctors have asked sick workers to self-pay 27 percent of the time, and 18 percent of the doctors have stopped taking the white card at all.

Part 3 is on the claimants' experience with home healthcare benefits. Twenty two percent of the respondents found accessing their home healthcare benefits difficult. Part 4 was on problems claimants who have authorized representatives have had getting their medical benefits. Twenty five percent of the respondents found DOL restricted their choice of an authorized representative.
Part 5 looks at how the different district officers deal with medical benefit problems. There's some large differences. For example, claimants' doctors dealing with the Denver District Office had problems 41 percent of the time as opposed to 11 percent of the time at the Cleveland District Office.

I'll leave you to look at the rest of it on your own. Thanks.

CHAIR MARKOWITZ: Thank you very much.

Ms. Barrie?

MS. BARRIE: Good evening, Dr. Markowitz and members of the Board. I thank you for allowing this public comment time to hear from the stakeholders.

My name is Terri Barrie and I'm with the Alliance of Nuclear Worker Advocacy Groups. Considering the number of people who wish to speak I'll keep my comments very brief and submit written comments for your consideration.

The written comments address issues with travel, concerning travel requirements for
sick workers, some inaccuracies, medical evidence
for wage loss and consequential disease claims,
and DEEOIC's changing policy without consulting
the Board.

The last discussion was about the
statutory requirement for causation under Part E.
I'd like to inform the Board that the Department
of Labor does have, and went through the
solicitors, for a definition on what the
causation, the legal standard is for causation
under Part E. When Dr. Eugene Schwartz was the
medical director he developed the DMC handbook,
in consultation with the Solicitor's Office from
what Dr. Schwartz told me.

The legal standard is the causation
has to be more than reasonably suspicious, but
less than the preponderance of the evidence which
means that it's less than 50 percent. In fact,
thanks to Donna Hand, she reminded me that in
OWCP's regulations of 2006 OWCP defined
significant factor as any factor.

So, you know, on paper it's a really
good piece of legislation, a really good program. We just need to implement it, and I look forward to all of your help doing that. Thank you.

CHAIR MARKOWITZ: Thank you very much.

Next is Paige Gibson.

MS. GIBSON: Hi, Dr. Markowitz, Board. My name is Paige Gibson. I'm a former worker protection employee and I also worked at Mound of Miamisburg. I have a couple points to make and I'll try to make it quick.

On the transmittal 1609 which Deb Jerison mentioned, as did Terri Barrie this hits the former worker program very deeply because Sam Ray started that program. He was instrumental in going to Congress and speaking, and he had the cricoid cartilage cancer, and it was allowed under the guidelines then, and now he wouldn't be paid. Unfortunately, he passed away.

I also wanted to say that I agree with on the occupational worker questionnaires that former workers should be in the resource centers. We know the questions to ask. We know the
routine of the workers. Even if we started late, the stories went around and we know each building just like we know our home.

What I brought was, this is an actual claim form, and as you can see, I've marked the jobs from October 24, 1966 through September 1987. This gentleman was turned down because he didn't have ten years in the same job for hearing loss.

Those all are the same job and salary. They just change them up every once in a while just to keep you in a job because their budget got cut. He went from B to A, and that was instead of getting a raise, so that's the kind of common sense we're dealing with when it comes to these job classifications.

Also, I have a gentleman who he worked at Mound for ten years. He was a janitor and eight as a lab technician, and because those ten years weren't in the same job category he was also turned down for hearing loss, even though he was diagnosed with it.
DOE says that they have IH reports,
and from 1943 through 2006 other than maybe
sitting in their office and writing a report, an
industrial hygienist was never on a job at
Portsmouth Mound, Paducah, and Oak Ridge, to my
knowledge, and I have a pretty good history with
that.

I just wanted to show you what we're
dealing with. This is a denial. This is how
much paperwork came with that denial, and it's
for an illness and hearing. This is breast
cancer, one whim, and that's how much paperwork
we're dealing with, with a sick lady.

Then I also wanted to show you, I
printed out the SEM incident reports from the 90s
for seven WHPP programs. I'm sorry, this is
after '95, incidents that are on the SEM, and not
one of them has a job title or a person that was
involved in these incidents. So you can't
connect them to a person even though you have
affidavits and witnesses. That's how that SEM
works so well. Thank you for your time.
CHAIR MARKOWITZ: Thank you.

Next is Mr. Glen Bridges.

MR. BRIDGES: I'm a little shorter than most, but I'm louder than most. My name is Glen Bridges. I'm a 49 year employee at Y-12. I'm still employed at Y-12 on a part time basis.

What I wanted to come and talk to you about is I've read the SEM. I've looked at that, and we've been through an awful lot of this, and I've listened to you all today and I'm very appreciative of what you're listening to today and what you all are going through. But the tasks is the biggest problem I have.

We have an awful lot of people out here that do an awful lot of different tasks under the same job classification and that's not being very well taken care of. I agree with what the lady said just a moment ago, that we need some former workers, retirees, or even current workers to work with the resource centers to try to determine exactly what these job tasks were for these people that worked in these areas.
Also, with the employee advocates and
the claims examiners they need some training.
And they don't need the decision making process
with them, unless it's cut and dry, yes. If it's
cut and dry, yes, than that's fine and dandy.
But otherwise, they need to move that on up and
let somebody else, a doctor or whatever, take a
look at that and make sure. Because these
people, like it was determined a little while
ago, are mostly lawyers and they like to make
lawyerese.

We also heard today disability versus
impairment. Those two go hand in hand,
especially when you work in nuclear weapons
plant. If you have a disability caused by that
plant then you also have an impairment. That
goes right along with that, and those two things
need to be taken into consideration also.

The causation thing that you brought
up earlier, Dr. Markowitz, was wonderful and I
really enjoyed that. I thought that was quite a
good way to put that. We really need to look at
those things, especially when it comes to those
tings that aren't determined: prostate cancer,
hearing loss. Those things that can't be
directly determined to asbestos or to the chronic
beryllium disease or whatever.

Fortunately, I've worked in it for
almost 50 years and haven't got it, but I'd say
thank you to my parents. Thank you very much.

CHAIR MARKOWITZ: Thank you.

Next is Mr. Tim Lerew.

MR. LEREW: Thank you, Dr. Markowitz
and Board. It's a pleasure to address you again.
When last we met it was April in Washington D.C.
and a lot's happened since then. A lot of work's
taken place that we've seen the good work product
from today and yesterday. We just wanted to
first say thank you on behalf of Cold War
Patriots for the sacrifices you've made on behalf
of the worker community.

And also thank you for this particular
venue and this particular meeting. By coming
into the field here at Oak Ridge, into the heart
of the complex you have the opportunity to hear
directly from the former workers.

That makes a real constructive
difference, I believe, in how this program's
going to be working out and the information and
input you'll have. I'd encourage you to have
future meetings elsewhere around the nuclear
weapons complex and hear directly from the worker
community.

Now, Cold War Patriots, and now we
have more than 40,000 members, has been following
with keen interest the work of this Board. We'd
like to encourage you in a couple of ways. You
have the direction and the opportunity to look at
presumptive causation.

Now, how many times, let me take you
back to that meeting in Washington D.C. How many
times did you hear, I wrote down the number that
I heard, did you hear the senior leadership at
Department of Labor use the word we are
challenged by different aspects of administration
of the program? Looking to this Board for your
leadership in trying to meet those challenges to meet the needs of the sick workers community.

                      Now, how many times did you hear that word? I heard it at least nine times that I wrote down on my notes from Washington D.C. Maybe some of you heard it even more. But that's an opportunity, a request for help from Department of Labor to act on behalf of this worker community.

                      I remember Dr. Sokas, you used the phrase, words matter, and they surely do, and I heard the same from Dr. Markowitz in other context. Just one word in one case I want to share right now. I'm the Lucero v. Department of Labor case in U.S. Federal District Court in New Mexico on August 5 of this year they found that the claimant, that the DOL's interpretation of one word, compensation, as described in the Energy Employee Compensation Act was arbitrary and capricious.

                      This is just one instance of DOL rule or policy potentially changing the intent to the
Energy Employee Compensation Act in practice.
The law was created to compensate and care for
those made ill by their nuclear weapons' work.
Not to impose unnecessary legal and
administrative burdens on those already
struggling with sickness.

Unfortunately, most sick worker
claimants or their survivors lack the resources
or, indeed, the time necessary to resort to
Federal Court to resolve or clarify DOL's rules,
procedures, and administrative practices that
adversely affect not only their claims, but by
precedent, the claims or benefits of many other
affected workers now and into the future, along
with their families.

This Board has both the charter and
the ability to respond to Labor's own many
requests to provide clarify and appropriate
processes when Labor's claims examiners are
challenged to fairly decide and administer
claims.

Finally, therefore, we ask that this
Board support Cold War Patriot's request that the Department of Labor formally withdraw its 60 plus rule changes proposed in the fall of 2015. Instead, engage with relevant stakeholders and workers in a negotiation rule making process consistent with prior executive orders, and in the best interest of those the Energy Employees Compensation Act was created to serve. Thank you very much.

CHAIR MARKOWITZ: Thank you.
We'll hear from Mr. Ti Le Ong next.

MR. ONG: Thank you. I had a feeling they'll be a lot of people that want to speak, so I'm going to cut my short. But instead I ran out and print it, so I make it succinct. Is it okay if I hand it out?

CHAIR MARKOWITZ: Sure.

MR. ONG: This is just a map and this is a three page word document. Thank you, again, for the opportunity to comment and appreciate your time again. Kudos to you for a very, very thorough job on all the topics.
The topic I'd like to share with the
Advisory Board today is about MSO, medical second
opinions. The topic I would like to raise to
your attention is that medical second opinion
often times are asked of our clients. We serve a
lot of clients who are very sick, who live at
home.

They were often times given short
notice and/or not consulted in prior to being set
up, and they are required. If you do not attend
a medical second opinion that could result in
your benefits being withheld. So it's difficult
to begin with.

If you look at the procedure manual it
calls for a travel distance of 25 miles in order
to get a medical second opinion from a CMC
appointed by the Department of Labor. Now, with
that said, in recent months we've seen an
increase in distances that workers are asked to
travel in order to get the medical second
opinion, to the tune of about 100 miles each way.

Now, we may think that that might be a
one-off situation, but in the handout that I gave out just now, the Word document, the actual document is 108 pages long, and I will send the link to this. It's actually on the DOL website. I'll just have to provide, I guess, the link that you can go download it. It actually is not a very clear document because we had to find it via Google searches, and it's not an easy way to find it. But this is the document that the DOL used to solicit bidders to come in and bid for the CMC contract.

As you can see, the bidding period has just closed about two weeks ago, so it was a pretty thorough process starting in August. On Page 11, which I've attached to the document, the entire document has a lot more substance to it. So it's the last page of that document which is Page 11. It points out that the CMC is supposed to bid for serving people within a 200 mile radius for medical second opinions.

So if you think about 200 miles, in terms of what kind of difficulty it creates for
people, especially for fairly sick former
workers. If you have to travel with oxygen and
you have a previously scheduled doctor's
appointment that you now have to go cancel in
order to go make the medical second opinion it is
a very difficult and new topic that is not in the
spirit of the original intent of OPA, and it's
spelled out in the procedural manual.

This change from where it was stated
in the procedural manual to a 200 mile was, as
far as we know, not communicated to the Advisory
Board as well as to other complaints, as well as
people, stakeholders. So we found it quite by a
roundabout way by Google searches. So just to
give you a sense, 200 mile radius, on the map you
can take a look and see.

That could potentially expose a formal
worker in Oak Ridge all the way in the South to
Atlanta to get an MSO or to the East to
Charlotte, or to the North to Cincinnati. Just
to give you a sense of how far it is. If you
think about, I know some of us flew in and
transferred planes in Charlotte or in Atlanta.

It gives you a sense of how far it is.

So I just want to make sure that
you're all aware of the topic of what slight
change in some of these rules could really mean
for a sick former worker. In this case, the
change was not even -- has probably not been
through medical advice from this Board. I can
think of two subcommittees who would be
interested in that.

For instance, the Medical Evidence
Group as well as the CMC discussion this morning.
That you might want to look into this and say, is
this medically necessary to require a sick person
to travel that far in order to get an MSO. We
respectfully ask that you'll help, I know you
don't like that word, opine, on whether there's a
need to have MSOs conducted 200 miles away versus
the intent that's spelled out in the procedural
manual of 25 miles or less.

Finally, just a second to re-comment.

Would urge the DOL as well as with the Board's
advice to communicate clearly when this sort of slight, perhaps slight changes, but that has large impact on the sick former worker community to have that communicated clearly to the people. Because the process of transmittal bulletin, procedural manual changes is often times not well-understood, and we didn't know about it until very recently.

The last bit of that is that, in this case, I think there's original intended of OPA to make it claimant friendly. With this sort of change, it's a very major change that is actually not claimant friendly, and we urge that the MSO process be confined to what the procedural manual spells out, and any changes that impacts further workers are communicated clearly, not relying on the former worker to have to go see out this information. Thank you.

CHAIR MARKOWITZ: Thank you.

Mr. Walt Schuman?

MR. SCHUMAN: My name is Winnfred E. Schuman. I'm 42 and a half year past employee at
Y-12. My mission today is to talk to you and let me say first for the opportunity to come and listen. I gained a lot of knowledge and I know I won't retain a lot of it, but some of it I will and I appreciate that.

I'm here because of a group of workers at Y-12 that have been left off of the workers compensation. They don't fit into the category for hearing loss. I know that the Department of Labor is here and I appreciate that, and I know that you're an advisory committee, and maybe you could take into advisement what I'm saying and pass it on.

But this group has called an assembly person. They're made up of machinists and they're made up of chemical operators. They have the have the qualification to be a machinist or have been a machinist, and they have to have the chemical training that deals with toxic chemicals. And so both of those come together. We are the final product of the weapon system that's made at Y-12.
That's before it's shipped out. We get the small parts in. We get the large parts in and we make them go together. Sometimes it requires machining and our groups to do that, and something it requires us to use methyl ethyl ketone, perc, Freon, and all the solvents. Five of the seven that were listed earlier is what we use in there and I've been doing it for 40 years.

I do have a claim in on a hearing loss. But this group has been left out of the categorical labor communities that have been put together and they needed to be added. Because it's not a large group, but they handle both chemicals and machining. I'm going to give you some examples of what they do.

We had a uranium bomb. We had it welded. When it came out of the welder it had a high rim on it from the weld joint. We would take it, this is back in the 70s, and we would take this ball. We'd put it on a fixture and we'd sit down with it. No respirators, no protective equipment whatsoever, and we would
file this with a file until we get the tolerance
down to where it would touch that tape, and then
we would know it would go into the weapon system.

We would have our cup of coffee on one
side of that ball and a sandwich or cookies on
the other, and we continue to file that.

MEMBER VLIEGER: Was that beryllium?

MR. SCHUMAN: Uranium. Yes, ma'am.

That's just one job and we did that for years and
years.

We would take weapons parts and clean
them. It's my responsibility for years and years
to clean those parts to make sure that they were
clean when they would go in these weapon systems.
We would use toluene and we would use methyl
ethyl chloroform, methylene chloride, and it
would be in big vats. You would put these piece
parts or tooling or whatever you had to clean and
put in these vats that were open in the areas
that we worked in.

We would clean those with the
chemicals. I had a rubber glove on my hand one
day and I took my glove off and I just put it in that vat of methyl ethyl chloroform. Went to lunch, and when I came back -- now, you see how large my hand is. This glove was this long. It was this wide. And I'm thinking, if that's doing that to that glove what is it doing to the people that work day in and day out there with no protection?

Around 1985, '87, '88, somewhere, we started doing plans and we would actually incorporate PPE into the system, into our jobs. But before that, they used to hand us a 3 X 5 card in the morning and they would say, go do your job. Whatever it takes to get this job done, do this job.

Of course, we had training to do that. But what I'm trying to say is the jobs that you have, you have the buildings where the chemicals are used, but you don't have how these processes were put together and what we did. It just seems to me that this group has been left out. Many, many of them have passed away because of cancers
and things like that.

I'm here because, just to let you know that the toxic chemicals that we use have been affecting us and our hearing losses as well. That's what my claim is about. But we machine, and --

CHAIR MARKOWITZ: Mr. Schuman, if you could begin to wrap up.

MR. SCHUMAN: I will. Thank you. I'm just going to say this, and then I'll leave.

Assembly at Y-12.

I think that the SEM database is lacking, I don't know if you put the job processes in that or not, but I think it's critical that when we go into an area and we identify that we go back and see what was done in the past history of these units instead of just saying that the chemical was used there. But find out how it was used and what it was used on and, you know, was it open or not. Thank you. I appreciate the time.

CHAIR MARKOWITZ: Thank you very much.
Claude Martin, the next speaker.

MR. MARTIN: Hello. I'm Claude Martin.

I'm 86 years old. When I was 15 years old I was in World War II in the Pacific. Then I got called into Korean War and I went through that.

After everything was over and we settled down, why, I went to work at K-25. I worked there for a while. I'm going to make this short. My nose would bleed. My eyes would bleed. My eyes would bleed. So the doctor's told me, they guys that I worked with, every one of those guys is five stone. The doctor told me, he says, Claude, you better do something.

So I quit. Then I went to Y-12 and I stayed down there and everything was all right. But, you can see my arms. It looks like a leprosy. I've had cancers, skin cancer, big ones, little ones. I've got them everywhere. But I've been denied from anything.

I appreciate it if you could tell me why and whatever. Thank you very much.

CHAIR MARKOWITZ: Okay. Thank you.
Louise Presley?

MS. PRESLEY: Good afternoon. Thank you for the Board for being here and what you're doing and being in East Tennessee. My name is Louise Presley. I'm retired from Y-12 after 36 and a half years of service in administrative capacity, part of the product certification division in the production area, buildings.

My late husband, Robert W. Presley worked at Y-12 for a total of 44 plus years as an employee and as a contractor. In full disclosure, for the record, I must let you know that he was appointed to the ORCA Advisory Board on Radiation and Worker Health in the fall of 2001, and served on that board until his death in 2011.

I was privileged to attend many of those meetings, so I'm seeing this process and not everybody has that opportunity in filing a claim. They recognized me with a memorial in Bob's honor after he passed. He was first a materials dispatcher in the production areas at
Y-12, carrying parts from shop to shop and eating lunch in the work areas.

I want to read something that a co-worker of his just gave to me last night. We worked in weapon materials dispatch as weapon materials dispatchers starting in the 1970s. He went there in February of 1969. Responsible for preparing documentation that transferred the raw materials and weapon components' parts from one production area to another.

Traveling with each part was an envelope they called a shuck containing and IBM-type card with the parts' identification such as part number and type of material. These cards and shucks were handled by production employees handling the weapon material as well as us, as we processed the parts from one area to another.

Each card was pulled from the shuck by the production operators and ourselves to clock the production operation completed as the parts travel through the various shops and production areas. The shucks and cards were highly
contaminated just from being handled by the
workers wearing gloves and placing the parts
coming out of the production area to a pallet or
inside a container.

We'd place these cards on our desk
while preparing the parts for transfer. These
desks were the same desk we all shared for work,
often for eating our lunches, where our coffee
and other drinks sat while working, and where
those that smoked cigarettes sat and smoked.

Bob nor I smoked, but in those days we
all inhaled the smoke from cigarettes as well as
smoke coming from the production areas: raw toxin
materials, enriched Uranium, depleted Uranium,
lithium, beryllium, and other weapons and non-
weapons materials I won't mention because of
classification. It often overwhelmed the old
equipment that was supposed to filter the air.

Even though we worked in these
contamination areas as office workers we were not
supplied company clothing or shoes, even though
we had to walk through the same production areas,
floors, as the machinists, chemical operators, and other workers to perform work responsibilities.

Bob then became an engineering assistant and a special nuclear weapons' production engineer in product engineering division. His work took him, often, to Los Alamos, Sandia, Albuquerque, Pantex, Livermore, and to the Nevada test site where he stayed on site and went down into the ground to set up items for testing.

One question I have there is how do you find out the rad exposure from all those different sites, and I'll tell you why later. In September 2011 he passed away after only seven and a half weeks from first pain acknowledgment to last breath of a stomach tumor, esophageal cancer, metastatic liver cancer, and cancer of the lymph nodes.

A claim was filed immediately after his diagnosis. I literally picked his brain in those last weeks and those of his friends for
specific information provided for inclusion of
the claim on his behalf. As the end approached
for him I was on a three-way call with the
Jacksonville office and received a verbal
approval for a total claim payout over the phone
from the supervisor there.

He passed away before the check was
deposited in the bank and the employee claim was
immediately closed. In early 2012 I attempted to
open a survivor claim. Five calls were made to
Jacksonville to my contact there and I never
received a return call.

With claim records in tow I went to
Susan Atkinson's office on Oak Ridge and she
literally got the ox out of the ditch. Your home
becomes the claims' library with all the
paperwork that you have. Over a year after his
death I received a survivor payout that was
denied the radiation testing portion payout.

Now, you heard me tell how he worked.
I was notified that only two radiation testing
results were located from his 44 plus years of
work at Y-12. No one who worked with him can believe that is possible. Could records not have been looked for? Were they lost or were they destroyed? That's why this person came up with that document that I read.

The rest of my story is that a year after Bob's diagnosis I was diagnosed with breast cancer and had a bilateral mastectomy. When I received the initial diagnosis, and before surgery, I went through the BRAC-1 and 2 and advanced genetic testing. The results were negative.

I've also had three skin cancer legions removed. I filed a claim and it was saying denied. I worked in salary administration, so the old key punch cards that used to be created in payroll would come to our office. We would send them out into the production areas where they would communicate to the employees the raises, and job titles, and things like that.

Supervisors would sign them. They
would come back to our office and we had the personnel records vault responsibility, and we would file those cards that had been out. From 1963 when I went to work out there we had the electric typewriters and I used to clean my typing keys with a solvent that was called carcinogenic in later years, and I think it had toluene in it.

I can't remember the name. I have it in my claim. But, you know, that was hands on. It was so strong that your nose smelled for at least a day from the odor from that cleaner.

Working just across the valley from the Oak Ridge Gaseous Diffusion Plant which was approved for a special exposure cohort for employees who worked there for 250 days and who received diagnosis of one of the approved cancer categories. It is hard to be a Y-12 or ORNL worker or retiree in Oak Ridge and not receive probable claim approvals.

We are not and should not be the stepchildren and should not be the stepchildren.
These approved claims are not handouts. They are medical insurance payouts for those who have survived after surgery and treatment, or life insurance payouts to the families of those employees who did not survive. Thank you.

CHAIR MARKOWITZ: Thank you.

Next will be Jan Lovelace.

MS. LOVELACE: Thank you for all for coming to Oak Ridge, and I hope on your tour yesterday that you got to see some of the things that we have at the nuclear sites. I am a widow of a fireman from ORNL who had worked there 26 years, and each one of his six cancers were not from another one. They were all separate cancers. None of them metastasized from any others.

The problem I have is with a couple things. It's with the SEMs. That there were no firemen in the SEMs for ORNL, but they were for Y-12 and they were for K-25. So I was able to get some classifications put in that were given by the commander now. Unfortunately, truck
driver and dispatcher does not tell you that that
fireman went into the nuclear waste barrel
grounds on an hourly basis every day he worked to
be sure there were no fires.

In 2008 when my husband was in the ICU
the headlines here in August were, 70 mason jars
of radioactive material was found on top of the
ground, so this was something that they had. But
he has been denied over and over and over. After
he died and one of his, I can't forget it, that's
why I'm here again today. Few last words he said
to me before he went into a coma and died about
12 hours later, don't give up. Get my justice.

I made a video after his death which
is on the YouTube with Y-12 clearings and several
others have made those here in Oak Ridge. We
have more claimants here than most any places.
But the duties of a job description or a category
does not tell those people what that person did.

I think that needs to be updated and
more data put into the SEM and into the
classifications. Because, like I said, a truck
driver and a dispatcher does not tell what that fireman does. My husband was -- when he first went to work in '74 he had worked there at Y-12 during construction which his time there was discounted because we had only the records of where he employed in and where he was out of work because of no more working in there at that time.

But there are so many things we ran up on. I could go on for days, I tell you, and get on my soapbox. But, you know, there's so many things that we have encountered as claimants. We have an unbelievable case, and anyone who's read his case and seen what has happened, the screaming fits that one of the Washington adjudicators, he screamed my head off and threatened me.

He just was on that phone, told me he'd have me arrested and all because he sent me the Social Security numbers and salaries of about 14 people, and I called him up to tell him about it and he started screaming at me. He told me he'd have me arrested by the FBI. That's another
But what we want -- I told you I could go on and on, but I won't. We had so many incidents where he was denied over and over. They would not, the CE, boy, you all got on a subject because they are not trained. Rachel told me, Ms. Leiton, please, in June of 2009 when I was on teleconference call that I didn't know what I was talking about because her CEs were very well-trained.

I had one of them. We had 17 in six years. This one did not know where that file was. It was lost for a year and a half. It went to dead file on time where he was deceased when he wasn't. It just goes on and on.

But this one particular claims examiner asked me what an expediter did. Well, I was dumbfound because I knew what he did and I thought, you don't know? And I said, did you look it up? And she said, no.

Well, if had been me in her position I would have looked it up to find out what an
expediter did instead of asking the claimant which, when he worked at Y-12, that's what he did. But that was his, again, his title. But he went all over those construction sites when they were building and working with the weapons and all there.

The other thing we encountered, greatly was the loss of his records. He worked 27 years and we had proof of that, but even his dosimeter record for '87 year, he had two exposures, was called in and kept for two days in quarantine. That record for '87 is totally blank when we have all the evidence.

From his records it says failed limits. I've never got an answer why those were on his records, but didn't have. I have a scant eight years for 27 and Peter Turek in 2007, maybe, he told me my husband didn't work there in 1987. That's why I explained. Well, we put in 22, and I think it's called an EE-4. Is that the number? I wasn't too sure. I'm getting old.

And so those forms were filled out by
his chief, his commander, and the man he worked
with that they had worked with him. We had the
plaque that said he worked 27 years. He died a
horrible death and we did not get medical
services. His oncologist letters were denied and
that, again, comes back to the CE.

So you all are all to a minefield of
ersors when you get into what the CEs know, what
they say to you, and how they decide, just like
this one that we had the last six years. She
said she wasn't accepting his fifth cancer. It's
in there now, and I was told by, I've forgotten
some of the people I've talked with because, like
I said, I've sort of distanced myself from it a
little bit because I was getting sick myself.

But this is not a claimant-friendly
program. We have to prove everything, and when
they won't accept your own personal oncologist
report that's bad. Again, that's coming back to
the power of the CE, and it's mister -- well, I
won't call his name, in Washington told me. He
said, you shouldn't -- well, I got tickled and
giggled when he kept on. I kept saying, I'm
going to send it back to you. I'm sending it
back to you. It's me that called you. You sent
it to me.

He just kept on and on, and I got
tickled and he got so mad and he said, you
shouldn't upset people that you want something
from. We were denied again. So --

CHAIR MARKOWITZ: If you could wrap it
up pretty soon?

MS. LOVELACE: Yes, yes. Like I told
you, I could go on for weeks and weeks. But
these CEs need more training and the contaminated
buildings, 2500, the firehall, is still
contaminated on the D&D list of the demolish and
destroy from DOL and men are still working there.

My husband, they burned beryllium in
the back parking lot, and just lots of things
that don't go into those job classifications.

Thank you. I'm sorry, like I said, I could talk
for two weeks on all the problems we had. Thank
you.
CHAIR MARKOWITZ: Okay. Thank you.

The next speaker is Leisha Tremmel.

MS. TREMMEL: Hi. Thank you for allowing us to come and do this. My name is Leisha Tremmel and my father worked at Y-12 as a construction laborer in 1953. He was declined and they said that the IH report was sent and he had found several exposures that my dad was exposed to.

But he determined that it was in 1953 and how would he know exactly what he was -- you know, how much exposure he was exposed to in these chemicals of asbestos and all these others? They also indicated that he wore protective equipment, and in 1953 I'm sure there were no protective equipment for these construction laborers.

I have an affidavit from a guy that worked there, and he said that my dad's duties was to clean up after all these different crafts that were there. Like, if there was an asbestos person there he had to clean up after him. The
painters, the iron workers, the welders, whatever the craft was. He had to clean up after them.

Also, they sent the letter, the report to the CMC and he also determined his exposures of 1953 and we are in question as to how he knows what my dad and the level of exposure he was exposed to in 1953. Also, my father-in-law worked at Union Carbide, not for a contractor, but actually for Union Carbide for ten years.

He was exposed to many, many different things. He was also declined. They didn't -- he has tried to get his claim since it started, and he has now died, and even his mother, or his wife, I'm sorry. She's still alive. These people that I'm just talking about, my dad and his dad, would be 93.

We don't have a lot of records, especially for my father who died 43 years ago. They don't keep hospital records and doctor's records after ten years. You know, we can't exactly tell everything that happened to him, to them, because we didn't have any doctor records.
We only know what happened with our father at home as we saw the struggles that he went through and the same with my father-in-law. So, thank you very much.

CHAIR MARKOWITZ: Thank you.

Our next speaker is by phone. It's Herschel and Becky Moore.

MR. MOORE: Hello?

CHAIR MARKOWITZ: We can hear you.

MR. MOORE: Hello?

CHAIR MARKOWITZ: We're here.

MR. MOORE: I worked out there as a roofer on a radiological areas declared. Our duties literally pegged the meters and we were only give Tyvek suits. We weren't even given respirators. We were given just these paper masks. I worked out there just a year and I'm a carcinoma cancer survivor.

I've been listening to all these people out there that worked all these years and I think it's pathetic that the Department of Labor, it would cost them billions of dollars to
I settle these claims to these poor people. I'm appalled about it really, and I feel bad because I only worked a year out there and they have so many years inside there.

What gets me is I haven't heard one comment to these people and that's all I'm going to say. Thank you.

CHAIR MARKOWITZ: Thank you. Our next speaker is Larry Lane. Is there a Larry Lane here? Okay. Take your time.

MR. LANE: Thank you all for being here and taking our concerns. I sort of have the same concerns as the gentleman from Y-12 long ago. I filed a claim for hearing loss based on chemical exposure and I worked for 39 years at X-10 as an instrument technician.

When I filed a claim my claims examiner recommended acceptance, but the final education branch turned it down because my work classification is not in the SEM. At one time there were 160 instrument technicians at X-10, but that category is not in the SEM.
So they turned it down, said they could not -- I couldn't prove exposure because there is no work category. I provided information to the SEM administrator, the fact that there were a classification there, and he has modified the SEM. Now, the problem is the SEM is still incomplete because it does not list me as being exposed to any of the solvents.

As you know, here at Oak Ridge there's basically three installations, and at K-25 and Y-12, folks doing this are referred to as instrument mechanics, and at X-10 we were instrument technicians. As budgets, throughout the years, we would swap between plants several times. We'd go from X-10 to K-25, Y-12 to X-10.

We were all doing the same work, exposed to the same solvents. If you were K-25 their SEM is complete. There is a link there. Y-12, their SEM is complete. There's a link there, but at X-10 it's incomplete. There's not a link. So I was asked to write an affidavit and also get other people to submit an affidavit.
So we submitted about five and SEM administrator informed me that he cannot change the SEM based on affidavits. It has to be on some kind of information that he can call inside the laboratory and then confirm it. But the claims examiner can use those affidavits, so he has submitted those to Washington D.C. to the industrial hygienist to try and come back in and make the SEM correct.

I guess my concern is how can, you know, my exposure happened in the 70s and 80s. Back then we had no work procedures, work control. How is someone in Washington D.C. going to be able to determine my exposure?

It's as if there's a catch-22 and someone from outside, being retired, not having access to resources inside the lab, I'm at a loss of what to do. You know? I was there for 39 years and I met all the criteria. I used the solvents, but I can't dot every I can cross every T, and it's very frustrating. Thank you very much.
CHAIR MARKOWITZ: Thank you.

Our last speaker is Tim Badie.

MR. BADIE: Can you hear me? Because I have a condition that effects my short-term memory I have to read this, so good afternoon. My name is Timothy Badie. I was a production machinist at Y-12 from 1980 through 1990. Like most machinists, I machined a wide variety of toxic materials, exposed to a wide variety of solvents and chemicals.

One thing in particular that I'd like to address is the materials that the machinist does with this machine that didn't have a name that I can tell my doctor. One thing that sticks out back in the early 80s is a particular assignment that they would have us go up to the third floor and say, you're a machinist, but it will put off a smell. It was a very odd smell. Said, it will cause an ice cream headache, so after you breath it for a while stop, go outside, breath fresh air, and it will go away. So we did that. Machine it for an hour
or two and back then we didn't have any -- I've
got a picture of me on a machine, actually on my
phone.

We had no protection or anything.
You'd breath this for a while, get a headache, go
outside, walk around, breath fresh air, go back
up, and after a few months you finally went up
and asked them, what in the heck is this I'm
breathing because now I've got a headache all
weekend? It hurts. Nobody could ever tell us.

So it's hard to sit down and explain
to your doctor what it is for him to try to help
you when you didn't even know. They didn't even
have a code name, which a lot of the things did.

The other thing I wanted to address is
solvents, a lot of them used as de-greasers. The
list I got back from the Department of Labor
industrial hygiene that they know that I used
trifluoroethylene, perfluoroethylene, methyl
ethyl ketone, anyway, there's a long laundry
list.

This caused, what they're calling,
chronic encephalopathy. They've looked at me and said your hearing loss and all this ringing that you have in your head is definitely caused by exposure to these chemicals. Because back then we didn't have rubber gloves. We didn't have any ventilation. We just got in there and worked with it.

They even took the labels off of it. They just gave us the little plastic bottles. We would use it and you would breath a lot of this stuff until you felt just drunk, I mean, really your head was spinning. You'd go outside, you'd breath fresh air for a little bit, come back, and it would absorb into your skin, but we weren't told that.

So they told me to go see a person to check my hearing and all the things that's going on. They did it and sent in my claim to the Department of Labor, and they came and they said, well, yes, you were exposed to the materials and solvents, but you had to have been there 10 years to cover your hearing loss. You were only there
nine years. Have a good afternoon. Thank you.

CHAIR MARKOWITZ: Thank you very much.

That concludes our public comment session and we
will reconvene tomorrow morning at 8:30. Thank
you.

(Whereupon, the above-entitled matter
went off the record at 6:03 p.m.)
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This is to certify that the foregoing transcript

In the matter of: Meeting of the Advisory Board on
Toxic Substances and Worker Health

Before: US DOL

Date: 10-18-16

Place: Oak Ridge, TN

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
true and accurate record of the proceedings.

[Signature]

Court Reporter