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
NOVEMBER 9, 2021

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The Board met via Videoconference, at 1:00 p.m. EST, Steven Markowitz, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

AARON BOWMAN
MARK CATLIN
KENNETH Z. SILVER
MIKE VAN DYKE

MEDICAL COMMUNITY

GEORGE FRIEDMAN-JIMENEZ

ROSE GOLDMAN
STEVEN MARKOWITZ
MAREK MIKULSKI

CLAIMANT COMMUNITY

JIM H. KEY
DURONDA M. POPE
CALIN TEBAY
DIANNE WHITTEN

DESIGNATED FEDERAL OFFICIAL
MICHAEL CHANCE

ALSO PRESENT

KEVIN BIRD, SIDEM
RACHEL POND, DOL
CARRIE RHOADS, DOL
JOHN VANCE, DOL

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

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

(1:02 p.m.)

OPERATOR: Welcome and thank you for standing by. I'd like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the conference over to your Host, Mr. Michael Chance. Thank you. You may begin.

MR. CHANCE: Thank you. Good afternoon, good morning everyone. Today is November 9th, 2021. Welcome to Day 2 of the teleconference meeting with the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

My name is Michael Chance and I'm the Board Designated Federal Officer or DFO. We appreciate the Board's participation in this meeting today.

We are scheduled to meet today from

1:00 Eastern time to 4:00 Eastern time. And I believe there will be no public comment period today. We had one yesterday.

Both of our meetings, last few meetings, today's meeting is completely virtual as a precaution against the COVID-19 pandemic. I am joined here on my DFO team by Ms. Carrie Rhoads from the Department of Labor.

And Kevin Bird from Sidem, the contractor that has assessed with these matters. Please bear with me while I talk a little bit about some of the meeting operations.

As everybody, just so you know that there's an agenda available, we took a break, we took one break yesterday. We'll probably take a break today, a little bit of a shorter session.

Usually Dr. Markowitz helps to move that along quite nicely. Copies of all meeting materials and any written public comments are or will be available on the Board's website under headings, Meetings, and the listing for this

subcommittee. The documents will also be up on WebEx screens so everybody can follow along with the discussion.

You can visit the Board or webpage for additional information whereafter today, I'm sorry, whereafter posting on today's meeting date, you'll see a number of helpful items on the page dedicated to today's meeting.

The webpage contains publicly available materials submitted to us in advance or submitted to the Board in advance. We'll publish any materials are provided today.

There you will also find the agenda that I referenced above as well as instructions for Board participation. If you're having a problem, please email us at energyadvisoryboard@dol.gov.

If you're joining by WebEx which most of us are, please note that the session is for viewing only and will not be interactive. Phones will also be muted for non-advisory Board

members.

And please be aware for also you folks that are in the speaker room, that if you're not speaking, keep your phone on mute to minimize any kind of background distraction.

Throughout today's session, you may contact Ms. Rhoads or Mr. Bird for technical assistance. A few notes on meeting minutes and transcripts.

The transcript and minutes will be prepared from today's meeting. During Board discussions today as we are on teleconference line, please make sure that you speak clearly enough for the transcriber to understand.

When you begin speaking, especially at the start of the meeting, please state your name, so we can get an accurate record of the discussion and who was participating.

Also, I'd like to ask our transcriber to please let us know if you're having any issue hearing anyone or with the recording so that we

can fix that as we go along and don't miss anything.

As DFO, I see that the minutes are prepared and ensure they're 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 regulations.

But if they're available sooner, they will be published prior to that day. Also, although formal minutes will be prepared, we'll also be publishing verbatim transcripts which are obviously more detailed in nature.

Those transcripts should be available on the Board's website within 30 days of this meeting. And last, I would like to remind all advisory Board members that there are some materials that have been provided to you in your capacity as special government employees, members of the Board, which are not for public disclosure and cannot be shared or discussed

publicly including in this meeting.

Please be aware of this as we continue with the meeting today. It's important to remember these materials can be discussed in a general way which does not include using personal identifiable information or PII such as names, addresses, specific facilities, if a case is being discussed, or the name of a doctor.

Thank you for bearing with me while I had to get all of that read into the record. And with that, I convene today's meeting of the Advisory Board on Toxic Substances of Worker Health and turn discussions over to Dr. Markowitz. Dr. Markowitz, please take it away.

CHAIR MARKOWITZ: Okay, thank you, Mr. Chance. Welcome to everybody. Welcome back. Welcome to the members of the public. Those who were here yesterday and those who joined us today.

We have no public comment period today, however, we always invite you to submit

written comments through our website which are then posted so.

That avenue is always open. I want to thank Kevin Bird and his group for supporting this meeting and, as always, Mr. Chance and Ms. Rhoades for working closing with us and the leadership of the Department of Labor, EOICP, who are on this call with whom we enjoy their enthusiastic cooperation, collaboration.

In any case, let's because there are some new members of the public today, I think we should just very quickly do introductions. We'll do it as we did yesterday.

Let me just, I'll call out your name, I'm Steven Markowitz, I'm an occupational medicine physician and epidemiologist at the City University of New York and I've been on the Board since 2016 and been experienced with the DOE health effects for a long time. Dr. Bowman?

MEMBER BOWMAN: Thank you, yes, I am Aaron Bowman, Environmental Health and

Toxicologist. I am also Professor and Head of the School of Health Sciences at Purdue University.

I've been on the Board now for about a year and a half. Thank you.

CHAIR MARKOWITZ: Okay. Who's next? Mr. Tebay?

MR. TEBAY: Calin Tebay. Sheetmetal worker, Hanford Workforce Engagement Center and Site-wide beryllium health advocate at Hanford.

CHAIR MARKOWITZ: Okay, and staying in Washington State, Ms. Whitten?

MS. WHITTEN: Hi, Dianne Whitten. I am the Health Advocate for the Hanford Atomic Metal Trades Council, also a member of IBEW Local 984. I've been at Hanford as a rad contact for 33 years.

CHAIR MARKOWITZ: Mr. Key?

MEMBER KEY: Yes, Jim Key. President of the United Steelworkers Atomic Energy Workers' Council of Washington, D.C.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: Ken Silver, faculty in the Department of Environmental Health and the College of Public Health at East Tennessee State University. Long involvement in DOE worker health issues.

CHAIR MARKOWITZ: Dr. Mikulski?

MEMBER MIKULSKI: Marek Mikulski at University of Iowa, Occupational and Environmental Health. I also direct the Iowa Former Worker Program for Former Nuclear Weapons Workers from two sites in the State.

CHAIR MARKOWITZ: Mr. Catlin?

MEMBER CATLIN: Thanks, good to be here. I'm Mark Catlin. I'm an Industrial Hygienist. I retired in 2018 from the, as Program Director of the Service Employees International Safety and Health Department and I've been on the Board about a year and a half.

CHAIR MARKOWITZ: Dr. Van Dyke?

MEMBER VAN DYKE: Mike Van Dyke,

Industrial Hygienist and Associate Professor at the University of Colorado Anschutz Medical Center. I've been involved with DOE sites and beryllium, in particular, for many years.

CHAIR MARKOWITZ: Dr. Goldman? You're muted I think if you're speaking. Okay. We'll come back to Dr. Goldman. Dr. Friedman-Jimenez, have you joined the call? I see. Okay, can you all hear me?

MR. BIRD: Yes, we can.

CHAIR MARKOWITZ: Okay. Fine, just wanted to make sure it wasn't my line. That's good. Okay, Ms. Pond?

MS. POND: Hi, this is Rachel Pond. I'm the Director of the Energy Program at the Department of Labor.

CHAIR MARKOWITZ: And, Mr. Vance?

MR. VANCE: Good afternoon, everybody. This is John Vance. I'm the Policy Branch Chief and Energy Compensation Program.

CHAIR MARKOWITZ: And thank you for

joining us today. Okay, Dr. Goldman? I don't know whether you're back or not, but when you speak first at the meeting, maybe I will have you introduce yourself.

So let me review quickly the agenda. We're going to have a brief discussion on the status of our request for resources. And then we will Segway into discussing whether we want to request a limited number of de-identified claims in order to prepare for having a contractor support to do a broader examination of claims.

We will then take a look at the public reading room which we've never done actually of the program. And look at the kind of information that program makes the publicly available.

And brainstorm a little bit. Although not too broadly, but about whether there are additional kinds of program metrics that we might find useful in our work.

Take a break, and then we're going to

come back to a couple of issues from yesterday. The program has asked us to clarify one issue around aldrin and dieldrin.

We're going to discuss briefly styrene, see if we can clear that up and then we may have a little bit of time to reflect on some of the public comments from yesterday.

Is there any other issue or topic that I haven't covered that we need to clear up today?

MEMBER GOLDMAN: Hi. This is Rose Goldman. I'm sorry my audio went off just when you came to me. I don't know if you want me to introduce myself.

CHAIR MARKOWITZ: Sure, please. Always.

MEMBER GOLDMAN: Oh, I'm also an academic Occupational and Environmental Medicine physician with a practice at Cambridge Health Alliance and I'm, this is my second term on the Board and I'm an Associate Professor of Medicine

at Harvard Medical School and Associate Professor of Environmental Health in Public School and Public Health. Thank you.

CHAIR MARKOWITZ: Okay. Thank you. And Dr. Friedman-Jimenez. I don't see him yet, but okay. So I want to just go over the status of our request for resources and Mr. Chance will add or comment or clarify or even correct what I'm going to say.

But so the Department has been working on securing us a contractor to perform certain tasks to help us in our work. There was a Request for Information that was issued a number of months ago in the Federal Register by the Department and a number of responses from potential contactors to that Request for Information.

And a subset of us after signing nondisclosure agreements, Dr. Bowman, Dr. Mikulski, Ms. Whitten and Mr. Catlin and I looked at the material that had been sent back

to the Department.

We looked at the actual responses, we looked at a summary of the responses for various potential contractors and some sorting out that had been done by Mr. Gardner I think in the contracting office.

We, the five of us, met on the phone a couple of weeks ago or so and provided the Department some feedback on the responses to the RFI, to the Request for Information, and more importantly, we looked at, or as importantly, we looked at a performance work statement which is a draft of what would go out when the Department issues a request for proposals to get responses for selection of a contractor.

So this performance work statement describes what it is that this Board would be using a contractor for and we gave some feedback to the Department just to give you flavor of the kind of comments we made.

We asked whether the Department

wanted the Contractor to be identified claims which is a lot of work so that actually when we want to, when the Board members want to go back and look at some of those same claims for details, they would already be identified and I think expedite our work.

We noticed that there was some variation among the RFI responses and the degree to which there was occupational Health expertise in the contractor organization for experience in that area and we suggested that prior experience in occupational health would be very helpful in understanding what it is that the Board wants.

We, looking down the list here, I don't think there was any detail provided on the number of scientific or technical reviews that we might require.

And obviously a budget would be based on, you know, what they expected, the magnitude of work. And so we estimated that there could be three to five scientific and, or technical

reviews per year as an estimate.

And we also emphasized that those should be based not on so much on an original very detailed review of the literature, but that it maximally stands possible on existing consensus or expert reviews of that area.

Because people have been involved in that kind of work before knowing that if we undertake, it would not be possible with or necessary to undertake in depth original reviews of topics about which a lot has been written.

So we're trying to provide some clarity in the performance work statement around that. And we emphasize that the Board wanted to provide specific direction in the claims review process undertaking by the contractor as well as in the scientific and technical reviews.

Finally, we had recommended some job titles that, you know, would be good to see in eventual responses to the RFP. Mr. Chance, anything I forgot or got wrong?

MR. CHANCE: No. I, you would just have to keep the comments very general at this point. And, yes, the only thing that I could emphasize and I think that you could agree, Steven, that you know, we're moving this as quickly as we can.

I know that there are a lot of expectations surrounding this, but the Government contracting process is not the fastest process in the world.

There's a lot of due diligence and there are a lot of checks and balances along the way so good reason so, you know, we're moving this as quickly as we can and trying to get the best understanding for what your needs are moving forward to make whatever it is that we're able to put in place as useful as possible.

CHAIR MARKOWITZ: Okay. Thank you. And by the way, I forgot to mention that there is, we were provided with a rough timetable for various steps. Am I able to share that?

MR. CHANCE: Yes, right. Yes, we shouldn't talk about that right now.

CHAIR MARKOWITZ: Okay.

MR. CHANCE: Yes. That timetable is very internal and there are a lot of things that could happen so we think that was just for your own edification and for the folks that signed the MBAs.

CHAIR MARKOWITZ: Okay, but we are discussing the foreseeable future so that's good.

MR. CHANCE: Right. And I mean, you know, we're trying to move this as quickly as we can.

CHAIR MARKOWITZ: Okay. So any comments from either the other people that took a look at the various materials or from other members of the Board? Okay. So let's move on.

The, you know, in thinking about the work plan of the Board over the next 6, 12 months, it occurred to me that at some point, we

will have access to some resources.

And one of the things we're going to want to do is look at claims addressing some specific questions, but that while the issue of securing a contract is being resolved, there's some work we can do in preparation.

To develop a plan, I'm looking at those claims, and realize that a good number of the members of the Board actually haven't seen any claims whatsoever.

So it would be a good idea for us to request some claims, a limited number, from the Department so that we can look at them with the idea of familiarizing ourselves with what the claims look like, are beginning to look at what kind of detailed information we would want from those claims.

And I should say that when we've done this in the past, then I think it's very useful. I think very interesting and formative.

It takes the Department quite some

time to de-identify claims for us to be able to look at them so weE need to formulate our request either today or in the very near future in order to realistically obtain claims in, you know, with some degree of notice prior to our next meeting in the spring.

So what I'd like to discuss is how many claims we should ask for, what kinds of claims, what years, what conditions, geographically, whether we are going to look at any particular sites, what's the ratio of accepted versus denied claims, issues involving causation or impairment, consequential conditions, and so that we can make a specific request to the Department. So anybody have any thoughts about this?

MEMBER BOWMAN: This is Aaron Bowman. I am one of the members of the Board that has not seen one of these yet. I just, I do want to second and support what you're saying, Dr. Markowitz.

It would definitely be helpful for you to send what's going on. I would as diverse a possible representation of what's been going on, the sort of the details of the claim, unique cases may be less helpful.

I think we may be more about representative cases. Both those that are accepted and denied I think would be helpful.

CHAIR MARKOWITZ: Okay. And --

MEMBER GOLDMAN: Hi.

CHAIR MARKOWITZ: Go ahead.

MEMBER GOLDMAN: This is Rose. Yes, I came in on the tail end of the previous times that we did it so two comments. One is, at that last closure of having done these, what were the questions or issues that were still remaining which would be the reason we're going back to doing this?

That's one because maybe you remember or have notes about that. And secondly, in the few that I did, it was very difficult to go

through the claim papers because they weren't really organized by different categories.

And one of the things my recollection was that we said that if we were to go back to looking at these claims again, that there would be some efforts or there would be a consultant or somebody to organize these papers in a way that there was more order to them perhaps with exposure and medical records because it was all over the place.

And so you had to spend a lot of time clipping through the pdf to get to that. So I wonder if you could comment on those two points please.

CHAIR MARKOWITZ: Sure. Well let me first, this is Steven, let me first just open the floor to other people who may have some recollection of some of these issues.

I don't think anybody forgets the problem of the lack of indexing of the claims and which reminds me actually, something, Mr.

Chance we have to discuss is whether the performance work statement, I can't recall whether it specifically mentions the indexing of claims as work with the contractor.

But we'll get back to that separately. Any comments in response to Dr. Goldman or otherwise? The, so let me ask Ms. Pond or Mr. Vance, if we requested claims and some sort of index, the guide to the contents of the claims, which we did see at one point, there was someone from the Department who reviewed some claims with us which did have some organization to it. Is that doable?

MS. POND: This is Rachel. I'm trying to think back to, I'm trying to figure out exactly what data index we're talking about. Whether it's about a dictionary or whether --

CHAIR MARKOWITZ: Well, yes, sure. I'm sorry. Let me just explain a little bit. So you know, what I recall is the claims were, there was a lot of chronological order to it.

But that there was a mix of, you know, the private physician's records with their recommended decisions with the, you know, the FAB decision with various EEE-1 completed forms and if these were somehow they were a one-page guide to where one could find these various things, that would be extremely helpful.

MS. POND: John, do you know how they were presented the last time? I think we just gave them the case files. Correct, or?

MR. VANCE: Yes, okay. So yes, this is John Vance. So I was very familiar with the prior submissions. So when we do the case pulls, what we are doing is we are extracting the paperwork from our electronic imaging system.

Now our OWCP imaging system has an index for the document so when you are electronically accessing the records through LIS, you can see the index.

However, for the Board, we don't create that in that we don't replicate that

index. What we do is we basically download the paperwork in whatever chronological order that it exists in LIS, and you're presented with that file.

So no, there's no indexing that we can do based on the extraction of all of that material from LIS. And if it would be a manual process, that would be extremely time-consuming so in the past what we have done is just provided a pdf of the entirety of the file and in whatever order it is, it is presented in our imaging system.

CHAIR MARKOWITZ: Yes, it's Steven. You know we have some sense of how time-consuming it is actually. But that is something that we're going to need to address in the performance work statement in the contract.

I see some hands here, Dr. Silver and then Dr. Friedman-Jimenez.

MEMBER SILVER: Thank you, Ken Silver. On the substantive aspect of what kinds

of claims we should resolve. More recent cases that received industrial hygiene referrals would interest me for two reasons.

I've been on the Board since 2016 and one of the first issues we took up was the Department circular that directed claims examiners to presume that if exposure occurred after 1995, those exposures would be presumed to be at or below OSHA's standards unless evidence to the contrary was presented.

So it took about a year before we convinced the Department to withdraw that guidance. But then I noticed in some of our subsequent claim reviews, it was like a dead horse that wouldn't lie down.

Claims examiners in some cases were still applying that assumption. That's one reason I'd like to look at some recent claims with IH referrals.

And then the second is, I'd really like to see how the new OHQ is performing. So

those would be very, very recent claims. Anyway, that's my take.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes, I've gone through a number of these claims and I think we had 80 with respiratory diagnoses and typically they're several hundred up to several thousand pages of a pdf file which is a bitmap pdf file that is not searchable.

So if we cannot get an index of where the Statement of Facts is located, et cetera, a distant second to that would be to at least get a pdf file that has been run through a character recognition program to make it searchable.

That way, we can search for key words and it would greatly help getting through these huge files. I mean, they literally are often several thousand pages and there may only be 60 or 100 pages out of that which are directly relevant to the case that summarize what we need

to know.

But finding those pages that are scattered in there, it can be really time-consuming for us as well as Department of Labor so if you could please send us pdf files that are searchable, I think that would help a lot if we can't get indexing, but I agree indexing would be a first choice.

CHAIR MARKOWITZ: So we want completed, this is Steven, we want completed claims. Right? Because we want to see the entire process including the decision.

And so, let me ask the Department because we would like to see more recent claims, but we also want them completed. What is, would 2000, would there be many claims, for instance, in 2020 that would have been completed by now?

MS. POND: Well, when you say completed, are you referring to a recommend decision, you want final decisions? I'm assuming you want final decisions?

CHAIR MARKOWITZ: Yes, final, well ideally, the final decision would be --

MS. POND: Yes, I mean, we can probably, I'm sure we have final decisions. There's plenty of final decisions that were done in 2020. What we'll have to do is run a report to kind of to show, you know, how many there have been, you know, there might be ways to sort it where we could determine, you know, what type of decision.

Whether it was a causation determination, kind of wean it for you, but we'll have to kind of figure out exactly what data points you're going to, what specific things you're going to be looking for like an IH assessment.

We might be able to pull cases that had one of those that are, have a final decision. I won't be able to tell you exactly how many of those there are until we have the requirements, but I'm sure there will be

decisions with that in it in 2020.

CHAIR MARKOWITZ: Okay.

MR. VANCE: Yes, this is John Vance. The key thing for these data requests is specificity. So if you're looking for completed decisions with regard to particular illnesses or particular sites or facilities, it's always going to be very important to try to be as specific as to the data that you're looking for.

CHAIR MARKOWITZ: And the handling of the claims, I mean, we looked at claims that were being handled during the pandemic. Would they be in some sense, unrepresentative of the prior claim handling or we can just use claims from during the pandemic period and feel confident that we're looking at the broader process.

MS. POND: Yes, you can, we process claims the same. I mean the resource centers are still doing OHQs. During that period of time all of them were on the phone.

So you know, I think the processes didn't change. We were just doing them remotely.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez, you have your hand up still. I don't know whether you want to add another comment or, but you're welcome to make it. Okay. So --

MEMBER FRIEDMAN-JIMENEZ: Again, I forgot to turn it off --

CHAIR MARKOWITZ: Yes.

MEMBER FRIEDMAN-JIMENEZ: -- after I started speaking. Sorry.

CHAIR MARKOWITZ: Yes.

MEMBER FRIEDMAN-JIMENEZ: It's off now.

CHAIR MARKOWITZ: So I, this is Steven, I think we do want to look at the industrial hygiene report and CMC reports. The, if we request or, if we request claims with an IH report, will they usually have a CMC report and vice versa?

Do they travel together I guess is my

question on claims?

MS. POND: Not all the time. Often times we will, I mean, especially more recently, we'll go back to the treating physician first.

Then if the treating physician provides us with enough information, then we won't go to a CMC, but if it's necessary to go to a CMC after an IH, we will.

So we really, we won't know that necessarily. We might be able to search by whether or not it went to a CMC, but I would imagine you'd want to see those with an IH report regardless of whether it went to a CMC or not.

CHAIR MARKOWITZ: A good point. This is Steven. What I'm thinking is this task of ours to look at the distance and quality and objectivity of both the IH and the medical input into the claims and so yes, we can certainly look at some claims that only have IH reports.

But you would also need a fair number

that have the CMC input as well, in particular in this sort of pilot work to get a broad view of claims evaluation process.

MS. POND: Yes.

CHAIR MARKOWITZ: Are there, yes, are there particular, oh, Dr. Bowman, yes.

MEMBER BOWMAN: I think the topic had come up in previous Board meetings about emergency responders, firefighters, et cetera. I would, if possible in this small set, it would be great to get a denied and an approved final decision claim from two emergency responders just because that would fit other conversations we've been having.

MS. POND: Unfortunately, our data base, we don't, we can't search by the job categories.

MEMBER BOWMAN: Oh.

CHAIR MARKOWITZ: The, so this does raise the issue of denied versus accepted claims and what's people's sense of the ratio that we

want?

I think before we ask for principally denied claims, but we did ask for a certain portion of accepted of successful claims.

MEMBER BOWMAN: I agree it's helpful to have both, but more denied could be more helpful maybe a two to one or three to one ratio.

But I'm, that's just a sense without really having as good of understanding as other members of Board.

CHAIR MARKOWITZ: Yes, this is Steven. I agree with you on that two to one or three to one would be fine. And how about particular health conditions?

Well, first of all, let me ask if causation or impairment versus others. My sense is we should probably look at some impairment because that issue's been raised.

But the majority of the claims we looked at would not be impairment. Are those

these, I'm going to ask the Department. Are those easy enough to sort out?

MS. POND: Impairment claims? Yes, I believe we have a code for that. John?

MR. VINCE: Yes.

CHAIR MARKOWITZ: Okay. And personally I don't think we necessarily need to look at consequential claims because those are, consequential claims are piggybacked on claims that have already been accepted.

And so they're coming back for another condition of they may be related to the successful claim. I think our, we have more interest in actually looking at original claims.

But that's a question for the Department. Can you explain once again for us the difference between cases and claims?

MS. POND: Well, a case is, when you're asking for a case first, to look at a case file, that's going to be all of the information in an employee's case.

So cases of an employee could have multiple survivors in it. A claim is, can be, there's a couple of different ways to look at a claim.

A claim form for an initial condition and a consequential condition is considered a claim when you're capturing a claim, but when you're looking at a case file, all the claims, whether it's for one condition or multiple conditions are all going to be in there.

And if they're, even if they're submitted at different times so if you have an initial, you have a case and in that case you have an initial claim form whether it's from the employee or from one of the survivors for one condition.

If they filed for more, it's going to be in that case file. But they will be considered different claims. So basically, when you get a case file and you ask for a case file, you're going to see all of the different claims

that came in, in that case file. You understand?

CHAIR MARKOWITZ: So this is Steven. So a case is a person.

MS. POND: Yes, basically.

CHAIR MARKOWITZ: Okay. And that person may over time or even at any, at the time of the initial claim, initial submission, they may be claiming multiple conditions.

MS. POND: Correct. Or they could have multiple survivors claiming multiple conditions, multiple for different people.

CHAIR MARKOWITZ: And if a person files an initial claim and it's for multiple conditions, is that considered a single claim for multiple conditions?

MS. POND: Yes.

CHAIR MARKOWITZ: Each condition --

MS. POND: Yes.

CHAIR MARKOWITZ: -- has its own claim?

MS. POND: No. It's one claim.

CHAIR MARKOWITZ: Okay. But if they come back at a different period of time with additional --

MS. POND: They might have additional --

CHAIR MARKOWITZ: That would be an additional claim.

MS. POND: Yes.

CHAIR MARKOWITZ: Okay. All right. Now I just have to wonder how long I'm going to be able to remember that this next one. Dr. Goldman?

MEMBER GOLDMAN: In the last couple of years, we've talked about Parkinson's Disease and we've also had a lot of discussion about cancer.

So I would be interested in seeing a claim particularly one that might have been refused or accepted with a Parkinson condition and one for some cancer.

I think that would help make our

recent discussions of some of those two things in putting our criteria sort of real. A reality check and see how, what we were doing really connects with the, what's happening on the ground.

CHAIR MARKOWITZ: Okay, this is Steven. Follow up on that, there's some cancer claims that come from the dose reconstruction side from Part B.

And when they're accepted under Part B, either it's a Special Exposure Cohort or dose reconstruction's been done and the claim was accepted for one of the 22 cancers. Is it automatically accepted under Part E?

MS. POND: Yes, as long as it is covered site under Part E. It has to be a DOE contractor or subcontractor.

CHAIR MARKOWITZ: Okay. So it's not as if you do any sort of repeat causation analysis of --

MS. POND: Correct.

CHAIR MARKOWITZ: So then Dr. Goldman, if we're going to look at cancers, it strikes me we should look at cancers that are not, that are just Part E only and they didn't cross over from Part B. If that makes sense.

MEMBER GOLDMAN: I don't know if you were addressing that to me, I'm not sure about that.

CHAIR MARKOWITZ: Okay, well and so Mr. Vance that --

MEMBER GOLDMAN: I mean either, I mean whatever you think, if you think it would be better to just look at the Part E, wherever you think there might be some more issues that would relate to the recent work that we're doing. I guess that we say.

CHAIR MARKOWITZ: Yes, this is Steven. I see hands up. I see them, I'm going to be call on you in a moment, but just to clarify this point, I think Mr. Vance knows the answer to this.

If we want to look at some cancer claims that are Part E only, is it possible for you to identify those?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay.

MR. VANCE: Yes, we would be able to do that.

CHAIR MARKOWITZ: Okay. Thanks. Dr. Silver or maybe your hand went down.

MEMBER SILVER: Well, just to synopsize what you and John ran through, if there is solely party, they won't likely involve much radiation.

There will more likely be just chemical exposures and chemical carcinogens at issue.

MR. VANCE: That's correct.

CHAIR MARKOWITZ: right. But the thing is that if we look at party chancers that are derivative from Part B, they won't go through the IH and the CMC because there's no

causation analysis.

MEMBER SILVER: Yes, I'm agreeing with you. We don't want those.

CHAIR MARKOWITZ: Yes, so I just mean it might be useful for impairment purposes, but not for, okay, so Dr. Bowman, and then Mr. Key and then Mr. Catlin. Dr. Bowman?

MEMBER BOWMAN: Thank you. I, it was just the hand was up back when you were asking about particular conditions. We just talked about cancer. It, just for my own sake I'll be going through a new time.

If it doesn't add too much to the burden. I know we want to try to keep this number down, but any claims related to commissions of Parkinson's disease or other neuro degenerative diseases might be helpful for me to familiarize myself with the claims given that I have a lot more knowledge in that area.

But again, I don't want to add too much to the burden to make this take, the

process takes too long.

CHAIR MARKOWITZ: Well, it would be, this is Steven. Let me respond. We're going to, the next item on the agenda, we're going to be looking at the comments, the most common neurologic claims so we can revisit that, your question or comment at that time.

MEMBER BOWMAN: Got it.

CHAIR MARKOWITZ: Mr. Key?

MEMBER KEY: Yes. Within the last month, I became aware and informed of a Part B cancer that stemmed from one of the original SEC, gaseous diffusion plants that is now required to go through a dose reconstruction.

I don't understand the change for that to be filed under B and have to go through dose reconstruction in E.

CHAIR MARKOWITZ: So you're saying, this is Steven, you're saying there's some, you talking about the gaseous diffusion plants so this is the original Special Exposure Cohort.

But there's a cancer that's on the list of the 22 types of cancer that you're saying nonetheless had to go through with dose reconstruction?

MEMBER KEY: That's correct.

CHAIR MARKOWITZ: Oh. And --

MS. POND: We would need to see that. That's not a, I mean, that shouldn't happen. So if that's a particular individual case, that could be something that could be sent up to look at.

MEMBER KEY: Yes, I thought that was very irregular or not needed for the original SECs.

CHAIR MARKOWITZ: So what do you want to have an offline conversation about that with Dr. Friedman-Jimenez.

MEMBER KEY: Yes, we can do that.

CHAIR MARKOWITZ: Okay. Mr. Catlin?

MEMBER CATLIN: Thanks. Wanted to follow up on Dr. Silver's support for looking at

the claims with IH review. Just in terms of the process, are there claims that would have been denied where there was no IH review and then claims a manager decided there wasn't a need for an IH review, but still denies the claim? Is that a subset that we might look at?

CHAIR MARKOWITZ: Well, I'm sure that occurs. So because then it would be interesting to look at claims where the claims manager didn't take advantage of the extra support to see how that looked.

CHAIR MARKOWITZ: There are those kind --

MS. PONDS: Yes, this is --

CHAIR MARKOWTIZ: -- yes, are they identifiable from the Department?

MS. POND: Well, we could do that, but I just need to understand that a lot of times we get in claims where there's no medical evidence of a diagnosis.

There's not an eligible survivor so,

you know, they can be denied for a lot of other reasons. There's no covered employment. So just because they don't have an IH doesn't mean that's the reason it was denied.

So it would be, you would be getting a lot of other things in there that could be completely unrelated to the exposure. Because we don't get to the exposure until we've confirmed the diagnosis, but there's covered employment, but there's covered survivorship in some instances so --

MEMBER CATLIN: Yes.

MS. POND: We identify if there's no IH, but you'd be getting a lot of other things.

MEMBER CATLIN: Yes, I appreciate that. No, I guess what I'm looking for is claims where there is a medical diagnosis. A person has, you know, the proper work history of the claims.

And I just know this from prior experience in workers' comp cases where the case

manager would not necessarily, they would decide they didn't need any additional support and they would just deny a claim for whatever reason.

And so, if that's occurring, then we ought to, that would be a subset we'd want to look at in our claims reviews.

MR. VANCE: Yes, this is John Vance. I think what you're speaking to is the establishment and the viable health effect because that's part of our claim adjudication process.

If we do have covered Part E employment, and a covered Part E illness, the first step in the review process is determining whether or not we have any viable health effect data either established through the Site Exposure Matrices or medical evidence specific to that employee.

Whether or not we could be able to identify cases that stop at that point because no health affect data is available for us and we

end up denying it on that basis, I think we'd have to take a look at what our requirements were, would be for identifying those cases if it's even possible.

MEMBER CATLIN: Okay. Thank you.

CHAIR MARKOWITZ: Yes, this is Steven. So Mr. Catlin, when you were thinking about a case in which the claims evaluator, examiner, the person has covered employment, they've gotten, you know, over the usual obstacles and that person's looked at, the examiner's looked at the SEM, perhaps not found any exposure that's relevant.

Or found something, but decided that the information was sufficient without sending to an IH and then made a decision. And you're wondering about the quality of that decision. Is that the --

MEMBER CATLIN: That's correct, yes.

CHAIR MARKOWITZ: Okay.

MEMBER CATLIN: Yes. Especially where

the claim might be denied as opposed to approved.

CHAIR MARKOWITZ: Right.

MEMBER CATLIN: If the claims manager felt like he had enough information she could support the claim, that's one issue. But the one that I would be more concerned about is the claims manager if they have that prerogative to not seek additional information and then deny a claim. I'd be interested in seeing those.

CHAIR MARKOWITZ: Right. So this is Steven. I have a question for the Department because we're going to look a table later on the public reading room which has, I think has this information or that or you provided previously to the Board.

You were able to sort through by a disease, the reason for the denial. It was, sometimes it was causation, sometimes it was various other not covered employment, various other things. And if you're able to, if you

recall, if you're able to sort by causation, the reason for denial and if you limit it to causation whether that would, the causation wasn't there.

Whether that would help sort through claims to get at what Mr. Catlin's driving at.

MS. POND: John, I'm going to let you answer that.

MR. VANCE: It's always certainly possible for us to go back and look at the nature of the request and try to figure out how we could utilize our coding scheme to try to identify a population of cases that may fit to that particular sample that's being sought. It really depends on the specificity of the request.

And yes, we do have lots of different coding combinations that explain justifications for denials, but again, it's going to depend on what it is that you're specifically looking for and then I'd have to go back or we'd have to go

back to our reporting and data analytics team to figure out whether there's some mechanism for us to extract that kind of data out of the system to identify cases that are potentially going to be fitting the specific request.

So is it possible? Yes. It just depends on what you're searching for and then what we're capable of doing within our system.

CHAIR MARKOWITZ: Okay, so it's Steven. Let me ask the Board members. We have this interest in Parkinson's disease or other neurologic illnesses. Is there some interest in cancers?

Other conditions that people have a particular interest in? I do think we should look at some beryllium disease. It's Part B so it's a little different.

And there's much more instruction in the statute around beryllium, but I think it's worth familiarizing the Board members with beryllium disease.

And I think we should probably also look at some pulmonary disease because it's very common and a very high rate of relatively high rate of acceptance actually.

So let me ask, in terms of the numbers of claims that we want, because we definitely do not want to be overwhelmed here, and so I'm asking this really of the Board members who did have the opportunity in the past to look at claims.

How many do you think you personally would find not overly burdensome to look in the way that we did before. To look at critically and then a brief report back to the group on that claim?

I think we actually had 92 people to each claim. That was in part because we were trying to see to what extent there was a common agreement on some of the weaknesses or strengths of the claims that we looked at.

But for instance, Dr. Silver, Dr.

Friedman-Jimenez, Dr. Mikulski, would looking at three or four or five claims, would that be overly burdensome?

MEMBER SILVER: Ken Silver here. It depends how close to the report backdate at our next meeting or working group the claim files arrive.

I remember getting a disk like ten days or two weeks before a working group meeting and spending the entire Labor Day weekend getting my four or five claims done.

If it had been in hand a lot earlier, you know, I'd feel a lot better about having done those four or five claims and on a few occasions, yes. We had them well in advance so.

CHAIR MARKOWITZ: Yes.

MEMBER SILVER: The number is directly proportional to the amount of lead time.

CHAIR MARKOWITZ: Dr. Goldman?

MEMBER GOLDMAN: The other thing I'm

thinking for doing these, I agree with Dr. Silver, is like the specific question we're asking or looking for.

For example, on the pulmonary that you noted, I recall from the previous discussions, for example, that there were issues with asbestosis not being diagnosed because somebody had a diagnosis of interstitial lung disease.

And somehow, interstitial lung disease wasn't being connected that it could be asbestosis. Or there was a word fibrosis and it wasn't being connected back that it could be asbestosis.

So I'm wondering if, just so we're not totally rediscovering the wheel again, if there were these things that came up previously and I know that Carrie Redlich wrote that and I thought that some changes made then implemented to sort of connect now fibrosis to asbestosis if there was an asbestos exposure.

I'm wondering if we could look back again at some of those issues that were identified in the past and then use this opportunity now if we're going to do a re-review of cases to say, okay this is something that was identified before.

So we want to pull out a case of interstitial lung disease and see if this issue, you know, was corrected or not corrected. So I think I'd like to see some building upon the past work.

CHAIR MARKOWITZ: This is Steven. That makes a lot of sense and what I think I'll do is go back and look at, I don't know if I have the stomach to look at the transcripts, but look back at some notes and see if we can identify some of those.

Although I have to say, the purpose of this look at the claims is not so much to identify problems in the process because I don't think we'll be looking at enough claims to

really be able to make much of a statement about that, but I agree with you.

Why not look at those issues and see what we can learn about those issues while we're doing that so I'll --

MEMBER GOLDMAN: This is Rose again. I don't know that you have to go through all of the transcripts per se. I think just from memory, I know that when I first came on, Carrie Redlich had put together a report for example on asbestos.

It was something she wrote and submitted. It was just a report and I think that we did a report on Parkinson. Dr. Mikulski and myself and others a year ago so I think looking at those past reports and saying, okay, let's pull a case of Parkinson's disease to see, you know, how that's being handled.

Let's pull a case of interstitial lung disease and seeing what's happening now with the, or a diagnosis of pulmonary fibrosis.

Is that, is there an attempt to connect that to an asbestos exposure or not.

So that I think in this process of just seeing where we are again, we could pull out a couple of these things that were brought up before and if particularly if we're going to pull cases from 2020 just see what the status is as long as we're going through the process as well as seeing if there has been a change from the past experience and what came forth.

CHAIR MARKOWITZ: Okay. Good idea. Dr. Silver, your hand's up. I don't know if you wanted to say something. Okay. So I'm taking notes here. Recent, relatively recent completed cases, mostly denied, some accepted. To the maximum extent possible inclusive of IH and CMC reports.

A mix of different diseases including neurologic, pulmonary, cancer and beryllium. The cancer cases shouldn't be a derivative from, except in Part B, cancers.

And I think that's pretty much it. I'm sure that when we prepare our requests and submit it to the Department, if you could give us feedback on things that we, that you need to know in order to locate these, cases, that we can provide you with additional details on subsets or the like.

As we will, our past experience is they're always still some questions remaining given our distance from the administrative data base.

Anything else on this topic, otherwise we're going to move on in the agenda? Oh, so I never got an answer to the questions of how many claims is reasonable.

I'm, I don't know that we need to have, well, to make it easy on the Department, actually we should have a claim reviewed by multiple people for our purposes is to a large extent learning about the claims, then that learning can be done.

That will also expedite things as it means we can request fewer claims. Is it reasonable for those of you have looked at claims in the past to consider that if there's sufficient time that by looking at three or four or five claims is a reasonable number?

MEMBER SILVER: Silver here. Yes.

CHAIR MARKOWITZ: Okay.

MEMBER MIKULSKI: I'd say yes. This is Marek and depending, of course, on the time involved and if it's at all possible to go the character recognition in that certain that Dr. Friedman-Jimenez had mentioned, that would be definitely much more helpful.

CHAIR MARKOWITZ: Okay. Good.

MEMBER GOLDMAN: I would say three depending on what they are, but no more than five.

CHAIR MARKOWITZ: Okay. Good. Well, yes, there are twelve members of the Board so we'll figure that out. Okay, let's, so I'm going

to, I'll draft the request and I will probably circulate, I guess I'll circulate it to the Board members.

If you could take a look and see if I've captured everything from the discussion today and then we'll submit it. Okay, let's move on to the next topic.

This topic is, I thought that we should take a look at program statistics data quickly. Not so much with the idea that we're going to dwell over each of these things that the program puts out as much as to understand the kind of data that are publicly shared and whether there are additional kinds of data limited, but additional kind of data that would be useful to us in doing our work.

And this in part, I remember for instance and those of you who are on the Board at the time when we got the top 10 conditions with the most number of claims, and then broken down by organ system, it was, I thought,

extremely illuminating about how the program operates.

So I've asked Kevin to pull up the publicly, the, bring us to the public reading room of the OWCP and then if we can look at any number of, if you would pull up, let's see Kevin, I think you, okay so Kevin, tell us do we have control over the page now or do you have?

MR. BIRD: No. Just let me know if you want to see. I have control. You should be able to zoom in, but other than that, I have control.

CHAIR MARKOWITZ: Okay. So the, let's just go in order. Some of them aren't going to take very long. Because it's very limited interest, but if you could go to the actuarial reports.

And we can go to the most recent one, 2020 and see if it's available. Okay, so this is a 42-page document. If you go just down the page, you'll see this is just basically mostly

about funds.

It, there are data in here about the number of claims. If you scroll down a little bit, now Kevin, can you, I don't know if this is, can you make it a little, the font a little bit larger than just the view?

A little bit more. Okay, how's that? Okay. So just scroll down a little bit. I want to get to, there's a section in here which gets beyond money.

Although the money part is interesting, it shows you how much impact the program has had over the last 21 years. But there are some data here in, keep going, okay.

So you can stop there. Okay, so you see, if we could look at the graph. So this is just RICA approved cases by quarter. You can go to the next page because we're not concerned with the RICA cases. So here's, so beryllium disease cases approved by quarter under Part B and you can look at 2015 to the present.

And you can see sort of the trend although I have to say I'm not sure what indicated versus prior selected, but I focus really on the blue or the actual number from past years.

So you can see the number berylliums of these cases. It varies, but it's going down over time. Sensitivity, it -- the vertical axis is, relatively small numbers in cases so there's some variation.

I'm not sure what it really means year to year. But you can see silicosis cases approved by quarter. So and if you could just make that a little bit larger, Kevin.

The bottom graph so we can see what actually the horizontal, okay so it's by year actually, by number of cases. So that's interesting.

Okay, we're not really discussing it so much at the moment to understand all of this just to see what's available, but number of

cases seem to have gone up quite dramatically actually in the last few years.

And Kevin, if you could keep going down. These are Part B SEC cancers. See these are Special Exposure Cohort cancers. And, going down per year, the beginning of 2015 of this graph, it was close to 400 now it's closer to 300 or less.

A cancer non-SEC Part B, could I ask, Mr. Vance, what are those cancers? There's Part B, but there, oh I see. These are those with instruction cancers. Right?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Yes, right. Okay. And then Part E, go to the next down page a little bit, Kevin. Okay. Part E cases approved by quarter. Okay.

So anyway, so that's what the actuarial data looks like. Let's go to the next and people can just chime in whenever with questions or comments.

And the response to the Ombudsman Report, I don't think we need to see that. The staff training manuals of interest, but not at the moment. The, let's go to the fourth item, the contract medic consultants and second opinion.

Okay. So these are the quarterly audits. It's just got the most recent one which I think is the top one. And we've looked at these before.

And we can look at, let's go to the fourth quarter, let's go to the medical director's audit. And so what this is, that's just the, bring the page up a little bit and bring it down a little bit. Yes.

Okay, you can, yes, you can stop right there. So this is done quarterly. The medical director looks at close to 50 and in this report it was 48 randomly selected CMC reports and with four distinct services, causation analysis or impairment ratings or

second opinions or file reviews.

And the medical director then looks through those for essentially quality in terms of auditing and then in the second paragraph, you can see the other 48 reports, six exceeded expectations, 39 met requirements and three did not meet requirements and then if you go to the next page.

Okay, there's a, and what they what this report then does is what the defects that are found what the problem was and this case inappropriate application of the AMA guides and there was yes, and then the WPI rating.

Again an impairment related for two of the reports. So these three reports, there were problems. All had, they seemed to have impairment issues.

So in any case, so this is done every quarter and then if you go back one, Kevin, the CMC report, this audit is then goes, you can go to the audit analysis report. Just below that.

So this goes to Mr. Vance. Oh, Susan, I'm sorry. Goes to Mr. Johnson who looks over these things besides on the audits and then what actions occur as a result of the audit.

So this is another level of review. It's where we would be more interested in frankly in the medical director's report than here, but in any case, this lets you know this exists.

And okay, so we can go back and go back again and let's go back to the reading room and look at program summary statistics. And that we can just pick the most recent one.

The, yes, September 2021. And if you could make this a little bit larger. So this is the report for September for two months ago. A number of new claims, number of cases across the country, the part whether it's a B case or an E case and then they give year to date in addition to the month.

So this really captures kind of the

flow of claims, really the incidents of cases and claims broken down by Part E and D for given months.

So it is useful because it just tells you the volume of work that's going on. I mean, new cases fiscal year to date that 2,673, the number of new claims, 6,239 and this is 2021.

You know nine months to the end of September. Okay, so if we can go back to the reading room. This is given for every month. And go back one more, Kevin.

Let's go to the next one, accepted claims cancer claims, data release. Okay so what we have here is a listing of accepted cancer claims by ICD code by, you know, the text correlate of the ICD code.

We're looking at a cancer of the lip, cancer of the tongue and what facility the person worked at or the dominate facility they worked at or whatever and then the year that it, the claim was accepted.

This seems to be in order of the ICP code and this goes on. This is quite a large table. And so one could look at the number of successful cancer, accepted cancer claims by the DOE site by year.

And also the total number of cancer claims for any given ICD code or cluster. Okay. Let's move on. And let me oh, let me just ask, I'm sorry, let me just ask Mr. Vance I think or Ms. Pond.

Why did you produce this data release? Do you remember? I know it's five years ago, a long time ago, but --

MS. POND: Oftentimes we put these out in the public reading, I'm sorry, public reading room when we get a multiple file request for the same information.

That way when we get another request for that information, we can just point someone to the web site and also it provides us with an indication of the kind of information the public

is asking for in general.

That's probably why we created this. I can't say for sure that's the reason, but that would be my guess.

CHAIR MARKOWITZ: Okay. Thanks. Kevin, let's go back to the reading room. See what else we find. Oh, yes, the accountability review. This is rough.

I've started 2020 and then why don't we go to the top one, branch of, well, actually why don't we go to 2020 AR, close out memos and overall summaries? District Office.

Are they, no I'm sorry, the overall summary, the third one down. I'm sorry. Within, yes, --

MR. BIRD: This one?

CHAIR MARKOWITZ: -- that one. Let's look at that one. Oh, okay. So this is a quality review and correct me by the way if I make mistakes here, but which is done at the District Office level of a certain number of cases, a

large number of cases, are reviewed and they look if you can go down, you can look at the described findings.

It's one of the 90 percent acceptability rating. And they look at the quality of the work of the claims review. So there are a lot of these accountability reviews.

Mr. Vance, can you just explain to us what they're really focusing in on?

MR. VANCE: Well, let me start by saying that we are no longer doing the accountability reviews, but in the past what we have done, this is like a qualitative assessment of performance by our District Office.

Our final adjudication branch in our medical benefit unit and it's basically evaluating the qualitative satisfaction of particular standards with regard to, you know, development accuracy and quality and then decision making quality and accuracy.

And so this was reviewing a variety

of different criteria that would have been assessed by the audit team.

CHAIR MARKOWITZ: Okay. And this is part of your sort of renewed quality review process. You've replaced this with a, I think a different system you mentioned yesterday.

MR. VANCE: Yes. It's an ongoing process now by a quality insurance group.

CHAIR MARKOWITZ: Okay.

MS. POND: Yes, the difference, this is Rachel. The difference in this rate is with the annual reviews we collected a sample for the entire year and it was usually, you know, a lapse with at least a month sometimes more than that.

That we had to go back so now we're looking at real time places and that's where we find it to be more helpful in the annual once a year review that we were doing before.

CHAIR MARKOWITZ: Thanks. So let's go back to the reading room. Additional program

information. The next, third to the left. Okay. And this, so let's look at the third blue line, the top medical conditions.

Okay. So we're looking at, is that large enough for people to see? We're looking at chronic silicosis, 2016 to 2019 so the better part of four years.

ICT Code there are 885 claims, 60 were approved, this is under Part B which has specific language on silicosis. And then certain number of claims pending, but 75 percent of the claims that have been resolved have been approved and here's the reasons for denial.

Actually this is what I referred to earlier, what I asked about. They can see that the majority of the denials were due to were you not covered and then there were some with negative causation.

But there's some other categories. Insufficient medical information, it's a survivor case that is not eligible, et cetera.

So Part B silicosis in those three plus years, 75 percent approved. Okay. Let's go to the next one.

Health conditions, top 10. That's where we're looking at that, okay. And then if you could move it over. So if I'm correct, I think these tables were created at the request of the Board.

But it helps me to understand what the, what people were submitting claims for and what they were getting approved for. So this takes, this is all health conditions, top 20.

These are Part E claims so these are not Special Exposure Cohort or dose reconstruction cancers, it's not silicosis, it's not -- actually there's someone typing.

If you wouldn't mind just muting your phone there, that would be great. Thanks. And you can see that large numbers of claims, the Column E is the number of claims for skin cancer.

Numbers, the second is for chronic obstructive pulmonary disease. And then cancer of the prostrate, hearing loss, et cetera. Actually when we looked at this, some of these rows kind of need to be aggregated, but for this purpose of understanding, and you can see on Column I the percent approved that it varies.

You know, prostate cancer was about 2 percent, COPD was about 40 percent. If you go down to row 17, pleural plaque, 68 percent, 67 percent were approved.

So a lot of cases approved and a lot of variation. And that's what we'd expect actually, a variation. Third line from the bottom, breast cancer 1 percent approved.

For whatever reason we seem, second row from the bottom, we see skin can -- oh it's melanoma and polyneuropathy, 39 percent. So anyway, this is through September 2019.

It's about three years old and then let's just look for the reasons for denial. And

you can see negative causation is the most important one for most of them, maybe even all of them actually.

With some medical information insufficient, but relatively few other reasons. But this issue of causation and the claims evaluation process of causation is key for a fair portion of the denied claims.

So let's keep going. Let's look at cancer top 10. And so we see skin cancer, prostate cancer, and et cetera. If you could look at Column Percent Approved, Column I, you can see that skin cancer 15 to 20 percent are approved, that lung cancer left 22 percent and other site cancers unspecified about 11 percent.

And then on the other hand, colon cancers is 3 percent, bladder is 9 percent. So considerable variation, some of the nature cancers, very little acceptance of the claim. And again --

MEMBER GOLDMAN: This is Rose Goldman

--

CHAIR MARKOWITZ: Yes.

MEMBER GOLDMAN: -- Goldman again. I'd like, --

CHAIR MARKOWITZ: Sure.

MEMBER GOLDMAN: When we looked it over, I could be misremembering, but from the spring I think I looked up whether breast cancer was anywhere because it had come up with this diary and I didn't see it as a compensable anywhere on those guidelines.

So it's interesting to me that somewhere breast cancer was compensated. So I'm not even sure where that derived from.

CHAIR MARKOWITZ: Yes, there were three approved cases. Yes.

MEMBER GOLDMAN: Interesting.

CHAIR MARKOWITZ: All there. Yes. Let's skip ahead to neurologic actually and then we'll come back to respiratory. If you could go to the, yes.

And the top claim is sleeping disorder. Now, there are question for Mr. Vance. Consequential conditions are in claims are included here. Right?

MS. POND: Yes, they are.

MR. VANCE: Yes.

MS. POND: They are.

CHAIR MARKOWITZ: Okay. Because my guess is a bunch of the sleeping disorders are a consequence of other conditions that people have.

MR. VANCE: Yes, that's a common consequential illness for pulmonary disorders that we accept.

CHAIR MARKOWITZ: And so you can see on Column I, percent approved, 34 percent are Parkinson's disease. A lot of the neuropathies, 39 percent of polyneuropathies and it appears again with the Row 13, 41 percent of inflammatory polyneuropathies and, in fact, even line 12 other neuropathy, other peripheral

nervous system.

So a lot of neuropathies approve 8 percent of Alzheimer's, et cetera. So there's a lot of claims and a lot of variation. And again, if you look at the Column K, causation is the most important I think.

And you've got to wonder about consistency in looking at these results. How consistent the determination is by frankly probably by the mostly by the CMC so.

But that's one of the things we might want to look at in the future. And then let's just go back to the respiratory, oh so I'm sorry.

Go back to neurology, because there was, when thinking about what kind of claims, we were going to ask for Parkinson's. Dr. Bowman, do you see another diagnostic category you think we should ask for?

MEMBER BOWMAN: I think Parkinson's is fine. For those that are not approved, I'd

like to focus on the negative causation and not the others.

CHAIR MARKOWITZ: All right. Okay.

MEMBER BOWMAN: I'd be curious to see an example of the Alzheimer's I suppose. Especially given the percent approved. It actually seems relatively appropriate given the incidents of that in the general population for that to be a lower percentage.

But it'd be nice to just get a sense of what is approved versus not approved so definitely an approved one versus nonapproved. And that could be good because again, I don't want to get too many of these points so it might be better when we have that group working with us.

CHAIR MARKOWITZ: Yes, okay. Thanks. Also I've made --

MEMBER GOLDMAN: This is Rose Goldman. What's interesting is Alzheimer's, do they mean Alzheimer's or is there a dementia

which is really the toxic encephalopathy?

The other thing that's interesting is peripheral nerve disorders which is actually there's not too many chemicals that can really cause that.

And yet, there were 44 claims, you know, 44 claims for it and 17 accepted which is sort of interesting.

MR. VANCE: Well, can I, this is John Vance. Let me clarify very quickly so everybody understands that we can actually accept cases such as Alzheimer's disease based not solely on information about known health affect data.

It can actually be accepted based on the weight of medical evidence assigned to a treating physician or a claimant physician offering a real rationalized explanation as to how in the view of the physician, a particular chemical or biological, radiological exposure is reasonably contributing to the onset of that disease.

So in other words, if there's a physician who has either a salient argument to be made about different types of hard metals that are potentially affecting the brain in some way, then they can stash on a very well rationalized argument as to why in the opinion of that physician that could be a contributing factor to the development of the disease like Alzheimer's.

That could serve as a basis to accept the case. So I just want to make that point of clarification.

MS. POND: And this is Rachel. Just to piggyback on that, you know, a lot of physicians of particularly more recently are talking more about aggravation and contributions and causation.

And that's the argument that they're making in a lot of these cases now especially that they understand the difference between Part B which is solely causation and Part E which is,

includes aggravation contribution and they're saying in a lot of these reports, well, it didn't, I can't say that this caused that condition.

But I can say it contributed to it so we're getting more and more of that as well.

CHAIR MARKOWITZ: This is Steven. That's interesting because, you know, the thing about a painter chronically exposed to solvents who develops memory loss and then Alzheimer's then you can see how, you know, it would meet a contributory or aggravating standard for sure.

Okay, let's just look at respiratory and then we'll move on. And COPD, most by far most common 40 percent approved. And as almost 50 percent approved. So a lot of and again, negative causation.

Although in a fair number of cases, this institution has more information so this is interesting. Okay, I think we can go back to the reading room unless somebody wants to say

something here.

And I think that we may be at the end of, yes, I don't think -- oh, I'm sorry. Could we go back to additional, the program information for one second and then go to the second line, count of living employees with accepted medical conditions.

So this is ordered by State and by ICD code. What I think each row is an individual and what their accepted condition is. Oh, I'm sorry, count, not individual, count of living employees. Okay.

Those are number per state per ICD code of living employees and so Ms. Pond or Mr. Vance, do you recall why this was produced or what this is used for?

MS. POND: I believe this was requested from a stakeholder through FOIA. You do know that this is from 2018 so a lot of these reports, they were run back then.

We said, oh, they've been asked for

from a number of different stakeholders through FOIAs and we put them out there. If you wanted updated, we could probably update some of these lists, but you know, we just have to update them and run that report was a new date.

CHAIR MARKOWITZ: Yes, I think the previous tables with the counts by ICD code were probably more useful to us, but this is interesting.

Dr. Goldman, you had your hand up. I don't know whether you, that's intentional or not. Okay. We can go back. I think that's it for the reading room so.

MEMBER BOWMAN: This is Aaron.

CHAIR MARKOWITZ: Go ahead.

MEMBER BOWMAN: Look on that last table. I just want to make sure I understand what's being presented. It says of accepted medical conditions.

Does this mean of accepted claims for medical conditions? I just want to --

MS. POND: Yes, this could be, the request I believe was for any living employees in these states, the numbers in each of these states with accepted conditions.

So basically, yes. These are people that would have accepted USS claims.

MEMBER BOWMAN: But would not be for example of a condition that existed, but was say rejected. Denied, per se, negative causation so it's not a summary of the illness of all employees currently. Is that correct?

It's just those with an accepted medical condition in which all of the criteria of acceptance has been met.

MS. POND: Correct.

MEMBER BOWMAN: Is it possible to create said document in which it, you know, not where there's not where there's insufficient medical information, or so.

But that would include some of the denials to get a sense for those, just the

overall health of the employees? Does, is that a doable type of information?

MS. POND: Well, we could train someone. I think we'd probably have to be specific about exactly when you say health of the overall health, you're, I'm not sure if you're meaning --

MEMBER BOWMAN: I'm sorry. I meant of say, of claim, of applications for claims regardless of whether or not they were accepted or denied.

MS. POND: So you want to list like this, maybe not by state, but well, however. We could probably work with you on something and one of the things I would suggest and I know Dr. Markowitz has done this in the past.

Is, when you phrase these Requests for Information, we have discussions before you put them all in writing with either John or Doug or somebody in our program.

Just because that way we can make

sure we phrase it in such a way that we're capturing what you need.

MEMBER BOWMAN: All right. And thank you.

CHAIR MARKOWITZ: Okay, I, that's it for our visit to the public reading room. I think if anybody has any comments or ideas, I think it is useful background for being ahead of what we might learn from claims review, where to emphasize, you know, where there seems to be lack of unanimity in terms of approval versus denial.

Not suggesting there's inconsistency, but just that there's, that maybe that's where there may be variation. Dr. Silver, you have your hand up? Would you like to say --

MEMBER SILVER: Yes. Can you hear me?

MEMBER MARKOWITZ: Yes.

MEMBER SILVER: One suggestion and one question. A couple of weeks ago I got a request from a public interest group for site

specific claims statistics.

And he's a long time public reading room and FOIA warrior so he was in the part of the Department of Labor website that we just looked at.

But it didn't have what he was looking for. I was able to direct him back to the name OWCP/Energy website where down in the lower right corner there's a compilation of links called Statistics and Public Reading Room.

My suggestion to the program is that for the public reading room site, you provide a way for them to get back to the state and worksite and total benefits by facilities data.

You can't get there from here where we just were so it'd provide a more holistic integrated experience for the kinds of data that some advocates and stakeholders are looking for.

And if that was too confusing, for Mr. Vance and Ms. Pond, I'd be happy to follow up in an email. And my suggestion is, when the

Board makes these claims requests, have we ever considered an efficiency process where we go straight to the claims examiners and ask them about their recent claims that have passed by their desks that maybe meet the Board's criteria?

Wouldn't that be a little bit faster than going through the massive computer system?

CHAIR MARKOWITZ: Yes, this is Steven. I, frankly I would, if that's true, I would leave that choice to the Department. If they think that's a way of expediting, identifying the mix of claims that we want.

It depends on the relative, you know, difficulty of working with the data base versus your suggestion. They can certainly consider that.

MEMBER SILVER: Has it ever been done? I guess I should reframe the question.

CHAIR MARKOWITZ: This, so let me ask Mr. Vance. Does that make any, would that help

the process at all or?

MR. VANCE: By doing some sort of employee survey of some sort? Is that what you're suggesting Dr. Silver? Like what are their concerns? I'm not aware of us doing that.

MEMBER SILVER: No, if the Board goes through with something we batted around today, we want some recent party, chemical cases that have had industrial hygiene referrals and maybe a mix of those that did and didn't.

Seems like a really efficient pathway to do it would be an all-points bulletin to the claims examiners and say, you got anything for us that has recently passed through your desk that meets these simple criteria?

You know, you may not get more than 50 percent response, but you probably, you know, get a bunch --

MR. VANCE: I think, this is John. I think anything is possible. It would just depend on how well Rachel and the rest of the program

decided useful in responding.

But you know, we do that frequently where we're looking for different things. I mean, it's certainly possible.

MS. POND: Yes, this is Rachel. I got, I actually hung up and I apologize. So I think that what you're asking is instead of having trying to pull cases with certain criteria, maybe we just pull our claims examiners and say do you have any of these I the ones that you've completed.

I would have to kind of probably talk to our District Directors and see how useful that might be, what we might get out of it. Because a lot of times you guys are asking for final cases that go all the way through final decisions and our claim examiners are usually working in active cases.

So they'd have to kind of remember a recent one that that might be a challenge. But we could have further discussions about it

offline.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: Dr. Bowman?

MEMBER BOWMAN: Nothing for me.

CHAIR MARKOWITZ: Okay. Sorry. Okay, so I think that concludes this part of the agenda. And, it's 2:40. Let's take a 10 minute break and then we're going to come back and clean up some things. So let's reconvene at 2:50.

(Whereupon, the above-entitled matter went off the record at 2:41 p.m. and resumed at 2:51 p.m.)

CHAIR MARKOWITZ: Okay, just to pick up the last point, and so the link that I just sent to you, so Dr. Silver sent me a link on some additional state and facility specific data that he thought was useful to, actually I'm just bringing up my WebEx here.

Okay. Yes, so these are program statistics and I guess and if you scroll down,

see you can access by state and then when you go, you'll pick a state, pick Colorado for example.

If you go into Colorado, you get to see a number of different facilities. You go into Rocky Flats about the middle of the list, and it gives you, if you scroll down part, you can get Part B, Part E, statistics, number of cases approved, denied, monetary value in relationship, et cetera.

So Dr. Silver, your point was that there should be a listing of events and a link into to the public reading room. Is that your point?

MEMBER SILVER: Right.

CHAIR MARKOWITZ: Okay. Well, sounds like a good idea.

MEMBER SILVER: I mean this needs to be really accessible on the main webpage, but putting myself in the shoes of a public interest information hound, some might go straight to the

public reading room and they would have no idea that these data exist on another webpage and that conceptually so closely related.

Let's just make it a little easier for them by putting the links on the public reading room.

CHAIR MARKOWITZ: Yes, okay. Mr. Vance, does that sound like something that could be done?

MR. VANCE: I always think anything can be done. It's just a question of looking at it and deciding whether or not the programs going to accept that as a change.

CHAIR MARKOWITZ: Yes, okay. All right.

MS. POND: We can talk about it. This is Rachel. Either, I mean, if you go onto our website and you see statistics, it's pretty straight forward, but you know, we can talk about it internally.

CHAIR MARKOWITZ: Yes, okay. Next

item, okay so let's go back to our agenda. There was a question, I think Kevin you had, oh on aldrin and dieldrin that was posed to us.

And while you're finding it, it was in an email. I think the issue, if I understand it, is that the question to us is does aldrin and dieldrin are we recommending it be linked to both female and male breast cancer or just male breast cancer?

I think that was the question. And then there's different ICD codes for male and female.

MR. BIRD: Is this what you're looking for. Correct, Dr. Markowitz?

CHAIR MARKOWITZ: Not that highlighted part, but if you go down, yes, the two questions there. Should the stem differentiate male versus female breast cancer.

Different ideas in linking it to Aldrin and dieldrin. So for those of you that looked at this literature, I'm guessing that

whatever was available was relevant to female breast cancer because male breast cancer is very rare.

MEMBER GOLDMAN: This is Rose. I would have to go back to the IARC. My recollection and maybe George is more familiar as they just noted breast cancer. I'd have to go back and see if the studies, you know, included males or female.

I mean, female is so much more common. I'm just not sure. I'd have to go back and --

CHAIR MARKOWITZ: Okay.

MEMBER GOLDMAN: -- perhaps look at the specific studies.

CHAIR MARKOWITZ: Okay. That --

MEMBER GOLDMAN: But --

CHAIR MARKOWITZ: And Dr. Friedman-Jimenez, you don't remember do you?

MEMBER FRIEDMAN-JIMENEZ: Well, male breast cancer is much more rare than female.

Maybe 1 percent of breast cancers are male or less.

The few studies I've done that have had male breast cancer cases, they've been one or two cases. So there's really not a lot known about the environmental causes of male breast cancer.

And to look at the other side of the coin, I don't know that there's enough information to say that they behave any differently. You know, obviously the hormonal aspects are different, but I don't think we know enough about male breast cancer environmental causes to say that it's significantly different than female breast cancer.

So I don't see a basis for differentiating them.

CHAIR MARKOWITZ: So shall we, this is Steven. So we sort of consider this a little bit and look at the studies, consider it offline and then get back to the Department?

MEMBER BOWMAN: We, this is Aaron Bowman. We could, I just recently looked up the IRAC volume on this and we are going by IRAC recommendations.

The statement is submitted evidence for breast cancer in humans. It does not specify sex. If that helps the conversation, but potentially some offline discussion would be helpful.

CHAIR MARKOWITZ: So how should we proceed on this?

MEMBER GOLDMAN: Well, if that's their conclusion, this is Rose Goldman again. I don't know that we would go to differentiate it if it's breast cancer in humans.

Men are human so I think rather than dig down and try to go into the various studies, they didn't distinguish breast cancer in females, they just said, breast cancer in humans.

So do we need to go down further than

that?

CHAIR MARKOWITZ: Okay so then the idea then is just to include both males and females in the association.

MEMBER BOWMAN: Yes, I think that would be consistent with IRAC and consistent with the philosophy that we took to this.

CHAIR MARKOWITZ: Okay.

MEMBER FRIEDMAN-JIMENEZ: This is George. I like Rose's agreement that men are human too. But I'd be willing to just take a quick look, I have a pile of epidemiology cancer epidemiology textbooks here.

I'll look through and I'll get back to you probably by the end of this meeting.

CHAIR MARKOWITZ: Okay.

MEMBER FRIEDMAN-JIMENEZ: Yes.

CHAIR MARKOWITZ: So we're leaning towards, we're leaning in one direction and we'll come back to this within the hour or so. Okay.

MEMBER GOLDMAN: I still stress by the way that they could never fractionate it, you know, whatever studies they were looking at for male breast cancer and I guess one of the issues would be, you know, if they didn't even have any cases of male breast cancer because it's so rare, would that mean and I appreciate George going to look at this, would that mean that we would then not include male breast cancer since it's still breast tissue even though there are hormonal differences so.

I mean, I appreciate George doing it, but I think in the end, it's probably going to come down to another one of these judgment calls and decide to be more inclusive rather than exclusive in this setting.

CHAIR MARKOWITZ: Okay. Well, let's revisit this then in a little bit. We should be able to resolve it today. Let's move on to the styrene issue. And let me ask you, there's been some email exchange around this.

Is it useful to show the summary language that Dr. Bowman came up with that people seem to endorse as a way of discussing this?

MEMBER GOLDMAN: That sounds like a good idea.

CHAIR MARKOWITZ: Okay. So --

MEMBER GOLDMAN: Do you have that email or I mean, you have the email. Should I try to forward it to Kevin or what would be the mechanism for doing that?

CHAIR MARKOWITZ: Yes, if you could, I also have it, but I'm going to forward it now to Kevin.

MEMBER GOLDMAN: Okay.

CHAIR MARKOWITZ: So that there --

MEMBER GOLDMAN: Yes, I think Dr. Bowman's succinct summary of our going back and forth and George's extensive, I want to shout out that George had done a very extensive in-depth review of this and then it just got into

the summary sentence which I think it captures our opinions.

MEMBER BOWMAN: This Aaron Bowman. I agree. It was, George, thank you for that work. In terms of work of the subcommittee, maybe just send just my part of the summary.

Otherwise, is that just not part of the work of the subgroup. I just want to make sure we're doing that right.

CHAIR MARKOWITZ: Well, I sent, the top part of the email is, there's, Aaron's just are three lines.

MEMBER BOWMAN: Yes, okay.

MR. BIRD: So Dr. Markowitz, just to, can you just confirm for me what you would like to share here, which part of this email.

CHAIR MARKOWITZ: Just the top part of the email. The one that's limited to Dr. Bowman. And we can skip the parts where Dr. Goldman praises Dr. Friedman-Jimenez.

MR. BIRD: But the entire text in the

email from Dr. Bowman?

CHAIR MARKOWITZ: Right.

MR. BIRD: Okay.

CHAIR MARKOWITZ: It ends with the name Aaron.

MR. BIRD: Yes, okay, perfect.

MEMBER GOLDMAN: I don't know for the record, somewhere you want George's expensive commentary and review that went into support the final statement from Dr. Bowman.

That could go somewhere perhaps in a record, but for the -- or if you wanted to show that, but I think we all came from different views to the same conclusion that Dr. Bowman summarized.

CHAIR MARKOWITZ: So if I remember correctly, the question that, the clarification that the Department wanted was whether styrene's' impact referred only to AML, acute myelogenous leukemia and T-cell lymphoma or whether it was more general than that? Is that,

that was sort of the question I think.

MEMBER GOLDMAN: That's correct and --

CHAIR MARKOWITZ: Okay.

MEMBER GOLDMAN: -- this was, went back to our committee or subcommittee where we looked at it and came up, we looked at the way that IARC researched it and phrased it and then George did a really deep dive and basically came up with they couldn't separate it into different sub-cancers and just came up with a general lymphohematogenous.

So that wouldn't mean that -- or lymphohematopoietic so that you would basically include all the leukemia and lymphoma. We couldn't separate it out.

CHAIR MARKOWITZ: Right. And this is Steven. Let me understand that WHO renewed its classification of lymphomas in 2017. And there are now 70 subtypes of lymphoma. So it's gotten to be an immensely complicated area.

MEMBER GOLDMAN: Yes, I think this inclusion after you read what Aaron summarized so succinctly and quoting from IRAC is basically the practical application would be that if a worker had styrene exposure as, you know, however it's specified by latency and extent and they had any kind of leukemia or lymphoma that would be compensable.

CHAIR MARKOWITZ: Okay, that's very clearly stated. Any comments or questions about that? So I think that answers the Departmental's question. Mr. Vance, is that clear enough, or --

MR. VANCE: I believe so. We'll have to take a look at it a little bit more. I'll have our folks take a look, but I think that should.

MEMBER GOLDMAN: We can send you those text and more of the email, but that's basically supporting that both what I said and what George looked into in great depth.

Basically that's what it comes down to and if people were unclear what this phrasing meant, my translation of it, I think would help perhaps to give the practical consequence of this phrase.

MR. VANCE: Yes, this is John. My only concern would just be the coding to make sure that we have the proper classification coding for that type of malignancy.

So if we can define that, in that phrasing, then that would be what we would use. So we might end up looking at the coding and making sure that if we do have some sort of classification of this as a group that the Board agrees that that's the proper coding classification for it.

Because that's what then would be utilized in assigning that to different cancers and some.

MEMBER GOLDMAN: Oh, that's going to be a real problem when you go to the ICG-10

coding because there's so many. I mean, you could take the higher level categories, but you're going to go down as Dr. Markowitz was just mentioning.

I mean there are so many subgroups and diagnostic codes that would fit under lymphoma and leukemia would be a lot.

MR. VANCE: Well, but if that's the classification using lymphoma as a key to this, I think that we don't have to look at what sticks for the site exposure matrices because we have those classifications in SEM so we can probably take this recommendation and go back to Paragon and ask them what they think can be done based on the current structure and the set exposure matrices.

But yes, I mean, I think we have something we can start that conversation with and see where it goes as long as we have a semblance of an idea as to what direction the Board wants us to go.

So the devil is always in these things so more than likely what I would do is go back to Paragon and ask them to help and then they're going to come back and say well, does this mean well this is how we apply it and then depending on how that conversation goes, we may end up coming back to the Board to ask for additional clarification.

But each step of this process I think is helpful in taking us where we need to go.

CHAIR MARKOWITZ: Okay, this is Steven. So if you get back to us with the listing of the ICB codes and the correspondence to this, then we can advise them whether it's, you know, need or correct. That make sense?

MR. VANCE: Is that being directed to us or is that going back to --

CHAIR MARKOWITZ: No, I'm sorry. Sorry, Mr. Vance. It's to the Department.

MR. VANCE: Yes, what I was thinking is that what I can do is I can go back and take

a look and see within the framework of the set exposure matrices what we could use to apply this guidance and see if there's something that Paragon can do to say, okay, if that's what the Board is suggesting, then this is what we think is going to work within the confines of the existing structure of the site exposure matrices.

Then we would probably at that point, come back to the Board and say, this is the proposal that we think is going to work and then see if that's agreeable or not.

CHAIR MARKOWITZ: Okay, fine. So, yes. So if there's further clarification that is required, you know, we'd be happy to help. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes, I'm just looking at the ICD-9 which is what was used in most of the cancer studies in the past and then the ICD-10 is more detailed than that.

Well, ICD-9 lymphohematopoietic

cancers is 200 through 208. That range, it's very simple. In the ICD-10, I don't know, I don't have it in front of me.

I have the ICD-9 in my hand. But I think that there must be a crosswalk between ICD-9 and ICD-10 and I think it's probably going to wind up being simpler than we're thinking.

Anyway, with so many classifications of lymphoma, that doesn't mean there are a lot of cases. It's still a pretty rare set of cancers so I think we can just look and see what the crosswalk says.

And I think it's going to wind up being fairly simple, but this is an important question. I think we should address it and I'd be happy to take that on and get back to you by email probably after the meeting.

CHAIR MARKOWITZ: Okay, great. Okay. So I think we have a plan here. I wanted to, we closed out the styrene, raised a couple of brief issues relating to a couple of the written

comments we've received and so Kevin, I sent you a link to essentially our meeting webpage for today.

And I wanted to go to the two written public comments that are listed. One is Terrie Barrie and the other is D'Lanie Blaze. And actually Ms. Barrie raised this on her verbal comments also.

I think she did maybe. I can't quite remember. If you go to Terrie Barrie, so the issue here is that there were certain cancers and, you know, and if you just scroll down some.

That's it right there. So there were certain cancers that I guess the Department asked clarification from NCI about whether they were essentially synonymous with the list of cancers on the 22 cancer list provided in the statute.

And for instance, looking at this, there was a previous bulletin Department had which added cancer of ureter as a specified

cancer and I guess in 2016, the Department withdrew these bulletins and decided that it would not be included because I guess the exchange between the Department and the NCI exceeded the allowable clarification around nomenclature essentially.

And, for instance, cancer of the pharynx is included in the 22, cancer of the larynx is not and so I went back and read some of the rationale from NCI for including some of these on the list as synonymous.

For instance, cancer of the ureter and the ureter connects the kidneys with the bladder and it's the same cell type as the bladder and it receives the same exposures as the bladder meaning whatever toxins are in the urine.

And I think the reasoning was by NCI that because of these similarities, it could be considered within the rubric of cancer of the bladder.

And I think a similar logic was applied to cancer of the larynx. My question to the Department, this involves Special Exposure Cohort cancers and dose reconstruction. Is this question or even within the realm of the topics that our advisory Board can, should, is able to provide advice on?

Because if it's not, then it's not within our realm. Fair enough. And we don't need an answer to that today, but I just couldn't quite tell whether this fell within our domain or not.

MS. POND: This is Rachel. Yes, Mike and I can talk about this after, but I, my initial impression would be that it's not. The reason behind changing our stance on this were legal reasons.

And we normally will ask the treating physician if there's a question about specified cancers or we've been known to go to EMTs or in the past medical director, so I don't want to

give you a definitive answer right now.

But I would be inclined to say since this is really coming from a legal stance, it's probably not. So it --

MR. VANCE: And this is John Vance. And, Dr. Markowitz, I did send Carrie a, some discussion that had been between the Department of Labor and the Board I want to say many years ago where this very topic came up.

So we did have a written response of this issue in the past.

CHAIR MARKOWITZ: Okay. Well anyway, that's fine. If you could just either remind us of what you said before or just let us know, that would be fine.

MR. VANCE: All right. Hey, Carrie, if you can share that, I think it explains it exactly. And we provide a written response, I don't know what it was, but it's an available written response that we provided to that, that Carrie has.

MS. RHOADS: Okay, I'll take a look.

CHAIR MARKOWITZ: Okay. So, Kevin, if we could go back to our webpage. I just want to look at the other public comments for a moment, D'Lanie Blaze's public comment. It's a related issue that's why I thought and I think also related to the styrene discussion we just had.

So here the point is it's being raised is that chronic lymphocytic leukemia is not on the 22 specified cancers, but I think lymphoma is.

And I think the point being made here is that chronic lymphocytic leukemia has been reclassified as a lymphoma in the, well she doesn't say it here, but in the 2017 WHO classification system.

And so the question she's raising or the point she's raising is whether CLL considered as a lymphoma should therefore be considered as one of the 22 cancers.

And this might be a nomenclature

issue that the NCI might be able to clarify for the Department. It seems to me if it's classified as a lymphoma, then it would fall under the lymphomas.

But NCI should be able to give an authoritative opinion on this. The --

MS. POND: I think there's a specific reference. This is Rachel, Dr. Markowitz, in the statutes of CLL being non-radiogenic. I mean, we'll need to double check on that, but there is a specific designation for CLL in our statute.

CHAIR MARKOWITZ: Okay.

MR. VANCE: Yes, no, this John Vance. The exclusion actually falls under our specified cancer definition, that's set by law so Congress, when the legislation was passed, explicitly excuses clinic lymphocytic leukemia from consideration as a specified cancer.

So when we do development, we need to have a very clear interpretation of the evidence as to whether or not a physician is interpreting

the information as whether or not the person has the clinical lymphocytic leukemia or the other variant which is the SLL.

The problem is now you have many physicians that are basically combining the two. And unfortunately, just because that legal mechanism that exists in our statute, that can't be something that we accept where you're taking a diagnosis and basically treating it as the CLL SLL combination.

The doctor has got to tell us because of that legislative requirement whether you're dealing with CLL or SLL and so this has been an interesting challenge that we've been trying to work through.

But at the end of the day, we need to have a physician telling us definitively are we dealing with SLL or CLL.

CHAIR MARKOWITZ: Right.

MR. VANCE: So it's a challenging scenario.

CHAIR MARKOWITZ: This is Steven. It appears to be the same entity so it may be the younger treating physicians with, we'll use the lymphopoietic lymphoma designation and the older ones will be used CLL because that's what we're used to.

To the advantage of some things I suppose. In any case, anyway, I just wanted to raise this issue that this was either a nomenclature issue, but clearly the statute has been specific about this.

So okay, the I don't know whether Dr. Friedman-Jimenez, I don't know whether you were going to look something up whether you were able to do that on this call or not and we can come back --

MEMBER FRIEDMAN-JIMENEZ: Yes, I actually found answers to both of the questions. The issue of ICD-9 versus ICD-10, in the Agent Orange report, which is online, there is a crosswalk table between ICD-9 and ICD-10 for all

the cancers.

And essentially the ICD-9 200 to 208 range maps into the ICD-10 range from T-81.0 to C-96.9. There are some miscellaneous malignant neoplasms at the bottom and I'd have to go through them one by one to make sure that they're on, that they make sense and this put, essentially it looks like ICD-9 mapped into ICD-10 fairly neatly.

So I don't think this is going to be a big issue. There may be a few exceptions similar to the CLL SLL thing that Mr. Vance raised, but I think this is not going to be a problem.

I can send you the reference. It's in the Veterans and Agent Orange update from 2012 Table C-2. And I'll email you the link. Regarding the male breast cancer, I looked in Schottenfeld and Fraumeni's Cancer Epidemiology and Prevention, Fourth Edition which is fairly new, 2019 I think to 2020 which is the only one

that actually comments on sex as a factor in breast cancer.

And basically they say that because of the rarity of breast cancer in males, it's 1/100th of the incidents of breast cancer in females.

The chapter basically can't differentiate between male breast cancer and female breast cancer. So no one has the data to really confidently say what the environmental determinants of male breast cancer are.

And even in female breast cancer there aren't many because it's just not what's coming up in the epidemiologic studies. So I think that considering them both to have the same determinants is a reasonable thing for our committee to say.

I can send you the exact wording from Schottenfeld and Fraumeni and Adami's textbook of cancer epidemiology didn't even comment on the issue.

Ladou and Harrison in occupational medicine didn't comment on the issue and these are the most recent textbooks of the classics in the field.

So I think we're on pretty safe ground there. I'll send you the exact wording by email.

CHAIR MARKOWITZ: Okay. Great. So that closes the topics for our meeting. I want to discuss what we're going to do between now and our next meeting.

But are there any other issues that we promised to get back to or we haven't raised that we need to discuss? Okay. So I think we need to reconvene probably in short meetings of the two working groups that we've had since the last time.

One of them IH and CMC and the other on public comments to look at the DOL responses. There were a number of questions in which they asked for clarification. And I think we should

clarify or not by bringing those things to closure so I would ask those two groups to meet for a relatively brief period of time to look at those things.

You may want to wait for the transcript of the meeting because there were some things said about some of those questions or responses and the transcript I think is, Mr. Chance, what did you say in terms of the trans -- is it the minutes and transcript in 30 days and the minutes in 90 days?

MS. POND: Yes.

MR. VANCE: Yes.

MS. POND: Transcript in 30 days.

CHAIR MARKOWITZ: Okay. You want to wait 30 days and wait for the transcript, otherwise, no need. We're going to track the issue of the progress on a contractor for the Board.

If there's some additional feedback they need then, I'll contact you to call a

meeting of the subgroup that made comments on the performance work statement and the responses previously received.

And then, I'm going to send around a formulation of the claims request to people. Hopefully next week and we can refine it and then send it in to DOL although I expect initially what we'll get back is, you know, some request for clarification which is fine.

And we'll finalize that. But the idea that we are, would get the claims, you know, a month in advance of our next meeting which from our perspective looks reasonable, but the holdup is always I think identifying the claims and de-identifying them.

And we know that takes time so we'll see about that. And what's, Mr. Vance, what's realistic I would say if we were to get a request to you say by the end of November an official request?

What's realistic in terms of us

seeing, you know, 20 or 30 claims, something in that range?

MR. VANCE: It's hard to predict until I can get the request and then understand what the requirements are going to be, work with our reporting and data analytics to build up the requirements and then to figure out from them how long it will be.

And then we have to do the logistics of pulling them and assembling them and putting on DVDs and sending them out to the Board. So there's lots of steps involved, but, you know, we would definitely try to move as quickly as we could with regard to fulfilling the request once it's agreed to.

CHAIR MARKOWITZ: Right and I'm, this is Steven, I recall doing this before when actually we got a lot more claims. It was in the range of, you know, three months or so.

So I think that works out that we would have ample time before our next meeting to

look at the claims and discuss it. Okay, was there any other and there are a few items on the action list that we'll pursue, but is there any, from the Board, any other issues that we need to follow up in an organized effort before our next so called in-person meeting?

Okay. Then, Mr. Chance, are there additional items you want to raise or say at the meeting?

MR. CHANCE: I don't have any, Steven. Carrie, do you have anything?

MS. RHOADS: Well, I think I have --

CHAIR MARKOWITZ: Well. Carrie?

MS. RHOADS: Sorry, no nothing else from me.

CHAIR MARKOWITZ: Yes, this is Steven. I want to thank everybody including obviously the Department of Labor and as always, Kevin and our EFO and Associate EFO.

And the public who have hopefully you're still in there listening to us. And we

will, you know, continue to do this work. That's it. Thank you.

MR. CHANCE: All right. Thank you everybody. Meeting adjourned.

CHAIR MARKOWITZ: Thanks everyone.

(Whereupon, the above-entitled matter went off the record at 3:26 p.m.)