U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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THURSDAY
NOVEMBER 21, 2019

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The Board met in River Room A at the Holiday Inn Paducah Riverfront, 600 N 4th Street, Paducah, Kentucky, at 8:30 a.m., Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN M. DEMENT
GEORGE FRIEDMAN-JIMENEZ
MAREK MIKULSKI
KENNETH Z. SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
ROSE GOLDMAN
STEVEN MARKOWITZ
CARRIE REDLICH*

CLAIMANT COMMUNITY

KIRK D. DOMINA
RON MAHS
DURONDA M. POPE
CALIN TEBAY*

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

*Present via telephone

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

Introductions 4
Dr. Steven Markowitz, Board Chair

DOE Energy Program Ombudsman Presentation 8
Malcolm Nelson

Parkinson-related disease Working Group
Update 33
Dr. Marek Mikulski

Review of Public Comments 41
Dr. Steven Markowitz, Board Members

Roll Call Vote on Proposed board
Recommendation-Approved................. 74

Review of Board Tasks 77

Dr. Steven Markowitz, Board Members

Plans for Next Meetings 111
Dr. Steven Markowitz

Additional Public Comments 113
Dr. Steven Markowitz

Additional Review of Board Tasks 116
Dr. Steven Markowitz, Board Members

Closing Remarks 119

Meeting Adjourned 128

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

(8:34 a.m.)

CHAIR MARKOWITZ: We're going to get started.

This is Steven Markowitz, I want to welcome you back to Day 2 of the Advisory Board for Toxic Substances and Worker Health. And what we're going to do is just some quick introductions, there being some new people, new members of the public here. So we'll quick do introductions and by that time maybe two more members of the Board will show up.

So I'm Steven Markowitz. I am an Occupational Medicine Physician and Epidemiologist at City University of New York. And I've run the Former Worker Medical Screening Program at 14 sites in DOE, including this site.

Ms. Pope.

MEMBER POPE: Duronda Pope, United Steel Workers and a former worker of Rocky Flats.

MEMBER MIKULSKI: Marek Mikulski, University of Iowa. I'm an Occupational

Epidemiologist and I direct a medical screening program for former Department of Energy workers from two sites in the State of Iowa.

MEMBER MAHS: Ron Mahs I'm a former worker at Oak Ridge plants.

MEMBER BERENJI: Mani Berenji, Assistant Professor of Medicine, Boston University School of Medicine. I'm a practicing Occupation Medicine Physician.

MEMBER DEMENT: I'm John Dement, Industrial Hygienist and Epidemiologist, Professor Emeritus at Duke University Medical Center in Durham, North Carolina. And a former worker program participant with the Building Trades program for the last 20 plus years.

MEMBER SILVER: Ken Silver, Associate Professor of Environmental Health at East Tennessee State University in the College or Public Health. I've never worked for DOL or DOE, but the program has been with me for 20 years. I used to live in New Mexico and work closely with Los Alamos families to advocate for passage and

implementation of the program.

MEMBER DOMINA: I'm Kirk Domina from the Hanford Atomic Metal Trades Council in Richland, Washington and a USW member. I've been, I'm a current worker and I've been there since 1983.

MR. FITZGERALD: I'm Doug Fitzgerald. I'm the Designated Federal Officer. I'm basically the liaison between the Department of Labor and the Board. And I work closely with Dr. Markowitz in making sure we adhere to all the FACA, the Federal Advisory Committee rules and regulations.

CHAIR MARKOWITZ: On the side there.

MS. RHOADS: I'm the alternate DFO.

MR. BIRD: Kevin Bird with SIDEM.

MR. HARTMAN: Tim Hartman with SIDEM.

STEFAN: Stefan with SIDEM.

MR. VANCE: John Vance with the Energy Compensation Program.

MS. MEALS: Lee Meals with Meals & Tolar, Impairment Specialist.

MS. DISMORE: Jill Dismore with Brightmore Home Care.

MS. STEELE: Donna Steele with USW right here in Paducah. I've worked at the Gaseous Diffusion Plant since 1975. I'm still there.

MS. WHITTEN: Dianne Whitten with the Hanford Atomic Metal Trades Council.

MR. NELSON: Malcolm Nelson, Ombudsman, Energy Program.

MR. BALLARD: Chris Ballard with Critical Nurse Staffing.

MR. McFADDEN: Steve McFadden former student at Hanford, Argonne and Livermore.

CHAIR MARKOWITZ: And do we actually, do we know whether there are people on the phone?

(Off-microphone comments.)

CHAIR MARKOWITZ: Okay, Mr. Tebay. Okay, okay. I'm sorry, yes, please, Rose. Yes.

MEMBER GOLDMAN: Rose Goldman, I'm an Occupational and Environmental Health Physician, Associate Professor at Harvard Medical School,

Harvard School of Public Health. And I have my clinical appointment to Cambridge Health Alliance in Cambridge.

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

CHAIR MARKOWITZ: Okay. So we have a full agenda for this morning. We're going to start with Mr. Malcolm Nelson, who is the Ombudsman in the Department of Labor for the Energy Employee's Occupational Compensation Program. Welcome, welcome back.

MR. NELSON: Thank you and good morning everybody.

MR. NELSON: Good morning, my name is Malcolm Nelson. And I'm the current Ombudsman for the Energy Program. And first of all, I want to thank you for inviting me to speak this morning. But more so, I want to thank you for all the work that you do.

One of the problems with my office is that we often encounter claimants who we simply cannot help. The issues that they're encountering are just beyond our capabilities. And I just wanted to let you know what a pleasure it is, or it helps me when I can tell them that there is a Board that is wrestling with those issues.

And I can refer them to your minutes of your meetings and say, look someone is actually listening to these issues and trying to address them. So again, thank you very much.

I'm just going to quickly just talk about a couple of issues that kind of came up as I was listening to yesterday's conversation. One of the things that came up, we talked about there was some reference to the need for more education. And that's something that I really have come to believe.

One, just more education about the program in general, but there's a really specific issue that really plagues this program. And that

is that this program is really unique among worker's compensation programs.

In most programs you file your claim, when you reasonably expect or reasonably know that your illness is related to your work. In this program, you're almost expected to file a claim before you know that it really is linked to it. And in fact, in many instances, you file your claim without even having information that can say that you actually worked there.

And I really find this to be a problem because most claimants don't understand that. We routinely encounter claimants who tell us, I'm going to file a claim as soon as I get that employment information. Or as soon as I find a doctor who can link my illness. And yet that claimant doesn't even know about SEM. So it's like how you going to find that information?

It was a conversation I had the other day that really hit home with this. I talked to a claimant who worked at a facility, clearly having illness. Always thought that that illness

was related to his work. But told me he never filed a claim because he always thought if he filed a claim and it was denied, he'd be arrested for filing a fraudulent claim.

And I just think that's the kind of information we have to get out. That this program is unique. That you're actually expected to file your claim, and then there will be development of your claim. Not the other way around.

Another issue that came up yesterday as I was looking at your chart. You had that row that showed the number of claims that were denied due to insufficient causation evidence. And I have to admit, I was not surprised at that.

Because one of the things we find is that many claimants simply do not know how to develop evidence. And specifically do not know how to develop medical evidence.

We routinely talk to claimants who have received that letter saying, your medical evidence is insufficient. They've gone back to

their doctor. Yet when we ask them, well what did you give your doctor? The answer is nothing.

They did not take the OHQ with them. They did not take a copy of SEM with them. They did not, you know, really discuss their employment. They just said I need a letter, can you write it for me?

And that's one of the, also they don't take specialist reports. Very often there's already an IH report, a toxicologist report, a CMC report. They don't think to take those with them to that doctor.

And again, going back to that education, I really think one of the things that we've seen is a need to educate claimants on how to develop that medical evidence.

It's not simply enough to tell them they need that evidence, but to really work with them and explain to them if you have this evidence, this relative evidence, you need to take that evidence with you to your doctor.

And in that sense, we also, there was

a reference to making SEM easy for the doctors to use. And I totally agree with that. But I find it's even more essential to make SEM easy for the claimants to read.

Because in most instances, or many instances I talked to, claimants are going to doctors who don't even know that SEM exists. That doctor is relying on that claimant to provide them with SEM information. So SEM needs to be easy for claimants to navigate.

We talked yesterday about terminal illnesses. And yesterday the Department of Labor, clearly explained its reasons for asking for imminent information on death. The question I get from claimants is whether that is reasonable?

Is it reasonable to expect a doctor to provide that kind of report? And what I'm simply hearing is, and what often happens. The claimant is terminal. They're in hospice. They go to their doctor to ask for this report that says death is imminent. And the first thing the

doctor says is, you're in hospice. It's already been determined you have six months or less, why do I need to write anything more?

We also hear that many doctors simply balk at providing that kind of information because they don't want to play God. Trying to tell somebody you have a couple of days or a week to live, they say that's just not my role to say that.

We also, I've taken it upon myself to talk to a couple hospice administrators, and one noted to me that their job was to extend life as long as they could and to make that life as comfortable. And they felt it was inconsistent with that mission to then try to tell somebody, you're going to die in a couple days.

They also thought that there was a really kind of a moral issue in terms of what is that patient going to think about your care if you've already told them you think they're going to die?

So there's just a lot of issues which

comes down to, is it reasonable for a claimant to be able to obtain that information? And especially to be able to obtain that information if their death really is imminent.

I would talk about hearing loss but, you know, I think that issue is still pending, so I'm not going to say much about hearing loss. But claimants still have a lot of issues with the hearing loss standards that are currently used.

But two other issues and I'll kind of end and open it for questions. One is consequential illnesses. That's again one of those concepts claimants simply do not understand. They can be compensated and covered for consequential illnesses.

But we find, one, claimants don't understand that. They don't know what a consequential illness is. And they don't really understand when they have to file, as opposed to what is automatically covered when that claim is accepted.

And that really just becomes an issue

we find very often. That many claimants, we'll probably see is that claimants will just assume, well this new illness I have is a result of my accepted illness, so it's automatically covered.

And they all too often find that that is not the case. That in order to have that second illness of them, consequential illness covered they have to file a new claim. And that's just something they really do not understand.

The last issue I'm going to talk about today is an issue that came up just last week, when my office was in Alabama. We visited Cullman, Alabama where the biggest employer is a beryllium vendor. And the way this law, the EEOICPA is interpreted, work employees of beryllium vendors are only covered under Part B of this program.

And under Part B, they are only covered for chronic beryllium disease and beryllium sensitivity.

I encountered a worker during my

visit, who noted that beryllium is now a known carcinogenic. And thus he asked, how come, you know, if you're covering me, you're covering us for the illnesses related to working with beryllium, why aren't we covered for cancers caused by beryllium exposure?

I'm not sure what this Board can do about that but, you know, I think if it is true that beryllium is a carcinogenic that is something that ought to be recognized. And the fact that there are these employees who are not being covered under the program.

In closing, I must say, and I should have said when I began. I want to acknowledge that I've been the Ombudsman now for, I think, 12 years. Time flies, it's been flying by, but I think 12 years. And in that time I've seen a lot of improvement.

So I always want to commend the Department of Labor, and the resource centers, and all the other entities that have worked to make this program better. Nevertheless, there's

still a lot that needs to done. And I just again want to thank you for your efforts in working to make this a better program. Thank you very much.

CHAIR MARKOWITZ: Thank you. I have a couple questions, but other Board members have questions, maybe. First of all, beryllium is an established human lung carcinogen. And it should be, I don't know whether it is or not, but it should be recognized as such under Part E. Part B is straight from the Act. So it wouldn't be under Part B, just only recognized as chronic beryllium disease.

MR. NELSON: Yes.

CHAIR MARKOWITZ: But under Part E, now vendor employees may not be eligible under Part E. I don't know that. But all I'm saying is that apparently the way the system works is Part E should, and perhaps does recognize beryllium as a lung carcinogen.

MR. NELSON: Under Part E, it is recognized. I looked at SEM, and under Part E cancer is a known result of exposure to

beryllium. So under Part E there is that recognition.

CHAIR MARKOWITZ: Okay, okay. So you describe that some claimants or potential claimants are at a loss on where to start.

MR. NELSON: Yes.

CHAIR MARKOWITZ: And they need in your view, to develop their claims somewhat to maximize their chances of succeeding even before they go to their doctor with -- so don't the resources centers, the DOL resource centers, don't they do that with claimants?

MR. NELSON: Well there's a couple of issues. One, many claimants again because they don't understand this program, they think they need to develop their evidence before they file their claim. So we often find that claimants begin the process of trying to develop evidence even before they ever approach the resource center, or approach the Department of Labor, or anybody else.

And that causes a problem because they

get that initial report, which is going to be inadequate. And so then they submit that inadequate report, the report is found to be inadequate. Now they have to go back to the doctor and the doctor of course is going to be somewhat peeved because they're being asked to have to rewrite a report.

So some of it the fact again that claimants do not understand that with this program it's okay to file your claim and to then develop your evidence.

The other is that yes, the resource centers will provide guidance, but what I'm finding is that even with that guidance, when we talk to claimants many of them when we ask them what did you give your doctor when you asked for that report? The answer is nothing.

And, you know, whether it's that they did not fully understand the guidance, or whether they weren't given the guidance, I really don't know. I can't say.

But I can definitely say that we find

that we can almost assume that most claimants when they're developing evidence, they have not gone and gotten into, they have not obtained the OHQ, the SEM reports, those medical specialist reports.

And they've not submitted those to their doctor, which as I said again, results in the fact it's not surprising when that report written by the treating doctor is not found to be, is not sufficient.

CHAIR MARKOWITZ: Does that mean in your experience that some claimants have sought that kind of detailed help from the resource center and not received that kind of assistance?

MR. NELSON: I can't say. I mean it's, you know, it's a case-by-case basis and I mean, I don't want to start making accusations without having heard both sides --

CHAIR MARKOWITZ: Sure, okay.

MR. NELSON: -- of the story. Because, you know, I often hear the claimant's side. And of course from the claimant that they

received no help. When I talk to the resource centers or I talk to the district office, they're usually telling me they provided help, you know. And I'm hearing this and I don't want sit here and --

CHAIR MARKOWITZ: Fair enough. I don't mean to force the issues. I get it.

Are there other questions, or requests for Mr. Nelson? Dr. Friedman-Jimenez.

CHAIR MARKOWITZ: We'll welcome Mr. Tebay a member of the Board is on the phone and participating. Welcome. And Dr. Redlich from Chicago, welcome. Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Okay. What you said about the imminent death struck a very deep personal note. Four months ago, my mother who has end stage heart failure and angina was told by her doctor that she had two months to live. It devastated her. We've been dealing with the aftermath of that for months. And it really affected her very deeply to be told.

That's not the kind of thing that

doctors like to tell their patients.

MR. NELSON: Yes.

MEMBER FRIEDMAN-JIMENEZ: When the patient asks you can give them some sort of an estimate couched in statistical terms. But the bottom line is we do not have mathematical models that can accurately predict prognosis on that level of detail.

So, I think it's unrealistic to try and put that burden on the doctor. It needs to be dealt with because Kirk raised a case yesterday, Number 4219, where the claimant was misclassified by their job title.

And it was an error that was made. I'm not going to say who made the error. I don't know the details, but the job title was misclassified. The exposure was grossly misjudged. And the case was denied.

The daughter was not a dependent. She was older than that. And the claimant died, so was not compensated however much he would have been. And the daughter then would have inherited

either the benefit or less debt from her father. Or anyway there was an error that really should have been avoided.

The question is how can we prioritize the workflow of the program so that it better addresses these urgent needs and avoids these kinds of really devastating errors?

So I think this is a question I don't have a single answer to it. But this is a question that we should deal with as a Board. How do we prioritize the work flow to get the most important decisions made sooner and more accurately?

MR. NELSON: There's two other things I would note. I often hear, I've talked to some hospice administrators who questioned what doctor is available to make that report? You know, very often when you're in hospice, you're no longer seeing your specialist.

So, you know, who's going to be this doctor who can say that you only have a few days to live? And then, you know, as you say there's

always that personal note. I can remember my own mother when she was passing away. My mother wanted to live. And had I asked the doctor how long does this woman have to live, she would have with her last dying breath reached up and slapped my face, you know.

So, I mean like you said there's a lot of emotion to that. And I think that's what we're hearing from claimants. That this is just -- sitting in a room we can talk about whether you can get that information or not. But in a real life situation, this is just something that was impossible to get.

CHAIR MARKOWITZ: I mean, Steve Markowitz, the problem is it's kind of understandable from the program's point of view that you want to prioritize, right. Because if there are a large number of people who fall within the hospice definition, then they can't, they may not be able to make it happen in that timeframe.

On the other hand, the bottom line is

it's too much to ask both the medical community and the families who bear the determination that death is imminent.

MR. NELSON: Yes.

CHAIR MARKOWITZ: Okay yes, Dr. Goldman.

MEMBER GOLDMAN: Dr. Rose Goldman. The other thing about it is, it's totally inaccurate. I mean I have told patients, I still remember somebody who had lung cancer. And they said, well how long do you think he's going to live? And I said, I don't think he's going to have more than two or three months.

So they got a whole bed set up in their living room and six months later they're calling me, well what's going on here?

(Laughter.)

MEMBER GOLDMAN: You know, we got this whole thing set up here. And, you know, so the point is -- and somebody who you think is going to live -- I've also been in that situation reassuring people, only to have some disaster

happen and they die in a month.

And so I think the other part of this besides the fact that it's difficult to frame it with the patients is that frankly, you really don't know. And to echo something that George said -- and statistics don't help.

Because what you have to tell patients is maybe 80 percent of people will die within a few months, but there's always the 20 percent and you could be that person. And you don't take away hope.

And having been on both sides of this I can say it's really very difficult.

CHAIR MARKOWITZ: Yes. We need to close. Is there any final comments or questions? Dr. Silver.

MEMBER SILVER: I've been concerned and a little bit of a dissenter about the role of the resource centers. I know they have a contractor who runs the resource centers. And I've noticed that some of them seem to emphasize volume over quality.

Going out to senior centers and saying, oh, just file a claim and it'll be taken care of. And claim development, well, doesn't go very well. And pretty early on a lot of people who succeeded and just filed the claim, get a bad first impression of the program.

It's analogous to something going on in higher ed. Let me ask you, who do you think develops better as an environmental health scientist? Choice A, someone who is on the ground with a professor on a regular basis? Or someone who's out there on the web looking at our lectures, a hundred of them.

I mean it's obvious that if you deal remotely with people who've never met you, the claims examiners, it's going to be bumpy. And it's not going to develop very well. So I think if we have this high hope for the resource centers doing more to develop claims, we need to look at their contractual obligations.

CHAIR MARKOWITZ: Dr. Dement, and this is the last comment.

MEMBER DEMENT: Last comment, we discussed yesterday the process of the OHQ and how it's used in assessing the exposures. In some ways, you know, to echo Malcolm's comment.

In most circumstances you would have an outcome and then you would develop the information about the exposures. And it would follow more of a logical path, rather than throwing everything out initially and then having less development later.

As you sort of follow, you know, down the path of those exposures and how it occurs. So in some ways it's a little flipped anyway. We would be better served if we had an initial sort of occupational history question.

I was very sure they basically got their occupational history, where they were, where they worked, the claim filed and then the exposures developed afterward. Because that could be much more directed. But that's not how the program works, but --

CHAIR MARKOWITZ: But I think EE-3,

the form EE-3, Mr. Vance, you can correct me, but I think EE-3 the employment history does capture that. And that is one of the initial forms if I got it right.

MEMBER DEMENT: It does come along with exposed to on the EE-3. It's a little more directed than the OHQ, that's true.

CHAIR MARKOWITZ: Mr. Nelson.

MR. NELSON: I didn't do this on purpose, but there is one additional issue I do have. And has to do with the OHQ. And what happens is --

CHAIR MARKOWITZ: And this is the occupational health questionnaire?

MR. NELSON: Yes, occupational health questionnaire. That's usually done very early in the claims process. And what often we find is that after the claimant is given that information, they think of new things.

And the issue we have is how do they revise that occupational health questionnaire? You know, especially as the claim begins to

develop and you begin to identify certain job categories or certain toxins to which they were exposed. That begins to jog their mind, and they begin to realize I have additional information.

And what we often find is that claimants will call the resource center. They will call the district office, the claims examiner to tell them information. But does that information get into the OHQ, so that when people are reviewing the claim, this additional information that the claimant has is included?

CHAIR MARKOWITZ: Well thank very -- Ms. Pope.

MEMBER POPE: I think we discussed this maybe a couple of Board meetings ago, about is there a process in which a claimant can update their information? And I think we threw around an idea of, it would be nice if there was a mechanism within the internet that they can go on line and update information, input information. That would be ideal, I would think. But what is the process, the current process to update

information?

CHAIR MARKOWITZ: Mr. Vance, I believe it's addressed -- the question is the claimant has submitted the original employment history form, they've submitted the occupational health questionnaire. If they then develop supplemental information, what's the procedure for them to submit that information?

MR. VANCE: At any point that a claimant wants to submit additional information in the form of written affidavits, any kind of occupational information that they feel warranted, they can do so.

And I'll just make a mention that if there would be a decision made in the case, they also have an opportunity for an oral hearing in which they can come and provide any kind of information formally to our appeals board.

CHAIR MARKOWITZ: Thank you. Mr. Nelson, thank you very much.

MR. NELSON: Thank you.

CHAIR MARKOWITZ: We're going to now

move on and talk about Parkinson's-related disorders. The Department -- when this term of the Board was started some, a little bit more than a year ago. The Department asked us actually to help them with sorting out Parkinson's disorders mostly on the question of which toxins are known to produce Parkinson-related disorders. And perhaps also on the medical side.

So we've had a Working Group addressing this issue. And Dr. Mikulski has an update.

MEMBER MIKULSKI: Thank you so very much, Dr. Markowitz. The document that I handed yesterday provides a summary of the presentation that we made earlier this year at the Board's meeting on the topic of Parkinsonism and the Parkinson's disease.

We included information in this document on the nosology, the most current classification, along with aliases and the references to ICD codes under both ninth and

tenth versions.

We also discussed briefly the pathology as well as some aspects of clinical diagnosis, which I can't stress enough. Should be done clinically, preferentially by -- preferentially but not exclusively by a neurologist.

We have also shown evidence from research studies that have shown associations with some exposures, or suggestions of associations between some of the exposures commonly present in the DOE sites and Parkinson's disease.

The research on Parkinson's disease is going sort of several ways. There are efforts to explain the hereditary etiology. And it is believed that a really small part of Parkinson's disease cases can be explained that way.

The second way are the research efforts to establish clinical testing to diagnose Parkinson's disease at the prodromal, early stages that can precede clinical onset of motor

function impairment by over two decades right now.

Third, are the attempts to investigate those potential risk factors that have been shown in the animal models in epidemiology studies in human populations. There has been a slew of epi reports that provide evidence in support of the association between Parkinson's disease and the exposures to pesticides, solvents, polychlorinated biphenyls and metals.

And these reports have primarily one thing in common. They provide evidence suggested of association. However, do not provide quantitative exposure assessments or for that matter, answer questions regarding latency or even temporality in order to, or making any causation presumptions premature at this moment.

So what we hope for this brief document is to provide a basis for recommendations to the Department of Labor, at least on the diagnostic questions. And we hope to work together with other members of the Board

on coining these into a set of recommendations.

And we are currently working on summarizing the information on the specific exposures and substances that have been implicated in these studies. Although this list is going to be fairly short, it does include substances as I said, that have been used widely at the DOE complex.

Hoping for any feedback.

CHAIR MARKOWITZ: So comments or questions? Dr. Goldman.

MEMBER GOLDMAN: I think one of best metals that have been associated with Parkinson's from very strong case series is manganese. The others as you said, are more epidemiological studies with pesticides.

But among Chilean miners there was a case series with, they were mining manganese and began, they had a syndrome that looked like sort of manic behavior that was followed by a strong Parkinsonian syndrome. So that's one of the most specific I think linkages.

But the problem with manganese actually is there is a very poor correlation between the blood measured level and whether or not you're going to get it. And so that was one of the problems with that case series. That the blood was not as predictive of who would have the most severe case.

So that's one of the ones that I think is more causally connected. And then the others that you mentioned are more based on sort of epidemiological studies where there the associations and the -- and it's harder to make that causality. But I don't know if you have a response to that?

MEMBER MIKULSKI: Well, it is really to establish causality would require a series of perspective studies. However, Parkinson's disease is still a fairly rare instance, which would require extensive resources to be directed into these studies. And the follow-up with a methodologically rigorous exposure assessment.

So far, basically the literature is

limited to retrospective research with self-reported occupational exposures and some case reports, some case studies along with a few case control type of a design. Studies which really limit the, don't give enough room here to provide these assumptions.

But yes, manganese is one of the most looked at in terms of metals, substances, given the obvious link with the manganeseism.

CHAIR MARKOWITZ: So the Site Exposure Matrices recognizes manganese and various manganese materials as related to Parkinson's.

I want to, yesterday we looked at some data. So let me just review it for Parkinson's disease in the last three years. There have 310 claims. Roughly half of them have been accepted. Some are still pending but most have been resolved. And roughly half have been accepted.

And those that have not been accepted, almost all of them are not accepted on the basis of negative causation. That there's no, there is no demonstration that the toxins people were

exposed to caused Parkinson's. And about ten percent were rejected or declined, denied for insufficient medical information.

And that's of interest, because Parkinson's disease is not an easy diagnosis to make. And yet very few claims are being denied because the claims examiner doesn't have enough medical information to make that decision. That's encouraging actually.

So it really boils down to causation. And so we really in this effort we need to drill into what we know about the toxins, the animal evidence, the laboratory evidence, the human evidence, whether its case supports, epidemiology or what have you. And really come down with some decisions that would help the process. And that's the next step I think in this Parkinson's work.

MEMBER MIKULSKI: That's what we are currently working on and hope to be able to present more on that the next --

CHAIR MARKOWITZ: Just thinking ahead,

this Board's term ends next summer. We expect, I think we should have a telephone meeting of the Board in a couple months. Or certainly between now and next summer. And any issues that this term of the Board has raised we should bring to conclusion to the extent that we can, including the issue of Parkinson's.

So maybe we could aim for, if it's realistic, at the next meeting to get to that point where we've fully considered other toxins and whether they're causal. And then develop that into a recommendation to the Department. Does that sound realistic?

MEMBER MIKULSKI: Absolutely, I think we definitely should meet and before the next, or discuss this over the phone before the next in person meeting.

CHAIR MARKOWITZ: And I know Dr. Mikulski welcomes additional members of the Board to assist him in this process.

Was there a question or a comment over here? Yes, Dr. Dement.

MEMBER DEMENT: I think you've touched upon some important issues. And as I sort of looked at studies. You know, temporality is a really big issue. And there are four or five prospective studies but they're done out of mostly cohorts that weren't designed to look at environmental exposures.

And so when we see things like cholesterol and smoking being protective, and asthma being a risk factor, but we don't see, you know, that other piece of you know, what are the real exposures? But that's what's really going to be needed to really nail down some of these other things, sort of beyond the manganese, I think.

CHAIR MARKOWITZ: Other comments or questions? Okay, thank you very much.

So we're going to spend a few minutes reviewing the public comments that we heard yesterday, or that came in in writing. I'll kick it off.

Ms. Barrie raised the issue of, I sent

this as a spreadsheet of, I think firefighters -- I don't know whether we have that? Whether you can find that on our website and bring that up so we can look at it? That'd be helpful.

Raised an issue of firefighters and what their exposures are at various sites. And I think she compiled information at the various sites on how many toxins they might be exposed to.

So we're looking at a number of substances in the SEM for firefighters. So at Ames it's a dozen or so. Hanford, it's 2,000. I think you can just scroll down. Brookhaven is 34. So mostly, it's a relatively modest number, 30 or 40 maximum. If you could keep going down. Or if you look at Paducah it's 15, Oak Ridge K-25 is 25. So a limited number of substances.

And I think the, if I recall her public oral comments, the issue was this kind of variation in sites. Whether there are, this job titles, and other job titles, and we've heard this comment before. Other job titles which

could be considered in the SEM as being site-wide workers. They get around to all aspects of the sites.

Obviously firefighters going to put out fires wherever the fire occurs in the site. Doing their inspections across the site. I think we've heard about the health physics technicians, or rad technicians who also, or industrial hygienists who go throughout the site.

Security personnel presumably go throughout the site. So, I have my own view of this, but I want to open the floor for other comments on this issue.

I'm sorry, Mr. Domina.

MEMBER DOMINA: Yes, it's kind of interesting looking at that where Hanford, because I'm from there, lists, you know, that many in this, because of, you know, we have a pretty robust system where they're pulling documents and stuff daily. We have a huge group of people who do that.

But for some of these other sites you

look at, the numbers are low. But part of that I look at, you know, our firefighters, you know, we're a large site, 570 some square miles. And they also do mutual aid where they could go across the country out fighting fires and whatever. And to respond to smaller communities when they need paramedics, instead of EMTs.

But it comes back, and like Dr. Markowitz said, you know, I've harped on the HPT thing. The other part which people may not understand that we send our people, like during the presidential inauguration, we have our techs in DC, slinging meters, looking for stuff.

And then there was an event which was not well publicized recently at a large hospital on the west side of the mountains, where they got into a cesium source. You won't see anything about that anywhere.

But our techs went over there because of the huge exposure that was involved. And state patrol guarding the building so nobody got near it. Because they called over and asked what

they should do? And our company said, you need to tear them down.

But it's the same thing as these different groups. Same thing with security, operations. When you have events, and like we have site-wide seniority, so we have backup seniority -- or excuse me, backup overtime groups where if there is an event, we have people that go everywhere. Not just in your assigned job area day to day. And it has to be looked at during these type of events.

And all these sites have, you know, you have your annual drills that's required. And the different things that we do. But I think it needs to look at, you know, widening I guess the path. It's just like when we approved that list a year or two ago about these job titles that DOL accepted. Because it's accepted in some other programs.

Once again, the HPTs are not listed on there. And it's, you know, it's just like when the SEM started with some of ours when we first

got together. You know, all the reactor areas for Hanford are in the 100 areas, near the river. And they didn't even list that job title. They're first in, last out. You know, and operations is right behind them, or any type of maintenance.

And so, I think things need to be looked at a little more globally. And then, you know, I can't speak for some of the other sites, but I'm sure some of the firefighters do mutual aid. You know, they help out their cities, and you know, good PR and everything. But I think we have to look at that. Because these people are exposed to all kinds of things and it's all the groups.

It's just like when we have car wrecks that are, "offsite". It's our members that are responding because they're there first. You know, whether it's shift traffic or whatever. I think we need to look at this more globally and you know, kind of think outside the box.

And it kind of goes back to the OHQs

and those different things that when some of these job titles may have been developed some years back on whatever, the program was in its infancy. And so you have to look now, how things have changed. And then think back about what we did back then and what's changed today, to make this morefriendly to the workers and the people that are trying to do the cleanup mission today.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Looking back at the history of studies of firefighters, Monson, Musk and Peters in the 70s, first made the point that I'm aware of that firefighter exposures are extremely heterogeneous.

And this has been confirmed through many firefighter mortality morbidity studies. The World Trade Center program sees people, tens of thousands of people with exposures to pyrolysis products of various structures.

The pyrolysis products are very hard to characterize. And the ones that are in the

largest concentration may not be the most potent toxicants, et cetera.

We are currently seeing wild fire firefighters exposed to a whole different range of toxicants from towns that burned down in California. Paradise, California burned down and the toxicants released from the pyrolysis of houses are completely different than what's in a wild fire, out in the woods.

So looking at Fernald and Hanford, with 7 and 2091, they just happen to be sitting next to each other, substances for firefighters. It seems to me that the SEM is just not adequate to characterize the exposure of firefighters.

And it has to be formally recognized, I think. That firefighter exposures go way beyond what can even possibly be included in the SEM, unless you include firefighter exposure, even then it's so heterogeneous.

So it's very difficult to simplify firefighter exposures in the variety of diverse situations that these firefighters are in, as

Kirk was describing. So I think we need to formally recognize that. And include the SEM certainly, because there are a lot of substances that are out of the ordinary.

But also make the point that firefighter exposures include pyrolysis products of all the things that we know that are in the SEM, which we can't really predict very well.

CHAIR MARKOWITZ: Steve Markowitz, so we know that the program has some, uses class of job classes, of job categories that have certain attributes in common.

So for instance, there's a list of job categories for the hearing loss, right. And those job categories are presumed to have noise exposure. Then the issue is do they also have solvent exposure?

That group has a higher likelihood of having solvent exposure, that's why they're in the group, in addition to noise exposure. So we see that for that list.

But there's a separate list that Mr.

Domina referred to for people presumed to be exposed to asbestos, supposedly construction and maintenance job categories. Again, a carved out identified list common across sites pretty much, which are presumed to have certain exposures.

So my question is could certain job categories that fairly universally across sites have site-wide jurisdiction, or do their work throughout the site, such as firefighters, such as the industrial hygienists, the rad technicians, security, I don't know all the job categories.

Could that class be developed and recognized in the SEM that those job categories would have frankly had potential exposure to any of the toxins at the site?

Yes, Mr. Domina.

MEMBER DOMINA: I think it could, because I think right now they use like surrogate data or a job title for another site, because I've seen it when they bled it down on some of the cases that we looked at. They'll use that

title from another site to try and find the toxic substance, you know, for a claim approval.

And I think that we could do that, because I think about the same thing with the firefighters with the burn pits. I'm sure most of these sites have burn pits. And they were escorted by security, you know. And you'd have rad techs, you'd have op, you'd have a whole bunch of people there, you know.

And so it's got to be more global and to get some of this stuff more claimant friendly.

CHAIR MARKOWITZ: Well, you know, Steve Markowitz, it's not just a question of claimant friendly. It's a question of getting it right. You know, getting the SEM accurate. You know accurate reflecting potential exposures.

And so let me ask Mr. Vance, not to put you on the spot, but has this been considered? Well, actually maybe it puts you on the spot, who knows. But --

(Laughter.)

CHAIR MARKOWITZ: I was just saying

not to put you on the spot. But has this been considered for these site-wide workers? And are there any administrative or other impediments to developing such a class of job categories?

MR. VANCE: With this, the answer is anything is possible.

CHAIR MARKOWITZ: We accept that answer.

MR. VANCE: Yes, okay. I mean we're always looking at different pieces of information. And of course anything the Advisory Board could certainly, you know, provide information on would be more than welcome. And we would consider that.

CHAIR MARKOWITZ: Okay. Other comments. Yes, Dr. Goldman.

MEMBER GOLDMAN: Well one thing that the State of Massachusetts did, because this is such a difficult problem with firefighters getting exposed to so many things is I think we have a law that any firefighter who develops a heart, lung, or may even be cancer, it's just

automatically said to be work-related. I'd have to check on that.

So what happens is just because you can't sort through and like, and try to figure out the individual chemicals, just like George said. So there's sort of this blanket thing that any firefighter who developed X, Y, and Z conditions just state that it's work-related.

So that's incredibly broad, you may not want to go there. But maybe something along that line where you just, because otherwise you're in a huge amount of work to try to tease it out for the firefighters at least.

MEMBER BERENJI: This is Dr. Berenji. I can actually confirm that there is a heart presumption, as well as a cancer presumption while in the State of Massachusetts.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: In the spirit of out-of-the-box brainstorming, I seem to recall some firefighter epi studies where a crude dose metric was number of fires that the person had responded

to over the course of their career. And I think the associated outcome was decrements in lung function.

So it may correlate with years on the job or it could be helpful in using firefighters first in this group of free roaming employees.

MEMBER GOLDMAN: Well, a problem with that is the exposures to firefighters goes beyond fires. Because, you know, there's an exposure somewhere. Somebody is worried about it. Who's the first one to go out? It's, they call the fire department. We had a mercury spill, the fire department came out. So it wasn't a fire, it was just a spill.

So what you have now -- and they have the hazmat teams. And part of the issue is first they go out with all their equipment. And this is true for fires too, however once the fire is put out or they think they have it under control even though they shouldn't, it's hot. They take their respirator off, and then there's smoldering.

So as you were saying the pyrolysis products. So the exposures for firefighters are really quite vast. And it goes beyond just the fires.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: Number of events responded to, which could be a crude exposure metric for the health physicist, IH techs as well. Just a thought, a quick response.

CHAIR MARKOWITZ: Yes, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: There have been many attempts to make an index of firefighter exposure, and none of them really worked very well. Because in the knockdown phase, as Rose said, after the fire they take off their respirator. And one exposure like that can be worth 20 fires where they've had their supplied air respirator on the whole time.

And it's very difficult, it's impossible to capture that in an index that you can actually get data to create. So I think it's

not realistic.

CHAIR MARKOWITZ: Yes, Steve Markowitz, the SEM doesn't address intense heat duration, frequency of exposure, that's up to the rest of the process. The SEM just tries to nail down what the potential exposures are at those sites.

So we don't really even need to get into, you know, likelihood of exposure in the sense of measuring number of visits, or number of fires put out, or whatever. That's just going beyond what the SEM purports to do really, so.

CHAIR MARKOWITZ: Mr. Domina.

MEMBER DOMINA: A couple of comments that Dr. Goldman just brought up about the Hazmat. Well prior to 2000 or about then, we were Hazmat. It didn't exist. That's to back up what I said early. And also I had Kevin scroll up Savannah River, and so you see they have 26, and Hanford has 2091.

Well, Savannah River has the tank farms like we do. And they had some of the same

reactors that we do. So there's a huge disparity right there, you know. And I think that some sites are similar, some are different. But it has to be looked at, because why is there that huge of a disparity between two sites that have a lot of stuff in common?

CHAIR MARKOWITZ: So, actually I have been, drafted a recommendation we could make about this as a formal recommendation. Or we could I suppose give it to the department as just a less formal observation.

Maybe if I got the language up we can take a look at it and see whether it's something we want to pursue? So Kevin if you could, just --

The Board recommends that the department as part of Site Exposure, the SEM -- well we could spell it out, develop lists of job categories at DOE sites that likely have worked throughout the applicable sites. And would have had a potential exposure to all listed toxins at those facilities.

Make it a little larger. Thanks. That good, in terms of the size? Can you see back there?

(Off-microphone comments.)

MEMBER FRIEDMAN-JIMENEZ: Potential exposure to some or all listed toxins.

PARTICIPANT: Toxicants.

MEMBER FRIEDMAN-JIMENEZ: Toxicants, yes.

CHAIR MARKOWITZ: Well toxins is the terms that, a toxic substance actually. Let's use toxic substance, that's from the Act.

So I don't know if Dr. Redlich or Mr. Tebay you could see this? So let just read it again out loud, what Kevin's written.

The Board recommends that the department as part of the SEM, develop lists of job categories at DOE sites that likely have worked throughout the applicable sites and would have had potential exposure to all listed toxic substances at those facilities.

Dr. Berenji.

MEMBER BERENJI: Yes, I just have a small edit. So let me see if I can point to the right spot. So list of job categories at DOE sites for workers. Yes, that's perfect.

CHAIR MARKOWITZ: I'm sorry, Steve Markowitz, I don't see how, we had, that seems to be covered by job categories, which again is the term that DOL in the SEM uses, is job categories. Develop lists of job categories that likely have -- or I guess lists of workers in job categories?

MEMBER BERENJI: Yes, I think you need to point out who this is referring to. Because otherwise it's a bit obtuse.

CHAIR MARKOWITZ: Okay, but the intention is that a particular job category captures all the workers in that job category.

MEMBER BERENJI: Correct, I think that needs to be explicitly stated.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: I guess I have an issue with saying all substances at the site. Because I think it's too broad. I think we

should say something like, a substantial number and quantifiable, or unquantifiable number. I don't, you know, all is a bit broad.

CHAIR MARKOWITZ: Right. Well so --

MEMBER FRIEDMAN-JIMENEZ: Some or all?

CHAIR MARKOWITZ: Well, some or all includes everybody who worked at the facility. So the question is, and I agree with you that all seems a bit of an over statement. But once you say many or most, the SEM process is about identifying particular toxins and pinning them to particular diseases.

So the question is does developing those classes with that kind of, the language that doesn't say all, does that actually help in the decision making process?

MEMBER MIKULSKI: This is Marek, I believe that by putting in the list of workers in job categories, we're kind of implying that we are developing the list of actual workers, rather than job titles, job categories. So maybe, it would be, maybe we could take it out, lists of

job categories.

CHAIR MARKOWITZ: Or maybe we could just say the SEM identified job categories.

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: So that the workers aren't seen as subsets, but --

MR. BIRD: Where do you want me to add that?

CHAIR MARKOWITZ: Take out the develop lists of workers, and just say identified job categories.

And then later on instead of saying all, to all or many, to many or all listed toxic substances. And you know, that leaves it up to the industrial hygienist and later the CE to weigh additional information.

Dr. Dement.

MEMBER DEMENT: I would also recommend that we include the aliases for these job categories because, you know, they can be called many different things across different sites. And so, maybe job categories, you know, takes it

into account? But, you know, we know that they're called different things across sites.

CHAIR MARKOWITZ: Right, well that's why they'd have to develop at each site the job category in that list. But we're not going to develop that list for them, here today.

Yes, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: My concern with saying listed toxic substances is that most, many or most of the exposures that are pyrolysis products, are not listed. They go beyond the list. That's the point.

That we can't accurately characterize and list the toxic substances because if you take two chemicals and burn them, you might have 40 different pyrolysis products that you haven't really characterized scientifically.

So I think that job category is what we're looking for, like IARC does it. They have a category of rubber workers. And they associate that with causation of cancers in that category. Because they're exposed to toxic substances that

haven't been as precisely characterized as -- because they can.

CHAIR MARKOWITZ: Yes, Steve Markowitz, well this is intended to be broader than just firefighters. So I agree with you that firefighters have a broader set of exposures outside that, or would be outside of the SEM. Hopefully the industrial hygienist has some appreciation of that.

But this applies to security personnel, to the safety personnel, you know, to a whole bunch of other classes of workers. And has the advantage of that kind of broadness I think. If we were developing something just for firefighters then I think it would look different.

Yes, Dr. Berenji.

MEMBER BERENJI: I'm just reading this and honestly I mean, I know we have to have some general statement so I understand the purpose. But I just have a feeling that this is going to be misinterpreted. That's just a general

comment.

CHAIR MARKOWITZ: Well, if there's some specific language that would decrease that likelihood.

MEMBER BERENJI: I mean just reading this as a non-clinician or a person who, you know, may not know all the specific terminologies. I mean what are we really trying to get at? We want to make sure that folks are able to get some sort of assessment based on what types of job tasks they have done. I feel that job categories, I mean that's just a general kind of, you know, categorization, which I do know we have to do.

But I mean based on what I've reviewed in these case files, you know, someone might be designated as a security guard, but they're doing a whole host of different other tasks. So, I'm not sure if we're going to be able to capture that by just designating job categories.

CHAIR MARKOWITZ: Well, Steve Markowitz, so the SEM is a starting point. The

desire is that it's a point that's used and hopefully a starting point for further developing using additional information that's particular to that person.

But this does set out sort of the universe of at least some of the concerns that these job categories would have.

Dr. Friedman- Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Maybe we should say identify job categories. And we're not talking about a large number of job categories for which the SEM cannot accurately characterize, meaningfully characterize their exposure with respect to the outcomes of interest.

CHAIR MARKOWITZ: Steve Markowitz, I would just say that that probably applies to a lot of job titles. I mean that raises a kind of a different point, that's true. But doesn't get at the sort of the core purpose here, which is to say that, you know, there are some job titles really that work throughout the facilities. And

that needs to be recognized in the evaluation process, which is the goal here.

Yes, Dr. Silver.

MEMBER SILVER: I agree. It's a place to start but in the spirit of Kirk Domina's call for out of the box thinking, I recall how asthmatics were liberated from the use of SEM, right.

It's no longer a toxic substance that has to be identified and there are special presumptions now for asthmatics. This could go in that direction a couple of steps down the road once we bump into the limitations of using the SEM for these peripatetic professions.

CHAIR MARKOWITZ: By the way, there's not a proposal on the floor so let me propose that we accept this, make this recommendation but we can't move further unless that's seconded.

MEMBER FRIEDMAN-JIMENEZ: I'll second.

CHAIR MARKOWITZ: Fine. So the floor is open for comments. That's just a formal procedure, that's all. Floor is open for

comments. Mr. Domina?

MEMBER DOMINA: I just want to make sure because you guys are way smarter than I am by a long shot, is it, you know, each one of these sites had certain exotic chemicals that were just developed for that site itself. And I want to make sure -- and there is no known studies for any of it. And I just want to make sure that that's captured somehow -- and I don't know how, that's why you guys are here -- that we don't forget about that.

Because I know, I mean, NIOSH has documented it for us, you know, and I think about some of the people that Dianne and I have helped over the years and different things that they go through and what we have to go through to try and get claims approved when there's classification involved. And we can't lose sight of that. You know, these are the people, you know, we owe a lot to. So.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez or Ms. Pope?

MEMBER POPE: I echo what Kirk is talking about. From a worker's perspective, is trying to capture every job category or, because every site is unique within itself and just trying to capture every job category I think is just critical.

And developing a language that can widen the scope to make everyone inclusive within that language to make sure that everyone is covered because I think we owe that to them.

CHAIR MARKOWITZ: Dr. Goldman?

MEMBER GOLDMAN: I'm wondering if it wouldn't be a better idea to actually carve out the firefighters because after listening to Kirk, what's different about let's say a security guard at one plant with the special exposures and maybe a firefighter who, as you said, may be going to other plants or may be deployed someplace else.

So the firefighter's going to have a way larger exposures and it's going to be a lot harder to fit into the SEM of that site.

So it may be better to carve out the

firefighter personnel because they just could be having a lot more exposures and not have them tied to the SEM of that site.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: You know, I agree with that too but then I was just thinking back to like, with the security personnel.

I remember back in the '80s there was a strike at one of the other New Mexico sites, so guess where Hanford security forces were, a bunch of them?

And so and then they go and they train too at different times with other ones and so I don't know, you know, I just don't know if, we have to, there's so much like I said when you got to look broad and over the time that -- on how things were done in the Cold War effort is a way different mindset than it is today.

I mean, I remember mixing up chemicals with my arm because that's how you had to do it to get something because of the situation it was in, was how critical on certain things for, to

maintain operation or whatever.

You know, I remember sticking my arm in a vat and stirring the chemicals in because that's what you had to do in a hurry, you know.

And so I know trying to cover everybody is a pretty tough task but, you know, for me it's like, I don't want to leave anybody behind.

MR. BIRD: Dr. Markowitz?

CHAIR MARKOWITZ: Sure.

MR. BIRD: We have Dr. Redlich on the line. She wants --

CHAIR MARKOWITZ: Dr. Redlich?

MR. BIRD: It's going to take a second to find her, sorry. She dropped off.

MEMBER REDLICH: This is Carrie Redlich. I'll just, I'm sorry about the noise, I'm in the Chicago airport.

I just wanted to second what Ms. Pope said in terms of -- and others -- that is when one's considering -- sorry, I don't know if you can hear me or not.

CHAIR MARKOWITZ: I'm sorry.

MEMBER REDLICH: Well, if you can't hear me we'll forget about it.

CHAIR MARKOWITZ: I couldn't understand what she said.

MEMBER REDLICH: Okay. If you can hear me, I just wanted to second what Ms. Pope said as far as the range of different tasks and jobs that you're considering generally on this (telephonic interference) employment over many years and also more chronic, generally more chronic conditions.

CHAIR MARKOWITZ: Did anybody catch that?

I'm sorry, could you just try one more time, Dr. Redlich because we couldn't understand what you said.

PARTICIPANT: Try not using the speaker phone --

MEMBER REDLICH: Sorry. It's not that important, so I will, I was just seconding what Ms. Pope said.

CHAIR MARKOWITZ: What's that? Oh, okay.

STEFAN: She was just seconding what Ms. Pope said.

CHAIR MARKOWITZ: Okay. Other comments?

So is there, if we could look at this language again, is there proposed modification of the language we're looking at, the recommendation?

MEMBER GOLDMAN: I'm just wondering if this --

CHAIR MARKOWITZ: I'm going to read the language again just for the people on the phone today. We're looking at this proposed recommendation.

The Board recommends that the Department as part of the SEM, identify job categories at DOE sites that likely have worked throughout the applicable sites and would have had a potential exposure to many or all listed toxic substances at those facilities.

Dr. Goldman?

MEMBER GOLDMAN: Just to second what Mani said and some others. Maybe we should put a preamble into this a little bit to explain why we have this and then also put a post statement saying that maybe more efforts need to be made by the industrial hygienist on the second part of the interviewing to focus on tasks.

CHAIR MARKOWITZ: Right. So yes, I mean, it's, on our recommendations, we always provide relatively succinct rationale. So where we can explain why we came up with this and what we think it means.

So we will do that, yes. I would draft that and you would all look at that.

Other comments? Okay. So, yes, Mr. Mahs?

MEMBER MAHS: If you're talking about the broad, it could be a very broad set of categories or job titles. Because you're talking about firefighters going to every building in that plant, while construction workers are not

like maintenance who are in one or two buildings most of their career.

I've probably been in several hundred buildings between the Y-12, and X-10, and K-25 over the years. Visible areas, radiation areas, material access areas, new construction, demolition. You know, so been everywhere in all kinds of substances.

CHAIR MARKOWITZ: Yes.

If there are no other comments then we need to take a vote. We would vote in favor or opposed, although I can't remember actually how we take these votes.

MR. FITZGERALD: I can do the roll call.

CHAIR MARKOWITZ: Okay. Fine, do the roll call.

(Off-microphone comments.)

CHAIR MARKOWITZ: No, a motion's been made and seconded. The issue, I guess we could read the, if you could bring it back up, if we could read it once more.

So Mr. Tebay and Dr. Redlich, we're voting on this.

(Off-microphone comments.)

MEMBER TEBAY: Can you hear me now?

CHAIR MARKOWITZ: Oh, yes.

MEMBER TEBAY: Okay.

CHAIR MARKOWITZ: Do you have a comment?

MEMBER TEBAY: No. I just heard you're taking a vote on it and then I dropped all communications there for a second.

CHAIR MARKOWITZ: Okay. Great.

So, Kevin, when you have a chance, could you just bring the language up for the recommendation?

MR. BIRD: Yes, sorry. Hold on one second.

CHAIR MARKOWITZ: The Board recommends that the Department as part of the site exposure matrices, identify job categories at DOE sites that likely have worked throughout the applicable sites and would have had a potential exposure to

many or all listed toxic substances at those facilities.

We're going to do a roll call vote now.

MR. FITZGERALD: Your choices are yes, no, or abstain. We'll start with the folks on the phone.

Mr. Tebay?

MEMBER TEBAY: Yes.

MR. FITZGERALD: Dr. Redlich?

MEMBER REDLICH: Yes.

MR. FITZGERALD: Thank you.

Dr. Berenji?

MEMBER BERENJI: Yes.

MR. FITZGERALD: Dr. Dement?

MEMBER DEMENT: Yes.

MR. FITZGERALD: Mr. Domina?

MEMBER DOMINA: Yes.

MR. FITZGERALD: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. FITZGERALD: Dr. Goldman?

MEMBER GOLDMAN: Yes.

MR. FITZGERALD: Mr. Mahs?

MEMBER MAHS: Yes.

MR. FITZGERALD: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. FITZGERALD: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. FITZGERALD: Ms. Pope?

MEMBER POPE: Yes.

MR. FITZGERALD: Dr. Silver?

MEMBER SILVER: Yes.

CHAIR MARKOWITZ: Okay. So we're going to take a seven minute break and at 10 o'clock, we only need one more hour so at 10 o'clock we're going to resume and then finish, close it off.

(Whereupon, the above-entitled matter went off the record at 9:52 a.m. and resumed at 10:03 a.m.)

CHAIR MARKOWITZ: Okay. We are going to start up now. Okay. So we're all here. Mr. Tebay and Dr. Redlich, we're going to start up if you're available.

So we could come back to the public comments if we have time but we do need to come back to the issue of the claims review and our discussion about the quality, objectivity, and consistency of the industrial hygiene and medical evaluations.

So we need to resume that discussion and then if there's time, get to the same for the claims examiner.

One observation, I'll kick off the discussion. When I looked at the last five quarters of the medical director's evaluation of claims, there are about a hundred claims that were looked at for the issue of impairment and 28 percent of them needed improvement.

So that says a couple things. It says that there are a fair number of claims where the impairment evaluation was considered not really adequate.

It raised the question whether there's a systematic problem in the work that the contractor's doing in terms of the impairment

evaluation because 28 percent is a lot.

It also raises the issue of, okay, the medical director's picking 50 claims per quarter to look at. If 28 percent of the impairment evaluations over a five quarter period needed improvement, what about all the claims that the medical director did not look at?

How many of them, is it likely that a fair number of them were also, would be found to need improvement, and yet those aren't looked at or re-looked at because they're not part of the medical director's review?

So that's a long way of formulating a question for Mr. Vance, which is, maybe I should have told you before I started that formulation but I will next time.

So to me, 28 percent of a sizeable number of evaluations for impairment, a hundred or so over a year and a quarter means that there's a quality problem with the contractor and impairment evaluations.

When that kind of feedback comes to

QTC, the contractor, what's done in terms of the other claims for impairment? Do they decide to re-look at other claims and say, hey, maybe there is significant number of other claims that also need improvement? Do you have any idea of what the process is?

MR. VANCE: Yes. So let me give you a brief synopsis. And so yes, we go through this quarterly audit.

We have a, Dr. Armstrong, our medical director, will give us a report. That report is then forwarded to my staff who will then do a post audit analysis of those ratings and determine what effect that issue had on the outcome of the case.

And I think you're familiar with the outcome of these audits. Some of them are substantive issues with the quality of the report, the narrative, or the application of the AMA guides.

And I think that's the challenge, from my understanding, is that the guides provide very

broad interpretations of how ratings are to be done. And in a lot of those instances, there's not something that prohibits physicians from doing things so it's a challenge.

But what we then do is we take this information, we go back to QTC and we have a conversation with them and we go through each one of these cases.

And they get an opportunity to make sure that they understand what the nature of the issue is, that they get an understanding of who it is that's causing these issues and then it's on the contractor to try to perfect future claims coming through the process and they have their own internal quality control mechanism for doing that.

And then this is relative to how we evaluate the CMC process. So you know, we don't do these kind of systematic reviews for folks that do impairment ratings outside of our CMC process.

So this is basically the discretion of

the program in evaluating what we feel is the appropriate way of administering the AMA guides and that's this process, but we don't have a process where we then expand out and look at other cases that are not part of this auditing mechanism.

CHAIR MARKOWITZ: Yes. Do we know what QTC's quality assessment or quality evaluations consist of?

MR. VANCE: That's their, as a proprietary contractor they have internal mechanisms that they have to employ to make sure that they are trying to satisfy the contract provisions on the quality of the reports and this is a mechanism that's included in the contract, this quarterly review.

So it's a systemic review that's going on on a quarterly basis and then, you know, they are improving with time but, you know, you have different doctors that are getting engaged, new physicians that are involved and so it's a continuing process.

CHAIR MARKOWITZ: So just a couple of follow ups. So it's not in the contract, at the elements of the contract from DOL stipulating that the certain kind of quality evaluation be done?

MR. VANCE: Just that it, I don't know what the exact terminology is but there is a quality assurance process that's engaged with, by the contractor and it is part of the contract.

CHAIR MARKOWITZ: Has QTC ever come back and said, you know, we see from the medical director's audit that there's an issue? We've looked at an additional number of claims and also found the, speaking specifically about impairment, and also found a similar kind of issue with these other claims that now require correction? Has that ever happened?

MR. VANCE: In our conversation with QTC, their main focus is making sure that they understand the nature of the issues that our medical director has identified and then applying lessons learned on future cases.

CHAIR MARKOWITZ: Other Board members? Dr. Berenji. Thank you.

MEMBER BERENJI: Thanks, Mr. Vance. So I actually do a lot of independent medical examinations and I know at least with the companies I do work for them, they do audit my reports and there is some sort of accountability, at least for the clinician or the medical examiner who's doing these.

I'm not sure if there's been any discussion in the higher echelons of the DOL. I don't know if you're familiar with Dr. Hodgson. I believe he's still at DOL if I'm --

CHAIR MARKOWITZ: At OSHA, Michael Hodgson, yes.

MEMBER BERENJI: I mean, is there any sort of reporting of your medical director to a senior person? I'm sure he is reporting to Dr. Hodgson or someone in that capacity.

I mean, there's got to be some sort of internal review of medical claims. I mean, there has to be. So I'm not familiar with that

process.

CHAIR MARKOWITZ: Other comments? Yes, Dr. Silver.

MEMBER SILVER: Do we have any insight into the distribution of errors in the impairment evaluations? Is it random like half of them low-balling the claim and half of them overestimating the impairment, or is there a consistent bias that is claimant-unfavorable?

CHAIR MARKOWITZ: So I mean, just I can't directly answer that question but if you read the medical director's report and the policy branch's review of those audits, that information is contained in those reports so it's available to us but I haven't looked at them.

And I don't think that kind of, as part of that process I don't see that that kind of evaluation's been looked at.

Yes, Dr. Silver?

MEMBER SILVER: So we don't have the data therefore my next comment's a little bit speculative but my impression is that a lot of

independent medical examiners do work for this program and do a lot more work for other workers' comp programs.

And it could be that this is one of the more claimant-friendly programs so that their habit of not granting high levels of impairment carries over here and this program has to issue a corrective. But we won't really know until we see the distribution of quote, unquote, errors.

CHAIR MARKOWITZ: So getting back to the issue of causation, the medical director did look at 80 or so claims for issues of causation and found one that needed improvement.

That seems low and so far and we have more claims to review so we need to look further. I don't know that we can come to any conclusion today but we do need to look some more, I think, at claims.

And I've compiled some of what you've sent me in terms of the summary of the claims limitations but we need, I need to add more to that in order to really have data to present.

But I have to say that one out of 80 causation evaluations that need improvement seems very infrequent and it raises the issue to me whether -- how good that kind of causation review is.

And I think that we, you know, we're not developing recommendations today around the issue of the CMC and the IH the, you know, the quality, objectivity, and consistency but we will and it's one of the issues that we need to talk about.

Dr. Dement?

MEMBER DEMENT: Sort of a workflow issue. You know, we've taken these claims that we have and we've all sort of picked the ones that we reviewed and we have some overlap and now we've reviewed a fair, a large number of them but there are still claims that we have not I think had at least one Board member look at.

Can we compile that and get it out to everybody and, you know, we can sort of pick a few additional ones to see what they are, if they

add more information to the base?

CHAIR MARKOWITZ: Yes. Sure. I'll do that. And in fact, you know, we, so in this, for today we looked mostly at the four categories. Asthma, ILD, sarcoidosis, and CBD.

But previously we had looked at, if you remember way back when, I think it was April or May of 2019, we looked at Parkinson's disease and COPD.

And I think we should add, those are different outcomes, I think we should add that to the same process so we have a bigger number.

It requires some work on our part but I think it would be worthwhile. I mean, it will I think allow us to make some recommendations about IH and medical assessments.

If -- thinking about the industrial hygiene evaluation, Mr. Vance, I need to ask you a question.

The medical director audits the medical consultant's reports. I know that the federal industrial hygienist reviews the

contractor industrial hygienist report when it comes in, because we see a memo to that effect on all these files.

But is there a separate, in parallel with the medical director's audit, is there a time in which a random number of the industrial hygiene evaluations are taken and a similar kind of audit be performed? And if not then what's the thinking about that?

MR. VANCE: The answer is no and I don't know what the thinking is on that.

(Laughter.)

CHAIR MARKOWITZ: Okay. Thank you for that succinct answer to the point.

So, you know, we're not going to, the question for us to talk about, we're not going to complete this today, is whether we think that there ought to be a process for review of those IH reports and what that process should look like? What it should take into account and will it likely improve the claims evaluation?

And I'm not, I don't think we have a

predetermined answer to that. I think it's something we need to discuss.

Dr. Berenji?

MEMBER BERENJI: I actually took the liberty of already kind of writing this process out, that we kind of get an understanding based on the discussion we had yesterday so I'm happy to, you know, formalize that and at least, so at least we can have some input into this.

I think it's better for us to be able to be on the front end and be able to produce a document at least with our expectations for an industrial hygienist, how they should go about interviewing the claimant, what information they should be on the lookout for at least as a guideline.

Yes, I'm happy to be a point person on that but I think that's something that we can actually contribute an actual document which could be helpful.

CHAIR MARKOWITZ: Well, I wonder, you know, that's a good point. I wonder whether it

would be helpful if we had, since the Department is going to begin to do those interviews, whether we had the form, the set of questions they're starting out with, they're using, and then providing some input into that. Is that something that sounds feasible?

Mr. Vance?

MR. VANCE: Absolutely.

CHAIR MARKOWITZ: Okay. Okay. So then the Board, Ms. Rhoads, requests the set of questions or a form that they initially used for the occupational health interviews by the industrial hygienist. And we will take a look and provide our input.

Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: One of the recurrent impressions in our reviews was that industrial hygienists do not frequently contact the claimants directly and get one-on-one information.

So my question is, do we have any data on that? Do we know what percent of claims

actually involve an industrial hygienist talking with the claimant and is that something that we could look at to see if we can tease apart the issue there?

CHAIR MARKOWITZ: Well, let me venture an answer to that and then Mr. Vance can correct it. At present, the industrial hygienists do not talk directly to the claimant --

MEMBER FRIEDMAN-JIMENEZ: At all?

CHAIR MARKOWITZ: At all, that's not part of the process.

About, we learned from Ms. Leiton about 26 percent of claims in a recent period were sent to, for industrial hygiene evaluation. But that evaluation consists of review of whatever relevant documents are provided by the claims examiner and whatever research the industrial hygienist does. And then they write up their report. So there is no direct contact but that's changing this week.

Dr. Goldman?

MEMBER GOLDMAN: You mentioned that

there's the occupational health questionnaire and that at least from the reviews that were done, it didn't appear that the IH person had looked at that. Do you know what percentage actually looked at that to see something more about the tasks beyond just a job category?

And if not, could that be a recommendation that that be consulted and included in what the IH people receive?

CHAIR MARKOWITZ: I'm going to let Mr. Vance have the final word on that but in my review of the claims, what I see is that the claims examiner is including the occupational health questionnaire as part of what they're passing along to the industrial hygienist.

They make reference to it. I think there's a line in the SOAF where it indicates what the claims examiner is sending to the industrial hygienist.

But the industrial hygienist reports that we've looked at, they use a fairly standard set of references for their report including the

SEM and other things but I don't see any reference that they've necessarily looked at the OHQ or not, but if the protocol is otherwise, Mr. Vance --

MR. VANCE: No, Dr. Markowitz, you have it correct. So when the claims examiner is preparing the case for an industrial hygiene referral they will prepare an IH referral worksheet and that's basically like an analysis that's been done by the claims examiner with regard to the data that is in the case file.

It also should illustrate or communicate the filtering mechanisms that the claims examiner used to identify the toxins that they're asking the industrial hygienist to opine on.

They will incorporate a Statement of Accepted Facts. They will incorporate any other type of data from the case file that's relevant for the industrial hygienist to review.

That would include the occupational history questionnaire. That will include any

industrial hygiene records from the employment site and in some instances they'll also include a medical report if the medical report is sort of the basis for the specific toxins that are being evaluated.

So in other words, if they're not utilizing SEM or they're not utilizing, you know, information from the case file but a physician is saying, here are the toxins that I'm considering in my opinion, then that'll be sent to the industrial hygienist so that they understand the background of why the CE might be asking about something specific.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: In our occupational medicine clinic in New York City, almost all intakes are done initially by an industrial hygienist.

And then she goes back sometimes and talks to the patient again to get more information and we find that this is enormously helpful to the physicians. It saves a huge

amount of time in our clinical evaluations.

And I believe we had made a recommendation that the industrial hygienist be able to talk to the claimants. And I'm wondering what is the status of that and should we make a formal recommendation again? Because I think this would be very useful in improving the accuracy of the causation determinations.

CHAIR MARKOWITZ: So you know, in fact they are, the fact that they are starting that this week, I believe is the result of their acceptance of the recommendation that we made a couple years ago. It's taken a while to unwind but --

(Off-microphone comments.)

CHAIR MARKOWITZ: Yes, I think that's a faithful I think representation of what happened.

MR. VANCE: The specific language is available now online. Our procedure manual has been updated with language relating this.

And again, it's not a mandatory

process but it is an option they can exercise when seeking additional exposure information from a claimant and that process of doing it via phone, telephone interaction, is in our procedure manual now.

CHAIR MARKOWITZ: So we learned yesterday that the contractor or the contract for the industrial hygiene evaluations is up for renewal or it's open for a rebid or whatever the proper term is and Mr. Vance told me this morning that the RFP is coming out soon.

And I think it seems to me that it would make sense for a new contract or an extension of a contract or again, whatever the term is, is flexible enough or incorporates appropriate language that the industrial hygiene interviews, subject to funding of course. But industrial hygiene interviews would be part of the new scope of work for under this industrial hygiene contract.

That doesn't require a response. That's not a question, that's a statement.

Yes, Dr. Goldman?

MEMBER GOLDMAN: Is that something that's feasible? Because you said that 25 percent of all cases go to the IH and if you're, I think it would be great if they interviewed everybody. Is that something that's feasible, I mean, with the numbers or could that be in the scope or the budget to put that out?

(Off-microphone comments.)

MEMBER GOLDMAN: I guess, I mean, because we're making a recommendation and I'm wondering if in your mind you're saying, well, that's ridiculous, we don't have the budget to be able to fund that. So is this a realistic recommendation?

MR. VANCE: Well, the good news is I have nothing to do with procurement so you guys can make whatever recommendation you would like and the Department will consider any input with regard to what we would potentially be able to do on a contract vehicle like this.

So my recommendation is that you

consider your options and decide how you best want to communicate that to the Department of Labor.

CHAIR MARKOWITZ: Okay.

Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I think in our language, you know, our discussion a couple years ago, we did talk about some way of triaging this and not everyone was going to get a full industrial hygiene interview.

And I don't think it's necessary in most cases. We have presumptions for the most obvious cases and many of the cases are easily resolvable without an industrial hygiene one-on-one interview. But we should have some system developed by which those cases for which it's likely to be helpful would be identified and we could focus on that.

I don't think everyone needs an industrial hygiene. That's not what I was saying before and I don't think it's realistic.

CHAIR MARKOWITZ: Right. Okay.

Dr. Dement?

MEMBER DEMENT: I would agree with George. I think, you know, what, 25 or 28 percent go to an IH ultimately. Probably a fairly small percentage of that would benefit from a direct interview. So I think we'd be reluctant to say everyone needed to have an interview.

CHAIR MARKOWITZ: Dr. Berenji, your card is up. I don't that you intended to say something.

MEMBER BERENJI: Yes, thank you.

So I actually agree with Dr. Friedman-Jimenez. I think having some sort of list of terms, especially when it comes to diagnoses like sarcoid, CBD, any type of beryllium sensitivity.

At least if those terms pop up that would be an automatic trigger to get to an IH because I have a feeling that a lot of these cases might kind of get missed.

And if there's a way where we can at

least identify, you know, those cases that could potentially be more complicated that require a higher level of review, if we can try to expedite that as much as possible in coming up with search terms or any type of, you know, medical diagnosis that requires further assessment, I think that could be very helpful.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: I agree with that and we've seen a few interesting cases slip through the cracks because the OHQ didn't list an explicit exposure yet.

Some of their tasks in various work areas were highly suggestive. Yesterday Dr. Berenji presented the carpenter at Savannah River site who remembered bagging up a lot of contaminated dirt.

He had sarcoidosis. I also spent a little time on this case, had PFTs as low with 28 percent. So something was going on but the IH with a little bit more effort I think could have figured out if beryllium was used in that

specific area where the contaminated dirt had been used.

And at our last face-to-face meeting there were similar issues in a Nevada test site laborers case where she'd been in a number of work areas that we know were tunnel construction but it was not well reflected on the OHQ.

And if the IHs could be prompted to dig a little bit deeper into work areas and the contaminants and the generic tasks present I think that would help a lot.

CHAIR MARKOWITZ: Dr. Goldman?

MEMBER GOLDMAN: I just want to third that. But to have a list -- but actually to have it very specific because I think if you leave it totally optional, I mean, people want to get their work done and get through quickly and calling a patient and arranging it is a time consuming task.

And so that kind of direction that Dr. Berenji mentioned I think would be really useful and for any of these kinds of conditions for

which an IH is called or recommended, that there be a high consideration for having the patient interview.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: One of the unique things about the DOE complex is that there are a lot of documents out there and some of those determinations can be made without interviewing the worker.

The SRS Savannah River carpenter said on his OHQ he's not sure if he was exposed to beryllium. But there are lists at each of the DOE sites of beryllium work areas and with a little bit of effort and organization of documents, I think a few more suggestive cases could be approved.

CHAIR MARKOWITZ: Oh, by the way, Mr. Vance told us this morning that the Procedure Manual 4.0 is now available online, so if any of you want to take a look.

We haven't yet discussed claims examiners, the issue, it's Task 2 of the Board

which is to look at how claims examiners weigh medical evidence and we focused so far on industrial hygienists and medical consultants.

But so let's move to the claims examiner. We made some comments around that yesterday. Kind of the challenge where the claims examiner who has presumably a limited background in health and occupational health in particular, arrives at a Statement of Accepted Facts which sometimes are contradicted in some claims we've seen, by the physician, the CMC.

Sometimes rightly, sometimes not rightly. But anyway, if other people have comments about the claims examiner's role and their work in, specifically in reference to what we've seen in the claims review. That's what we're discussing now.

Ms. Pope?

MEMBER POPE: So it seems like the claims examiner's job, in my opinion, is really they've got a lot of responsibility.

And I was, my question is who reviews

their claims, the claims that they're submitting to the CMCs, to the IH? Is there a senior CE that reviews a sample of claims that they submit? Or, I'm just curious about that process.

CHAIR MARKOWITZ: Right, right.

Mr. Vance, if you could describe how they're evaluated, specifically how the content of their work, the SOAFs that they come up with, how they're looked at for quality?

MR. VANCE: All right. So each one of our district offices has a managerial structure and then you have your staff that are actually adjudicating the cases. So as part of that normal routine you're going to have supervisory oversight of staff.

So there is performance assessment for each claims examiner to determine whether or not they are performing the functions of their job adequately and that would involve looking at the quality of the work that they do in conjunction with exposure analysis, the preparation of documents for decision making, development, and

that sort of thing. So that's one quality assurance process, the normal management of staff.

We also have a supervisor review process where they're looking at some basic features of every decision that's being issued before it goes out the door.

We also have our annual accountability review process. And that's where we actually go out to each district office and commit to a team review of the work of each jurisdictional office.

And we devise categories of review for, you know, the accuracy of payments, the quality of recommended decisions, the quality of development, the quality and calculations of impairment and wage loss and those type of things.

And that occurs on an annual basis, not only of our district office but our final adjudication branch.

So we have these tools that are employed to make sure that staff are adhering to

the processes, the rules, the legal constructs that exist under the law.

And then of course like what I mentioned yesterday is we are also moving to develop a formal quality assurance plan through the use of a unit that will be dedicated to doing this on a cyclical basis as well.

CHAIR MARKOWITZ: Thank you.

Comments, questions? Dr. Silver.

MEMBER SILVER: Do you see evidence of claims examiners avidly performing their jobs where maybe they're developing a career interest in occupational health and causation issues, putting Dr. Markowitz's textbook on their cubby bookshelf or really getting into it? Or is it still kind of a thankless slot in a bureaucracy?

MR. VANCE: My general comment to that is I think our claims staff try to do the best possible job that they can with the information they're presented with. And I'm sure some of them have wonderful libraries at their cubicles.

I have a vast source of information

sitting on mine but, no, I think that the overall impression that I think a lot of people recognize with our staff is that they are hardworking and they are trying to do the best they can with this very challenging set of circumstances that they have to face in each and every one of these cases.

So, you know, this is an organization of 240 claims examiners and 65 appeal board staff that are trying to do their job and you're going to have all kinds of different issues with regard to that.

But I think the overall focus and effort of the program is really making sure that we are producing the best possible outcomes that we can given the resources and the evidence that we have in these case files.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Seeing that we have the new claims or procedure manual out and it, we talked about it yesterday a little bit, I was wondering if we could pull up that language, the

one they're talking about terminal claimants because it came up again this morning, if we had time to look at it real quick or not, just to see what the claims examiners want.

You know, and I know we discussed it this morning and it was discussed yesterday but I just wanted to see and with the conversation I had with Mr. Vance, I kind of wanted to see maybe what's on there for us to look at if we had time.

CHAIR MARKOWITZ: Sure, we can try to look it up.

(Off-microphone comments.)

CHAIR MARKOWITZ: EEOICP PM 4.0. He'll find it.

So are there other comments on the claims examiners while we're on this topic? Okay.

We have 20 minutes. This was, my plan was to, we should talk about our work over the next period of time and set some time frames and some goals, and then if there's time we can come back to the public comments and discuss those.

The Board, this term of the Board ends in July, I think, 2020. So that means that there's roughly eight months for us to continue this work.

My feeling is that the topics we've entertained, that we should pursue them to conclusion, handle new topics if we can, but the very important issues that fall within our charter we should address.

That means two meetings. One would be a telephone meeting, probably in roughly two months. Another would be an in person meeting probably in the April time frame, perhaps May.

But we want some time before the Board's term expires because we want to be able to submit those recommendations and then have some interaction with DOL after we submit those recommendations.

So we're not going to pick an exact time or place today, I just wanted to give you the time frames which is that we'll do a full telephone board meeting roughly in January, maybe

early February. We'll send out dates and try to figure that out. And then we'll meet in person April or May and take it from there.

Now at the next meeting, the telephone meeting, we're going to come back to the issue of Parkinson's disease, see if we're ready to make a recommendation to the Department.

I think we should revisit the issue of firefighters since there was a lot of interest in firefighters and I think we should re-discuss it and see if there's some particular recommendation we want to make about firefighters.

I think on the issue, to me the main issue in the telephone meeting will be to resume the look at claims review. And then begin to formulate and if we can, actually make some recommendations regarding the industrial hygiene, the medical consultant evaluation, with respect to objectivity, consistency, and quality.

And also, if we have some recommendation to make around the claims examiner or not regarding their weighing of medical

evidence.

So we would shoot, in that telephone meeting to continue the discussion and to develop some recommendations if we're ready, around those topics.

Are there other, and then there's an action list that Ms. Rhoads has been keeping track of and we will get information about that.

Between now and then we'll continue to review claims and compile claims and then look into the various topics that we've developed an interest in, continuing the work on Parkinson's Disease.

Is there anything that I've forgotten or anything else that needs to be on our radar?

Well, if you think of it at 11:01 today, you know, send me an email and I'll put it on the list.

Any questions about our workflow or what we kind of anticipate over the next six or eight months? Are there any big topics under our chartered mission that you think that we're

neglecting?

We do need to, as we've done in the past, periodically look at the public comments and -- because they are provocative in terms of our mission and introduce knowledge and ideas that maybe we haven't thought of, different emphases of affected community. So I urge you to read those comments.

We have developed in the past a summary of public comments, a spreadsheet in which we've compiled them, shortened them. Some of them are a little bit longer. Ms. Rhoads has done that work and will continue to do that work hopefully, Ms. Rhoads, yes, thanks.

Actually there is something from the public comment from yesterday that I'd like some clarification on.

In Ms. Hand's written comment, there is allusion to a list of authoritative sources that claims examiners, the CMCs and the like could, I think the implication was, should use to make their decisions.

And this is a question for Mr. Vance. I'm sure you don't have a set list of sources that would limit anybody in the process, that they could only go to those sources and that there's no list of sources that are excluded.

But, you know, the sources that Ms. Hand lists are things like the National Toxicology Program, the toxicologic profiles from the Agency for Toxic Substances and Disease Registry, OSHA, Haz-Map, NIOSH, and the like.

So I assume those sources are all legitimate in a claims evaluation process for a claimant to submit or a physician, a personal physician who's doing a well-rationalized report, that those are perfectly legitimate and acceptable sources if they address, if they address the question at hand, the issue of causation in a particular case?

MR. VANCE: The answer is yes.

CHAIR MARKOWITZ: Okay. Great.

(Off-microphone comments.)

CHAIR MARKOWITZ: Thank you. Thank

you for that short answer.

Okay. I'm sorry, Dr. Goldman?

MEMBER GOLDMAN: What, for the CMC? What about other papers from the literature that could be something really good and how often, that's part one. Part two, how often, I saw that on the list, the approved list, of ATSDR profiles, are those consulted by the IH?

CHAIR MARKOWITZ: I, that's a question I guess for Mr. Vance.

MR. VANCE: I mean, you know, I know that we have various resources that our staff utilize in researching issues for claims, researching issues from the Advisory Board, researching issues from just different stakeholders.

So I mean, we really do have an expansive reach in being able to obtain information to help us evaluate epidemiology, to evaluate toxicology in issues relating to these claims. So I think that we're pretty open to using anything that we can look to to help us

through this process.

CHAIR MARKOWITZ: You know, I think looking at some claims, that it might be helpful if the industrial hygienists and the physicians were encouraged to list all the sources that they use so it's a little bit more, it can be more transparent in perhaps reassuring in the claims evaluation process.

This is true for the industrial hygienist as well. They typically don't list, for instance, that they've looked at the occupational health questionnaire.

They're given it but in their list of references they don't, I think it's a habit. I mean, I think it's just this is what we use for references and because they use the same references over and over again.

I think it would help if actually what they actually used to look at was, it was more inclusive. And that would communicate, increase transparency, would communicate to all the parties that, yes, we did take a look at that

study that you gave us to look at.

You know, that your physician cited or provided. It would increase I think transparency and communication.

I have a request from Department of Labor so we're going to add Ms. Rhoads to that, which is in, say from 20--, January 2018 to the present, so a reasonable time period and recent, is what changes in the exposure disease links have been made in the SEM.

I think it's probably limited so I mean, I don't think it's, it's not a huge task but because it gives us some sense of how much evolution there is in that particular aspect of the SEM.

Well, you know there's evolution in the number of agents listed, a lot of work in that. You reviewed the numbers yesterday.

But I don't get -- and you cited a couple of carcinogens I think that have been added with the help of IARC documents, but still don't get a sense of how active this scrutiny in

evolution of the SEM is in terms of specifically the connections between agents and diseases so if that's possible, that would be helpful.

Any comments, questions? Yes, Dr. Dement?

MEMBER DEMENT: Just one comment and I'm not sure where it's going to take us. We've tried, you know, even in the current manual we still have the only presumption for COPD being 20 years of asbestos exposure which I think we all agree that's probably is a presumption that's scientifically valid but is very limited and there are many other exposures with lesser duration perhaps that would also, at least in my view, qualify as a presumption.

I don't know how we move this forward. I mean, we've made a couple of shots at it. We've, and it's still sort of in the limbo stage, I guess.

But I think, you know, it's a big issue and we look at it from our cohort of building trade workers, it's as big or bigger

than lung cancer with regard to mortality. The relationship of occupational exposures is clearly there.

CHAIR MARKOWITZ: Yes, well, I think it's something we need to talk through as a working group, how to bridge this chasm between a dozen or so specific toxic substances that are listed in the SEM as being related to COPD.

And the current state-of-the-art medicine which states that in the industrial environment, a much broader set of agents that lead to dust, gas, vapors and fumes.

So we can discuss that further. I mean, it's, we haven't come to agreement about that, the Department and the Board.

So but, Dr. Dement?

MEMBER DEMENT: Yes, I just was encouraged. You know, I state presumption but when we look at the proportion of COPD cases that are actually awarded, accepted, it's pretty good.

I mean, it's not, I'm not saying that we aren't, you know, the program's not doing a

good job of, you know, looking at it in a detailed way, but in some cases I think we, the whole process could be short circuited and dealt with more quickly and more efficiently.

CHAIR MARKOWITZ: Right. But there is an action, there's an issue I wanted to raise that we haven't really discussed much. We were provided with the types of claims that have been reopened as a result of the change in presumptions and categories. This was a meeting or two ago.

So the particular kinds of conditions that were reopened were bladder cancer, mesothelioma, lung cancer, and a couple of others, I don't remember.

But when I looked through, and we were given details on individual cases. So I looked at the lung cancer. There were some 500 lung cancers that the Department looked at because the presumption around asbestos had changed.

And so they went back and looked at those 500 and decided 50 of them needed to be

reopened and re-looked at. And I know the Department's going to give us a status update on that process.

But when I looked at the job titles of a lot of those cases of lung cancer, there were many job titles, many people who frankly would appear to qualify for occupational lung cancer based, not knowing necessarily what their SEM says because that's not part of what was provided to us, we could look at it.

But people like electricians and pipe fitters, and carpenters, who worked for a long time in the right era, '70s, '80s, earlier, that frankly looked like on the face of it that their lung cancer should have been considered to be occupational but that's only looking at very little information.

So what I would like to do if others on the Board are interested is to request from the Department a certain number of lung cancer claims, denied claims, from that list. So the relatively recent and in fact, I would propose we

select out the job titles of interest to high suspicion job titles. And take a look at those claims and just see how they're being handled. See what the considerations are, what the sticking points are.

I'm wondering if other Board members have some interest in this besides Dr. Dement who just raised his hand, Dr. Redlich.

Is anybody on the Board opposed to this idea? No, okay.

MEMBER SILVER: Reviewing cases has become habit forming.

CHAIR MARKOWITZ: Yes, right.

Okay. So, Ms. Rhoads if you could add it to the list and I'll formulate, Dr. Dement and I will formulate the requests with some detail and we'll circulate it before we submit it.

Any other closing comments or because we're about to close the meeting, questions, yes?

(Off-microphone comments.)

CHAIR MARKOWITZ: Is that for Mr. Tebay?

PARTICIPANT: From Dr. Redlich.

CHAIR MARKOWITZ: Dr. Redlich, okay.

MEMBER REDLICH: This is Carrie Redlich. Can you hear me?

CHAIR MARKOWITZ: Yes, we can hear you.

MEMBER REDLICH: So I apologize. I've been sitting on the runway at O'Hare quite a while so I heard all of you.

I did send, I thought I had sent a PDF last night but it did not leave my house fax until a few minutes ago so it's obviously for the future, but I just thought it was -- just some issues probably were already discussed this morning but others I would think we could address in the future. I think it's sort of self-explanatory.

CHAIR MARKOWITZ: Did anybody make out that comment? I'm sorry --

MR. BIRD: She had sent a PDF and she was talking about discussing it and wanted to know if now is a good time.

MEMBER REDLICH: So I apologize. I don't know why it's not, I don't know why it's not there.

CHAIR MARKOWITZ: Okay. You sent us a PDF?

MR. BIRD: It just came through so we have it there.

MEMBER REDLICH: Yes, I can send a PDF for the future and I just thought if people could give it, it was some of the issues that were already raised yesterday and this morning but I just, after our meeting yesterday just summarized what some of the take home lessons I have learned from the cases we've reviewed.

So I think some of these we have discussed, I've put them down just so I wouldn't forget them before we meet again.

CHAIR MARKOWITZ: Okay. That's great. So as a question for Kevin. Is this 14 pages?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay. Okay, so --

MEMBER REDLICH: But there, but it

also just included one or two examples of some of the issues we've raised.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: So we need to sit and read this.

MEMBER REDLICH: Yes, no, I realize. This is more of a memory aid for the future since it's something we tend to lose track of where we've left off.

CHAIR MARKOWITZ: Okay. Okay. So, Carrie, we'll use this as background for our Board telephone meeting in January. Is that all right?

MEMBER REDLICH: Perfect. Thank you.

CHAIR MARKOWITZ: Okay. No, thank you.

Okay. So will you distribute that to us?

PARTICIPANT: Yes.

MEMBER REDLICH: And I obviously turned off my computer too quickly last night so I apologize.

CHAIR MARKOWITZ: Okay. And then another thing that actually we need to do is take a look at the changes in the PM 4.0.

Is there a transmittal memo with the changes in the 4.0 or?

MR. VANCE: Yes, there is.

CHAIR MARKOWITZ: Okay.

MR. VANCE: So there will be a, just for everybody's information, there will be a transmittal document which actually communicates what's changed in Version 4.0 and then the PDF of 4.0 in its entirety with those changes will also be up on the website.

CHAIR MARKOWITZ: Okay. It is on the website.

MR. VANCE: Yes, I just checked.

CHAIR MARKOWITZ: I'm looking at it, great.

Okay. So if there are no other --

PARTICIPANT: Can you scroll down on this terminal illness thing so I can see the rest of it, please?

CHAIR MARKOWITZ: Oh, yes, sure. I don't see use of the word imminent. Did you see it?

(Off-microphone comments.)

CHAIR MARKOWITZ: I'm sorry, could you scroll back up Kevin and then make it a little larger?

Do you see it?

(Off-microphone comments.)

MEMBER BERENJI: There it is. It's in that second, in that paragraph. Yes.

CHAIR MARKOWITZ: Well, that, you know, the way that reads is that if it's determined that at either end stage or death is imminent, end stage is synonymous with terminal or hospice care. So, leeway there.

But I think my sense is that the Board's made its kind of collective opinion known on this issue, that application of an imminent standard for priority setting is quite a burden on the family, on the patient, and on the physicians taking care of that individual, if

I've captured that correctly.

Mr. Domina, was there anything else about this that you wanted to discuss?

Mr. Fitzgerald, are there any closing comments that you would like to make?

MR. FITZGERALD: I just want to thank you, Mr. Chairman, and the Board for all their work this past day and a half and I want to thank the public for their participation and attendance, both here physically here in Paducah as well as those on the Webex.

And I want to thank the SIDEM contractors here for doing a great job and my alternate DFO, Carrie Rhoads. Thank you very much.

CHAIR MARKOWITZ: I echo all those thank yous and add others, Mr. Nelson, Mr. Vance, the public, Board members, and the like. So thank you very much. The meeting is now adjourned I think.

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