U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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TUESDAY
JANUARY 28, 2020

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The Board met telephonically at 1:00 p.m. Eastern Standard Time, Steven Markowitz, Chair, presiding.

MEMBERS PRESENT

STEVEN MARKOWITZ, Chair
MANIJEH BERENJI
JOHN M. DEMENT
KIRK D. DOMINA
GEORGE FRIEDMAN-JIMENEZ
ROSE GOLDMAN
RON MAHS
MAREK MIKULSKI
DURONDA M. POPE
CARRIE A. REDLICH
KENNETH Z. SILVER
CALIN TEBAY

ALSO PRESENT

MICHAEL CHANCE, Designated Federal Official
CARRIE RHOADS, Alternate Designated Federal Official
RACHEL LEITON, Director, DEEOIC
MELISSA SCHROEDER, SIDEM

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

1:04 p.m.

MR. CHANCE: Yes, good afternoon everyone. My name is Michael Chance. I'd like to first of all introduce myself. I'm the new DFO, the federal officer, so I'll look forward to working with you all on the board, and we look forward to a productive meeting today.

First, we appreciate the time and diligent work of our board members in preparing for this meeting and the forthcoming deliberations. We are scheduled to meet from 1:00 to 4:30 today, so please bear in mind the time.

In the room with me are Carrie Rhoads, Rachel Leiton, Kevin Bird from SIDEM, our contractor.

MS. RHOADS: He's on the phone.

MR. CHANCE: He is on the phone, yes.

MS. RHOADS: Yes.

MR. CHANCE: Yes, and I'm sorry, you are?

MS. SCHROEDER: Melissa Schroeder.

MR. CHANCE: Melissa Schroeder, as well. And, so we will go ahead and I will begin discussing the remainder of the meeting.

We have agreed upon a break at 2:45 or anytime that seems like a good time to stop. So, that's our agreed upon time.

Copies of all meeting materials and written public comments are or will be available on the board's website under the heading Meetings, and the list, and the listing there for committee meetings.

The documents will also be up on the Webex screen so everyone can follow along with the discussion.

The board's website can be found at dol.gov/owcp/energy/regs/compliance/advisoryboard.htm. I think I got all that.

If you haven't already visited the board's website, please do so. After clicking on today's meeting date you'll see a page dedicated entirely to today's meeting. The webpage contains publicly available materials submitted

to us in advance of the meeting.

We will publish any materials that are provided to the sub-committee. There you should also find today's agenda, as well as instructions for participating remotely.

If you are participating remotely and you are having a problem, please email us at energyadvisoryboard, that's all one word, @dol.gov.

If you are joining by Webex, please note that the session is for viewing only and will not be interactive.

The session will also be muted for non-advisory board members and please note that we do not have a scheduled public comment session today.

About the meeting minutes and transcripts, a transcript and minutes will be prepared from today's meeting. During board discussions today as we are on the teleconference line, please speak clearly enough for the transcriber to understand.

When you begin speaking, and I hope I'm doing that as well, when you begin speaking especially at the start of the statement, please state your name so that we can get an accurate record for the discussion.

Also, I'd like to ask our transcriber to please let us know if you're having any issue with hearing anyone or can't spell a name, or have any trouble with the recording.

As the DFO, I see that the minutes are prepared and ensure they are certified by the chair. The minutes of today's meeting will be available on the board's website no later than 90 calendar days from today per FACA regulation. But if available sooner, they will be published before the 90th day.

Also, although formal minutes will be prepared, we will be publishing verbatim transcripts, which are obviously more detailed in nature. Those transcripts should be available on the board's website within 30 days.

I would also like to remind the

advisory board members that there are some materials that have been provided to you in your capacity as Special Government Employees and members of the board, which you are not for public disclosure, not to be shared or discussed publicly, including this meeting.

Please be aware of this as we continue with the meeting today.

These materials can be discussed in a general way, which does not include us using any personally identifying information such as names, addresses, specific facilities, and if a case is being discussed, or doctors' names.

So, thank you for your patience as I went through that list and with no further ado, I will turn it over to Dr. Markowitz.

CHAIR MARKOWITZ: Thank you.

This is Steven Markowitz and I want to welcome everybody to the meeting of the board. Welcome to Mr. Chance as the new DFO working with us, that's great.

In a moment we'll do introductions but

I want to just welcome any members of the public who are on the phone. Hopefully also able to get online and look at some of the presentations we'll be making.

I want to point out certain documents on our website that we'll be referring to today that are now available on our website under today's meeting, and these include a letter with new duties from the Deputy Secretary of DOL that was sent December 30, 2019.

Secondly, responses from the Department of Labor to our recommendations from early in 2019 that was sent to us December 18, 2019. So, that's on our website.

And, then also on our website are the board's data and case review requests that we made at the end of December 2019.

So, otherwise other documents we'll be discussing today, which should appear on the website soon, there's, or not depending on Department of Labor's policy, that we've been provided with yesterday maybe for board members,

we were sent a copy, a draft of a new elements, new chapters for the procedure manual, it's called Bulletin 20-02, which we'll be discussing today somewhat.

And, also today we received this morning we received Department of Labor's responses to our end of December board information requests and claims review requests. So, we will walk through those today as well.

This meeting is kind of an interim meeting between our face-to-face meetings. I don't know that we're going to make any recommendations at this meeting. I kind of review this, view this meeting as an opportunity to catch up, to react to some of the recommendations, or some of the responses we're getting from DOL, and kind of brainstorm a little bit about how to move forward on certain issues.

So, this may be a little bit more of a free flowing discussion, I hope so, than at some of the previous board meetings. But that's just fine because that should move us ahead.

And speaking of ahead, so the board's term, this term ends mid-July 2020. This meeting, we'll have another face-to-face meeting. I think we'll discuss this again at the end of the meeting but likely shoot for sometime in the second two weeks of April, which would give us enough time between now and then to do some work, but also would give us time between that meeting and the end of the term to close out or finish up any board work at the end of June or beginning of July.

So, that's, so in our discussion today when we think about our work schedule and what we hope to get done when, I think in April when we meet face-to-face that's when we should shoot to really have our recommendations that pertain to some of the things we're discussing today ready to go, which means probably work group meetings between now and then.

So, with that, let me just then move to introductions. Briefly the board members can introduce themselves, mostly I guess for the

public, but I'm Steven Markowitz. I'm an occupational medicine physician and epidemiologist with the City University of New York.

Dr. Silver?

MEMBER SILVER: Hi, this is Ken Silver, Associate Professor of Environmental Health at East Tennessee State University, College of Public Health.

CHAIR MARKOWITZ: Dr. Mikulski?

MEMBER MIKULSKI: This is Marek Mikulski, I'm an occupational epidemiologist with the University of Iowa, Iowa City.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Hi, I'm George Friedman-Jimenez, I'm an occupational medicine physician and epidemiologist at Bellevue NYU Occupational Environmental Medicine.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: John Dement, professor emeritus at Duke University Medical Center,

Division of Occupational and Environmental Medicine and Industrial Hygienists and epidemiologist.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Kirk Domina, I'm the Employee Health Advocate for the Hanford Atomic Metal Trades Council in Richland, Washington. We represent 14 affiliated unions and about 2,500 active members. I've been out here almost 37 years, I'm a USW member.

CHAIR MARKOWITZ: Mr. Mahs?

MEMBER MAHS: Yes, Ron Mahs, and I'm representing the building trades.

CHAIR MARKOWITZ: Ms. Pope?

MEMBER POPE: Duronda Pope, United Steel Workers, retired, Rocky Flats worker, 25 years.

CHAIR MARKOWITZ: Mr. Tebay?

MEMBER TEBAY: Calin Tebay, I'm a sheet metal worker for the first 20 years, became the Hanford Site Beryllium Health Advocate, and now I am the Hanford Workforce Engagement Center

representative.

CHAIR MARKOWITZ: Dr. Goldman?

MEMBER GOLDMAN: This is Rose Goldman on occupational and environmental medicine physician, Cambridge Health Alliance, and Associate Professor at Harvard Medical School and Harvard School of Public Health.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: This is Carrie Redlich, a pulmonologist and occupational environmental medicine physician and a professor of medicine at Yale School of Medicine, and also director of the Yale Occupational Environmental Medicine Program.

CHAIR MARKOWITZ: And, Dr. Berenji?

MEMBER BERENJI: This is Mani Berenji, occupational and environmental medicine physician, as well as an assistant professor of medicine at Boston University School of Medicine.

CHAIR MARKOWITZ: Okay, thank you and let me just say that Ms. Pope has told just that she may not be able to attend the whole meeting

today because of a kind of urgent competing work issues. So, we appreciate your attendance and understand.

I want to spend a couple minutes reviewing the agenda. We're going to discuss the DOL's responses to our recommendations that was, response that we received, it was dated December 18, 2019.

We have a PowerPoint, a couple of presentations I think that we'll summarize their response and also some of our thoughts.

And, then we're going to discuss the new board duties that the Congress passed as part of EEOICPA that we learned about December 30, 2019.

And, I've added next an acknowledgment and brief discussion of the new draft Bulletin 20-02 from DOL, which we received yesterday.

We're going to spend a few minutes on public comments. There was one public comment that's been posted to our website for this meeting. There were at least a couple comments

that came in after our last meeting in November.

And, then we're going to review the action items that we developed in November, and DOL's now given us a response to those action items as of today. So, we can discuss their responses and our reaction and the like.

I would like to get Item No. 7 to a discussion about, beginning discussion about how to improve or how to address the issue of the quality of the industrial hygiene and medical assessments as part of the claims process.

And, then we'll hear a brief update on the Parkinson's disease issue, and then finally, if there are any new items. And then we'll discuss the next board meeting.

Are there any items that people would like to add to what I've mentioned so far?

(No audible response.)

CHAIR MARKOWITZ: Okay, that's good.

So, Kevin I'm addressing you and I'm addressing Melissa in terms of bringing --

MR. BIRD: Yes, that's actually going

to be Missy, so I'm actually participating remotely like everyone else. But Missy is in the room with Carrie.

CHAIR MARKOWITZ: Okay, so Missy, you can hear me?

MS. SCHROEDER: Yes, I can hear you.

CHAIR MARKOWITZ: Okay, great.

Okay, so there was a document PowerPoint that I sent recently called Asthma.

(Pause.)

MEMBER REDLICH: Are you going to be showing that on the Webex or should we have that --

CHAIR MARKOWITZ: No --

MEMBER REDLICH: -- as a separate?

CHAIR MARKOWITZ: -- it's on the Webex. You haven't gotten these documents. PowerPoints haven't been sent to individual board members.

But this was a recent one, it's just a few slides long. And Dr. Redlich, these are the revised slides that you sent me, so worth waiting

a moment for.

(Pause.)

CHAIR MARKOWITZ: So, we're discussing our reactions to the DOL responses, and then for anybody who wants to look at actually the full text of the DOL's responses to us, again it's on our meeting website under Briefing Book Materials, it's called the Recommendation Responses from February, from the board's February and April meeting. So.

So, Missy, are you able to locate, ah, there you go. Okay, that's good. If you can go to the next slide.

Okay, Dr. Redlich, you want to take over here?

(Pause.)

MEMBER REDLICH: Sorry, I just had my phone on mute. Oh, what happened to --

Sorry, my Webex just disconnected.

CHAIR MARKOWITZ: Okay, well if you want --

MEMBER REDLICH: Yes, so I, okay, I'm

back.

Okay, so just as a quick review, the advisory board had initially submitted four recommendations regarding work-related asthma.

And the first three recommendations related to either the definition of occupational asthma, and so as to include both new onset work-related asthma, and exacerbation of pre-existing asthma.

And the other two recommendations related to diagnosing asthma and defining an asthma exacerbation, and I think there was general agreement and the DOL incorporated those, those recommendations.

So, currently the fourth recommendation related to, and that's just to fill in the history, the fourth recommendation related to concerns that the advisory board had as far as the criteria used to diagnose work-related asthma and the specific wording that was in the procedure manual.

And, so the, and since the concerns

that we had are highlighted in yellow as people can see the PowerPoint, which was the two parts, the just reading from what's highlighted in yellow, but these are sort of the section that was the criteria for deciding whether someone's asthma was work related.

And, it stated the qualified physician must provide a well-rationalized explanation with specific information on the mechanism for cause and contributing or aggravating the conditions. The strongest justification for acceptance in this type of claim is when the physician can identify the asthmatic incident, or plural, that occurred while the employee worked at the covered site, and the most likely toxic substance trigger.

So, and the Department of Labor on the next slide if someone could switch to that, responded. And I think at this point, we have discussed the issue of a specific toxic substance and that is wording that's in the original act. And, the Department of Labor felt that they

should stick with their initial language.

And, I think we had probably discussed this issue sufficiently. If anyone else wants to chime in or voice an opinion, just briefly we've considered for various reasons that most exposures are mixed exposures, or even a substance that is a single entity, like a sepsis or lead. It actually it could be multiple different exposures. But the DOL feels that the, they should stick with the existing language.

So, if we go to the next slide, I thought that a good ending of this discussion would be that the advisory board and the DOL respectfully differ in their interpretation of a toxic substance.

So, I will just pause to see if anyone else wants to comment further on that.

MEMBER GOLDMAN: Hi, this is Rose Goldman, Carrie.

MEMBER REDLICH: Yes.

MEMBER GOLDMAN: A few questions quickly. Would the, well particularly for

exacerbation of the asthma since it could be just any irritant, would it be sufficient to label the toxic substance as irritant? You know, rather than having to actually name which particular irritant, it could be a cleaning agent or whatever in that particular instance?

MEMBER REDLICH: Yes. So, I know you haven't been in on these prior conversations regarding this topic. The issue is that the original EEOICPA Act has the wording that is quoted in the slide in terms of a specific toxic substance.

I know people are not -- there's a lot of background noise.

(Pause.)

MEMBER REDLICH: That's better.

CHAIR MARKOWITZ: Can I just, this is Steven. Let me just make a, let me just offer a friendly amendment. I don't think the Act says specific toxic substance. I think it says toxic substance.

MEMBER REDLICH: Yes, thank you.

MEMBER GOLDMAN: So then if that's the case, would it not be okay then to just have it as a group label like irritants?

MEMBER REDLICH: I would be okay with that. We have brought this up on several occasions and have not convinced the DOL to consider a broader interpretation of that word.

MEMBER GOLDMAN: But that would be for --

MEMBER REDLICH: But I am open --

MEMBER GOLDMAN: -- exacerbation.

MEMBER REDLICH: But this is --

MEMBER GOLDMAN: For exacerbation.

MS. LEITON: Can I? This is Rachel Leiton. I can address that in a little bit.

You know, we've gone back and forth with our lawyers many times about using something, you know, irritant is pretty much going to be like generally toxic substance. We would need a specific toxic substance. Specific to the exposure that they might have had.

So, I don't think saying irritant's

going to really have that much of a difference in terms of if you revise this and come back with irritants. I think our lawyers are going to come back with the same response as the one that we provided to you already.

In terms of exacerbation and aggravation, you know, our standard is a little bit lower there but it goes on a case-by-case basis. And, if a doctor comes in and says, you know, this person was exposed to X, Y and Z exposures or toxins, it can be more than one but they have to be named, we have to be able to verify them. That's what we're looking for. Just for, from our perspective.

MEMBER REDLICH: But, I, you know, also I think in practice a relatively high percentage of the work-related asthma claims have been accepted if I'm understanding the data correctly.

MS. LEITON: That's correct. This is Rachel Leiton.

MEMBER REDLICH: Yes, so I think that

there is some judgment that's being used in the interpretation.

So, I think we felt that we had probably discussed this issue sufficiently and maybe we can move on to others. But I wanted to just review the recommendations and the DOL's response.

CHAIR MARKOWITZ: This is Steven Markowitz. Can I just add something?

So, this, the slide we're looking at says that we differ in our interpretations of a toxic substance. I actually don't think it's a different interpretation of toxic substance because obviously we accept that the Act says toxic substance. The issue is trigger. And the issue is incident.

And it's, you know, it's because the current language frames the events in the workplace in terms of this specific actions that happened, which is just unrealistic.

But regardless, we disagree and I guess we agree to disagree and so we can move on.

MEMBER REDLICH: Okay, and so I did want to just go back to the other yellow highlighted sentence, which the DOL didn't directly respond to, which was the qualified physician must provide a well-rationalized explanation with specific information on the mechanism for causing, contributing to, or aggravating the conditions.

And I think as we had previously explained but maybe not provided the best alternate wording, that the mechanisms by which most agents cause asthma are actually, remain poorly defined, and that most qualified physicians would not be able to even provide that information.

So, we were suggesting a simpler alternate wording to that sentence, which would be the qualified physician must provide a well-rationalized explanation for his or her conclusions, period.

Our prior, we don't need to go through all the prior recommendations the life, we had

suggested prior alternate wording I think if it's a simpler wording that I'm hoping would be acceptable and that the DOL would reconsider for that one sentence.

That's not something we've voted on as a group but as I was reading over the DOL's responses to our recommendations, I thought this might be a simple improvement.

Does anyone have any comments?

CHAIR MARKOWITZ: Yes, this is Steven Markowitz.

In our recommendation, previous recommendation on that, we pointed out that the mechanism of disease was a problem. And, we recommended that the request of here quoting in our recommendation, quote, thus the request that the physician identify the mechanism of disease is not feasible and should be deleted, end of quote.

And, I think that's been rejected. So, we can raise the issue again in the event that, you know, perhaps the focus was on

something other than this word mechanism.

But, I think we can make a soft recommendation on that and then move on.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez.

The word mechanism is not defined here and you can go as deep or as shallow as you like in terms of how specific you get in the mechanism. Mechanism could just mean inflammation. Or it could mean allergic or irritant mechanism, or it could mean an IgE-mediated allergic mechanism with a specific molecule identified.

And, in many, in most cases of occupational asthma, the specific mechanism is not understood at the specific molecular level but it's understood that it's irritant-induced, or it's irritant-aggravated, or it's sensitizer-induced.

And, sometimes you can't even distinguish sensitizer from irritant, and that's agent specific.

So, I think that this would not be an impediment for diagnosing occupational asthma because you can just interpret mechanism to mean what's known about the mechanism for that kind of asthma.

CHAIR MARKOWITZ: So, can we agree on Dr. Redlich's suggestion that the minutes reflect that we advise reconsideration of the use of the term mechanism, but that we not necessarily make that into a formal recommendation since frankly, you know, it's been the subject of a previous recommendation.

Is that all right, Dr. Redlich?

MEMBER REDLICH: You know, the fire alarm has gone off in my building, so I am going to have to --

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: -- leave the building.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: I apologize.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: I just have the phone on mute so no one else has to hear it.

CHAIR MARKOWITZ: Okay. So, let us know when you come back or whatever, but I'll accept that as a yes.

(Laughter.)

CHAIR MARKOWITZ: Okay, any other comments, Dr. Redlich if you're still on the line about asthma?

(No audible response.)

CHAIR MARKOWITZ: Okay, so let's move on.

MEMBER FRIEDMAN-JIMENEZ: George Friedman-Jimenez again.

Maybe we could put in a sentence saying that mechanism can be understood as irritant, or allergen, or, you know, at that level. We can work on the wording but just put in a definition of mechanism that allows for our current understanding of occupational asthma.

CHAIR MARKOWITZ: Yes, but, this is Steven Markowitz.

But look at the sentence. It's quote, the qualified physician must provide a well-rationalized explanation with specific information on the mechanism for causing, end of quote, which means now that the personal physician has to not only specify that there is a mechanism, but actually name the mechanism, right?

So, I, I don't think that addresses the problem.

MEMBER FRIEDMAN-JIMENEZ: Well it has to know the mechanism is inflammatory in most cases and we can just say that that's the level at which the mechanism needs to be stated.

CHAIR MARKOWITZ: I just, I think it's a higher requirement of the personal physician who frankly, is, may not be all that well versed with any mechanism for asthma. It makes it tougher.

MEMBER FRIEDMAN-JIMENEZ: Okay.

CHAIR MARKOWITZ: Okay, so any other comments on this issue or can we move on?

MEMBER REDLICH: Yes, it's Carrie again. I'm sorry, now I'm outside with the noise outside but I think to be optimistic, I'm not sure that the DOL necessarily rejected our prior recommendation, but I think our alternate wording sort of included both items, the toxic substance and the mechanism.

So, I thought if we separated the two it would be clearer. Because it seems to be a relatively minor edit but the concern is if this, I mean for no diagnosing physician generally need to provide a mechanism.

And I think that just would sometimes hinder a physician providing, making the decision, the diagnosis.

I'm going to put my phone back on mute because it's noisy.

(Pause.)

CHAIR MARKOWITZ: So, okay, Dr. Redlich, are you still there?

MEMBER REDLICH: Yes, I am here.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: I'm just keeping it on mute.

CHAIR MARKOWITZ: Okay, fine.

So, maybe we should just formulate a recommendation here and vote on it. That's probably the best mechanism we have so to speak.

So, the proposal is that the procedure manual be modified, so in the relevant section regarding work-related asthma such that the following sentence would represent the corrected language. Quote, the qualified physician must provide a well-rationalized explanation for his or her conclusions, period. The strongest justification dot, dot, dot, dot, end of quote.

That's what you have on the slide there, Carrie, so would that suffice as the wording for a recommendation?

MEMBER REDLICH: Yes, it would.

CHAIR MARKOWITZ: Okay. So, that's my proposal and my motion as a recommendation. It needs a second.

(No audible response.)

CHAIR MARKOWITZ: Would anybody like to second?

MEMBER GOLDMAN: I second it.

CHAIR MARKOWITZ: Okay.

MEMBER GOLDMAN: I can second it, Rose.

CHAIR MARKOWITZ: Okay, fine. So now we're open for further discussion.

(No audible response.)

CHAIR MARKOWITZ: Okay, so the question is whether anybody's capturing the exact language of this. Kevin or Carrie Rhoads, can you let me know whether?

MS. RHOADS: Yes, Missy's opening document you might want to let her know what to type, that's fine.

CHAIR MARKOWITZ: Okay. Okay, so the recommendation, so shall I repeat it, Carrie Rhoads?

MS. RHOADS: Yes, please repeat.

CHAIR MARKOWITZ: Okay. Okay, so the recommendation is that in the procedure manual in

the applicable section with regard to work-related asthma, that in Item 2 mid-paragraph, new modified language conforming to the following be used to replace existing language, colon, quote, the qualified physician must provide a well-rationalized explanation for his or her conclusions, period. The strongest justification dot, dot, dot, dot, end of quote.

Okay, so that's the proposal we're going to vote on. Are there any, let me ask are there any other comments on this?

(No audible response.)

CHAIR MARKOWITZ: Okay, so I think Carrie Rhoads, we need to do a roll call because otherwise it will be chaos.

(Pause.)

MS. RHOADS: We're getting ready to do a roll call.

CHAIR MARKOWITZ: Okay.

MR. CHANCE: Are you ready, doctor?

CHAIR MARKOWITZ: We're ready.

MR. CHANCE: All right, bear with me

my first time through.

(Roll call vote.)

MR. CHANCE: Okay, that looks like a unanimous vote.

CHAIR MARKOWITZ: Did you get Ms. Pope?

MS. RHOADS: Yes.

MR. CHANCE: Yes, we did.

CHAIR MARKOWITZ: Okay, thank you. Okay, great.

MR. CHANCE: That's all yes.

CHAIR MARKOWITZ: Okay, thank you.

So, if we could remove this PowerPoint and we go to if you put up Markowitz PowerPoint, we can continue on slide 5.

So, this is I'm going to discuss asbestos now, and just to refresh your memory. Most of our recommendation was accepted by the Department of Labor on asbestos. The issue was, the pending issue was this list of, hold on, let me see if this is coming up here.

Okay, so we can, next slide we can go

through these. These are just excerpts from which there was agreement. Next. And, next. Basically industrial hygienist was given the task of deciding on the significance of the exposure.

And, okay, so the pending issue is whether there's a table that, a list that DOL has in the procedure manual. You're on the next slide I think it has the table.

So, these are the occupational titles, the job categories, that are presumed to have asbestos exposure. And, several of us, I think it was Mr. Domina and Dr. Dement and I went through five different DOE sites on the SEM and looked for additional job titles that we thought out to be included in this list, and so I provide some examples in the lower left here.

And, so and we were asked by the Department of Labor to, if we wanted to recommend additional job titles that we do the research and provide the published references supporting this, which is fine.

If you go to the next slide.

So, we haven't succeeded in doing that, we just haven't had the time to compile that list and to more importantly actually, to develop the scientific rationale, but we will and this will be presented in April at our next meeting.

But I want to point out just this is a publication from a couple years ago, so this is national mesothelioma mortality data from the U.S. over a long time period, 1999 to 2015.

And mesothelioma is the signal tumor related to asbestos, so it gives us an indication of job categories that we can safely presume have significant exposure to asbestos.

So, you'll see actually that many of the non-highlighted job titles here are already on the list. Let me point out that the middle column with the numbers is the number of cases, number of deaths in this database, and on the right is the relative risk of the, of the given job title.

There's some that are, titles that are

clearly irrelevant. Sailors, marine oilers is one, and I think there's another one but I don't quite see it.

But in any case, and then there are a number that are highlighted that aren't on the list, and these, this is just an example of the kind of information studies that we'll be pulling together to support modification of the list.

There are some titles here that we would favor adding, excuse me, some titles that have not made this list that we would favor adding based on other studies. These studies are never uniform in terms of identifying the V-set of occupations or industries with an increased risk for asbestos-related disease.

But this is the kind of information we'll be putting together for specific, a limited number of job titles in order to pursue this.

Are there any comments or questions? We're not going to make any decisions about this today, we just a commitment to do the work before the next meeting.

MEMBER MAHS: This is Ron Mahs. I think I'm up. I think I have six other occupations to add to the list.

CHAIR MARKOWITZ: I'm sorry, you have some more occupations to add to the list?

MEMBER MAHS: Yes, I believe I have six more.

CHAIR MARKOWITZ: Oh, yes?

(Off-mic comment.)

CHAIR MARKOWITZ: So, if you could send that to me.

MEMBER MAHS: I was going to before I left but then it just came up so suddenly so I had to wait till I go next week when I get off of this class.

CHAIR MARKOWITZ: Okay, okay, so right now the, Mr. Domina, Dr. Dement and I are the ones who are working on this. We would welcome additional people if you want, or if you have, you don't want to join the effort but want to send in information or ideas, just send it, send it to us and we'll use it.

MEMBER MAHS: I was on that list.

CHAIR MARKOWITZ: Oh, is that right? Okay, yes, Mr. Mahs' fourth, number 4. Thanks.

Okay, so let's continue. Dr. Dement, we're going to discuss the Occupational Health Questionnaire. Do you have a document or you want, I have excerpts from in my PowerPoint from there if that's helpful.

(Pause.)

MEMBER DEMENT: Let's use the Word file that I sent to Kevin this morning if you can pull that up, Kevin.

CHAIR MARKOWITZ: Okay.

MR. BIRD: Carrie, you guys have that file, correct? I think you were on the email.

MS. RHOADS: Yes, we do. Would you be able to provide me with the title?

MR. BIRD: It's just called, it's called Occupation of History Questionnaire as discussion. OHQ Discussion.

I see it as DOL ADTSWH Meeting January 27 OHQ Discussion.

CHAIR MARKOWITZ: Correct.

MS. RHOADS: Oh, here we go. Thank you.

MEMBER DEMENT: Thank you.

What I wanted to do in this discussion is just go over a bit of the history behind the occupational history recommendations that we're currently discussing.

The original board had a sub-committee, a working group, that looked specifically at the SEM, as well as the OHQ, and how these two were used on the claims adjudication process.

And, based on the work of this sub-group, the board adopted a number of recommendations at the April 2017 meeting.

If you can scroll up, please. I think I can do that. I have control.

And, among these were expansion of the list of toxic substances to include among other things, materials listed on the V-2 MediWorks history that have been used for about 20 years

now.

Include frequency of exposure, and that's just a rough from no exposure to having been exposed daily, to allow some worker generated free text to describe the circumstances or tasks related to the exposure.

And, we've been looking, had been looking closely at COPD and exposures causally related to COPD. And, we suggested adding some questions about vapors, gas, dust, and fumes, which collectively, provide the strongest relationship to COPD.

The original recommendations were pretty much rejected by the DOL and I put in, you know, on this slide, what the sort of a baseline come back was is the OWCP recommended, welcomed specific recommendations concerning modifications of a draft with a draft revised OHQ, which was apparently under development about the time the recommendations were being made.

We did review that draft in great detail and what we felt was that the new history

questionnaire is largely a pretext document whereby workers can describe the work and work circumstances, and exposures of the experience.

And, the board felt that recording pretext was good but it needed more structure to provide memory triggers to help claimants recall specific tasks and exposures.

It's certainly been our experience in the building trades program, that memory triggers are helpful.

In some cases as we've discussed, the board having co-workers discuss their exposures with them, that is knowledgeable for on-site work also was helpful.

So, the board went back to work. We had a working group of this board established in November of '18 and we went through the OHQ, the draft OHQ in a great deal of detail and we made specific recommendations with regard to changes that might be made.

Is there a next page to this? Okay.

And I'm not going to through all of

the, there was a lot of recommendations made. I'm not going to go through each one in great detail. I guess as we heard at the last board meeting, the DOL is developing another Occupational History Questionnaire. They plan to do pilot testing on it.

The board hasn't been provided with a draft of it yet but we're hopeful that many of our recommendations will be incorporated in the responses that had suggest many, if not most, of the recommendations that we made with this November 2018 committee are going to be incorporated.

There are some areas of disagreement or where we don't know exactly where that's going to go. We recommended actually that there be some broad categories of toxic substances and a list of specific substances provided in the current Occupational History Questionnaire.

As I stated before, the draft questionnaire that we looked at didn't have a lot of information that would allow claimants to,

would stimulate claimants to at least recall exposures, and we felt that that was not an advancement of the Occupational History Questionnaire.

We also suggested that, where there are direct disease links in the OHQ, that these substances really need to be added to the OH, to the Occupational History Questionnaire. If there's a direct disease link in the SEM, then that needs to be added to the OHQ.

The DOE response was that they really didn't want to add a whole list of specific materials. That is that would require the interviewer to read a long list of chemicals and require the interviewee to pick chemical names.

I think, you know, I think we in principle agree with a long list that read over a telephone interview, or even an in-person interview are not necessarily helpful.

But we do feel that the toxic substances that have direct disease links that have common exposures at the site, they are

commonly related to claims that we are having reviewed, for example the COPD, the lung diseases, those need to be specifically on the OHQ to stimulate workers to recall those exposures, if in fact, they had them.

So we'll have to wait and see what that looks like. You know, it may not be an issue but may be something for further discussion.

The other area of some disagreement was exposures related to COPD. The board, you know, we've been trying to deal with the relationship of exposures to COPD for, since the board started.

The strongest associations are not necessarily with any one toxic substance, but as a group of toxic substances commonly called vapors, gas, dust, and fumes.

In the literature, those exposures, those complex mixture exposures, provide the strongest relationship.

But, next page, please. But the DOE

response is that they didn't feel it was appropriate. And, you can read it here to how they, a linkage to a specific toxic substance and a disease in the, in the OHQ.

We're not really asking for that. All we're really asking for is that substances that are known to be related to COPD be added in the Occupational History Questionnaire.

These are common exposures, at least the ones in the literature, individual toxic substances in the literature that are related to COPD. And, also many of the exposures are related to other diseases such as pneumoconiosis.

So, I guess we'll have to wait and see what the list entails, you know, the new OHQ.

I guess that's pretty much, you know, what I have to say about it. You know, I guess it's, you know, it's encouraging that we should be seeing a new draft hopefully soon.

They are planning a pilot test of it. It would have been my desire to see the draft before it's pilot tested but I don't know that

that's going to happen.

Any other comments?

CHAIR MARKOWITZ: This is Steve Markowitz, I have a comment.

You know, I understand some of the point about not necessarily wanting to target one condition like COPD for drawing attention to particular exposures. But in fact, you know, when we looked at the approved claims or excuse me, the top 10 respiratory conditions under the data given by DOL, there were really just three or four dominant respiratory conditions which in and of itself, is a dominant category.

And it really is COPD, asthma and a couple in the pneumoconiosis, silicosis and asbestosis with pleural plaques in there.

So, it is feasible actually to list, to develop a finite list of target respiratory toxins which would provide more information about the dominant conditions that claimants submit claims for, and would make, frankly, the life of the claims examiner and the IH review, you know,

better informed and more straightforward.

MEMBER DEMENT: Well, I agree with you, that statement, and I think, you know, I think the list could be a rather succinct list. It would cover a vast majority of the exposures that we've seen related to these, these outcomes.

I guess the other issue with this, you know, we've specifically asked for each of the substances that the worker, you know, be provided and queried about the conditions under which they were exposed. Whether it's the task, the buildings, whatever they want to provide in a free text.

That can go a long way in terms of assessing the potential for exposure, as well as the possible exposure levels if that is paid some attention to.

The other sort of operational issue is here, I, and BTMed before the interview was actually done, the exposure interview, the work history interview, the worker is provided with a paper copy of the Occupational History

Questionnaire that does in fact, list these materials and tasks, and acts as a, more or less a guide for them to try to recall exposures before they come into the history interview.

I'm not sure operationally how that could be incorporated in the DOL procedures or if in fact, it already is. But it's a very helpful process for us.

CHAIR MARKOWITZ: This is Steve Markowitz. I have a question for Ms. Leiton.

So, what's the timetable for the draft OHQ being ready for us to take a look at?

MS. LEITON: This is Rachel. Last time I looked at it I thought it was pretty much done, so I do expect that to be available in draft form probably within at least the next few weeks.

So, I am, I don't, I think we are going to have the resource centers test it out, pilot it. I don't want to speak for John Vance's group to say exactly when they're going to start that pilot or our research center contractor

folks, but I do expect it before your next board meeting. I expect you to have the draft and at least to be able to review what we've done.

I do think we've incorporated a lot of what you're talking about here. With the latest slide, we're trying to put it into a format that will work well with our contractor's database so they can just enter the information.

But, the draft as I said should be available soon to you. Hopefully you'll be pleased with some of the things that we've put in there, while maybe not everything you guys have asked for.

I think it will be a better product and we'll see how it goes from there.

CHAIR MARKOWITZ: Will we see it before it's piloted?

MS. LEITON: I have to actually see what the exact plans are. I mean, I expect that you will be able to see a draft shortly. Whether or not we're not going to start the pilot before your next board meeting I would doubt that, which

is when you'd be able to vote.

We'd at least like to see how what we have is working out before we finalize it. So, if we were to wait for you guys, that would be April probably before we would, you know, see your comments, your additional comments and then, this can always be altered, you know, throughout as we go.

I'd like to be able to start to use something, see how it works, and then, you know, if you guys have comments after we provide you with the draft and you make recommendations based on those comments, we'll take a look at those and we can always revise it in the future.

But I would like to get it moving to at least see how this pilot goes, see what comments the resource centers have, what they receive from the public.

We can take all of that with whatever you guys come back with and revise it accordingly after the pilot, if necessary. Or as appropriate.

CHAIR MARKOWITZ: That's great, thank you.

Dr. Dement, anything else on this?

MEMBER DEMENT: No. You know, and I'm encouraged with the responses to our recommendations from the Department. You know, I, we'll see what it looks like but so far, I'm pretty pleased with the responses back.

CHAIR MARKOWITZ: Any other comments on the OHQ?

(No audible response.)

CHAIR MARKOWITZ: Okay, so we can move on, thank you.

Just very quickly, let me just say that this board and the previous board made a recommendation that the board be provided with some resources to assist in, in particular in claims review.

And, the response from DOL in December 18 is that DOL will confer with the board's chair to explore options for providing contractor support.

So, that's great and I'm ready to confer whenever DOL wants.

(Laughter.)

CHAIR MARKOWITZ: I look forward to that discussion.

Any other comments or feedback with regard to that?

(No audible response.)

CHAIR MARKOWITZ: Okay, so let's move on to the next one, and I think we can turn you back to Dr. Dement on the industrial hygiene reports recommendation that we made.

So, is this, this is another PowerPoint, another document, right, that --

MEMBER DEMENT: Yes.

CHAIR MARKOWITZ: -- this is the companion document that you sent Missy. Carrie, if you could locate it from the same email.

There you go.

MEMBER DEMENT: Okay. All right, I sort of went through the same, the manner as I did with the OHQ. And sort of going back and

looking back sort of the history of the board and where it's been with regard to some of the issues.

This specific recommendation was that the (telephonic interference) reports not consistently use the language that appear to, appears to assume the exposures after 1995 were within regulatory limits.

And, we, as we reviewed these claims I know I've seen it many, many times and it's nearly the exact same word phrasing, slightly modified in some circumstances to make it specific, but nonetheless, the same sort of fault pattern and rationale.

So, I needed to go back and look at, you know, where this came from. The first board reviewed the procedure manual and the associated circulars in a lot of detail, and one in particular was Circular 15-06, and had to do with post-1995 occupational toxic exposures guidelines.

And, it was both a circular, as well

as a memo, attached memo, and it went through sort of the rationale with regard to coming to the decision that exposures post-1995 were within regulatory guidelines.

And, I think the board recognizes, accepts that, you know, industrial hygiene programs at most of these sites certainly improved substantially in the mid-1990s after a lot of investigations and implementation of different programs and policies.

But the board did not accept that that was universally true of all exposures. At the October of 2016 board meeting in Oak Ridge, we recommended that this particular circular be rescinded, and on this slide I've shown you what our rationale was.

And, that is that there are a number of issues with regards to the basis. First, it's just sort of the data to support such a broad conclusion that all exposures would be within regulatory limits all the time, which is a pretty bold statement.

And, so the DOL responded back favorably. This is the DOL response. The committee communicated to us that they had rescinded the circular and I wanted to pick out one sentence that I think is key, and it says, this sentence sort of the third one from the bottom, it says: the circular was rescinded to avoid the appearance that any one cohort of claimants was held to a higher burden of proof than others.

And, so, you know, the board accepted that and as we started to review these cases, next page, please. As we began to review these cases, we saw this language which almost mimicked what was in this circular and in the associated memo, appeared in the industrial hygiene reports.

That is, and I just pulled this as an excerpt of one of the cases that I reviewed. There is no evidence that this personal area and industrial hygiene monitoring to support that after the mid-1990s this would exceed existing regulatory standards.

And, you know, while we accept that exposures decreased substantially during this time frame, it's hard to rationalize to come to the conclusion that all exposures would have met this standard.

And, so this statement appears and the cases, the many that I reviewed despite the fact that the document acquisition request produced no IH monitoring personal or area, and that, in most of the industrial hygiene reports that make the statement, there's nothing in the report itself providing data that supports a conclusion of exposures within regulatory standards.

So, we made again, that a recommendation that this not be included in the industrial hygiene reports, it's just a matter of just what appears to be just as a matter of standard practice.

And, I didn't put on this slide the detailed response. It said at least the Department didn't agree with our recommendation and there was about a four paragraph response and

I've summarized their major points.

And, they still maintain that in the absence of definitive monitoring data, it's not appropriate to assume a much higher toxic exposure would occur by a contractor, or either a contractor, or subcontracted employees.

It talks about exposures being significantly reduced during time frame which we certainly agree to. Next slide, please.

They also mention that, in addition to regulatory standards, the sites adhere to other recommendations such as the ACGH-TLVs, which typically are lower than OSHA PELs.

They also said that the IH assessments review all accompanying documentation, OHQ, the claims form, work statement, affidavits, IH records, et cetera, and will assign higher exposures based on, and I put this in quotes, employee descriptions of specific work activities or work processes.

And, so this is sort of the final statement in the, in their response back. Take a

position that unless there is definitive evidence of significant exposures past the mid-1990s, whether that's specific monitoring data or relevant information, it's disingenuous to apply industrial hygiene criticisms to make an affirmative finding of significant exposure.

And, I guess the response to that is that the board has never said that we want the DOL to assign significant exposures post-1995. So, I think that's a misinterpretation of the board's recommendations.

We're not recommending a presumption of exposures to toxic substance post-mid-1990, however, we are recommending that the presumption that all exposures were within regulatory limits also not be made by the (telephonic interference) in the IH assessments.

As I said in this one paragraph, that in nearly all of the cases reviewed by the board thus far, no industrial hygiene monitoring data provided in the DAR or in the IH assessments to support a definitive conclusion with regards to

exposures post-1995.

So, and I think this goes back and this sentence, I think, you know, the board's recommendation is I think consistent with the DOE's response when you rescinded the circular. You know, we see the possibility that it places individuals whose exposures were either largely or predominantly post-1995, it places those individuals at a higher burden of proof.

It also places them at a higher burden of proof to produce data, IH data, exposure data, which the claimant not only is not aware of and doesn't really have access to.

Next slide, please. That may be the last one. I think it is the last slide.

MS. SCHROEDER: That's correct. That's the last slide.

MEMBER DEMENT: So, the bottom line is we are not suggesting a presumption of significant exposures post-1995. We are suggesting that this statement not be placed into the reports without likewise supporting evidence

to make a negative exposure conclusion.

We are particularly concerned with regard to individuals whose predominant exposure was post-1995, and I for one, would like to, I would like to review some claims that were denied based on the lack of exposure post-1995 to see specifically how the data available to the IH is in fact, being used.

That's all I have to say about it. I recommend reaffirming the board's position with regard to this, specifically quoting the rescinding of the prior circular and memo.

CHAIR MARKOWITZ: Thank you. Are there comments?

(No audible response.)

CHAIR MARKOWITZ: This is Steve Markowitz. I'll make a comment.

This has a couple of I think areas of importance. Remember the CMC is probably keying in on the industrial hygienist report as their source, as their expert source of information on exposure.

It's unclear that the CMC is really going to go and look at the other sources of information on exposure that might be available even if the person, even if they're provided with it.

So, and there's, in a way it's understandable for the CMC to rely on the IH. So, when they see blanket language post-1995, that means they interpret there as being no, no significant exposure post-1995.

So, it has some practical, some real practical meaning.

Second comment I'd make is that if the gold standard is industrial hygiene data and it doesn't exist, then we don't have a gold standard. Then you have to rely on whatever additional information might exist, and the best source of that information is going to be the claimant.

And that's why we need an enhanced OHQ and a better, more frequent industrial hygiene interview.

In order to get that additional information in the case of industrial hygiene monitoring data, it's not going to be additional because most of that monitoring data probably doesn't even exist. So, it's going to be any data.

So, I'm just reinforcing what Dr. Dement says and I think I want to hear if anybody else has comments but frankly, I think we can just -- based on what we're looking at this document that we're looking at and just reviewed, that we could compile a response that it doesn't represent a new recommendation but it authorizes a sub-set of people on the board just to write a response to DOL summarizing these points.

Other comments?

MEMBER SILVER: This is Ken Silver. Dr. Dement suggested that a review of claims after 1995 might be illuminating. In particular, I think looking at claims from clean-up workers after 1997 might bring out the issues because a lot of the work in the DOE complex in the

mid-1990s changed over to clean-up projects.

And, if anyone is going to have their exposures measured, it would have been people going into chaotic environments with a large number of exposures, and working for contractors who supposedly were selected because of their IH and safety credentials.

So if we are going to review claims with denial, let's make sure we get some from clean-up workers.

MEMBER DEMENT: Yes, this is John again.

I think to me as a hygienist, if I'm asked to review a claim for an occupational disease for which there's a known relationship to an exposure, and the worker was there post-1995 and the OHQ clearly puts them in the category that would, would have the exposure, then I think this, this type of case really requires the industrial hygienist to dive deeper including perhaps a discussion with the, the worker themselves and how that exposure occurred, and

under what circumstances it occurred.

So, I don't know how that was being done before the new change to allow the hygienist to speak with the worker, but I'd like to, I'd like to see how that actually is, is implemented based on the DOL response back in this, in this letter.

MEMBER POPE: This is Duronda Pope.

I totally agree with Dr. Dement and Dr. Markowitz, as well as Dr. Silver. Having that IH interact with that worker is critical in building the case. And, extrapolating all that information that will help support that case being developed.

I think, without that conversation happening, you miss a lot of information which we've seen with so many cases that we've reviewed. But having that extra, having that piece in there in that process is critical in helping developing their case.

CHAIR MARKOWITZ: Other comments?

(No audible response.)

CHAIR MARKOWITZ: So, then the question is, okay, so do we agree that Dr. Dement can draft a response basically explaining what he's explained to us that we'll submit to the board without a formal recommendation, and we'll authorize him and a small set of people to do that?

Does anyone object to that way of moving forward?

MEMBER GOLDMAN: No objection.

CHAIR MARKOWITZ: So, now to the second issue that's raised is looking at additional claims.

And the question is whether we, we want to, whether we can come back to that a little bit later in the call and maybe someone while they're on the call can begin to formulate some language around that claim, around that request so that we're looking at language we can actually either vote on or agree upon as opposed to working it out right now.

What do you think, Dr. Dement, could

while we're dealing with other issues, do you think you could put together a language of a request for claims?

MEMBER DEMENT: Yes. I'll draft some language we can discuss later.

CHAIR MARKOWITZ: You know, so far we've seen they seem to key in on employment dates so post-'95 claims and maybe that translates into initial employment date post-'95. But in any event, okay.

So, fine, if you could work on that language then we can move on.

I don't know if any other comments on this issue?

(No audible response.)

CHAIR MARKOWITZ: Okay, thanks. So on the Webex you can take down that document.

So, next we're going to discuss the new board duties. Actually, if you go back, go to my, back to my PowerPoint because I've listed, I've snipped these.

Okay, go to the next slide. Okay,

next. Next, these are just -- next. Next. Keep going. Okay, next.

Okay, so here, so December 30, the December 30 letter from the Deputy Secretary DOL with language about the new duties acquired by the board as a result of congressional amendments to EEOICPA.

So, we need to discuss these. We need to understand them to see where this leads us in terms of what we discuss in the future.

So, the first is to provide advice upon the, quote, the claims adjudication process generally, including review with procedure manual changes prior to the incorporation into the manual and claims for medical benefits, end of quote.

And, in the December 30 letter, OWCP's plan is to submit changes to the board and publish those changes within 10 days. The board's recommendations are, quote, welcome at any time, end of quote.

So, two aspects of this. One is we

have a new task. We've had four tasks in the past. This seems to add a fifth task.

It's now on our website, to provide advice upon the claims adjudication process generally, which strikes me as a very broad, potentially very broad set of activities or area to, to look at.

Anybody have any thoughts about this?

MEMBER BERENJI: This is Mani Berenji. I actually agree with you, Steven.

I actually went through that letter and honestly, I think it's very vague. What does advice entail? And, how would, you know, the DOL reach out to us to seek that advice? I mean what's the process behind that? It's a little vague to me.

CHAIR MARKOWITZ: Yes. You know, the, I think the language frankly that came over from Congress is not, you know, very specific I think is the underlying issue.

I mean, I don't personally feel like we necessarily want to ask for further

specificity or definition at this point because it's not clear how you get to that specificity given the language we're looking at.

But I just want to set it out there as a challenge.

MEMBER SILVER: This is Ken Silver. I hope this isn't grandiose but what I take from the congressional language is that they have confidence in the work the board is doing, and they're hoping to expand our scope to include, well, what the language says, procedure manual changes, and things that really involve claimant interactions.

And, I don't know if it's an overreach but maybe involving us at an earlier stage to the process of changing the procedure manual would fulfill the intent.

I'm a little bit troubled by the fact that they'll publish changes within 10 days of submitting them to us. That doesn't give us a lot of opportunity for input particularly as, you know, volunteers with other things going on in

our professional lives.

So, we could ask DOL to consult with us earlier in the process of modifying the procedure manual and adjudication process. I think that will make our elected representatives happy.

CHAIR MARKOWITZ: This is Steve Markowitz.

So, you know, we, actually we had a real live example because we were provided yesterday with Bulletin 20-02, which is 69 pages of language, some of it new, for the procedure manual revising or maybe adding in relation to three chapters in the procedure manual and it's going to be published February 10. And, we were provided with it yesterday.

So, on a practical basis, you know, there's no way we can review it and make recommendations as a board within that 10-day period.

It's conceivable but not, by no means likely that even if the board were not to vote on

recommendations, that we would be able within 10 days to simply review the document and provide comments essentially as individual members of the board.

I'm not sure that that's all that useful to the Department frankly, and so I think the 10-day period is at best, awkward and realistically impossible for the board to make consensus comments on.

Now, I think the Department anticipated that because they further said that our recommendations are welcome at any time.

So I, you know, I don't know what the intent of Congress was when it said, quote, review of procedure manual changes prior to incorporation into the manual, end of quote.

To me it sounds like they wanted the Department actually to hear us and for it to have some impact on the changes before they were made.

So, the board only meets every three months. You know, and that three, every three months it's we alternate between face-to-face and

telephone meetings.

We could review a document in, within that three-month period and make consensus comments, recommendations about changes. But we need certainly a much longer time frame than 10 days.

And so by way of example, this new Bulletin 20-02, which we're not going to discuss today because it was given to us yesterday and it's 69 pages and so we can't have an informed discussion.

I think we're going to have to put into a committee to look at it and probably, frankly it's best if we want to make some consensus recommendations or comments, do that at the end of April meeting. You know, well past February 10. But I don't see what our choices are here.

Comments?

MEMBER BERENJI: This is Mani Berenji. I wasn't sure if there was any reference to any additional resources. Didn't seem likely but I

thought it might be worth asking.

CHAIR MARKOWITZ: And resources for what? What do you have in mind?

MEMBER BERENJI: Like, administrative support or at least someone who could help with, you know, doing some additional, you know, research and helping us actually put together the comments.

I mean, I usually in my practice, I dictate to a staffer. So, if there was a way where we could, you know, read the, you know, recommended, you know, change to the procedure manual, we could review it, we could have some way to provide our input via Dictaphone or some sort of transcription service.

I mean, would there be additional resources to be able to meet that really tight turnaround of 10 days?

CHAIR MARKOWITZ: Well, you know, I can raise that. The Department's supposed to confer with me about the issue of resources. So, I can add that to the task that we're interested

in, sure.

MEMBER BERENJI: Thank you.

MEMBER GOLDMAN: This is Rose. I want to go back to what you said, Steve. I think 10 days is not a reasonable time frame to review and confer on something this important.

CHAIR MARKOWITZ: Yes. It's not going to happen actually.

MEMBER GOLDMAN: Right, so I'm wondering if the response is, well, we think this is -- if we do think it's a good idea, we then we need X amount of time and if for some people X amount of resources or something. You know, but something along that line?

CHAIR MARKOWITZ: This is Steve Markowitz.

I agree, I think three months is unrealistic. I mean, I think the Department probably wants to move faster on procedure manuals than that and they should, right?

So, maybe it's not 10 days but three months is, and our limit is excessive, too.

So, that would require kind of a new, a new way for the board to work, at least on this specific issue. But it could be fashioned.

MEMBER REDLICH: This is Carrie Redlich. I think also that on something like the Bulletin or the new procedure manual, there may be, it may be many pages long but the relevant pages that we would want to review is probably a small number of those pages.

So, I mean, obviously we need more than a day or two, but I think something like a week or 10 days would be reasonable. And the, you know, and the way to give timely feedback.

It would be worthwhile that our feedback with them (telephonic interference).

CHAIR MARKOWITZ: So, you're saying that some members could review it within 10 days and then provide comments. We certainly couldn't get a board consensus around that. We could maybe get a subcommittee consensus around that, at best.

You know, we could use this new

Bulletin 20-02 as a test case. You know, the clock started yesterday.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: So, that said, by the way, let me ask Ms. Leiton. Bulletin 20-02, is there kind of a track-change version of it so we can actually identify the text that's changed in the procedure manual? Or, you know, the equivalent?

MS. LEITON: I think that's a Bulletin and Bulletins tell you in the whole content of it what the changes are.

And, so a transmittal is where we're actually making changes to the procedure manual right now. We're saying we're going to replace what the procedure manual says in this whole chapter.

So, I don't remember if this is a transmittal or a Bulletin.

So, in transmittals at the beginning of the transmittal we'll outline here's what all the changes are in the procedure manual that

we're making.

In a Bulletin, we're actually saying these are changes what we're making right now. They will be incorporated into the procedure manual at a later date. We are working on an update to the procedure manual for the spring, probably, time frame that will incorporate a lot of little changes that have occurred, or that we've had to make over the course of time that we, we see.

And, in that transmittal you'll see oh, here's all the changes including this Bulletin.

This Bulletin that you have right in front of you has to do with a realignment of our staff and centralization of preauthorizations for medical benefits.

And it's really, it's really it's outlining for them a process whereby instead of just having, we've centralized all of our home healthcare, now we're centralizing all of our preauthorizations for anything that requires a CE

to review it before we can authorize a service.

That's just adding a little bit more to the centralized unit. That unit has recently increased significantly. This Bulletin is critical in making that change so that they know how claims examiners are going to get those medical, those preauthorization requests to the right person.

And, a lot of our procedures are that kind of thing. We need to know what our process is for getting this work done, or shifting this work, or something like that. And, that's why time is of essence. And, it's critical that we can make these changes. Otherwise, our work stops.

So, you know, just so you understand, waiting months for the board to vote and be able to provide us with comments, particularly when it's something like this as an example, where we've already made the change internally in terms of our organization, now we need to give the work to the people that are waiting to do it. And,

this Bulletin outlines that.

So, to answer your original question, basically the Bulletins just say is telling you everything that's happening right there in that Bulletin. It's not necessarily change in the proceeding manual, where it is right now.

CHAIR MARKOWITZ: Yes, I'm looking at it actually. Steve Markowitz, and yes, it's described as updated chapters, chapter 2, 28 and 29.

Okay, so is there, so are there members of the board who would like to review this document and provide some feedback comments to the Department within the next 10 days?

MEMBER REDLICH: You're referring to Bulletin --

CHAIR MARKOWITZ: 20-02.

MS. RHOADS: Dr. Markowitz?

CHAIR MARKOWITZ: Yes?

MS. RHOADS: Just so while you're formulating this, I just wanted to remind the board that under the FACA rules, anything that's

done by a subcommittee or a working group, or a subset of the board, has to be presented to the full board before it can be presented to the program.

So, that doesn't necessarily have to be a meeting. I don't know, I have to ask if there's a way to do that other than by convening the entire board at a meeting.

CHAIR MARKOWITZ: Okay, so to clarify. So, if it's a committee of three and they agree on certain comments, they're not really formal recommendations but they're comments, then we wouldn't be permitted to do that?

MS. RHOADS: You can't give something directly from a subcommittee or a portion of the board to the program. It has to go through the full board first.

CHAIR MARKOWITZ: Okay. Okay, thank you.

So, we don't, that's not going to happen in 10 days. So, what we're going to do is to have a committee that looks at 20-02 in a

longer time frame and since we're welcome to provide comments at any point, we could develop recommendations if needed, and submit those comments at our meeting in April. And, that looks like the best that we can do.

MEMBER REDLICH: Yes, and I think from my review of this last night, it seemed that it's more in terms of the procedures of how things were working and not actually the contents or, you know, any of the medical decision making or that sort of issue. Just billing and other issues.

CHAIR MARKOWITZ: Okay. Okay, so are there, is there a subset of people on the board who would like, over the next I guess three months, to take a look at this document and, and come back with some description or a comment on any aspect that we might be helpful to the Department on?

MEMBER REDLICH: Steve, this is Carrie Redlich again. I just think our time may be better spent if there are going to be, let's say,

changes made to the procedure manual, or, you know, one thing we haven't seen since early on was the training materials that are provided to train people how to carry out what's in the procedure manual.

So, it seems like those sorts of documents would be our, you know, where we should, could best put our efforts.

CHAIR MARKOWITZ: Okay, so we're going to postpone then the formation of a sub-group to look at this particular document so we can move on and then we'll just, we'll figure it out. That's the best we can do at the moment.

It's 2:45, so can we take a 10-minute break and then resume at five of 3:00?

(Simultaneous speaking.)

CHAIR MARKOWITZ: Yes, don't hang up.

MS. RHOADS: Just put your phones on mute so you don't have to reconnect.

MEMBER POPE: Dr. Markowitz, I need to leave the meeting, Duronda Pope.

CHAIR MARKOWITZ: Okay, yes, okay.

MEMBER POPE: Okay.

CHAIR MARKOWITZ: Good luck.

MEMBER POPE: Thank you.

CHAIR MARKOWITZ: Okay.

MEMBER MAHS: Dr. Markowitz, it's Ron Mahs. I have to go also now.

CHAIR MARKOWITZ: I'm sorry, who is this?

MEMBER MAHS: Ron.

CHAIR MARKOWITZ: Okay.

MEMBER MAHS: Ron Mahs.

CHAIR MARKOWITZ: Okay, thank you. Take care.

MEMBER MAHS: Thank you.

(Whereupon, the above-entitled matter went off the record at 2:45 p.m. and resumed at 2:58 p.m.)

CHAIR MARKOWITZ: Let's see, we're still looking that this PowerPoint on the Webex. Let me just bring this up. Okay, could you go to the next slide?

Okay, so the next one is about this is

a new authorization. When the slide appears, it has to do with the board being able to communicate with the program medical director.

Does everybody -- let's see? Can you bring up that new slide or wrong thing here.

MR. BIRD: Dr. Markowitz, I think you should be -- everyone should be able to advance the PowerPoint to whatever slide.

CHAIR MARKOWITZ: Mine's not working.

Okay, here we are. Okay, fine, it's up.

So, okay, so we make available to the board the medical director of the program, toxicologists and industrial hygienist, and contractors when requested. And, the OWCP's plan laid out in December 30 letter is that we will submit questions and the specialist will respond to the questions and then --

MEMBER GOLDMAN: But, Steve, this is Rose. I'm not seeing that on the, on my version of the webinar.

I'm still on the other slide.

MEMBER BERENJI: I'm not seeing it either. This is Mani Berenji. I'm not seeing it either.

CHAIR MARKOWITZ: Okay, so now let me just while that's happening or not happening, I can just read it to you just so.

So, this issue has to do with new authorization to us, to the board, that the EEOICP medical director, toxicologists, industrial hygienist and the contractors when requested, will be made available to the board.

And, the plan as laid out by the Department to comply with this is that the board will submit written questions and the specialist will respond to those questions, and how to handle follow up questions will be determined later.

So, one thing I'm curious about actually, and Ms. Leiton if you're there, is all this a written interaction? Is that what's envisioned by the Department that we send in written questions and we get back written

responses?

Or, the alternative is could there be actually face-to-face communication at one of our board meetings?

MS. LEITON: So, the way that the Deputy Secretary wrote the letter was that yes, the first step in this process would preferably be, would be that there be a set of questions in writing to be addressed by the specialist so that they can be prepared to respond to what the questions, or the set of questions are going to be in advance.

They'd be able to prepare and they could respond to those questions and then if the board felt that there was still follow up questions that required further interaction, we'd work together to figure how that would, how that would go.

CHAIR MARKOWITZ: So, if we for the next board meeting, I don't know that this would happen, but if we developed written, send in written questions in ample time, might it be that

the medical director, industrial hygienist, whomever, would actually be at the board meeting and would give us verbal responses?

MS. LEITON: I believe the first step that they would respond in writing with the responses to those questions, and then if there were follow up, follow up questions from there, we'd determine whether it's appropriate for them to be at a full board meeting or whether it'd be appropriate for them to be a smaller group, or how that interaction would occur.

CHAIR MARKOWITZ: Okay, so it would be initially be back and forth would be in writing and then with the possibility of face-to-face communication later?

MS. LEITON: That's correct.

CHAIR MARKOWITZ: Okay, thank you.

So, I don't really see that we need to discuss this much. I think that if we accumulate questions for the named persons in this, in Item No. 2 over the next period of time, that we can collect those questions and submit them.

But we have a number of things we want to get done today so I don't really see opening up the floor to a general, to make a general list of questions, if that's all right.

Comments?

(No audible response.)

CHAIR MARKOWITZ: Okay, next slide and maybe I can do this. Okay here, so No. 3 can you all see this No. 3 or not really?

PARTICIPANT: Yes.

PARTICIPANT: I can.

CHAIR MARKOWITZ: Okay, anybody --

MEMBER BERENJI: I can't see it.

CHAIR MARKOWITZ: Okay, you can?

MEMBER BERENJI: Cannot. This is Mani Berenji.

CHAIR MARKOWITZ: Okay, fine.

So, the next one is that it simply says that the Department of Labor will respond to the board's recommendations in writing within 60 days of the date of submission, and that if the recommendation is accepted, a time line of

implementation will be provided. If it's not accepted, than a rationale and supportive medical or scientific research will be provided.

So, that's, that's great. Any comments on that?

(No audible response.)

CHAIR MARKOWITZ: Okay --

MEMBER BERENJI: This is Mani Berenji, sorry, I had a question.

CHAIR MARKOWITZ: Yes.

MEMBER BERENJI: So, in terms of how that actually will happen, does the DOL Secretary directly respond to you, or does he have to go through an intermediary?

CHAIR MARKOWITZ: I get, this is Steve Markowitz, I get a letter from them and when I get it, I ask Carrie Rhoads to send it to the rest of the board. You know, more or less right away. But that's the way it works.

MEMBER BERENJI: Got it, thank you.

CHAIR MARKOWITZ: Okay, next slide, Item No. 4, which I'm having a hard -- oh, here

you go.

So, this is blanket language that the board will advise the Department of Labor Secretary in other matters that the Secretary considers appropriate and that OWCP may provide the board with directives in the future regarding specific topics for its review and recommendations. So, that's what it is.

Any comments on this?

MS. LEITON: Dr. Markowitz, this is Rachel Leiton.

I do believe that there will likely be forthcoming some additional topics that will come from the Department for you guys to consider.

CHAIR MARKOWITZ: Okay, great. And we're hoping to get you the answers in all the previous topics.

(Laughter.)

CHAIR MARKOWITZ: Okay, so that's it for this agenda item.

Next on the agenda is review of public comments. I just have a couple of items that I

looked at that I wanted to raise quickly if others have also have items.

We got one public comment this time, it's on our website from Terrie Barrie, and raising an issue that we're not going to discuss now but it has something to do with the letter of medical necessity. I think it's part, maybe part of this new Bulletin 20-02.

So, when we get to look at that and if we have a comment to make then, then fine. The other issue that is raised in this public comment actually is something that we've raised before.

There's a part of the procedure manual called Exhibit 18-1. This is the matrix some of you may recall, that was devised in 2006 by Econometrica. Kind of a basis, I think, for some of the decision making in the program early on.

And, we've looked at this, board members have looked at this in the last few years and it's increasingly discrepant with other sections of the procedure manual.

So, for instance if you look at the

latency numbers that are latency periods that are indicated in, in this Exhibit, it's different from the new latency figures that were put in for asbestos.

It says that the COPD consideration is restricted to people who have never smoked, which is obviously not the program policy.

So, I don't know that we need an official recommendation of this, but it's a bit of an embarrassment I think frankly, that this Exhibit 18-1 is so out of sync with the rest of the procedure manual that I think you should take a serious look at it and either do away with it because most of it's been integrated into the rest of the procedure manual, or correct it.

I don't know if anybody else has any comments about that.

MEMBER REDLICH: This is Carrie Redlich. I agree there is just multiple inaccurate pieces of information in the tables.

CHAIR MARKOWITZ: Another public comment, it came in in December, it had to do

with the well-rationalized medical opinion from the personal provider and seemed to indicate that this was, it's a challenge for any number of reasons, but the particular issue that's being raised was, was whether there was an inordinate delay in, and the receipt of those letters from the personal physicians.

I don't know Ms. Leiton, if you all track that. You know, the underlying problem is that many of the physicians don't feel capable of providing that kind of well-rationalized argument because that's not what they do in life.

But regardless of the underlying problems, what was pointed out was that the delay ends up causing delays in the claims, in the whole claims process.

So, I don't know if you have any comment about that, Ms. Leiton.

MS. LEITON: I would have to look at the letter in context. I'm not sure. You might have it on. Is this the one from Terrie Barrie, or are you referring to a separate one?

(Simultaneous speaking.)

CHAIR MARKOWITZ: No, this is from Faye Vlieger back in December.

MS. LEITON: Okay, so I haven't looked at that specifically but if I guess your question is if the, are requests for letters of medical necessity causing delays in the home healthcare --

(Simultaneous speaking.)

CHAIR MARKOWITZ: No. No, no, it's not letters of medical. No, this has nothing to do with that.

MS. LEITON: All right.

CHAIR MARKOWITZ: It has to do with the request to the personal physician for a well-rationalized, you know, report.

MS. LEITON: But we, that's going to always be our first place to go is to the person's treating physician because we want to make sure that we're giving the claimants the opportunity to provide that from their own doctor.

Oftentimes if we have some sort of letter or an opinion from a doctor but it's not fully well rationalized, that's often when we'll go to a CMC to get further information.

But in terms of whether or not that's putting a delay in the process, I think we're pretty, our stats show that we're pretty timely in our adjudication of our claims.

So, this is something we've always asked for. It's something that again, it's an opportunity for our claimants to go to their own physicians instead of a lot of people sometimes say that we'll go to our doctors instead of their doctors and, and that's not a fair practice.

So, we always want to make sure that when we're asking for additional information that's medical in nature, that we'll go to them first. And, some claimants actually do have physicians that want to respond. We'll send them specific letters asking for specific information and we want to allow that time.

But again, we will go to a CMC, a

contract medical consultant to help us in those situations. We have very tight deadlines for our contractors to provide us with that information, so they do it pretty quickly these days, and again, I haven't seen, our statistics don't show that there's demeaning delays as a result.

CHAIR MARKOWITZ: Okay, thank you.

So, let's we're going to move on. I want to review the document that we got this morning. These were the DOL's responses to our information requests from our last meeting.

I don't have a PowerPoint on this but we're going to just walk through this and I think we can do it without any real difficulty, although I see there is a document here.

Is this what you've brought up, is this -- no, no, this is December 18. No, I'm talking this is the one that we got this morning, it's labeled DOL Response to ADTSWH December 23, 2019 Information Request.

So, if board members, if you got this by way of email this morning, this is, yes, this

is an attachment actually. That is part of the document that we're looking at on the Webex.

Okay, so the first item was that we had requested 20 lung cancer claims from, that has been denied under Part E from 2013 to the present, and that we wanted certain, the claims to meet certain requirements regarding the latency and job title. And, the response back is that, and we asked for it to be, the claims to be indexed.

The response back from DOL was that they couldn't do this. Their system doesn't permit them to retrieve these cases because it's very burdensome in terms of labor because it will require manual review of cases.

But here's my question. So this request grew out of a table that the Department provided to us having to do with -- okay, so on the Webex we're now looking at the request and the response.

But here's the issue. We were provided with a report 658 or it's listed in, I'm

sorry, 682 by the Department and the report 682, which we can't show because it has personally identifiable information, lists a large number of lung cancer claims that were denied from 2013 to 2019.

It lists their job title, predominant job title, and it lists their earliest date of employment and some other employment relevant date. So, and it lists them by name and by ID number.

So, it was from that list that we were requesting the 20, the 20 claims. So, what I don't understand is why this would require manual review to find these cases when the cases are simply a subset of that table that we were provided with.

And, I guess that's a long way of asking Ms. Leiton a question. You may not be familiar with the details so I get that, but of those 500 claims in that report, we wanted just 20 of them that met the latency and job title criteria, which are variables provided in that

report.

MS. LEITON: Are you sure that latency is provided? I know the earliest date of employment is provided. I don't know that diagnosis date is provided. Again, as you said, I don't have the report in front of me and other staff members did a lot of work on this particular request.

But my understanding is trying to get the latency period of 15 years --

CHAIR MARKOWITZ: Okay, well, yes.

(Simultaneous speaking.)

CHAIR MARKOWITZ: I'm looking at the report. It provides earliest verified employment start date, which is good enough for us as a latency date. And, we have final decision denied date.

So, you know, the first case, case X was denied November 2013, Hanford, earliest employment date was April 1974 and the person was an electrician. And, then there's diagnosis date.

So, you could use earliest verified employment date and diagnosis date frankly, for the latency. And, the job, the position title is in a separate variable.

So, I mean I'm happy that we can get all, you know, at a subsequent time to speak to whomever about the particulars here, but what we were, we were trying to create a simple request based on this table such that it wouldn't, wouldn't require a lot of work on the part of the Department.

So, you know, can I follow this up with a conversation with you soon, or whomever? John or whomever?

MS. LEITON: Yes.

CHAIR MARKOWITZ: Okay.

Okay, so back to the Webex. The next question we had for them was does Department have a guide for treating physicians on how to use the SEM, and the answer is no but that there are resources available on the SEM online that if the physician wants, wants to go there.

Offhand I don't know how user friendly they are for the physician, but that was the response.

So, the next item we requested, the next page --

MEMBER GOLDMAN: This is Rose, could I ask you a question about that?

CHAIR MARKOWITZ: Yes.

MEMBER GOLDMAN: On the use of the SEM, are you talking about it for the treating physician or that consultant physician?

CHAIR MARKOWITZ: The treating.

MEMBER GOLDMAN: Consultant physician?

CHAIR MARKOWITZ: Yes, the treating was the.

MEMBER GOLDMAN: The regular treating physician I mean, is really going to go and try to look through this SEM? I mean more likely the treating physician's going to look at the questionnaire, you know, about what the person says they were exposed to, rather than try to use the SEM.

I could see it as the consultant, you know, being expected to use that but a treating physician to just say what's wrong with their patient? I think that's probably not likely, do you, somebody in their office?

CHAIR MARKOWITZ: Yes, I would agree with you. I think it's probably the uncommon physician who's going to have the time and interest to delve deep into the SEM --

MEMBER GOLDMAN: So --

CHAIR MARKOWITZ: -- but.

MEMBER GOLDMAN: -- I think that that might be a question to ask with this new questionnaire that you're, that's being developed. If, that might be something easier for a treating physician to look at, which is if somebody that says they're an electrician.

Now if you add any of these possible exposures, or for the request to the physician who's writing a letter on behalf of their own patient to say, you know, your patient has these potential exposures.

But I just think this is unlikely. We ought to figure out another mechanism that you really want the treating physician to make that kind of commentary.

Anyway, that's my two cents on that.

CHAIR MARKOWITZ: And, so Ms. Leiton, is it possible for the treating physician to get a copy of a completed Occupational Health Questionnaire?

MS. LEITON: Well, that would have to come through, it would likely normally come through the claimant. The claimant can give him a copy of that.

If they specifically ask us for it, I believe that we have, I would have to look at all the privacy act issues --

CHAIR MARKOWITZ: Right.

MS. LEITON: -- and stuff like that.

We usually give them our, well, we try to give them our assessment that after we've gone through the SEM and all the OHQ, and the documentation that the electronic exposure from

the IH, all of that, will go, often go to a doctor if we're asking a specific question about causation. Or we'll say these are the, you know, here's what we have determined they were exposed to.

As for the OHQ, I don't think that there's a bar against it but I don't know number one, that it's been asked for, or number two, whether there are other reasons why we wouldn't give them the exact OHQ itself.

CHAIR MARKOWITZ: Right. Does the claimant, this is Steve Markowitz, does the claimant get a copy of the OHQ routinely?

MS. LEITON: A lot of times they'll get it if they ask for a copy of their case file. If they want a copy of it, we can provide it to them at any time, they're welcome to it.

I don't know that we routinely send it back out but often times at the resource centers, especially if they walk in, they're sitting there completing it with them. See what they're completing.

If it's over the phone, if they're on the phone with them I don't, you know, I would have to check and see how often the claims examiner asks after that can you please send me a copy of what we've recorded here. I'd have to look into that a little further to see how much, how often that happens.

CHAIR MARKOWITZ: Okay. Other comments?

MEMBER SILVER: This is Ken Silver. I think based on something Rose Goldman said, these resources might be used if they were nested within another educational resource aimed at physicians who are writing letters for a resource that provided guidance on what DOL is looking for in those letters, and the factors to weigh.

And, the doctor who was presented with that educational resource might take the deep dive and poke around in the SEM and the procedure manual.

I can't remember, is there a program educational resource aimed at doctors who are

writing letters?

MS. LEITON: I'm not sure if that was, this is Rachel, I'm not sure if that was for me or not.

(No audible response.)

MS. LEITON: Go ahead.

(No audible response.)

MS. LEITON: Okay, well I think your question had to do with whether or not there is an educational program aimed at physicians.

What we do do a lot of outreach towards the medical provider community around the country. We will go out and talk about what our procedures are, what our requirements are, we go into pretty deep, deep dive on that.

We're doing one of them in fact, in Santa Fe and in the end of February where we send out letters to providers that we, that we have lists of and they'll come to these events, and we publicize these events, that sort of thing.

We also have an email blast that we send out to subscribers who want to know more

about what's going on in terms of the medical requirements aspects of the work. And those will go out monthly. You can subscribe to those online.

So, those are the kinds of educational activities that we are involved with with regard to the medical community.

CHAIR MARKOWITZ: Okay, thank you.

Other comments?

(No audible response.)

CHAIR MARKOWITZ: Okay, so next I think we're looking at these Item No. 2, how many, we asked how many public submissions were there to the SEM in 2019 and what was the outcome.

And, you can see them, there were 32 toxic substance inputs in 2019, and eight disease inputs. And, you can see the fate of these inputs in that some of them were of a toxic substance says 32, eight of them were accepted, five were already in the database.

And, others were either not verified

or classified as requests for information only.

And, of the eight disease inputs, none of them were accepted. One was already in the database and five were, couldn't be verified.

So, that's the answer to our question.

If there are no comments I'll move on to No. 3, which is in the last two years what change has been made to the SEM regarding exposure disease links. And, if you could go to the last page of this letter, there's a table that gives you details. Keep going. Next, okay, there you go.

So, I can summarize this for you in that there are 32 items, actions taken. In 22 instances some disease exposure link was added, and in 10 circumstances they were deleted.

And a lot of the additions were around pneumonitis, and some of them, other ones related to infection. Adding Lyme disease, adding Hepatitis B and liver cancer, for instance.

And, then of the ones that were removed, there were 10 and some of them were also

pneumonitis, and a couple of them were acute toxic effects of solvents.

So, you get a sense of the level of activity of the exposure of disease linkages.

But it just, while we're looking at this for a second, Ms. Leiton, who actually is the one that identifies these to add to the set?

Does this come out of Haz-Map and then you all bring it up from Haz-Map into, into the SEM, or is it done internally within your department?

MS. LEITON: We have, our contractor does a lot of the research that goes into this. This is looks like these are the disease changes.

I'm not sure if this is just what was added as a toxic substances or if these are all effects from. Are these all effects or if these, these might just be indications. Yes, these are the links. So some of them would come from the Haz-Map database.

CHAIR MARKOWITZ: And some would come from Paragon, right?

MS. LEITON: Well, Paragon will do the research for them, yes. A lot of times we get this from various sources.

We can get it from NIOSH will uncover some information that then will come to us and we do additional research. They obviously don't do the toxic links, they will do the actual toxic substances that they might have found.

But the links will go through Haz-Map normally and if not through Haz-Map, then it's something that we've made a polity determination on here.

But they all come through the national office before they're added to the SEM through the federal, through our federal staff.

CHAIR MARKOWITZ: Okay. Thank you.

If we could go back a couple of pages to Item No. 4, we asked how many CMC reports were issued each month in 2019. We just wanted a sense of the volume.

So, it's you can see it's quite numerous. I added it up, it's about 2,400 CMC

reports per year, or at least in the most recent year.

And, I think John Vance told us there's something in the order of 7,000, 8,000 new claims per year, or new cases or claims, I'm not sure.

So, it gives you a sense of what proportion gets CMC reports. A rough sense. But that's a, there are a lot of CMC reports in the, being developed.

Comments or questions?

(No audible response.)

CHAIR MARKOWITZ: Okay, the next Item 5 is an update on something we, this is just the status of reopened cases from changes that the program made in part as a result of board recommendations.

And, if you look at the orange one on the left, that's the total for all the district offices and you can see that 50 were reopened out of a total of, well, that's your lung cancer. There's about 100 are reopened out of the total

of about 2,000. And, with the status on the bottom left. We've seen this chart before.

Item 6 is the, we asked about pending claims, which is an item found in the top 20 health conditions and we just wanted to know how long they'd been pending.

And, turns out that's a very complicated question, which the Department isn't able to answer because there are any number of sort of decision points, time, time periods. And, so they wanted us to develop a more specific question to answer that.

I'm not inclined to pursue that although I'm open to doing that if there are comments, or.

(No audible response.)

CHAIR MARKOWITZ: Okay, and the next page, and this is we asked to have the quality assessment evaluation conducted on this.

So, just to summarize here, so the, there are federal industrial hygienists, a few in the national office. Correct me, Ms. Leiton, if

I have this wrong.

There's an industrial hygiene contractor named BGI. The IH contractor does the IH evaluations which are reviewed internally by a program manager and corrected for certain requirements of the contract and consistency.

Those are sent to the national office and then the national office federal industrial hygienist then looks at it and checks it for scientific technical accuracy and consistency. And, so that's how quality assessment is done.

We're going to discuss this more in a few minutes but go ahead.

MS. LEITON: That's correct.

CHAIR MARKOWITZ: Okay. Comments?

(No audible response.)

CHAIR MARKOWITZ: We're going to talk about our own ideas for IH assessments so.

Before we get to that I just want to go back to my PowerPoint. I just want to raise one item that I thought was of interest. If you could advance that. I can't do that here.

Keep going. Keep going. Okay, we just reviewed that. Next. Okay.

Just, yes, we submitted this, oh, I'm sorry, go back. Go back. Go back one.

Okay, just this is a recommendation from our last board meeting just to remind you that having to do with site wide job titles. Okay, next slide.

So, this is for the we have a working group that will, is continuing to work on authoritative sources for use by the Department in improving updating SEM.

And, this grew out of a review of the SEM program by the IOM and Student Medicine in, I think it was 2013.

And, we don't really have an update but we will by April on which sources to use, but here's a question I have for that group and for the board as a whole. Next slide.

So, if you look at the language of the Act, as least as likely as not that the exposure to a toxic substance was a significant factor in

aggravating, contributing, or causing the illness, my question is when you look at IARC classification of carcinogens, next slide, we have Group 1, which is definitely carcinogenic, and we have Group 2A, which is probably carcinogenic.

And, so the question is whether Group 2A carcinogens meet the standard from the Act, at least as likely as not aggravate, contribute, or cause. And, that's a question I would put to the, to the working group.

The IOM review doesn't address this head on. Can we go to the next slide, and just give you the details from the IARC classification, how it is they decide something's a Group 1 vs. a Group 2. Set aside Group 1, those we all agree. It's after definite human carcinogens.

Group 2A, there are several ways you can become a 2A carcinogen. One is to have limited evidence in humans but sufficient evidence in animals, and then you can read for

yourself the other combinations.

Regardless how you get there, the conclusion of IARC is that this is a probable human carcinogen.

So, if you go to the next slide, I think it may be the last of the -- next one. Sorry.

So, there aren't that many 2A carcinogens around. We've got 80,000 chemicals in use throughout the U.S., about 1,000 have been evaluated by IARC, next slide. Of those 1,000 evaluated by IARC, half of them, the yellow, IARC couldn't classify because there's not enough during the studies. So, we set those aside.

Group 1 carcinogens, 120 are labeled as definite human carcinogens. Another 83 is Group 2A. And, so, these are on the next slide.

What's the practical significance of this question? There's a Group 1 for lung cancer and I looked at the SEM and as far as I can tell, the SEM addresses most or all of these. I didn't look through every last one but I looked through

the main ones and I didn't find any.

Group 2A, currently the SEM does not to my knowledge, appear to address these as lung carcinogens. Some of these agents here you might be a little surprised to find.

Benzene is a probable human lung carcinogen. Dioxin, which is 2, 3, 7, 8-Tetrachlorodibenzo-para-dioxin, the last one on the list, is a probable human lung carcinogen.

And then there's some other which are probably not relevant to DOE, a bunch of them actually.

So, but my question really for the working group on this is should 2A carcinogens be included in the SEM as exposure disease links?

Any comments or thoughts about this?

MEMBER BERENJI: This is Mani Berenji.

So, I'm actually heading this work group. I honestly feel that, you know, we need to look at the IARC in more detail and then compare to the other data sources that the DOL is currently referencing, which I believe is

Haz-Map.

Rachel, feel free to correct me if I'm wrong, but what is your main source, at least according to the procedure manual when I last checked, I believe it's still Haz-Map.

(Pause.)

MS. LEITON: I'm sorry, was this a question for me? This is Rachel.

MEMBER BERENJI: Yes, this is Mani Berenji. So, I just wanted to clarify what's in the procedure manual in terms of what the SEM, at least from my understanding of the procedure manual, I'm trying to find the exact reference but looks like most of the information that's in the SEM is based on the data from Haz-Map? Is that current? Okay.

MS. LEITON: So, it is but a lot of that the Group 1 from IARC are all in Haz-Map, at least that's my understanding. And, we use the Group 1.

Group 2A is a very good, I would suggest that that's a very good place to start

with regards to what more could be added, or how exacerbation and contribution play into Group 2A.

But yes, the majority we do have others that we've added in terms of that we've made policy determinations on that we have Bulletins and such for in terms of what, where there's a connection and that, those sorts of things are added into, to the SEM.

But SEM's always been a causation link that we've said these are really more causation that exacerbation. But thinking in terms of exacerbation and aggravation is probably beneficial.

MEMBER BERENJI: Thank you.

CHAIR MARKOWITZ: Other comments?

(No audible response.)

CHAIR MARKOWITZ: Okay, so let's move on. If you could go forward with the PowerPoint here.

The next issue has to do with assessing the quality, objectivity, and consistency of the industrial hygiene and the

physician input into the program. This comes directly from our charter. Next slide.

Now let's talk about the M.D. evaluation. Next slide. So, this is from the minutes just to refresh your memory.

I had looked at, so the medical director of EEOICP reviews a certain number of claims every quarter and looks at them for quality basically.

And, I've summarized here in the highlighted that I looked at the most recent five quarters, this is as of last November. I evaluated about 250 claims, 100 of them for impairment, and 28 of those were described as needing improvement.

Eighty-three claims were for causation, one needed improvement, and the remainder of the 60 claims which were different types, about a quarter needed improvement.

So, from the current quality check that the program does, there are a couple of things here. One is that the at least for that

time period, 28% of the impairment evaluations requiring improvement is pretty high. Of the 60, 25% required improvement, that's also pretty high.

On the causation front, only one required improvement, that's clearly an outlier compared to the others, and given our own review of claims, my hunch is that the evaluation of the causation argument in those claims is not, is not complete is my hunch from our own look at claims.

But anyway, that's just describing what the program does at present.

Any comments on that?

(No audible response.)

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: This is Carrie Redlich. Can we have a better idea about what aspect was considered needing improvement?

CHAIR MARKOWITZ: You mean on the impairment?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Yes. I didn't track

that so I can't, and I did the work several months ago so I can't tell you. I can't recall offhand what, what the dominant problems were.

Okay, next slide.

So, I looked at the CMC contract, so the name of the company is QTC, I think. Ms. Leiton, is that right?

MS. LEITON: Yes, that's correct.

CHAIR MARKOWITZ: Okay. So, the contract is QTC and they have a contract that expires at the end of 2021, it's a five-year contract. So, they're beginning the fourth year of that contract.

And, let me just ask actually Ms. Leiton. What's the time table for reissuing that contract? I'm thinking in terms of if the board wants to provide input into quality assessment that may eventually impact what the RFP looks like, what is the, how soon would the board need to do that?

I mean, in other words, the contract still has two years to go, so understood it's

there's some time.

MS. LEITON: Yes. I would probably not be the best person to answer that question because I'm not familiar with all of the contractual rules.

That does take some time for us to develop new proposals, language, RFP and there's a timetable the Department has to go through, so it's usually a good fair amount in advance but I hesitate to give you an answer on that. We can get back to you.

CHAIR MARKOWITZ: Okay. Okay, yes, that would be useful because you know, it would be nice to know that A is that our work while I'm thinking about this might actually be used, but B is what the time frame is because it takes a little time to figure this, figure this out.

But so I've taken some excerpts from this contract and there's training required for the CMCs. I think we had some question about that in the past. Next slide.

Either the Department of Labor or

QTCcan disapprove physicians in this program, and I think that has been done to some extent in the past. Next slide.

And, so here's what the contract obligates QTC to do with reference to quality control. So, this is separate from what I described before as the program medical director.

And, you can read some of the language there about conforming to the requirements of the program. Doesn't really get into the nuts and bolts but that the contract will be evaluated, their performance, in accordance with certain performance standards. Next slide.

So here I think is little bit more informative. Performance requirement, summary of performance objective on the left, and the standard is that the report from the CMC has to be complete, offer well-rationalized opinion, unequivocal. That's rough. And, ensure the proper forms are filled out and they use the AMA Guide.

The performance threshold is that no

more than 5% of the medical evaluations will need clarification, correction, completion, or re-performance. And, that the contractor is supposed to as a method surveillance, do periodic evaluation of reports weekly, monthly, quarterly reports and handle complaints from the program.

On the face of it, this no more than 5% requiring correction seems to be a lot lower than the 25, 28% that the program medical director found in the latest five quarters.

So, I would ask for the clarification not on this call but in general from the program about what, what this means.

Actually, we would like to see the products of the method of surveillance, which is the periodic evaluations that are obligated of the contractor to understand better how that jives with the performance evaluation that the, that the Department's own medical director does. If that's understandable.

Anyway, people have some comments about this?

MEMBER BERENJI: Yes, this is Mani Berenji, and I actually agree with you 100% Steven. I really feel that there needs to be some sort of, you know, process by which they have some sort of automatic auditing every quarter, or every six months. And, this 5% number is a little disturbing, quite frankly.

And, then that begs the question, you know, is there some sort of when, where, DOL can actually, I'm sure they have something but how do they systematically track contractors?

I mean, is there something already set in terms of, you know, periodic evaluation, are these folks meeting their metrics? I mean, there's got to be some sort of internal process that we just don't know about. I'm not sure.

MEMBER GOLDMAN: This is Rose. I agree with that. Like, what are their internal metrics and if they say 5% maybe they're not really putting forth critical metrics, or that they're reviewers don't have the same either expertise let's say, that you brought to it when

you reviewed it and thought the 25% needed improvement.

So, there's a whole lot that needs further evaluation both the criteria and who is the one actually doing the review of the cases, and on what criteria?

CHAIR MARKOWITZ: Just so, this is Steve Markowitz. Just unless I misheard, the 25% was not mine. That was what the program medical director found in the miscellaneous cases. And 28% were --

MEMBER GOLDMAN: Oh, well that's even worse. Then their own person is finding 25% when they're only supposed to have 5% is what you're saying.

CHAIR MARKOWITZ: Yes, if we're dealing with apples, comparing apples with apples, yes. You know, I don't, I don't know.

MEMBER GOLDMAN: Oh. Well, we still need to know what their criteria are but clearly then what's the remediation if they're applying their own criteria and find that 25% needed

improvement? Then what happens?

MEMBER DEMENT: Hey Steve, this is John. One slide up, didn't it require that the contractor develop a QC plan? Have we ever seen that?

CHAIR MARKOWITZ: What kind of plan?

MEMBER DEMENT: Quality control plan.

CHAIR MARKOWITZ: We, I don't recall seeing.

MEMBER DEMENT: Track quality. Yes, have we ever seen anything in writing on what that really is? I don't recall seeing anything.

CHAIR MARKOWITZ: Yes, I don't recall.

MEMBER REDLICH: This is Carrie Redlich. I think we had seen some data in terms of the timeliness of the reports but not an evaluation of the, the content and the decision making.

And, so I think the challenging question is review of the decision making. Because I think we, those of us that have been on the advisory board now for several years have

reviewed enough of these cases that, you know, while some were adjudicated properly, we feel that, you know, that we've come across a number that there's a problem.

And it's, you know, we've identified several steps where the problem could be but we have identified specific CMCs that we really questioned their competency, and they seem to be continuing to adjudicate cases. Or I mean, be sent cases to --

CHAIR MARKOWITZ: Right.

MEMBER GOLDMAN: -- provide an opinion on. And, so that is concerning.

MEMBER DEMENT: This is John again. This quality control section 6.5 says that the government has to approve of the contractor's QC plan. I guess I'd just like to see the QC plan. What is it?

MEMBER GOLDMAN: That's a very good point, John.

MS. LEITON: This is Rachel. I believe we responded to these, this line of

inquiry with regards to what we can give out from the contract. There are certain proprietary interests that we can't violate. There are certain contractual obligations that we have through the contractor.

And, so some of these things that, and I believe you have asked for them before and we've had to tell you that there are contractual reasons that we're not allowed to give them out.

I'm just making that as a blanket statement. I'm not saying individual inquiries so like, you know, it might vary depending on what you're asking for. But when you're asking for contractual things that are proprietary to the contract, there are issues.

CHAIR MARKOWITZ: All right, this is Steve Markowitz and I recall that response.

(Laughter.)

CHAIR MARKOWITZ: But maybe there is some information we could get. For instance, these results of the method of surveillance, and the like.

But here's my question. We've looked at a number of claims and a lot of the CMCs are fine, and there's some subset that, you know, we don't agree with their evaluation.

We don't, I don't see any evidence that the program's medical director is finding much problem with the causation in the causation front, which frankly, is the primary thing we looked at, adequacy of medical evidence and causation, not, not impairment.

So, if we had to design a quality program, assessment program for the CMCs, how would we do that and what would it look like?

(No audible response.)

CHAIR MARKOWITZ: And, I'm talking about the content of the evaluation, not timeliness or their credentials, or, you know, other things that you're probably already pretty well addressed.

MEMBER DEMENT: Steve, this is John. I suspect it will be exactly what we're doing and that's reviewing a, a sample of each CMC's

reports and recommendations. I don't know if that helped.

CHAIR MARKOWITZ: Yes. So, the program would identify some expert resource to review a sample of claims and look specifically at the issue of, of the content of how good the CMC evaluation is.

MEMBER DEMENT: That would be the most appropriate way to do it, and that will require some resources to get that done.

CHAIR MARKOWITZ: Is it adequate to have the, a single person who is the program medical director do that, which is the way it's set up now? Or is it, would it, should it be a resource that has a little more distance from the program, or maybe a different set of skills?

I don't have a predetermined answer to that. I'm just trying to tease out elements that, of, you know, potential advice.

(No audible response.)

CHAIR MARKOWITZ: I mean, should there be a different contractor, a much smaller

contract, but different contractor that, that looking specifically at the issue of, of the quality and consistency of CMC reports?

MEMBER DEMENT: You know, I think there should be some sort of peer review. And, peer review should be outside individuals who have the expertise and speciality to review the cases.

I think, you know, I think some level of peer review is needed.

MEMBER BERENJI: This is Mani Berenji. I agree with John, there needs to be some sort of independent entity that doesn't have any sort of, I wouldn't call it biases but can maintain that neutral stance.

CHAIR MARKOWITZ: But the, why can't, again, I'm asking questions to try to tease out the issues.

Why wouldn't if you had all that expertise in-house, say in the medical director, is there any built in conflict of interest? Is there any built in problem with having that

person do it? Or what's the rationale for having an independent entity do that?

MEMBER GOLDMAN: Well, this is Rose. I think there is I mean, two situations. I mean, if you look at a lot, most programs or even a hospital, you have your internal quality control. And, you do all of those things, right, in a hospital?

And, then you do have at certain points in time, an outside agency come, you know, the, to now inspect and see that you're doing the right thing.

So, that's a model that is out there and also for educational programs the same thing is true.

I don't know if that applies to this type of work and assessment but it is certainly a model that's out there in at least those two realms.

MEMBER REDLICH: This is Carrie Redlich. I agree that I think it would be in everyone's interest to have an external group

review the quality.

You know, and I think we found that in a number of case, we agree with the decision making but I think it's, it just leaves the Department of Labor up for criticism if it finds that it, that they, you know, agree. It, you know, provides more objectivity if it's an external group.

MEMBER GOLDMAN: I think you need both. And, I think we need to see the particular criteria and since there was greater concerns about problems with the causality approach, then maybe that would be something more specific that would be looked into in terms of what was the process for determining causality or exacerbation then.

And, if that was an area that was particularly problematic, then maybe there would be even greater focus on, on that. For the external, if there was an external organization.

CHAIR MARKOWITZ: I do think, you know, from an occupational medicine point of

view, Steve Markowitz, that to expect a single individual to be, have a broad enough set of knowledge to cover with all the areas encompassed by the program, is stretching it.

That, you know, generally within occupational medicine we occupy niches. And, I'll be frank, I'm not very good at impairment. And, so you wouldn't want me to be the person who judged the quality of impairment ratings.

And, in that sense, given the limited resources in-house at the Department, then one advantage to an external entity is that they could draw on different experts who could look at specific issues. Say, beryllium. Say, cancer. Say, impairment. You know, causation, et cetera.

MEMBER GOLDMAN: So, this is Rose again. Is it only one person who does all the quality control, and is that from the contractor or from the Department of Labor?

CHAIR MARKOWITZ: Well, the, let me give you, this is Steve Markowitz, a partial answer and Ms. Leiton can correct me.

There are two levels. The contractor does its own quality assessment and what we've looked at on the PowerPoint is some of the elements of the contract from Department of Labor, the requirements of the contractor. We don't know exactly what the contractor does or what the performance level is. So, that's one set.

The second is within the program, there's a medical director who on a quarterly basis, looks at a certain number of I think it's 50, 40 or 50 claims of different types, from different locations, and then makes that assessment.

And that was my summary earlier in the call where I said that, you know, 25 percent of the impairment evaluations he judged to be needing correction. You know, 1 percent of the causation evaluations and, you know, whatever.

So, it's those two separate activities. The --

MS. LEITON: So, this is Rachel.

CHAIR MARKOWITZ: I'm sorry.

MS. LEITON: Is it okay if I jump in?

CHAIR MARKOWITZ: Sure.

MS. LEITON: So, we do have, so the QC process for the contractors is they have to QC just about everything. So, you're talking the 2,500 cases that go to CMC are being looked at. That 5 percent's related to that, I believe.

The 50 cases that doctor, that our medical director reviews every quarter are 50 cases and so, I mean, he gets different kinds of cases in each set.

Impairment is always going to be something that is a little bit more, well, it's subjective but there's a lot of detail involved in that. And, some of those affect the outcome and some of those that he finds don't necessarily affect the outcome but could have been done slightly differently.

That being said, whenever a CMC report goes to our claims examiners, they review it also for thoroughness and for, to determine whether or

not it's answering the questions that we'd asked. They'll go back for follow up. It won't pay a bill if the report doesn't contain it needs to contain.

Those are all done at the claims examiner level. Now granted, they're not doctors but they do know what they're looking for in reports.

So, there is another layer in and of itself right there to determine whether or not the report is at least meeting the requirements that we need it to meet for the Department to move forward with a decision on the case.

So, those would be right now the levels of review that it undergoes outside of whatever internal processes they have in the contract.

MEMBER MIKULSKI: This is Marek Mikulski. Very briefly, do we actually know, and I don't think I've heard an answer to that, whether those 25 percent of the cases that required improvement based on the medical

director's review are the same cases as the contractor reviewed?

CHAIR MARKOWITZ: Well, you know --

MEMBER MIKULSKI: Is it the same pool of cases rather?

CHAIR MARKOWITZ: Yes. I mean, this is Steve Markowitz. I mean, it's a subset of the CMC reports kicked out by the contractor, right?

So, they may kick out 2,500 a year and what we're hearing is that, you know, roughly 200 per year are looked at by the medical director if I have the numbers right.

MEMBER MIKULSKI: I think it's extremely important to look at the criteria that both are using in order to be able to recommend or suggest anything else.

MEMBER REDLICH: Yes, and I think that ones related to disability are quite different than the causality.

And we've expressed before just the concern that just the number of physicians who have sort of expertise related to effective

causality is a relatively small, small subset of the various specialists. Internists, med docs, pulmonary docs.

CHAIR MARKOWITZ: Steve Markowitz. You know, according to the contract, no more than 5 percent of the medical examinations should result in need for clarification, correction, completion, or re-performance.

And, yet when the medical directors reviewed a large number of claims, of the non-causation looks like 25 percent needed some level of correction.

Now, maybe they're defining level of correction differently. I don't know but that those are highly discrepant percentages.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez.

Assessing causation is quite different from assessing impairment. There's a lot of criteria and clinical practice guidelines for impairment assessment. There are really no good guidelines for causation assessment that make any

scientific sense.

It's something that requires a great deal of interdisciplinary understanding of the exposure assessment, epidemiology, biostatistics, and it's not easy to assess whether it's right or wrong.

And, so it seems to me that they're apples and oranges in that 1 percent and the 25 percent can't really be compared.

But I think there is a cause for concern about how do we assess the quality of the causation evaluation. And that evaluation I think maybe should be done by a group that includes expertise in industrial hygiene, in epidemiology, in clinical occupational medicine.

And, I don't know the medical director. I don't know what his skill set is in terms of those disciplines but I think this is worth looking into more.

CHAIR MARKOWITZ: Other thoughts, comments?

(No audible response.)

CHAIR MARKOWITZ: So, if we could just spend, we've got 25 minutes so we've got to save a couple, a few minutes for Dr. Dement's recommendation, and a couple minutes on discussing the next board meeting. And, Dr. Mikulski, you need a couple minutes on Parkinson's?

MEMBER MIKULSKI: Sure. I can give a brief update.

CHAIR MARKOWITZ: Okay. So, then let's spend just a few minutes then on industrial hygiene evaluation because it's different, it's different --

MEMBER REDLICH: This is Carrie Redlich.

CHAIR MARKOWITZ: Yes.

MEMBER REDLICH: Can we just go back to one second? I do think that with the causation, I think we just have to remember that this isn't perfect science. We're dealing with a standard that is, you know, is it a contributing cause? It's not, so I think there is some

judgment issues.

I think what we're looking to identify is if there are really sort of major or gross issues. Because I think there are some where they can be a judgment call.

MEMBER FRIEDMAN-JIMENEZ: Absolutely, I agree. But let me give you an example.

MEMBER REDLICH: And, also practical issues of administering a compensation system where --

MEMBER FRIEDMAN-JIMENEZ: Yes.

MEMBER REDLICH: -- you know, you end up making decisions based on the available information.

MEMBER FRIEDMAN-JIMENEZ: Right, I understand.

So, let me give you an example of what I'm talking about. When you have, some of the cases that we've reviewed, there seem to be a great deal of discrepancy in what the patient thought they were exposed to, and what the CMC or the treating physician said they were exposed to.

So, determination of exposure is one area where, that we can look at the quality of the, the decision making in the -- and that's part of the causation.

The causation judgment, and I'll call it a judgment, requires confirming the disease, how well was the disease confirmed. It requires confirming exposure, how well was the exposure confirmed, or how close is it to reality do we think.

And, then it requires the general causation literature, how good is the evidence that this particular exposure can cause the disease? And, that's an epidemiologic exercise.

And, these are three different processes that we may be able to assess one at a time without really having to do the whole causation judgment.

But I'm not saying that there should be criteria. In fact, I'm more and more believing that there can't be good criteria to determine causation. That it is always a matter

of judgment and there seems to be some consistency in the biostatistical literature and the philosophy literature that that's true.

So, I'm not proposing that we try and nail down an exact scientific causation but that we look at how well the exposure of record reflects the likely exposure, and how well the disease diagnosis was made, and how well the epidemiologic links were evaluated. Is it likely to be a confounded association or a real association based on the published epidemiology.

So, these are things that I think we could assess, or that a committee could assess but it may be difficult for one individual to, to do all of those assessments on multiple cases.

So, maybe that's why the medical director didn't call a large number of questionable judgments.

CHAIR MARKOWITZ: So, clearly we're going to have to do some work I think, some more thinking out loud as a working group before the next meeting. If perhaps we could come up with

an actual recommendation by the next meeting that would be good.

But we also need to address industrial hygiene. If you just go to the next slide. No, actually we're on the, I'm looking at the agenda on the WebEx. Could you go back to my PowerPoint for a second?

So, the, and you go to the last slide. Keep going.

Okay, so and this is a response from the Department on quality assessment industrial hygiene and I mentioned it before.

The contractor, the manager reviews each report and then sends it up to the national office who reviews it and approves it. So, it's a different process than what we've been talking about with the, with the MV.

And we don't, I don't have the industrial hygiene. I don't think we were provided with a contract to know, we would request it though, to know about the comparable kind of performance metrics that we see in the

QTC contract.

But is there any, because we need a little bit more information on the industrial hygiene side. But looking back on the claims that we've looked at on industrial hygiene, would we need to think about at least, what a, whether their current process requires any change on the quality assessment.

I should say the consistency doesn't appear to be the problem with the industrial hygiene reports.

(Laughter.)

MEMBER REDLICH: John has made some suggestions.

CHAIR MARKOWITZ: Yes.

MEMBER DEMENT: Well, this is John.

You know, there are based on this response there are certainly multiple levels of review of the, the IH assessment.

You know, these assessments are in many ways very similar to the CMC assessment, so the causal link. It's highly dependent on the

experience and knowledge base of the industrial hygienist doing it.

And, you know, I think some level of peer review of that you know, is, should be designed into the program as well. I'm not sure this just passing it up the line through the chain of command is, is that necessarily that type of peer review.

MEMBER SILVER: This is Ken Silver. I've been struck by the remarkable consistency of the cited sources. I have not seen a lot of specific gray literature, NIOSH HHEs, to reason by analogy or focus research studies from industrial hygiene journals cited. It seems to be the same handful of textbooks that come up again and again.

So, while consistency is one of DOL's criteria, it may be compromising the quality of this work.

MEMBER DEMENT: I agree. I don't think there's a lot of necessarily original review of the older or contemporary literature in

the process of putting together many of these IH reports.

And, I have to say and I have reviewed a few of them that I thought were done very well. They did in fact, like, go to the literature and look for information on exposure that was in, that was at least published.

So, I, you know, I think early on I was a big advocate for more IH review of cases, and I still am.

Unfortunately, I think the, you know, I'm feeling as I'm going through these more in detail that it, in some cases I'm not sure it's really helping. It's actually hurting as opposed to helping the case.

CHAIR MARKOWITZ: This is Steve Markowitz.

You know, one aspect of this is looking at it prospectively. If the OHQ is modified and provides more useful information, and if a sufficient number of industrial hygiene interviews are done and provides information,

then it's possible for the industrial hygiene evaluation to have well, first of all they'd have different kinds of, and probably better information to depend upon, and then we would see less consistency in those reports, and more kind of well, thought really, go into, you know, the level, the likely level of exposure to the various agents.

Which it's hard for them to do now because frankly, the individual information they give is so limited. So, it may be that looking ahead that quality assessment program could, could look at those new tools or new and improved tools and how useful they are.

MEMBER REDLICH: This is Carrie Redlich. I mean, this is speaking only concerning the occupational pulmonary cases, but those are a good number of them.

I feel that this attempt to provide greater and greater precision is, is not necessarily improving the overall accuracy.

And, your point earlier that to sort

of, the number of exposures that actually cause occupational lung diseases is relatively small. The number of diseases is relatively small.

And, so they're, you know, some of these go on and on about relatively esoteric exposures that, you know, where what's needed is to focus on the few biggies, you know, asbestos and silica and metal dust.

So, I think that narrowing it to, and I understand that for other diseases and I don't mean to overly narrow things, but especially depending on what the condition is, it seems that this desire for greater precision is where some of the conclusions that sort of defy common sense, where that ended up. And, it was I think putting both the exposure and the potential diseases together.

And it's just sort of the SEM that has all these, I mean, I see more occupational cases then probably very few other physicians in the United States. And, so much of what's in the SEM is not anything that's on either the exposure or

the disease side. Or so rare and unusual and is so limited literature on.

So, I feel that sometimes, and I don't know how to stop that from happening but that to me what was most helpful in almost every single case was the questionnaire. Not to, you know, devalue the SEM and the like. But the descriptive information on the questionnaire, and I think that point's been made before.

MEMBER DEMENT: This is John. I feel like --

MEMBER REDLICH: And, looking at this, and I think we should give some more thought in terms of, and I think we do have and maybe if we just tally it up from the cases we've reviewed, what would be the, a way to fix the issue we found.

MEMBER DEMENT: I agree. This is John. I agree.

In some ways, I think the industrial hygienists have been constrained by one, just having what's available in the file itself, which

in some cases is an occupation history that certainly have proved, could probably actually have been administered in a way that enhanced information on exposure.

So, you know, it seems like the IH assessments have I don't know, they've, in some ways they've just become pretty rote and routine. And, you know, if it's '87 to '95, pre-1985, '87 is high, then medium, then none, incidental.

So I'm not sure that, I'm not sure it's really helping in most cases. And, actually I saw in some cases where this statement about low exposures and no exposure post-1995, was used by the CMCs to ignore the possibility of causal exposures in that time frame.

So, it's in some ways it's not helping. It's not helping to inform this disease or in adjudicating the case.

They need their proof. And, hopefully the access to workers and access to a better OHQ will improve the process.

CHAIR MARKOWITZ: Okay, so we, this is

Steve Markowitz. We need to close this discussion. Very useful, and then move on to the recommendation that Dr. Dement was drafting.

(Pause.)

MEMBER DEMENT: Hi Kevin, did you get a, get that email in the draft? Can you bring that up?

MR. BIRD: Yes, Carrie and Missy, you have that right, I forwarded it to you.

(Pause.)

MEMBER DEMENT: This is John. I, after our discussion drafted this for consideration of the board for, this for a request for information that is judicial claims to evaluate the process that was elaborated on, and the response to our recommendation concerning post-1995 exposures.

And, basically the essence of it is we would like to look at, and I'm saying 10 claims that's to me a lot, that having first employment at a DOE covered site after 1995.

I'd like to list certain diseases that

we know was a common exposure and a common outcome at the DOE sites. And, so I've suggested the four that you see here.

And, the claim was denied because of lack of a causal connection as submission information. So, limited exposures to the outcome.

And, I also again this request that we have at least some rudimentary index in these claims that are sent to us on a PDF, that will allow us to go to documents, the key documents such as we saw in our review of some claims with the claims examiners on a telecon.

There clearly is an index. We'd like to see it included in the file.

(Pause.)

CHAIR MARKOWITZ: So, Steve Markowitz. So, Item No. 3, these are negative causation claims, right?

MEMBER DEMENT: Yes.

CHAIR MARKOWITZ: I think the DOL, you know, has their categories of reasons for denial

and I think negative causation is --

(Simultaneous speaking.)

MEMBER DEMENT: Yes, maybe that --

CHAIR MARKOWITZ: -- addressed there.

(Simultaneous speaking.)

MEMBER DEMENT: -- needs to be stuck in there.

CHAIR MARKOWITZ: Well, no, I think it's, no, I think it's _ well, yes, it does because another category is insufficient medical information. So, medical evidence. So that could be confused with that. So, we should probably just modify it to use the negative causation.

MEMBER DEMENT: Now, why don't we just put it in there the claim was denied because of negative causation?

CHAIR MARKOWITZ: Yes, yes. I don't think there are going to be many claims for, good claims for asbestosis with first exposure after 1995.

MEMBER DEMENT: Not likely.

CHAIR MARKOWITZ: So that it would be good to know, it would be good that there aren't too many asbestosis cases.

(Laughter.)

MEMBER DEMENT: Well, you know, we could target something else if it's appropriate. I thought COPD will probably be a likely one to look at, maybe even asthma.

But if there is at least say a leak with a likely lower level of exposure in asbestosis or silicosis.

(Pause.)

CHAIR MARKOWITZ: Yes. Other comments?

(No audible response.)

CHAIR MARKOWITZ: Okay, so then the, this is a recommendation or a request. I think we should probably vote on it.

I second this proposal. Are there, the floor is open for discussion. Any comments? Friendly amendments?

(No audible response.)

CHAIR MARKOWITZ: Okay, so we're looking the proposal that's been modified, Item No. 3 at the end conditions claimed, and what was the phrase, John, that we, you added?

MEMBER DEMENT: Had their claim denied due to negative causation.

CHAIR MARKOWITZ: Right, okay. Okay, so any comments?

(No audible response.)

CHAIR MARKOWITZ: Okay, so I think we need to do a vote.

MR. CHANCE: Okay, you ready?

CHAIR MARKOWITZ: We are.

MR. CHANCE: All right.

MR. CHANCE: Dr. Berenji?

MEMBER BERENJI: Yes.

MR. CHANCE: Dr. Dement?

MEMBER DEMENT: Yes.

MR. CHANCE: Mr. Domina?

MEMBER DOMINA: Yes.

MR. CHANCE: Dr. Jimenez?

MEMBER FRIEDMAN-JIMENEZ

GEORGE: Yes.

MR. CHANCE: Dr. Goldman?

MEMBER GOLDMAN: Yes.

MR. CHANCE: Mr. Mahs? I think he's gone. Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. CHANCE: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. CHANCE: Dr. Redlich?

MEMBER REDLICH: Yes

MR. CHANCE: Dr. Silver?

MEMBER SILVER: Yes, my phone was on mute.

MR. CHANCE: And Mr. Tebay?

MEMBER TEBAY: Yes.

MR. CHANCE: All right.

CHAIR MARKOWITZ: Okay, thank you.

MR. CHANCE: All right.

CHAIR MARKOWITZ: Dr. Mikulski, you want to give us a very brief update on Parkinson's?

MEMBER MIKULSKI: Yes, absolutely, I

thank you so very much. I don't have a PowerPoint this time but maybe this is good in the interest of time.

Just very briefly. So we've had a chance to provide the board members with a, with a short write up at our last in-person meeting.

This write up covers topics and provides answers to at least some of the questions that the DOL has requested of the board in terms of definitions: clinical, symptomatology, as well as disease classification coding for Parkinsonism and Parkinson's.

We've also touched upon the main risk factors associated with the increased risk for both Parkinsonism and Parkinson's, and I feel fairly confident that we have done a fairly complete review of the literature research studies on the topic.

As we are moving ahead in this process of formulating the final recommendations for the Department of Labor, we've also reviewed a handful of Parkinson's accepted and denied

claims, which has provided some very interesting information in terms of things that are in common, as well as discrepancies in a way that, that this disease exposure based claims are being reviewed.

I don't want to go into any details but it seems as at least in terms of the accepted cases, what really provides the basis for a decision in favor of the claimant is a very well-rationalized review, medical review of both the disease and the disease exposure links existing in the SEM.

In other words, for those with accepted claims, the SEM provides with the disease exposure link for their particular jobs held during the DOE employment.

On the contrary, with the denied cases, most of these denied cases lack that information or, or the primary care physician or a neurologist out of the house was not able to provide a fully detailed review of work history, as well as provide a well-rationalized argument

in favor of accepting the claim.

One might argue whether a mechanic is more likely to be exposed to manganese than a janitor and again, the devil is in the details. But I think what this provided is, what this review provided will also be helpful in making the final recommendations.

On behalf of the working group I'm hoping that we will be able, I'm planning on the, on being able to present the final recommendations at our next in-person meetings.

If there is any opportunity, or if any board members would feel like the document that we provided previously needs any edits, please contact us. You have our email information, address information.

And, let me stop it here.

CHAIR MARKOWITZ: Great. Any comments?

(No audible response.)

CHAIR MARKOWITZ: Okay --

MEMBER REDLICH: Did you send that out

again? Is that possible to circulate it again? I think I've got a paper copy of it, I'm not sure I had an electronic version of it.

MEMBER MIKULSKI: Should I send it --

MS. RHOADS: It's actually posted online. It's posted online at the last meeting, I think.

MEMBER REDLICH: Oh, okay.

CHAIR MARKOWITZ: Why don't you send it to Carrie Rhoads and then she can send it around?

MEMBER MIKULSKI: Sure. I will send the most recent version.

CHAIR MARKOWITZ: Okay, thank you.

I think the end of the board's term in the mid-summer provides a useful deadline for us closing out some of the issues that we, this board has dealt with, so that's a helpful timetable.

So, this is the last item. We're a minute late now but, which is the next meeting.

So, I'm going to ask Ms. Rhoads to

send out some dates. I think we're going to look at the last two weeks of April in particular.

And part of the timing of that because we always have trouble with scheduling, but is that in the event that we need a telephone meeting to close out certain issues of the board prior to mid-July, that still gives us the necessary six weeks lead time to publish in the Federal Register the notice of a telephone meeting.

So, would be reluctant to go much into May, so that's why we'll be looking that last two weeks of April in particular.

As far as locations, so we've been going in order, rank order by the most number of cases and claims, and Ms. Rhoads has provided the data for that, and the next place to go I'm sorry to say, is Las Vegas because that's where the Nevada Test Site is. It's got 20 percent more cases and claims than the next highest, which is Portsmouth.

So, although I'm told the Nevada Test

Site would, which we'll get a tour of, is very interesting so that's nice. So, that's sort of the target location.

Any questions about this?

MEMBER DOMINA: Hey, this is Kirk Domina. Hey, you know, if we could have this meeting the third full week of April, April 22 and 23, the Advisory Board on Radiation and Worker Health is going to meet in Hanford. And, so that's a little bit of a conflict for us, and so, you know, if we could stay away from that, it would be greatly appreciated.

CHAIR MARKOWITZ: That's the 22nd and 23rd?

MEMBER DOMINA: That is correct.

CHAIR MARKOWITZ: Okay, okay. Well, good, that's good to know.

Okay, so that's it pretty much for our business. Any closing comments or questions? I'm going to be sending around --

MEMBER REDLICH: This is Carrie Redlich. I know it's super late. Can I just set

up one quick thing?

It's just about fixing small things with the SEM. I forget what that is but I bring it up because we last time meeting, we identified two issues. One that fibrosis is not linked with asbestos or pulmonary fibrosis. I mean, there were two common things that accounted for a large number of the decision making that's just sort of defied reason.

And, the other was that sarcoid is not linked with beryllium, so multiple times someone was asked, you know, the question of an exposure link with sarcoid, which is not possible.

And, I did play yesterday and the day before with the SEM again to see if this had been changed whether, you know, pulmonary fibrosis was in there, was it linked to asbestos. And, it currently is only to silica because of coal workers and mass of fibrosis.

So, this seems like a easy, fixable thing that someone could do. And I was just raising what is the process and I don't, maybe

this could just get passed on?

CHAIR MARKOWITZ: Ms. Leiton, what do you think? What's your advice on this?

MEMBER REDLICH: Just so we know what, how to enable this to happen.

MS. RHOADS: Rachel had to leave so why don't you send me an email about it and then I will ask her.

MEMBER REDLICH: Because I think I'm happy to send an email, just be nice if we could do whatever steps are needed to fix it.

MS. RHOADS: Sure.

MEMBER REDLICH: I was sort of hoping it would have happened, but it hasn't.

MS. RHOADS: Yes.

CHAIR MARKOWITZ: Yes.

MS. RHOADS: I'll pass it on to her.

MEMBER REDLICH: Okay. Thank you.

CHAIR MARKOWITZ: Okay, thanks.

So, I'll be in touch about the working groups that we need, the work that needs to get done, and we're going to have form a new one

around this quality assessment but we've started with a really good conversation and I think we need to make some requests for information from DOL, and but also then continue to talk through improvements in the quality assessment.

Any closing comments?

(No audible response.)

CHAIR MARKOWITZ: So I don't know whether Mr. Chance, you have anything? I mean, just thank everybody for your attention, for your preparatory work, for the willingness to entertain some documents that were sent around more or less at the last minute, and look forward to getting some more work done.

Mr. Chance, any closing, anything else you need to say?

MS. RHOADS: No. He had to step out as well. We don't have anything else.

(Laughter.)

MS. RHOADS: You're good.

CHAIR MARKOWITZ: Okay. Bye now.

MS. RHOADS: Meeting is adjourned.

Bye-bye, everybody.

(Whereupon, the above-entitled matter went off the record at 4:36 p.m.)