UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

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MEETING

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WEDNESDAY

APRIL 27, 2016

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The Advisory Board met at the Department of Labor, 200 Constitution Ave, N.W., Washington, D.C., at 8:30 a.m., Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

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

MEDICAL COMMUNITY:

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

CLAIMANT COMMUNITY:

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

DESIGNATED FEDERAL OFFICIAL

ANTONIO RIOS

PRESENTERS

RHONDA CHAPPELLE, Branch Chief, Outreach and Technical Assistance, DEEOIC
CURTIS JOHNSON, Unit Chief, Policy, Regulations, and Procedures, DEEOIC
RACHEL LEITON, Director, DEEOIC

JOHN VANCE, Branch Chief, DEEOIC Policy, Regulations and Procedures

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

8:37 a.m.

CHAIR MARKOWITZ: So, let's begin. This is our second day of the Advisory Board on Toxic Substances and Worker Health.

There are some people participating by WebEx and the internet. So, I thought we should introduce ourselves again in case there are some new people in the room or new people online.

So, George, do you want to start?

MEMBER FRIEDMAN-JIMENEZ: I'm George Friedman-Jimenez. I'm the Medical Director of the Occupational and Environmental Medicine Clinic at Bellevue Hospital, NYU School of Medicine.

MEMBER REDLICH: Carrie Redlich. I'm Professor of Medicine and Director of the Yale Occupational and Environmental Medicine Program and, also, a pulmonary physician.

MEMBER GRIFFON: Mark Griffon. I'm an Occupational Safety and Health Consultant.

MEMBER DEMENT: I'm John Dement. I'm

a Professor in the Division of Occupational and Environmental Medicine at Duke University and an industrial hygienist and epidemiologist.

MEMBER BODEN: I'm Les Boden. I'm Professor in the Environmental Health Department at Boston University School of Public Health. I have spent a lot of time looking at workers' compensation programs.

MEMBER CASSANO: Hi. I'm Tori Cassano. I'm a retired Navy occupational physician, industry medicine officer, radiation health officer. Did a lot of work at VA, environmental hazards and radiation compensation claims for VA, and now I do private consulting.

MEMBER SILVER: Ken Silver, Associate Professor of Environmental Health in the College of Public Health at East Tennessee State University.

CHAIR MARKOWITZ: Steven Markowitz. I'm an occupational medicine physician and epidemiologist and Professor at City University of New York.

MEMBER SOKAS: Rosie Sokas, a Professor and Chair of Human Science, Georgetown University School of Nursing and Health Studies.

MEMBER VLIEGER: Good morning. Faye Vlieger, Hanford worker/injured worker claimant.

MEMBER DOMINA: Kirk Domina, Employee Health Advocate for the Hanford Atomic Trades Council in Richland, Washington.

MEMBER WHITLEY: Garry Whitley. Worked in Oak Ridge for 42 years and worked with the Worker Health Protection Program in Oak Ridge for all plants.

MEMBER POPE: Duronda Pope. United Steelworkers, former Rocky Flats worker, 25 years.

MEMBER TURNER: James Turner from Rocky Flat plant, Denver, Colorado, with the Beryllium Support Group since about 1992.

MEMBER WELCH: And Laurie Welch. I'm an occupational physician. I'm the Medical Director for the Building Trades Medical Screening Program, one of the DOE-funded Former

Worker Programs.

CHAIR MARKOWITZ: Okay. Thank you.

So, we will begin our first discussion. This is on the first area of the assigned tasks from our mission or charter of the Advisory Board. We will have John Vance, who is Branch Chief, Policy, Regulations, and Procedures of DEEOIC, and Rachel Leiton as well.

So, welcome back.

MR. VANCE: Hello, everybody. Can everybody hear me all right?

So, I don't expect everybody to careen over here to look at me in the corner. What I am going to do is I am walk through the Site Exposure Matrices. I have actually pulled up the public variant of the Site Exposure Matrices.

What we are going to do is I am going to talk a little bit about the history of the Site Exposure Matrices. I am going to talk a little bit about its functionality. This is a publicly-available resource through our website. So, this is something that I would encourage you

on the Board to go and play around with. It is a very interesting resource. It contains a huge amount of information about the information that we have collected over the years with regard to the toxic substances that are at the sites that are covered under Part E.

Many of you are probably familiar with this, but I want to give you a little bit of background if you do not. I had my folks work up a relatively-descriptive series of talking points or discussion points that I think are in your binders. So, I am not going to really go through it word by word, but I just want to touch on some of the functionality that I think is important for you to understand, some of the strengths, and some of the weaknesses that are contained in the Site Exposure Matrices.

So, it is a huge database. It is basically a database that contains information that organizes data about exposures at the different worksites. And if you could just take a look, you can look at just the basic initial

search criteria, which is basically predicated on the substances that were at these sites, the health effects which are the information about diseases that we know are linked to particular exposures and, then, work processes. But it gets more detailed than that.

This version of the Site Exposure Matrices, this public version, is not identical to the one that the claims staff used in the district offices, the reason being that, as our contractor, Paragon, is developing information relating to the Site Exposure Matrices, they are incorporating it into a version that is cleared for use by our claims examiners, but is not cleared for public release.

So, what ends up happening is you have a clearance process that every six months or so we will have basically a freeze of the internal Site Exposure Matrices for vetting by the Department of Energy. They are going to basically go in and evaluate the information to make sure it is okay for public release.

This is, of course, a publicly-available resource. So, of course, there are security concerns, and that is the issue that the Department of Energy is interested in making sure that there is no problems with any of the information that is available through the Site Exposure Matrices. We have users that are accessing this resource around the world. That is definitely a concern that we have to be aware of and conscious of.

It is a very large database. I think I had some information added in the discussion about some of the amount of information that we have in the Site Exposure Matrices. For example, the Hanford site, we have tens of thousands of rows of data of information about toxic substances that were at the site on page 3. So, huge volumes of information, 783 cells of data in 2010. That has increased to 921,000 cells of data. This is just for the Hanford site.

Hanford, of course, is a very large site, but you can imagine that, if we have this

amount of information just on Hanford, think about some of these other large operations like Savannah River, the facilities at Oak Ridge, you know, Los Alamos, and some of these other locations.

A huge volume of information is being incorporated into the Site Exposure Matrices. So, it is a very, very valuable tool in the sense that it does catalog a lot of data. Now, that being said, it does not catalog everything. It is basically a collection of information that our contractor has gone out to the site and collected.

So, basically, they have gone out, and we talk a little bit about it in the write-up here, the history of how they went about searching these records. They went out and did worker roundtable interviews. They met with workers. They tried to identify sources where the records were. They tried to get a framework or an understanding of some of the work that was occurring at the different sites. And then, the

contractor went off to contact the different sites and work with the Department of Energy to collect data relating to exposures and work processes at the sites. And so, this effort resulted in the culmination of the Site Exposure Matrices.

The data that is maintained in the Site Exposure Matrices is directly affiliated with documentation from the site. This is materials that the contractor, our contractor, Paragon, has collected and has assessed. They are evaluating that documentation to determine how best to report exposure data in the Site Exposure Matrices.

So, the Paragon folks that are doing this -- and we have a bio on the lead project manager, Keith Stalnaker -- many of the folks that are involved with the review and the collection of this material actually have site experience. There are experts in industrial hygiene and epidemiology that are involved with the SEM contractor and reviewing this material,

and they have internal processes for evaluating and assessing the documentation for use in the Site Exposure Matrices.

The Site Exposure Matrices itself is a collection of data that is primarily focused on chemical and biological materials at the sites. It is not intended to collect radiological information because that is generally viewed as being part of the dose reconstruction modeling that NIOSH does.

So, the Site Exposure Matrices really focuses on biological and chemical toxins. As you go through and look at some of the substances that you can see in the Site Exposure Matrices, you can just go see some of the thousands of different substances that we have in here. So, you can do very broad-based searches, and I will just direct you to the main screen or the screen over here in the front of the room.

Just huge amounts of information with all these different toxins. If you can think about the different types of materials that are

involved with making nuclear weapons. There is going to be a lot and there is going to be a lot of very unique materials.

And so, as the Paragon contractor was collecting data, they are looking for information, identifying specific toxins, tradename toxins and other types of things. And then, they will begin looking at how was this material used at a particular site.

And so, they will look for that data, and it has to be a primary source document. They are not going to be taking information without some sort of affirmation through documentation that they have collected.

Now, as we were talking about yesterday several times, the reality is, of course, there is missing documentation. If the documentation doesn't exist, it can't be used to populate data in the Site Exposure Matrices. So, this represents a reflection of data that we have been able to get our hands on.

And this effort is continuing. The

Site Exposure Matrices is not a static system. It is constantly being updated as the contractor identifies new sources of information, as they get additional information from either the Department of Energy or submitted through public channels.

We have a link on our website that allows the public to submit information in their possession for evaluation and consideration for additional data into the Site Exposure Matrices. And we do get a fairly good clip of information coming in. It is reviewed, catalogued, and it is assessed for inclusion in the Site Exposure Matrices.

As you can see, it is just thousands of different toxins. I mean, it is a very broad-based amount of information about toxic substances that were available.

What is nice about the Site Exposure Matrices, though, is the searching and filtering functionality. So, when you go up and you actually look at the different components of the

Site Exposure Matrices, the first thing you will notice is that there are different kinds of searches that you can do by DOE site, mines, mills, or ore-buying stations, or transport, or uranium transporting operations.

The main functionality, of course, is looking at the Department of Energy site. So, that is going to be your default option for searching the Site Exposure Matrices. As you can see, you can go into the Site Exposure Matrices and select what site it is that you are interested in doing research on. I am just going to use Hanford as an example because that is the one I used in the handout.

As soon as you select a site, you are going to immediately come up with additional information and search criteria that can be applied to the evaluation of a claim, right? And so, let's talk a little bit about that.

The information in the Site Exposure Matrices is a very broad collection of all the information that we have about toxins. The one

big feature it does not include is temporal data, which means we don't know and do have in the Site Exposure Matrices any information about when this material was utilized at the site, merely that at some point there was a material toxic substance that was utilized at the site and is going to be recorded in the Site Exposure Matrices. All right? And that is certainly a big issue for us because that is a degree of specificity that doesn't exist.

A lot of these toxins may have been utilized in historical operations and were ceased from use at certain periods of time. But that would not be reflected in the Site Exposure Matrices. We find, through our industrial hygiene referrals and looking at some things, in some instances toxic substances may have been used for a singular work activity that may have occurred at a singular point in time and was never utilized again.

But, in looking at the Site Exposure Matrices, you would think, okay, well, this was a

material that was at the site, but you really don't have any understanding or context as to the extent of the use of that material, merely that there was this material at the site at some point between whatever the operation period is at the facility you are doing research for. So, that is certainly something that the Board could be looking at with regard to specificity in the Site Exposure Matrices.

You can take a look and see all the different information that we have available on facility-wide searches. So, you can search by these different -- you can search by substance, if you so choose. The health effect data, which we will talk about, which is basically the information about the diseases we know are linked to particular toxins.

Work process is over here where you are talking about site history, areas, buildings. Work processes is very important, search criteria, labor categories. And then, we have this incident thing. We talked a little bit

about that yesterday.

The point, we were talking a little bit about that yesterday, and this is something else that you might want to jot as an asterisk. Again, the Site Exposure Matrices is focusing on biological or chemical exposures. If we have radiological incidents that occurred, that is probably not going to be something that we are going to regularly be seeing in the Site Exposure Matrices. Again, the context here is really chemical and biological exposures.

So, we are looking at Hanford. The claims examiner, once they have actually done -- if you are going to go back to yesterday's discussion about the claim process, once they know what disease they are dealing with, they are going to start a correlation evaluation. They are going to go back and look at the exposure and employment history that has been presented by the employee, and they are going to try to match data that the employee or the case file has identified to information on the Site Exposure Matrices.

For example, if we are going to click on disease or health effect, we can go in and look for, let's use chronic obstructive pulmonary disease because that is a very common one. These are all the diseases the claims examiner can utilize as essentially we know that there is a toxic substance that causes or is affiliated with one of these diseases.

So, you know, we have quite a list of these things. This is information that is populated from Haz-Map. There is a brief discussion of that in the handout. This is also material that is vetted and evaluated by Dr. Jay Brown, who is basically the author or the editor of the Haz-Map. This is clearly an area where I think the Advisory Board could be instrumental in looking at additional expansion of health effect data in the Site Exposure Matrices and other sources of information we could utilize to populate the database.

Getting back to this, though, if we look at chronic obstructive pulmonary disease, it

is going to pull up a relatively-broad list of data relating to the different kinds of things that we know are affiliated with chronic obstructive pulmonary disease.

As I scroll down, you will see the different categories that are listed. So, you can see the toxic substances that are linked to that disease. You can look at some of the disease links that are associated with that exposure or that health effect.

And then, we can do other types of search functionality. In other words, if a claims examiner is seeing something where it doesn't really match up very well with what is in the Site Exposure Matrices, they can do these alias searches where they are going to go in say, what is pulmonary fibrosis? Is that an alias of COPD? And they would generally see that that is.

So, it is a very interesting system in the sense that it does have a lot of data. The other neat feature about it that the claims examiners do you utilize quite a bit is the

filtering functionality. So, let's get out and see if we can get to that.

You can actually go in and do additional searching. So, let's say they want to look at somebody that was a welder. This is the example in your handout. So, they go in and they say, "Here, let me look at all of the information that we have about the different labor categories at Hanford." And what they would be looking for is information that correlates to data that the employee has reported.

So, let's say the employee has presented a claim saying, "Hey, I was a welder at Hanford for whatever period of time." Well, the first thing the claims examiner is going to do is they are going in and say, "Okay, let's take a look at welding or welders at Hanford and what we are able to sort of establish as a link between the welder labor category and the information being provided by the employee.

So, you can see right away we already have a list of toxins associated with welding.

Some of the ones that you would obviously know would be welders would be exposed to welding fumes and other types of things.

But the CE is, then, going to start trying to narrow that list down. Because we are operating in essentially the absence of reliable affirmative data specific to an employee, we are basically having to recreate their exposure history. This is the real challenge in this program, is the absence of individual-level data.

So, the Site Exposure Matrices and the functionality of the claims examiner is to try to identify and prioritize exposures that have the greatest likelihood of a positive outcome for the case. In this case, we have a welder. Let's say we are looking for welder who has made the claim and has established a diagnosed chronic obstructive pulmonary condition. So, the CE is going to go in and say, "Okay, these are my two filtering criteria." So, it would be "welder" and "obstructive chronic pulmonary disease".

You can immediately see they have

whittled this down to two toxins. Okay? This would be a relatively-good result because it is basically limiting it to two identified toxins. So, this is one where you would see this is where we would, then, turn to an industrial hygienist to the answer question, what would be the level and extent and duration of exposure for a welder, for whatever period of time, at Hanford working around these two specific toxins?

We would not go beyond that because this is affirmative data that we have been able to collect about welding at Hanford. Okay? So, of course, the question would be, you know, well, could there have been other toxins? There certainly could have been. But we are trying to identify the ones with the highest probability of the employee coming in contact with. This information would be based on specific data that we have about welders at Hanford. Okay?

So, this information would be based primarily on what the employee identified in their employment history or any other kind of

information in their DAR records, which is the information we get from the Department of Energy about their exposure history. We would also be looking at their occupational history questionnaire. All that information would also be something that would be considered by the industrial hygienist.

So, they would go and they would say, if I am welder and I have described my work activities as primarily welding, well, we can basically assume that that person is going to have a high level of exposure, but we are going to want to make sure that the industrial hygienist validates that kind of exposure.

I mean, this is a very good way of looking at it. You can search further by different kinds of work processes. Let's just select "welding" here. So, you know, we can also look at that.

So, let's say you have a laborer who identifies on their occupational history questionnaire, for example, that "Hey, I'm a

welder, too. My job classification is laborer, but I did a huge amount of welding at the site. I was a welder's assistant and I did a lot of work with them." Well, then, you can start searching by that labor category and, then, also add in additional filters for, say, welding.

Common ones we see, the laborer one is a good example because laborers are a very broad classification of labor category. You oftentimes have to search the labor category for a laborer, but, then, refine it by work process, so that you are limiting or trying to figure out which are the ones that are associated with a laborer doing that type of work activity. So, you could have a laborer who was perhaps doing like demolition activities, a laborer doing outside landscaping and that sort of work. So, those kinds of things are all captured in the Site Exposure Matrices.

So, it is a very good resource. I don't want to spend a lot of time on it. But I think it is definitely something that you all should take some time to just play around with

and have a good sense of the search-filtering capabilities.

One of the things that I do want to talk a little bit about is some of the things that are basically not going to give you good results. As I was talking about, as you filter these results, there is a fine balance between taking it too far or being too broad in your search criteria. In other words, if you apply every single one of the filters here up on your screen, it could be that you are going to exclude any data that is relevant to the case.

So, what we try to tell the CEs to do is to really use multiple different filtering techniques to try to identify those toxins that are coming up in different variances or different variables of a search criteria. In other words, if you are looking at labor category, health effect, facility, and let's say work process, and you are identifying toxins, and then, you do a similar search, but, then, are looking at a laborer category, if you are starting to see

replication of those toxins, replication in your search filter parameters are going to be ones that you will definitely want to identify.

Some of the things that are problematic -- somebody brought this up yesterday -- is the scope of the searches when you are talking about like building-level data. So, some of these locations were huge industrial operations. I am sure many of you are familiar with these sites where you had lots of different operations occurring in very large facilities.

One of the common misconceptions that we get is that, as soon as you walk onto a site and you go into the Site Exposure Matrices and do a search for, let's say, all the toxins that were at Hanford, does that necessarily mean that every employee was exposed to every single one of those toxins? No. We stress that a building-level search is not very reliable on its own. Simply because you have different operations that are occurring throughout the site, you have to bring the employee into contact with that material in

some way beyond just saying you were there.

So, when we are utilizing building-level searches and that sort of thing, what we are trying to do is add that into other filtering functionality. If you are talking about health effect, facility, work process, and building location, that is a good search. But, if you are simply saying, you know, this employee worked in Building X-10, or whatever the building designation is, we can't simply say, "Simply because you walked in that building you were exposed to every toxin that was in that site."

That has to do with the fact that, first of all, we don't have the temporal data on that. These locations were very large. Think about this building right now. We are in this room having a conference, but there are people upstairs doing work in the cafeteria that are doing things that are probably involving exposure to certain things that we will never be exposed to. So, I mean, that is just a reality of industrial operations, and that is something that

we generally say is not a very reliable source of information without additional filters, which is that building-level search.

The other big thing that I did mention before, you know, we are always looking for additional information. This is an area where I think the Board would be very helpful in looking at this. If we have sources of information that would be helpful to populate the data in the Site Exposure Matrices, that is definitely a source of information that we would be looking forward to getting.

We are always interested in information that I think would be helpful in utilizing this in our claims education process. This is a very complex system with regard to the development of these cases. As you can see, there are a lot of different ways to go about filtering and evaluating a case. That is what makes this so complicated, is that we have to utilize this data in a manner that corresponds with information that we have on an employee. If

we have not a lot of information about the work processes or the activities of the employee, this is not going to be very helpful. So, the Site Exposure Matrices can only really work when we have data about what the employee was doing at a site.

The Site Exposure Matrices is also not very helpful when we don't have a health effect that is listed in the database. So, if the CE cannot identify a linkage between the disease that has been diagnosed and something that is in the Site Exposure Matrices, this system can't be used. Okay. So, that is something that is an issue with the Site Exposure Matrices that I think that we would be looking for some input on.

The big drawback I think is the temporal data. We really don't have a lot of information about when these materials were there. The more specificity that we get, you know, that is a good thing. But, at the same time, you also have to be conscious of the fact that, as we get more data about the use of

materials, as we get more information about temporality in the system, then that could have an effect on claims adjudication in a sense that, if we are looking at cases and the Site Exposure Matrices includes temporal data saying this material was no longer at the site or utilized in industrial operations after 1960, well, that means that anybody that is filing a claim for employment at the site after 1960 is not going to be able to ever say that they were exposed to that toxin. So, there are always going to be pluses and minuses as you add additional information in the system.

The other thing that I want to also mention with regard to the addition of material, this system is always, the Site Exposure Matrices is always going to be changing with regard to how the information is presented. So, as clarification is obtained with regard to how materials were used at the site, this could change.

So, we have had instances where we

have added information. There are instances where we have taken information out as documentation becomes available to our contractor team and as they evaluate it. So, just because it goes in doesn't mean it is going to stay there forever.

For example, in your handout we talk a little bit about the work that is going on with tradenames where we talk about different types of tradenames for like window-cleaning agents. We talk about Windex and Clorox window-cleaner. Instead of calling them by tradenames, we have reduced that down to glass cleaners as a general search parameter.

In the handout we have also included several different things that we are interested in looking at. I have already touched on some of those. Let me just go through them. I'm not going to read through all this, but we definitely would be looking at input and assistance in identifying new health effect data to incorporate into the Site Exposure Matrices. The list of

items that you see here in your handout are items that we have struggled with, folks have mentioned in the past, and it is just issues that, from a policy perspective, we don't have clear answers for or there's lots of issues to consider with regard to those.

The effect of geriatric problems on these cases, you know, people are going to get sick. They are going to develop diseases as they get older. What is the connection between geriatric illnesses and occupational exposures that occurred in one's early working career? That is a very challenging topic for us to address, and it is one where we see individuals making claims for. So, you have individuals with heart disease, other types of problems that you would associate with age and that sort of thing, but the claims are being made that there is some effect of an occupational nature on those diseases. And how do we evaluate and consider those claims?

Yes?

MS. LEITON: There is a title in what he is reading from, and you are going to see this in most representations. It is advice and guidance, basically. I don't think it is called exactly that.

But, when he is talking about this list, this is the list of things that we think the Board might be able to help us with or the things that we struggle with the most that we think you guys might be able to take a look at, just for clarification in case anybody was confused.

Thanks.

MR. VANCE: Right. And then, as I was saying, you know, other types of things that are obvious here are the issues with the data itself, how it is presented in the Site Exposure Matrices, how it could be utilized more efficiently and effectively by our claims staff to avoid problems, to make sure that there is some sort of regimented process for doing this.

We have never been able to develop a

formulaic way of doing some searches, simply because there are just too many variables involved with these subsearches. So, if you prescribe a particular methodology for filtering, well, then, is that really going to apply to every single case that comes along and is it going to produce a good, valid outcome? So, we have struggled with that.

You know, just the mere categorization of information. Is there information in here that would be helpful to add in? Is there some topic or some sort of information that would be helpful to add to provide clarity to some of this information in the Site Exposure Matrices?

Improved data descriptions or just the general presentation of data or clarification of like, say, generic toxic profiles, which we do do to a certain extent in the Site Exposure Matrices, but could we apply that more broad-based across the board for certain labor categories? Could we apply that in certain temporal situations?

The site contractor or the SEM contractor, could we not identify areas where we could prioritize what their search functionality would be? Where should we be looking at data? You know, simply because we are out there collecting data doesn't necessarily mean it is going to be applicable to a lot of cases. The more information we have, obviously, the better off we will be, but does that necessarily mean that we should be expending a lot of time and resources trying to collect information on sites where we don't have a lot of claims? So, I mean, those are questions that I think certainly warrant some consideration.

I don't know, Rachel, if you have more to add to that?

MS. LEITON: No, I think you have covered it. You guys, obviously, when you start looking through the database, you will have ideas and thoughts about how it can be improved and that sort of thing. But these are just some of our struggle points.

MR. VANCE: So, questions at this point?

MEMBER VLIEGER: John, when looking through the example that you have on the screen, I notice that solvents are not included under the welders.

MR. VANCE: Uh-hum. Right. Like I was saying before, when you are doing a search, it is always going to produce data that relates to information on a document that the Paragon team has obtained in some way. So, in other words, somewhere it is saying, for somebody doing welding who has got -- let's use COPD and see what we get -- it is going to produce whatever information is available on a document that our contractor has obtained at the site.

So, you know, somewhere they have gotten information basically saying welding produces two types of toxic substances that we know are associated with that work process, and what we have is asbestos and welding fumes. If you are going to be talking about adding

solvents, we would have to look at, right now, if we were to be adding solvents, we would have to identify what are the solvents and what documentation exists to support that, or what information could you rely on to add that information to the Site Exposure Matrices.

MS. LEITON: John, isn't this, though, being filtered on COPD?

MR. VANCE: Yes.

MS. LEITON: So, if it was filtered on hearing loss, you might get a different result, correct?

MR. VANCE: Right.

MS. LEITON: But you still filter on COPD here.

MR. VANCE: Right.

MEMBER VLIEGER: I think the issue -- excuse me -- I think the issue comes, John, from you have another statement in your presentation that, when there is a later development for a labor category, that that supersedes data in the SEM. But welding as a labor process has metal

cleaning in it, and that is where the solvents come in. Anybody in the room here who has worked on welding or welding projects knows that metal cleaning is part of it, and that is solvents.

MR. VANCE: Right. So, you could always look at whether or not this information would be something that you could look at welding fumes in general and just look at -- so, here's welding fumes as a description, "to describe the toxic materials that a person doing maintenance welding of carbon steel, aluminum, stainless steel would be exposed to. Thorium" -- and whatever this is -- "are also constituents of welding fumes."

So, you know, you are going to be looking at this as the general profile for welding. But, if you are talking about solvent exposure, well, then, maybe that would be a criteria you would apply separately, you know, saying, okay, was this welder exposed to -- saying, "I was around all kinds of cleaning solvents" or other types of activities that were

going on.

It really depends on the profile, and that is what makes this so complicated, in the sense that you have got to look at what the employee is telling you. So, if the employee is saying, you know, "I did this type of work," or "I did this type of activity," then you have got it all applied in the Site Exposure Matrices. If that information isn't available, then the employee has no basis on which to do the filtering based on that data. And that is how this works. It is the absence of information is the challenge.

CHAIR MARKOWITZ: Dr. Redlich? And then, Dr. Friedman-Jimenez.

MEMBER REDLICH: Yes, I don't know where to begin, but it seems like you have got a lot of COPD claims. There is very extensive literature of occupational exposures increasing risk, causing COPD. And those exposures and those studies are generally vapors, gases, dust, and fumes. There is not identified the specific

exposure that a welder has that causes COPD.

So, if you knew someone was a welder for many years, stop, and none of this matrix is relevant because that is actually not what the occupational literature shows. It is extensive; there are multiple reviews. And the specific exposures that cause COPD have not been identified, but the types of, you know, general work in a dusty, dirty environment. So, something like COPD, if one were to look at the relevant literature, this just doesn't make sense.

CHAIR MARKOWITZ: So, is there a specific follow-up question to this on this track, Dr. Welch?

MEMBER REDLICH: I think it would be greatly simplified.

MEMBER WELCH: Well, I think that is an important point. And I was going to say, I mean, Steve asked me to chair the little Subcommittee, which I'm excited to do. Maybe you'll join?

MEMBER REDLICH: Which Subcommittee?

MEMBER WELCH: The SEM Subcommittee.

MEMBER REDLICH: Oh.

MEMBER WELCH: The one that talks about, well, it is really exposure identification, because, I mean, I think that is an important issue. I mean, I, for my life, have been diagnosing people with occupational disease without personal exposure information, sometimes with material safety data sheets. But you can tell by the occupational history the complex exposures that they have had. And the concern would be if this is leading the claims examiners to think that you need to identify specific exposures when, as Carrie was saying, the literature supports generic category of complex exposures.

And it is a problem that OSHA has dealt with and we dealt with in Health Effects, because many times it is hard to regulate something that is a complex exposure. It is hard to assess the components of a complex exposure,

and we don't want to get lost in the weeds or lost in the --- not see the forest for the trees kind of thing.

MR. VANCE: Yes, and welding itself, that is a fairly compensable labor category simply because welders are going to be welding and they are going to be exposed to a fairly high level of welding fumes. What you also have to consider is welding might be one where that would be very true with regard to the general information, but, then, you have to look at other types of labor categories across the board and how do you deal with that reality.

MS. LEITON: John, one thing you might just want to mention here is the work process search because the work process search is something that we will look at and it is okay. We know that they were involved in this particular job, this type of work. We are working currently, I believe, on a circular that will help the claims examiners say, well, if they were involved in this work process, and there is

a relation to a COP, or whatever it is, then we can make certain assumptions. But that is a different kind of filter that I think is a little bit more specific to the type of work that they were doing and might be relevant here.

MR. VANCE: Right. I mean, you know, Rachel raises a good point. So, what we would look for, too, is all the different kind of work processes that we have in the Site Exposure Matrices to further filter and resolve what do we know about the activities of the employee based on their information in their case file, based on what we have in the Site Exposure Matrices.

So, you can just see for Hanford, I mean, there is just a huge volume of different work processes that individuals could be associated with that we could, then, search further on health effects and looking to see if we can identify toxins that this person could have been potentially exposed to.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I can see the huge amount of work and information that has gone into these Site Exposure Matrices. However, there is a lot of missing information here. And we understand that. We recognize that. Nevertheless, it is probably better than a lot of the information we get on many of our patients that we make decisions on based on job title and length/duration of exposure, et cetera.

So, my question is, the claims examiners, a lot of this is going to depend on the judgment of the claims examiners, I think. It doesn't make sense to have a formulaic mathematical application of these to come up with a conclusion because there is a very high probability of getting a wrong answer.

So, my question is, what is the level of training and the skill set of the claims examiners? Who are the claims examiners and how are they trained to use this information in a way that reduces that high likelihood of error?

MR. VANCE: Well, the claims examiners

are exactly that; they examine information. They are examining data in the case file. They are trained to look at data. The way I have always explained it when I have done training is that, you know, our claims are words on paper. They are evaluating information that is contained in the case file. They don't necessarily have to have industrial hygiene experience.

I mean, they are going to have understanding of what the terms and terminology are on the cases. They are going to have an understanding of the facilities that they are looking at. But their functionality is really looking at and examining evidence. They are going to be looking at what information do they have about that employee in the case file and, then, comparing it to what they are able to obtain through the use of the Site Exposure Matrices to identify and prioritize those exposures.

MS. LEITON: And just to expand a little bit on that, the claims examiners are

going to be trained in looking at this. We go out and do a lot of training on how you filter what you are looking for and how you are going to categorize it in order to send it to an expert. That is why we do rely right now on the industrial hygienist to assist us in wrapping that into a statement that we can, then, use for a doctor to review, that we can say to the doctor, "This is what we have determined based on the evidence we have in the file that we have gathered and the opinion of the industrial hygienist." So, again, that is where they are not experts, but that is why we rely on some experts to help us with that.

CHAIR MARKOWITZ: So, I have a follow-up question on this topic. You described the use of this SEM as complicated. That was your word. Have you ever looked at the claims examiners' ability to do these searches, their repeatability? In other words, if a given claims examiner does a search multiple times over different time periods, or across claims

examiners, how different ones approach the same questions, to what extent do they actually come up with the same answers? Because it would be a way of looking at their ability to do this complicated task.

You probably haven't done that, but their ability to penetrate this data source in a way that is reliable is critical. And I don't think it is just a function of -- I mean, training and guidance and all that help, but somehow there needs to be a way of measuring that. Maybe you have done it. I don't know.

MR. VANCE: Well, let me make a couple of points, and I am sure Rachel is going to want to add something. Our claims process is designed to have this two-step process of making a recommended decision, having the employee present their point of view with regard to how the CE interprets this information, and then, having an independent review by the final adjudication board, where they are actually going to go in and they are required to go back and evaluate the

Site Exposure Matrices again because of the fact that it is constantly being updated. So, the mere process of evaluation of a claim necessitates two individuals looking at it and agreeing that the Site Exposure Matrices is being applied in an appropriate manner.

The other thing that I would like to point out is we do annual audits of all our district offices through our accountable review process, whereby we have an independent review team coming in and looking at -- one of the categories that we look at is Part E case adjudication, where we are looking at the quality of the Site Exposure Matrices application, the quality of the use of our medical physicians in coming to the certain claim outcomes.

And the last point I would have, just to make a mention, is that the GAO did just conduct an audit of this process and identified that we have done a fairly good job in keeping with the policies and procedures of this program with regard to the specific medical conditions

that they were looking at, which included some of these Part E conditions that we really have struggled with in the past.

I know Rachel might want to add something.

MS. LEITON: Just real quick, in terms of the Final Adjudication Branch review process, first, the claims examiners, depending on their journey level, whether they are new or not, they will often have a senior examiner look at this again before a decision will go out. And then, at the Final Adjudication Branch, you might have a CE doing an initial search and, then, a hearing rep doing a final search when they do their signoff.

And mentioning the GAO report, that is one of the processes we are going to put in place in terms of we are going to have another level of review before a recommended decision and before a final decision for hearing reps. That is one of the procedures we are putting into place.

When John mentioned an independent

review team for the accountability review, the team is made up of staff in the district office and our Policy Branch, but they are from a different district office looking at cases from other district offices, with the direction of our Policy Branch team.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: First, I wanted to comment on Dr. Markowitz's point, which is what you are talking about is good and I think important, but I want to emphasize I think what Steve was saying is something somewhat different, which is, if you actually have two people looking at the same case file independently -- that is, not one person reviewing another person's case file -- then how frequently they come up with the same answer is not only a measure of how consistent their reviews are, but it is a measure of how good the Site Exposure Matrix is in assisting them to do that. So, I would just say what you are talking about is not exactly the same thing.

But, getting back to where I was going to go originally, it seems to me that the Site Exposure Matrix has two features. One is that it helps us to learn something about potentially specific exposures at specific sites. But the other is it is kind of an expert system, right? Independent of all that, it is supposed to help people who are not occupational physicians or industrial hygienists figure out what people's likely exposure is.

It seems to me it would be an important thing to think about as this group reviews the Site Exposure Matrix, about whether the way it is being used now really helps the process. I kept thinking to myself, well, wouldn't it be better to have, let's say, the occupational physician who is interviewing the person have information about the potential exposures at the site, because, presumably, that person would know that a welder is exposed to solvents? And then, they could report to the claims examiner without having things sort of

filtered for them through the Site Exposure Matrix. At least I think that is something that we could try to think about as a group.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: First of all, I think the Site Exposure Matrix is useful to an extent. The issue that we have always faced with exposures as an industrial hygienist, a labor category is a very rough first-level cut. The next cut really comes when we talk about specific tasks that the individual does. What we have found a lot of times is there's so much crossing between labor categories in terms of work that is actually done. Welding is a good example.

We have so many people on the DOE site who are not welders who actually do a lot of welding. And the same with the use of solvents, welding on coated materials. So, you have a metal exposure in addition to the welding thing.

So, my concern is how it is one thing to go into this SEM with a labor category, but how flexible is it for the person who is looking

at this information to say, "Well, this is a welder, but they said they did solvent cleaning."? Is there a way to actually put that together?

I mean, I see that welders don't have solvents as a potential exposure. If I go into solvent cleaning, you know, a welder is somebody who might have that.

MR. VANCE: Yes, it is going to depend completely on what is in the Site Exposure Matrices. So, if you --

MEMBER DEMENT: But, if it is not there, how would they use the information? If it is not in the SEM, how do they use that information that is given to them by the individual who is filing the claim?

MR. VANCE: Yes, well, I mean, they are going to look at it and say, okay, in what context is that information coming? So, in other words, let's say we have a welder who in the occupational history questionnaire is really providing a lot of data about solvent use. That

is also something that is affirmed in documentation that we have gotten from the employer. That could certainly be something that they could add into the profile documentation that goes to the industrial hygienist.

The Site Exposure Matrices, though, may not have that information because there is no primary source information that they have identified that specifies the use of solvents by that labor code category at the site. That would be --

MS. LEITON: But -- sorry.

MEMBER DEMENT: Go ahead.

MS. LEITON: But I think that the bottom line is that, yes, we are going to use this as a tool. Oftentimes, what we find is that the claimants don't know. When we talk to them or they have an occupational history questionnaire, as I said earlier, particularly survivors, they don't know this information.

So, we will look at whatever they have described, especially if it is an employee who

knows what they did, but they don't know what they were exposed to. That is where the work process can come in. And if there were a work process in here that said they were cleaning, you know, they were using solvents or there was a certain process, it may be in there that we would look under that process. But, if it is not in there and a person is specific, we can include that in our Statement of Accepted Facts that goes to the scientist or the doctor.

We are not going to exclude information, particularly information that the claimant does know and they are very specific. And we can say, "This is what this person says they did." That is something we can move forward to both the IH and/or the physician when we are making that assessment.

So, we are not trying to say we are going to ignore everything that the claimant says. We are just saying that a lot of times the claimants don't know very much. And so, it is a starting point.

MR. VANCE: Or there is conflicting information between what the claimant is saying, what our SEM is saying, and that raises issues about how we can decide, okay, is this an accurate portrayal of what the employer was doing.

I think we are running low on time, but I think that the Site Exposure Matrices is obviously ripe with a lot of different options for improvement, but I think that it is a good, useful starting place. And the question would be, where do we take this into the future in the application of this data in the claim process?

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Hi. Dr. Cassano. Sort of a follow-up to Dr. Boden's comment.

When I'm doing a claim, or many people that are doing a claim, I like to see all of the information that is available. What I see happening here -- and I don't know if it is true or not -- but what it looks like is that the information gets narrowed and pigeonholed to a

point that the industrial hygienist sees what the claims examiner has specified they need to see. So, if it is a welder, they say, "Well, according to SEM, they were exposed to asbestos and welding fumes," and you go from there. And then, the doctor sees even a more narrow view.

My first question, if somebody says they are a welder, I say, "Okay. What were you welding on and what was the flux?" And that isn't included in this discussion because the difference between galvanized steel and hard steel or chromate steel is very, very big.

So, what I am trying to find out is how much discretion does the industrial hygienist or the physician have to say, "No, this is not a nail. I can't hit it with a hammer. It's actually a different problem or a broader problem."

MS. LEITON: And I think that the industrial hygienists, they are given the occupational history questionnaire. They are given whatever information we have gathered on

exposure, whether it is from the claimant or from some other source. They are given that. So, they are provided the discretion to tell us those things.

Now, obviously, you guys have a lot of expertise? That, again, we think can really help in that process.

But the industrial hygienist does -- it goes to a physician, and we do try to include as much as we can in that assessment or that Statement of Accepted Facts for the physician.

CHAIR MARKOWITZ: We are going to take one last question and, then, move to something else. But, after the break, we will continue this discussion.

But Mr. Turner?

MEMBER TURNER: James Turner.

Okay. I'm thinking about your cutoff dates, okay? I know you have to have a cutoff date sometime or another, but your cutoff date to me is not working.

Take, for instance, like at the Rocky

Flats Plant, they are destroying a lot of beryllium, supposedly destroyed, cleaning up, but beryllium is a very light metal. When it is machined, it goes wherever, the high beam areas, up in the ducts and ceilings. Years later when they was tearing down these buildings, the workers, they got exposures, okay? So, a few days, years down the road, people are going to come down with CBD, chronic beryllium disease. So, what are you going to do about that?

MS. LEITON: I'm not sure. We don't have a cutoff. So, I'm not cure what you mean by cutoff.

MEMBER TURNER: Well, you made mention earlier that --

MR. VANCE: Yes, what I was suggesting is that is something for the Board to consider. Now that information, we don't have cutoff dates in here now, but what you are raising is a very valid point. And that would be something that certainly would be considered.

The example that I tend to use is lead

paint. You know, they stopped using lead paint years ago, but that doesn't mean that somewhere at one of these sites there was a reserve of this stuff that somehow got back into production somehow. So, saying they stopped using it, or let's say that they prohibited the use of that material at a set period of time, doesn't mean that that, in reality, they stopped using it. There could be circumstances where it continued to be used, for whatever reason. Temporality is an issue that the Board should consider as part of this because it is not in the SEM right now.

CHAIR MARKOWITZ: Okay. We are going to just take a break from this discussion and hear from Dr. Rosemary Sokas, who served on the Institute of Medicine Committee several years ago which took a look at the SEM database and issued a report three years ago, which is accessible through our website. So, if you want to take a look at the IOM report, you can see it through our website.

Dr. Sokas, please.

MEMBER SOKAS: Thank you. And IOM reports, you can actually scroll through them pretty much anytime you want to. You don't have to actually purchase and download, but they will let you look at it.

So, the Institute of Medicine, which is now called something different which I don't recall, the National Academy of Medicine, okay, formed a committee in response to a DOL request that met five times in 2012. The first two times were public meetings and, then, the last three times were really writing the stuff up. And then, it got reviewed externally and, then, was published in 2013.

So, this Committee was chaired by Mark Utell. The staff person from the IOM was Rebecca Koehler, who is a radiation expert.

I did want to just take a moment and recall in gratitude the work of Julia Quint, who has since passed away, but who was an incredibly active contributory member to this Committee.

So, the background for the Committee,

which we were given actually before the first meeting, was a 2010 GAO report that talked about a number of things that will sound familiar. But, basically, what they recommended were to strengthen the independent review, the quality assurance and the independent review of the claims process. Then, the second thing that they wanted to do was to enhance the exposure input information in the SEM and make it publicly accessible and readily usable.

Then, they also wanted to create -- and this was the comment that Mr. Nelson made yesterday -- that there had been an ombudsman report that was never publicly addressed by the Department of Labor. And so, that has changed directly, it seems, in response to this GAO report.

Those were the executive recommendations from that report. They also had a congressional recommendation, which was to form an independent review board similar to the one for radiation. So, that is why we are sitting

here now.

The second item that I would like to share that was presented at the first meeting to the Institute of Medicine, the first Committee meeting, was actually a presentation by Ms. Barrie and Dr. Fuortes from the Alliance of Nuclear Workers advocacy group. It was focused on Haz-Map really as a problem, because, as you have seen this whole SEM, there is one source of information for health outcomes and that is Haz-Map. So, to look at Haz-Map, just to step aside and take a look at it, Haz-Map was created by an occupational physician who had previously practiced for many years as a primary care clinician, was really developing a tool, an instrument for other primary care clinicians without occupational health training to deal with patients in their clinical practices.

And it is kind of like, if you look at the old -- those of us of a certain age will remember the old NIOSH Blue Book where you could look up the activity; you could look up the job

category; you could look up the disease; you could look up the exposure, and kind of work backwards and forwards if you had somebody who came up with something that you weren't quite sure about.

That was actually the starting point for this. And so, if you go to the National Library of Medicine, you will find the Haz-Map and it has got all these kinds of functionalities.

Now the problem is, when a clinical person sees someone in their office, they are mostly worried about not calling zebras if it is in North America and they hear hoof beats; they are looking for horses, right?

(Laughter.)

MEMBER SOKAS: They have zero interest -- zero, negative zero interest -- in any form of compensation system and will run out of the room screaming, typically, if anybody mentions that. So, it is apples and oranges.

So, having said that, the ANWAG group

gave a lovely presentation of all of the many problems that derive from using that as the single metric for health impact.

In addition, Rebecca Koehler sent everybody on the Committee a memo that is unsigned, but was, presumably, sent by Dr. Eugene Schwartz prior to his departure as, I believe, Medical Director for the program in 2009, where he laid out two densely-written or three pages of -- and I think I sent that link to Steve. So, it could be part of what we look at.

But it is a very detailed look at what all the different problems are with making use of Haz-Map, in addition to some other items, making use of Haz-Map for this particular purpose.

Okay. So now, getting into the IOM meeting, I am going to go into -- I think people have it. Wait a minute. Okay, the next one. Does it work? How do I get it to work? Oh, this is the one. Okay, this is the one. If you can expand that to just focus not on the front, not on the top, but on the little bullets there?

Okay.

So, this is the task, and people have this in their books right now. The task list that was the negotiated scope of the work was really around these particular questions, right? So, these questions, the eight questions that you see in front of you -- and you can kind of like enlarge them -- were really what we were allowed even to ask about. So, if we strayed off into quality assessment for the claims examiners or for the review process or for anything else, we could ask those questions, but, basically, would be reminded by Rebecca that the Institute of Medicine had agreed to answer these questions.

So, I am going to go through the task that was assigned to us and what we were able to do with that. In your handout, in the end of the first summary section, there are longer answers to each one of these questions, but I just wanted to frame the questions for you.

One of the questions was, what are the diseases that aren't in the SEM? There were a

handful. Instead of going through -- at the time there were 1300 chemical exposures listed in the SEM; now there's something like 1700 -- so, instead of doing an expansive look at all of those chemicals, there were some sample ones done where you looked for exposure disease outcomes, where you thought that they should be there, and they weren't.

So, the first one is the diseases. The second one was what are the links that seem to be missing. And I am going to go into that in one second. Again, it was a kind of a sampling of, well, let's look at a few things and see what we think is missing. Is there additional information? And it was preferably from epidemiology. So, there were a number of epidemiologists on this panel, in addition to toxicologists that should be used.

What other databases might be included, and the Committee came up with a laundry list of additional databases that would have good information in them.

What are the strengths and weaknesses of the NIH/NLM peer-review process? Now here, again, I mean, I am a little confused, I would say, about whether any of the -- so, the responses that I know got accepted from the Committee report were some of the critiques of the Haz-Map program for where it missed different things. The person who organizes that, who runs it, went back and included some. So, by the time the report appeared, some of the deficiencies in specific examples were corrected. But, apart from that, it is not clear to me that any of the other recommendations were actually acted upon.

And I particularly want to point out this one about the NIH/NLM peer-review process because there the NLM, the National Library of Medicine, personnel responsible for putting up that program came to the Committee and said, "We do not do peer review on the content of this. All we do is an editorial review for language and missing links." So, there is no peer review.

So, I am a little concerned that on

page 4 of the handout we just looked at from the SEM it still says that "Dr. Brown's work is then submitted to NLM for review and editing." While that is technically true, it has a completely different meaning to people who read it than what is actually the case.

So, that is technically true. They do review and editing, but it is for things like broken links and that is it. They don't do any content.

There was another question about synergistic effects. And so, there was a whole little report, mini-report, in the document about, well, what is the science behind synergistic effects? We do know that they occur. What do we think is -- but there is a lot of missing information on that. And so, it is a ripe are for further investigation.

And then, what consistent process or approach could be used to consider a disease or a cancer? In fact, the group got into some additional recommendations and suggestions.

I would like to move to the next one. What did I do with the thing, the slide changer? Here it is. Okay, great. So, again, does this change the slide? Yes. Okay, great. No, wait a minute. Hold it. This one. Okay, great.

So, this one, again, if we could maybe just expand the top piece, if people can see it? This is just an example. So, for example, the exposure cancer links in the Haz-Map -- which then are transported into SEM, right, so it is now the same thing -- are only IARC 1 carcinogens, at least at that time, which is a very strict rule. I mean, an IARC 1 carcinogen doesn't include some of the OSHA standard carcinogens, for example, right?

And so, the IARC 1 carcinogens that were looked at, not all of those outcomes were made. So, these are the missing IARC 1 exposures and outcomes that were missing from Haz-Map; therefore, missing from the SEM.

There is a whole other -- and again, this is in the document itself -- there is a

whole other table of IARC 2As, for example, that are possibly human carcinogens for which there is a body of evidence that was not included.

And then, there is another table that shows just, again, as a random sampling, looking for exposure outcome links for cardiovascular outcomes -- and, for example, at that time, disulfide was missing as a cardiovascular outcome.

So, there were enormous gaps. And this is spot-checking. You know, we didn't have subcontractors. We didn't have somebody to go through 13,000 items.

So, this was kind of obvious immediately. And then -- all of which is documented earlier, but we kind of re-documented it -- the quality assurance for this database is that one individual with some subcontracting reviews a handful of journals periodically and, also, relies on textbooks which may be, as we all know, years out of date. Again, it makes sense if you are a primary care clinician who is trying

to figure out if this person's kidney disease might or may not be due to their work, but was shocking, in fact, to the members.

So, the clear recommendations are pretty obvious. And so, we will go to the next step, which if we can scroll down to the middle of that, there are just basically three recommendations.

If we go to those three recommendations, let's just see. The first one was to add supplemental sources of information on health effects to supplement Haz-Map, to either change Haz-Map and have it be the sole source of health effects or you could add stuff, you know, that somehow gets incorporated apart of Haz-Map. But you have to do something because, really, as it stands, it is insufficient and it is not appropriate.

Not saying that it is not a useful thing to have up on the NIH website, because primary care clinicians need this. You know, it is useful for a lot of people, but it is just not

useful for this purpose.

The other concern was that the structure and function of the SEM itself could be a little easier to do. For example, if you are a construction worker and you have worked at a bunch of different sites, you have to kind of flog through each one. This, again, was meant for the public.

And this was a really -- I don't want to speak for the industrial hygienists on the Committee -- but there was a sense among them that, through all of the DOE-funded studies that were done in collaboration with NIOSH or with other people, there should be a lot more information because it is not clear to me yet that the information that is in the SEM about exposures is anything more than kind of a purchase inventory and the MSDSs that go along with it.

I mean, although it is described that there are tons of sporadic, and often missing, but there are places where exposure has been

assessed and other kinds of assessments have been made. It is not clear how or whether that has been incorporated in the SEM. So, that I don't really understand.

And then, the third advice was use an external advisory group for the health information data on the SEM. So, it really was not the whole SEM; it was really, you know, this health information data. We don't think it is going to be fixed real easy. So, you are going to need a group.

By the way, 12 meetings, and et cetera, we are not that group, said the IOM Committee at the end of a year of doing this; somebody else is going to have to do this, right?

And so, then, the next couple of bullets I just wanted to go through. If we could just scroll down to that first set of bullets? These are just some of the thoughts that the Committee had about what an external advisory group could do.

Now, again, I don't want to belabor

this, but the GAO report was in 2010. That one memo was in 2009. This Committee met throughout 2012 and reported in 2013. So now, we are in 2016, but we are here.

So, these were the kinds of things that we thought might be useful. People can read through that. But it is you want to have criteria for causal linkages that could be used, and there was a lot of discussion about weight of the evidence, that you could develop something that is similar to IARC where you go from, yes, we know this is true to, you know, we think it is probably true, to, well, it could be true, and then, we are really sure it is not. So, those kinds of things the IOM has done in different places.

And also, look at different sources of information, again, beyond the handful of journals and bunch of textbooks that are put into the Haz-Map.

Develop some sort of a worksheet that could, then, assist in making these

determinations. And then, there was some thought that maybe the exposure information might be able to be more robust through readily-available data, but that is not clear that that is true. And I would defer to people here who have done those studies.

And then, again, they wanted to have some other ongoing responsibility, which is peer review of the new links, assessing occupational diseases. This, I think, is exactly what the list that we just saw kind of gets at, is where there may be more information about some of these exposure outcome relationships.

And as well, look at the existing causal links. It wasn't all sins of omission; there were actually one or two items where a link was in there that was not clear from the data where that link actually came from. And so, when you see the word "link" here, it means really the exposure outcome, exposure link. So, there was probably a false-positive around, I think it was hemolytic anemia that was in there. And then, a

periodic review.

So, again, I don't want to beat this to death, but I think there were fair amounts of -- I mean, the IOM reports are always really consensus documents. There was no disagreement. There was no separate appendix where people got a chance to kind of say they didn't agree with it.

So, these recommendations were really consensus. I think the information in the document itself may be useful for people as the Subcommittee moves forward on this. Again, the list of some of the other databases that might be useful, if that is of any interest.

But, as someone who spent five meetings over a year when other stuff was going on in my life, you know, I would have hoped to have seen a little bit more specific responses to some of this, but we're here.

CHAIR MARKOWITZ: Laura?

Thank you. We are here.

So, are there questions or comments?

Laurie?

MEMBER WELCH: Laurie Welch.

It is partly a question for you, too, Steven. Some of the things that Rosie mentioned that the Committee had looked at, such as the report from ANWAG and that letter from Gene Schwartz, is that something that is available to us? I mean, we have the IOM report, but the background documents are generally not up on the IOM website.

MEMBER SOKAS: They are publicly available through -- you know, they keep a file. So, anything that they have used is publicly available.

MEMBER WELCH: So, we could just go back to the staff member and --

MEMBER SOKAS: And the Schwartz memo is actually, when Rebecca sent it around, she actually gave a link. So, I was able -- she had accessed it in January of 2012. In preparation for this meeting, I used her link and found it again. So, it is out there. I emailed it to Steve. So, you have that link.

MEMBER WELCH: Okay.

CHAIR MARKOWITZ: Sure. I mean, whatever documents, we can just make a request of DOL to produce.

MEMBER SOKAS: Okay.

CHAIR MARKOWITZ: We have a few minutes on this before we break.

Yes, Dr. Boden?

MEMBER BODEN: So, maybe some of you have seen this, but I think it might be useful, to me at least, to see what the report that goes from the claims examiner to the evaluating physician looks like. If we could get some examples that are redacted adequately, so that they didn't identify, you know, we couldn't identify particular people, but we could get a picture of what the information is that is presented, I think that would be helpful.

MEMBER SOKAS: I agree, and that was outside the scope.

(Laughter.)

MEMBER SOKAS: But it's not.

CHAIR MARKOWITZ: Okay. So, I am told we will have that tomorrow.

I would just like to make a comment on the IOM report. It is extremely useful for us to have this review and critique. You should take a good look at this report. There are things that they call for that probably we could assist with. There are other changes we call for which are pretty fundamental and are probably beyond the ability of this Advisory Board to achieve.

For those not familiar, the process of reviewing a single agent and its ability, say, to cause cancer, which is done routinely by or on a regular basis by IARC, also by the National Toxicology Program, is a multi-year process on a single agent for which there is a lot of evidence that it causes cancer. It is a protracted review process by a number of peers. It goes back and forth internal/external review. And so, it is very complicated, and that is for a single agent for a well-known outcome for which there are a lot of studies.

So, part of what the IOM report calls for is this kind of injection of this peer-review process into essentially what Haz-Map has taken on, these exposure/disease links, on an ongoing basis. That is an immense task. We are not going to do that, I think, because that is not really what we are capable of doing, but we could probably help point the direction in this.

Other comments or questions?

(No response.)

CHAIR MARKOWITZ: So, let's take a break. Oh, yes, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Just a quick general question. Did treating physicians have access to this Site Exposure Matrix and all the information on exposure?

MEMBER VLIEGER: They do have access to it. Whether or not they want to take the time to learn the intricacies to find adequate data, although most of the physicians that I deal with, with claimants or on my own claim, their eyes glaze over as soon as I mention that there is a

source.

CHAIR MARKOWITZ: Okay. We will take a break for 15 minutes, and at 10:15 we will start up again. Thank you.

(Whereupon, the above-entitled matter went off the record at 9:58 a.m. and resumed at 10:17 a.m.)

CHAIR MARKOWITZ: We are going to spend the next 45 minutes discussing the area of our assignment, which, according to the Act, is that we will advise the Secretary of Labor with respect to the Site Exposure Matrices of the Department of Labor.

For the next 45 minutes we would like to begin discussion or resume discussion of some of these issues among ourselves and, also, form a committee to carry on the work beyond this three-day meeting. We are going to form four committees, one corresponding to each of the four tasks given us by the Department of Labor.

So, think about which committee or committees you would like to serve on. It would

be good to have representation from the various communities represented on the Board, including the claimant or the worker community, the scientific community, and the medical community. You can serve on more than one committee if you want, and you can make an initial volunteer today and tomorrow as we form these committees, but we will also allow you to switch your committees over the next period of time, in case you change your mind, or whatever.

So, there will be some flexibility, but we would like to get to the point where we have committees because we would like to schedule committee meetings in the next couple of months to continue the work that we are starting here.

So, it is open for discussion now about the Site Exposure Matrices. I think there may have been maybe Dr. Redlich or some people from the previous session who had questions who weren't able to ask those questions. If not, I can --

MEMBER REDLICH: I'll wait.

CHAIR MARKOWITZ: Okay. Yes, Mr. Domina?

MEMBER DOMINA: I have a question for Mr. Vance, if we are going to have access to the SEM that the claims examiners have.

MR. RIOS: As I stated in the opening statement on day one, if you have any questions that require participation from the public, please go through the Chair. Thank you.

MS. LEITON: So, your question was that you want to know if you are going to get the one that the claims examiners have. I'm going to have to get back to you on that. I'll let you know for sure exactly what we can provide to you.

CHAIR MARKOWITZ: So, while we have Ms. Leiton and Mr. Vance here, any other questions, in particular, for them, carryover from the last session?

Go ahead, Dr. Boden.

MEMBER BODEN: Well, I just want to follow up on the question that I raised from Dr. Sokas' presentation, which is, is there a way

that we can have access to the claims examiner reports that go to the physicians who are, then, going to make initial decisions on the claims?

MS. LEITON: As part of our presentation tomorrow from Jeff Kotsch, who is our Industrial Hygienist, he is going to be -- I'm sorry, our Lead Health Physicist -- he is going to be providing a sample of one of the referral packages. At least we can start there because he is going to have that redacted. He has already used it other things.

So, we are going to provide you both with the package that goes to the industrial hygienists as well as a sample of the industrial hygienist report that is written as a result of it. So, we can start there tomorrow with that.

MEMBER BODEN: Okay. Then, we may want to follow up with looking at more stuff to get a more general sense.

CHAIR MARKOWITZ: Sure.

MEMBER GRIFFON: Steve?

CHAIR MARKOWITZ: Yes, sir, Mr.

Griffon?

MEMBER GRIFFON: Yes, I just wanted -- I will direct it to you, Steve. A question about the procedures that the claims examiners will use in putting all this together.

So, they have the SEM as, I won't call that a tool, but I am wondering if the procedures -- and I looked online. There is this Procedures Manual and there is a subsection on the SEM or using the SEM.

Are there other procedures or guidance that the claims examiners will use in compiling this information before it goes to the medical side?

I guess I am directing it to them.

CHAIR MARKOWITZ: Sure, sure. I'm not sure I'm going to give you an informed answer. I am going to turn that over to Mr. Vance and Ms. Leiton.

MS. LEITON: So, the Procedural Manual is the basis for what how they do their work. It outlines step by step exactly what we expect them

to do. So, that chapter in the SEM is how they are supposed to use the SEM. We have chapters on referrals to the IHs. We have got chapters on how they are going to write their recommended decisions. So, each step of the process there is an outline.

Outside of that, the training that has been conducted and is conducted yearly by our industrial hygienists and by our policy staff, that is where we get more into, okay, so here's where we're at; here's where you use it.

There are training resources out there for them to use, but that is why we do a lot of -- every year pretty much we go out and do hands-on training with them to ensure that they understand and that we are explaining things, and as things change, they have an understanding of that.

MR. VANCE: Yes, there is also on our website, if you go to the SEM initial page, there is also a SEM User Guide that will give you some more technical information about how to utilize

SEM.

MEMBER GRIFFON: Okay. So, I mean, I am just looking at those procedures. I mean, they are useful, but they are pretty broad. I am wondering, there is no site-specific guidelines? Say I work, I am a claims examiner and I'm in a region where I get a lot of claims from Savannah River. There is no site-specific guidelines that might help for the consistency issue?

I know this has come up on the radiation side. That is why they have a lot of guidance that isn't necessarily published as public procedures, but there are guidelines for the dose reconstructors to have when they are doing claims because there are areas of professional judgment, and they are trying to assure that there is at least some level of consistency in how people interpret certain pieces of evidence. So, I am wondering, is there any such thing? Any guidance for sites?

MS. LEITON: We haven't had the resources to have that kind of level of detail

for each site.

MEMBER GRIFFON: Okay. Yes.

MS. LEITON: But just keep in mind that our administrative costs that we get are for claims examiners and doing the claims process. And so, you know, Rosie talked a little bit about the recommendations that were made there. A lot of that would require a lot of resources that we weren't given.

And so, over the years we have tried to like get together either more IHs or a panel. First, we have got to get interest for a panel. This a lot of people don't want to touch, as you can imagine, because it is rather complicated.

In addition, we have been trying to get a contract, which now it looks like we are going to get, and we have got this Board. But, yes, it has taken years.

If we can get that level of detail, that would be fantastic. We just haven't had the resources to do that thus far.

MEMBER GRIFFON: Thank you.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I have a process question and, then, I think a request for some information. So, I will direct it in both directions.

A claims examiner gets a statement from a claimant that says, "I was exposed to" this, this, this, and that, at such-and-such a site. "I have this disease." The claims examiner can't verify that in SEM.

I need to be closer. Usually, I can bellow pretty good.

(Laughter.)

MEMBER CASSANO: Does the claim get denied at that point or a recommendation for denial go up to the Final Adjudication Board at that point? Or does it go through an industrial hygienist and a physician at that point who can exercise a little bit more discretion or judgment on the case? Or does it get denied at that point?

MS. LEITON: If a claimant has

information, you know, it might not be in the SEM, but they might have very detailed information. And in some cases we have experts that will provide us with this saying, "I'm an industrial hygienist" or "I'm an HP" or "I have this level of expertise, and I know this is a process I was involved with." They can describe exactly what.

Like sometimes we have incidents. Well, those sorts of things we will move forward to NIH in some circumstances. Sometimes we get medical reports along with that where the doctor says, "I believe that these toxic substances this person was exposed to were related to...," and we will follow up on that. We are not going to just outright deny it because it is not in SEM.

But there are certain other circumstances where we have no, zero information, zero detail. At that level, if we can't get anything else, there will be circumstances where it will be moved to a recommended denial.

MR. VANCE: Yes, and let me give you

a quick example of a real-life situation we just encountered recently. Information in the document acquisition request that we get from the Department of Energy trumps any information that might be in the Site Exposure Matrices. So, recently, we had a case where there was some sort of chemical incident at one of the sites. There was no information in the Site Exposure Matrices about this, but the DAR itself contained information about this employee's exposure as part of this incident. And we ended up looking at that and saying, okay, well, that clearly is documentation of an exposure that, while it might not be in the Site Exposure Matrices, it is clearly probative enough to us to accept that that exposure occurred.

And because we already had the medical documentation linking that exposure to a skin problem, we ended up accepting that case. That entire process existed to acceptance without the use of the Site Exposure Matrices at all.

MEMBER CASSANO: And I think the

request for information, it would be nice to be able to see some data. It would be nice to be able to see some data at what point claims are denied and for what reasons. You know, if they were denied before the industrial hygienist, before the physician, at the claims examiner level, and for what reasons. And then, at each stage, what they were denied for.

CHAIR MARKOWITZ: We are keeping a list -- Steve Markowitz -- a list of the requests. And if anything is unclear after the meeting, then we will get back to you about some clarity.

Dr. Welch?

MEMBER WELCH: If you guys can clarify, it is my understanding that using the industrial hygienists as frequently as you are now is a relatively new procedure. I think that is a conversation we had when you were at our building trades meeting.

MS. LEITON: Yes, we have been using them more than we used to. As I tried to explain

yesterday a little bit, we are getting criticisms for our claims examiners not really having expertise to make any of these sorts of judgments. And so, we were trying to balance that with, okay, well, we don't want our claims examiners who aren't IHs and aren't scientists or doctors to be doing this. So, we started referring more cases to the industrial hygienists for their opinions. And as I indicated, I believe we are very close today; maybe with getting this contract tomorrow, we will know for sure.

CHAIR MARKOWITZ: I am sorry, what contract are you referring to?

MS. LEITON: We are getting a contract of industrial hygienists that can help us with the workload that we currently have. And so, we are hoping to have official word on that this week.

CHAIR MARKOWITZ: So, I have a follow-up question to this about contractors. It seems from the IOM report that one of the areas that

needs some attention is the Haz-Map part of the SEM. And we may be able to help in certain respects with that.

What is the relationship between the Haz-Map contractor, you know, creator, maintainer, and the Department of Labor? Is there a contract relationship?

MS. LEITON: Yes, we have a contractual relationship with them. I think it is a subcontract.

Tell them who you are.

MR. PENNINGTON: Sorry. Excuse me. My name is Douglas Pennington. I'm the Deputy Director of the Energy Program. I won't give you all the details I gave because I am going to make this quick.

We have an MOU with another agency, and Dr. Brown is a contractor with the other agency that we fund through this MOU in what is called an interagency agreement. And so, we do fund his work, but it isn't through a direct contract that we hold ourselves.

CHAIR MARKOWITZ: And what is the agency that you fund?

MR. PENNINGTON: It's HHS.

CHAIR MARKOWITZ: Oh, okay. Okay. Is that the NLM?

MR. PENNINGTON: Yes.

CHAIR MARKOWITZ: Okay. So, you contract with NLM who contracts with Jay Brown?

MR. PENNINGTON: Say it again?

CHAIR MARKOWITZ: You contract with NLM who contracts with Jay Brown?

MR. PENNINGTON: Yes.

CHAIR MARKOWITZ: And what other contractors are involved with the SEM? You mentioned Paragon. They deal with exposure data. Are there other contractors involved at all with the SEM?

MR. PENNINGTON: No.

MS. LEITON: Not currently.

CHAIR MARKOWITZ: Okay. Dr. Redlich? Thank you.

MEMBER REDLICH: I mean, obviously,

this is a huge, complicated task where you are trying to reconstruct years of historic exposures, and you have people now presenting with probably multiple chronic diseases. But I think people present with diseases and not with thousands of exposures. And so, I think more information about the actual data, the number of cases of COPD, cardiac disease, the major cancers, in terms of just where you spent your efforts. And then, for those major diseases, what percentage of claims are accepted, denied, reasons for denial? We would be able to at least focus, prioritize efforts.

Because there are certain diseases that there is just not a lot of association with occupational exposures and there are other diseases like the COPD where digging in the weeds is not supported at all by the literature. So, in terms of just where you would spend your efforts.

MS. LEITON: Yes, and I think I got that from you yesterday, and we have got it. We

are tracking what kinds of reports you want. We might have to come back and ask you to be specific, so we can build a report and get that information and see what we can provide. So, we will just have to further delve into those requests for data.

MR. VANCE: Yes, let me add, too, I want to share an experience for the Board because I think it is an important one for you all to be aware of. It relates specifically to your question or your comment.

We have tried to do that in the past by identifying -- you know, we have presumptive standards. We have worked on trying to develop information about health effect data.

We did have an experience where we tried to go back and do exactly what you suggested by identifying those diseases which science really doesn't have any information linking it to workplace exposures. And we actually created a list at some point where we said these are just conditions which we can't see

are in any way related to employment. And that ended up just creating a firestorm that we ended up having to rescind.

So, I just want to throw that out there as a lesson learned from the program, that while we did it for that very purpose, we got ourselves stuck in this reality of how to deal with that kind of a scenario.

MEMBER REDLICH: Yes, I would probably word it as less data and not no data.

CHAIR MARKOWITZ: Yes, Mr. Whitley?

MEMBER WHITLEY: So, what I think I just heard you say, a pipefitter that worked 25 years at a plant passed away with lung cancer. The spouse comes in and all that client has is a death certificate that says lung cancer, and "I know he worked 25 years at Y-12." Okay? So, that is all the claims examiner is going to get. Where do they go from there? I mean, they have got very little information.

MS. LEITON: That's all they got from the claimant. That doesn't necessarily mean --

as I have tried to explain, we do a lot to try to develop a case like that. We will go to DOE first and, then, we will try to get DAR records. We will look at the SEM. The SEM in that case would probably give some more information. We will go to an IH, based on what we can get.

You know, there will be circumstances that there is nothing, but it is rare that we get absolutely nothing. I mean, we will do whatever we can to get more information on a case like that.

MEMBER REDLICH: But I think this is where some expert guidance -- you know, if a pipefitter, and I'm not an industrial hygienist, but was working in the fifties and sixties and seventies and has lung cancer, I think there is a high likelihood that there was asbestos exposure. And how much time and effort do you want to spend trying to tease that out?

MS. LEITON: True, we could --

MEMBER REDLICH: But I guess the other request as far as data, just because I am less

familiar with those whole program -- and maybe it is somewhere -- would be it sounds like these contractors are more challenging in terms of records as far as employment. It might just be helpful to have some summary idea of what the major categories of the subcontractors. I don't know if that is possible. You know, what are the most common sort of subcontractor types of jobs, if you have that or not?

The SEC, you know, the Special Exposure Categories that are listed, those are for the radiation and the cancers. That is actually helpful for that side. But, my understanding, that doesn't address the whole issue of all the other exposures and the subcontractors.

It does contractors? So, it is subcontractors at -- okay. But it is cancer?

MS. LEITON: Okay. We will evaluate the ask again and see what we have, what we can provide.

MR. RIOS: Right. You are asking the

agency for information, but I think your request is amorphous, and we need very specific parameters. If you are asking us to mine data from a system, we need specific parameters. So, I'm going to probably ask you, because you have asked a couple of times for this, I am going to ask you to actually write down your request, so we can work with you and tell you whether what you are requesting will get you what you need, and whether it is sufficient for us to actually mine data out of a system.

MEMBER REDLICH: Thank you.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: It may not help in all instances, but we are dealing with different departments' definition of what an incident is. The Department of Energy has very specific definitions of what an incident, accident, and off-normal occurrence is. Yet, in each state that they operate, an incident, an accident is defined by the state labor and industry definitions.

What we are seeing on the Site Exposure Matrix mostly is the Department of Energy definition of a radiological incident. What I would like to see, and my specific request, is for the sites that are here -- and it may be a request to the Department of Energy -- there is a database that they use to report, and it is a more recent database called CAIRS, for the accidents that actually occur onsite. And more accidents are chemically-related than radiologically-related.

Wouldn't you agree? Would you agree with that, Kirk?

So, what I would like to see is that lower-level reporting because we are dealing with Part E here, is that accident reporting with the chemicals, because that, I think, is what is not being reflected in the Department of Labor's data, whether it is on the SEM or anyplace else. And that data is not in the personnel records, nor will it be in the personnel records. And so, you can't even get it unless you know

specifically what to go ask the Department of Energy for. But the Department of Energy has those records because they report it to headquarters DOE.

CHAIR MARKOWITZ: Other questions or comments? Sure. Dr. Silver?

MEMBER SILVER: Having seen this program grow up, revisiting some fundamental assumptions, hearing the discussion. I think we heard yesterday that the SEM grew out of a statutory requirement for Site Profiles. No?

MS. LEITON: No.

MEMBER SILVER: No? How would you rephrase it?

MS. LEITON: Our statute does not require the Department of Labor to create Site Profiles. That is not where our expertise is. Our statute requires the Department of Labor to administer the program, to adjudicate claims, to write recommended decisions. But we were never provided with expert -- you know, the Site Profiles was a NIOSH mandate. They were required

to do that, but we didn't have -- that wasn't our mandate, is to create Site Profiles or the Site Exposure Matrices.

This is something we did on our own because we decided that, without it, we would be denying a lot more claims, frankly. That was our incentive for doing it.

So, you know, I will look into that statement that was made yesterday about that, but I know for a fact that we have never been mandated to either create Site Exposure Matrices or Site Profiles.

MEMBER SILVER: So, that's helpful, in that there was a statutory requirement to administer Part E for chemicals and the agency used its discretion to create the SEM. Equally, the agency could use its discretion to develop another approach to toxic chemical exposures.

And broad categorical solutions, as Dr. Redlich's remarks drive at, as Mr. Whitley's remarks drive at, might be something for the Committee to look at, back up out of the trees

and the weeds of the SEM and see if there is another way to address people by job title, location, and era.

MS. LEITON: I agree.

MEMBER SILVER: Okay.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: I won't ask for data again, but could you just tell us what sort of data systems you have? Like for the claims data, what variables you have entered? So at least I won't ask for something that doesn't exist.

And I think it is very important, even whatever data systems you have now, what you might want to put in place moving forward. Because to really sort of assess some of these issues, that would be helpful.

MS. LEITON: So, we created our case management system for the sole purpose of tracking our claims process. When a claim comes in, we are able to enter information about when that claim came in, when we started development on it, when that recommended decision is issued.

We do record, usually, what type of recommended decision it is; sometimes we have reasons behind it. Final decisions.

So that when we are looking at it for our purposes of managing a program full of claims examiners, we can say it took 30 days, it took 60 days, it took 90 days. We can measure their performance that way, and we can actually track where we are in the process.

So, the database wasn't created for reporting purposes, other than reporting on how, for our purposes, because that's what our need was immediately. And it continues to be our need. We get a lot of requests for information. So, you know, we can go back and mine data in certain way, but we can't always get information for research purposes that is being requested at all times.

So, there is where the challenge lies, that the database is created for a different purpose than what a lot of people would like the data for. So that's kind of why it was created

and how we use it.

CHAIR MARKOWITZ: So, can you provide the variables in the database so we know what's easier to look for than not?

MS. LEITON: What might be easier, I mean, if you have a request, it might be easier for us to tell you whether or not we can do it. We have a very large number of variables. The data dictionary is humongous if you want to look at every code that we enter in the system.

So, we do track when it goes to a health physicist, when it goes to an industrial hygienist. There's a lot of things we put in the system. Whether we could pull a report on it is another question. That's why, for us, it would be a lot easier than to try to give you the litany of every single thing if you give us a request, and we can tell you yes or no and whether or not we can -- how we can --

CHAIR MARKOWITZ: That's fine. That's fine. Others? There were some hands over here on the left.

(No response.)

CHAIR MARKOWITZ: This is Steve Markowitz. One follow-up to the issue of the contractors. It would be useful to see the scope of work for the contractors in the SEM. I'm not interested in the administrative or financial arrangements, but I'm thinking, in particular, about the Haz-Map. If there's some interest in trying to improve the quality of that process, it'd be good to know what that contract -- well, in this case, NLM -- but, you know, is presently asked to do.

If you could find out, further, whether NLM has a different kind of contract with Jay Brown on a Haz-Map that the SEM would benefit from. So, your contract with NLM may say "X, Y, Z," but NLM has a broader set of tasks for Dr. Brown. If you could get that, that would be useful.

Where I am heading is that, in order to improve that piece of it, it'd be nice to know the extent to which the current vehicles can be

used to move ahead.

MS. LEITON: I'll find out what we can give to you.

CHAIR MARKOWITZ: And if you need greater specificity, let me know.

Okay. Any other comments or questions? Yes, Mr. Turner?

MEMBER TURNER: I've been a claimant. I went through the process. What happened when I would check with the claims examiners, each time that I checked with them, it was a different claims examiner. I would write their name down each time.

So, I was wondering, it seems like they have ones that they weren't currently familiar with my case. And then it would take time, it would take time, on and on and on and on.

And my thing is, I was wondering, is there a way that a claims examiner can take your case and keep it, like from the cradle to the grave? Is there such a thing?

MS. LEITON: Actually, no, that's not something we can do, because of the fact that we do have turnover of our claims staff. People leave. They retire. They come and go. So, we don't have a way that -- if somebody starts on your case and they leave, then we can't keep them there. We can't make them stay and continue to work on your case.

One of the things that we have talked about doing is trying to inform you first in advance when we change claims examiners. And I think that some of our offices have been able to come up with a mechanism for doing that.

And we do try to tell them, "Please become familiar with the claims if you get a new caseload." But, unfortunately, there is no way to control for people coming and going and fluctuations in staff.

MR. VANCE: Let me add, too, that in an imaged environment, we actually can have staff become very quickly familiar with material anywhere in the country. So, all of our cases

are fully scanned for the most recent ones. Some of our historical cases are hybrid between physical and imaged case files.

So, we have systems in place that allow people to completely understand what is going on in cases, but this is a concern that I think we've heard in the past and we try to mitigate. But the reality of case management is such that, when people leave or workloads shift, we've got to change personnel around to make sure that the work is distributed evenly amongst available staff. Or there could be specialized, prioritized case assignments that are, you know, shifting the workload around, so that we can get certain cohorts of cases processed quickly.

CHAIR MARKOWITZ: Other questions or comments? Mr. Whitley?

MEMBER WHITLEY: Rachel, in the law is there anything that says you can't have presumptions like you do for hearing? Like for chemical hearing loss, it says this many years, this group, these chemicals. Is there anything

in the law that says you can't have presumptions?

MS. LEITON: No. In fact, I've got a list of about a half a dozen bulletins or circulars here where we've made assumptions. We have been able to tell staff how to make those assumptions.

And that is why when we talked earlier about presumptions, if we can get this Board to help us come up with more, it's just that the statute doesn't give us any. They don't come out and say you can make assumptions here and there. So, we have to kind of make that up as we go along.

MR. VANCE: Well, let me also make sure everybody is clear. The presumptions that are enumerated in our policy are derived from the Part E causation standard. So, it is an interpretative question as far as what is the program determining that fits into allowing us to accept a case within that significant factor at least as likely as not standard.

So, our presumptions are basically

saying, if you meet these standards, you have satisfied that requirement. So, it's sort of a dichotomy that you need to understand exists. All right?

CHAIR MARKOWITZ: Any other comments, questions? So, at this point, I would like to see who would like to serve on a subcommittee to deal with Site Exposure Matrices. So, there will be four subcommittees. They correspond to the four areas that we have been asked to address. This is in Section 2, I think. Section 2 of the briefing book, for the public on the phone and for the attendees. These are the four areas set out for us by the Department of Labor.

One is Site Exposure Matrices. Two is medical guidance for claims examiners. Three is evidentiary requirements for claims under Subtitle B related to lung disease. And the fourth is the work of the industrial hygienists and staff physicians and consulting physicians to ensure quality, objectivity, and consistency.

So, right now, we're talking about

Site Exposure Matrices. Okay. So, we've got here John Dement. In our first three volunteers -- Laurie Welch, John Dement, and Gary Whitley -- we've covered all three communities represented on the Board. Okay. Mark Griffon. So far, I have Laurie Welch, John Dement, Gary Whitley, Mr. Domina, and Mark Griffon.

I intend, by the way, as Chair, to participate in all the committees as much as possible. So, you won't see me volunteer for any particular one, but I will be present as much as I can.

Okay, and, Laurie, you volunteered to be the chair? Excellent.

Now I thought that we might just think about what an agenda would be for the subcommittee, actually, a generic, if we could, agenda for the subcommittees as they move forward.

And the expectation is that these subcommittees will meet before the next in-person meeting of the entire Board once or twice,

depending on exactly how long it takes to get notices in the Federal Register.

But we have to actually come back to that point, which we will later, and make a decision about public access to those subcommittee meetings.

In any case, I thought as an initial agenda for each subcommittee, it would be to define the initial issues and scope, as we see it, of the particular area that DOL has asked us to look at.

Secondly, to begin to define data or information needs to understand that particular area better.

And thirdly, to draft an initial work plan for the committee with a timetable, so that we have some roadmap as to how that committee is proceeding.

And my question is, does that suffice or are there amendments to that? Or is it complete enough? It is certainly non-specific enough.

MEMBER SOKAS: So, I would make it a little more non-specific by saying data needs and review, and/or review.

CHAIR MARKOWITZ: Okay. So, we have the Committee here. We've got an agenda.

We've got a few minutes before 11 o'clock, before our next speaker. So, I would like to return to the issue that we began to discuss yesterday about how we are going to conduct the subcommittee meetings and whether they will be open. We've learned from FACA that it's optional. We've learned from the Radiation Advisory Board this is what they have done from the beginning. We've learned from, I think, the Department of Labor that it's essentially up to us. And we also learned a little bit yesterday about what steps we have to go through in order to have a public meeting, meaning probably six weeks or so advanced notice published in the Federal Register.

So, it's open for discussion. I would like to, if we can get to a vote before 11:00,

fine; if not, we can resume this discussion. But I'd like to come back to this issue.

Thoughts? Dr. Welch?

MEMBER WELCH: I think Mark's discussion of what the Advisory Board does for radiation convinced me that -- I mean, I probably would have thought it anyway -- but I think the subcommittees should be open.

You know, I think that the public input, that people can listen to the conversation and then point us to things that we have missed, would be so valuable. Because, although we have representatives of the workers and the advocates on the Committee, there are so many people who have spent so long thinking about these issues, I would hate to miss some great ideas. And I think it is worth the work to make the subcommittees open.

CHAIR MARKOWITZ: Okay. Other comments? Okay. So, I just need a proposal here, so we can vote on it.

MEMBER CASSANO: I move.

CHAIR MARKOWITZ: Well, what do you move exactly?

(Laughter.)

MEMBER CASSANO: I move to keep the subcommittee meetings open.

MEMBER BODEN: Second.

CHAIR MARKOWITZ: Okay. That was Dr. Cassano, and there is a second by Dr. Boden.

Okay. So, any further discussion? All those in favor, please raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: And I will, for the people on the phone, indicate that everybody has raised their hands. So, it's unanimous. Thank you very much.

I think we are ready, actually, to go with the next speaker a few minutes early. So, we're moving on to the second area that the Department of Labor has asked us to address.

While she's setting up, let me just remind the people on the phone who may not have access to this: this second area, according to

our charter, is we would advise the Secretary of Labor with respect to medical guidance for claims examiners for claims under this Subtitle with respect to the weighing of the medical evidence of claims.

We'll start up in a minute. We are just waiting for the setup.

It's no problem. I'm just telling the people on the phone, that's all.

(Pause.)

CHAIR MARKOWITZ: So, let me introduce Ms. Rhonda Chappelle, who's the Branch Chief of Outreach and Technical Assistance in the Division of EEOICP. Welcome.

MS. CHAPPELLE: Good morning.

MR. RIOS: Rhonda, I'm sorry. Thank you. Yes, speak all the way into the microphone. Thank you. Or get it as close to you as possible.

MS. CHAPPELLE: Okay. Good morning. It is a pleasure to be here to talk to you this morning about weighing medical evidence in the

claims process.

I started with the program about 10 years ago as a hearing representative, and then became the Assistant Branch Chief over at the Final Adjudication Branch, and then came here to the Branch of Outreach and Technical Assistance about four years ago.

So the first thing I would like to talk about: there are various sources of medical evidence when we are looking in a case file. So, the first source of medical evidence, of course, is the information that comes from the claimant's healthcare provider. That will include documents from the claimant's attending physician and any other consulting experts that the attending physician referred the claimant to, as well as reports from hospitals or medical facilities where there are laboratory tests or anything like that performed.

The second source of medical evidence in a file would be information from the Department of Energy's medical screening

programs. These programs are located throughout the country. And what they do, they maintain examination records and exposure data on their employees.

We also have information from the Oak Ridge Institute for Science and Education, which we refer to by the acronym of ORISE. And ORISE offers extensive testing for chronic beryllium disease and monitoring for people who've been diagnosed with a positive beryllium sensitivity.

Then there are three other sources of medical evidence, and those are usually from the Department of Labor. And I say they are from the Department of Labor because these are provided by our contractors.

So, the first would be the contract medical consultants, which I will talk a little bit more in detail about a little later. We also have contracts with physicians who render second opinion evaluations. And we refer to them as SECOP. So what they do, they will actually sometimes examine the patient and review all the

medical records before rendering a decision.

Then we have the referee specialists who are also contracted by the Department of Labor. And the referee specialist is chosen to actually resolve a conflict, usually between an attending physician and another physician, either another specialty or another contract medical consultant.

The referee specialists are chosen according to their specialty, and they are chosen at random. And they examine the employee, or they may just review the case file.

So, incongruent with the sources of medical evidence, I will talk a little bit about the actual types of medical evidence. As I said, the first source of medical records are records from the employee. And those are usually the records from the employee's treating physician, the attending physician's notes, charts, various things like that from actually examining the patient.

The treatment records can also consist

of records from physicians that the attending physician consulted, or, for instance, if the employee went to have a second opinion or independent evaluation.

Then the treatment records also consist of diagnostic testing, such as X-rays, EKGs, any other type of test. And then the records from any hospitals or in-home healthcare that's provided to the patient.

A second type of medical evidence would be medical evaluations that are done for reasons other than to actually treat or diagnose the patient. So, this would include things like reports from the Department of Energy's Former Worker Program, such as pre-employment physicals or termination physical exams.

These would also include examinations, for instance, like from the VA if a person applied for disability benefits with Social Security or VA, those or other types of medical evidence.

And then the third type of medical

evidence would be any type of medical report that a person is instructed to undergo in regards to the litigation of maybe a state or federal case.

A third type of medical evidence would be reports produced in response to the Department of Labor's referral to one of our contract specialists, either to the CMC or the SECOP position or to a referee specialist.

Then, lastly, we have a group that we call other types of evidence. Those consist of things like the Cancer Registry records, which we can use in some cases to establish a diagnosis of cancer or the date of diagnosis of cancer.

Also, one of those other types are death certificates. If the death certificate is signed by a physician, we can use that information to help establish a date of diagnosis on the death certificate or even a cause of diagnosis -- cause of disease or diagnosis -- cause of death. I'm sorry.

Then we have secondary evidence, and this would be evidence that the actual attending

physician relies upon. And we call it secondary because it's not evidence that the physician himself finds, but he may have referred the patient to another doctor and he's relying on that information. So, it's secondary to that particular physician.

And then, lastly, we can use affidavits. Usually, these are used with regard to date of diagnosis.

So, I'll talk about the contract medical consultant referrals that we do. Of course, the first thing that we do is rely on, as I said, the evidence that is submitted by the claimant. But we realize that oftentimes the claimant isn't able to get the type of evidence that's needed to prove his case. So, what we did, we have a contract and we implemented this as a way of helping the claimant.

So, what we will do, we will refer the case to either a CMC or SECOP or the medical referee as a way of helping to develop the medical evidence in the case file.

So, some of the ways that the contract medical consultant can assist would be confirming a medical diagnosis, by assisting with providing medical causation, and impairment evaluations can be used so they can review the records and actually give the percentage of whole-person permanent impairment. We use them in wage loss claims, and we use them in that manner to determine the onset and the period of a specific illness that's related to wage loss.

We also use them if we are looking for medical treatment, if a person needs in-home healthcare. If they need durable medical equipment, we can use the CMCs for that purpose.

If a person has a consequential illness, we can refer the case. If it it's not clear, we can have a contract medical consultant render an opinion on whether or not a condition is a consequential illness to the originally-accepted condition.

And then sometimes we just need the CMC to give us clarification on a specific report

or test result.

And then, again, as I said, the last one we would need, if there's a conflict in medical opinion, we can use the CMC to resolve that conflict.

So, developing medical evidence. The initial responsibility -- or, actually, the total responsibility for developing medical evidence lies with the Department of Labor. The claimant's responsibility is to submit medical evidence that they have in their possession and to respond to any inquiries that the claims examiner may have. If the medical evidence on file is not sufficient to establish the claim, then the claims examiner's responsibility is to develop the medical evidence.

So, the first thing that they will do is look in the record. They will explain to the claimant what is lacking, what the deficiencies are, why the report isn't sufficient. If they do that, then they can assist the claimant by telling the claimant exactly what is needed to

help support their case. Oftentimes, the claims examiner will actually communicate directly with the treating physician. If he needs to reach out to get some clarification, he can reach out to the treating physician himself.

And if he is unable to get the information from the claimant or either from the treating physician, then that is when the CE would refer the case to a CMC, the contract medical consultant, or either for a second opinion or referee evaluation.

So, I want to talk a little bit about the contents of medical reports. As you know, all medical reports aren't the same. Usually, we say a medical report has added value if it follows the SOAP acronym, and that's S-O-A-P. Okay. So, if the report contains a subjective section which uses information that is relayed to the physician by the patient -- oh, I'm sorry. Yes, it should say SOAP, S-O-A-P.

So, the subjective section, as I said, is what the patient is actually telling the

physician. For instance, a subjective section might say, "The patient comes in today to have us look at a lump on his neck that has gotten larger over the last month." So, that's strictly what the patient is relaying to the physician.

The second section is the objective section. That records the physician's findings based on his or her observation. So, for example, the objective section might read, "The patient's breathing is labored and his X-ray shows a spot on his left lung," because it's actually what the physician himself is seeing and observing.

We usually say there are three different types of objective findings. The first would be laboratory findings, such as bloodwork or a tissue biopsy or what we use, like a beryllium lymphocyte proliferation test.

A second type of objective finding would be diagnostic procedures such as X-rays or ultrasounds, CT scans, MRIs.

And then the third would be the

physical findings that are actually noted by the physician upon either visual inspection or manipulation of the body. So, this would include the description of the demeanor and readings of temperature, pulse rates, respiration rates, those types of things.

The assessment section of the medical report contains the physician's opinions, suspicions, and diagnosis, along with any medical rationale.

And then, finally, the plan section describes exactly what it says, the treatment plan and the prognosis. So, the physician, for example, may refer the patient for additional testing or may prescribe medication.

We usually say that a good medical report is one that follows the SOAP, and most medical reports do, even if they don't necessarily spell it out. Some physicians will actually put "S" and then talk about the subjective. But most of them will follow this format even if they don't specifically say it is

in that format.

So, that gets us to weighing evidence, actually weighing medical reports. Some medical reports we consider are more probative than others. We would say that a medical report that's based on an accurate and complete medical and factual background has more probative value than a report that is incomplete, that is subjective, or is based on inaccurate information.

For instance, if a physician knows exactly where the employee worked, knew his job duties, knew his exposures, his opinion would generally be more probative or have more probative value than a physician who didn't know all of these things. An opinion that is based on the definitive test is considered to have more probative value than one that is incomplete or subjective.

We use the term "rationalized opinion," and you will sometimes hear the term "reasoned" or "rationalized." That simply means

that the report -- that the medical findings are supported, that the report is supported by the medical findings on examination through a thorough review of the medical records, and, if appropriate, references scientific articles.

We need more than just an affirmation. We need an explanation of a cause and relationship of the factors to the condition and/or disability.

Also, the opinion of an expert is usually considered to have more probative value than an opinion of a general practitioner. So, a board certification or an appropriate field carries more weight. So, if a physician is, like, a board-certified pulmonologist, his opinion would carry more weight in terms of a lung condition than just a general practitioner or an internist.

Then sometimes we see medical reports that use what we call vague or speculative language. So, an opinion that is unequivocal is given more weight than one that we consider vague

or speculative. So if the physician's offering a clear, unequivocal opinion, it's more probative value. And when you talk about vague or speculative terms, when the physician uses terms such as "could" or "may" or "might be". You know, like you may say, "Well, it could be caused by," "It might be caused by." If he says "probably," that is a little less speculative. And if he says "medical probability," that is a little better than if a doctor just says, "Well, it's medically possible."

So, the ways in which we could use the Board's assistance, we outlined four different things that we could probably use your assistance with. And that would be to help us to clarify and make recommendations regarding the assessment of medical opinions. For instance, if there are some standardized triggers for requiring an independent review or the review by a second opinion specialist or a contract medical consultant.

Another way would be to help us with

the methodologies for improving physician responsiveness to data requests, including reviewing development letters, outreach efforts, and any provider communication.

Another way that would help would be training resources for improving the quality of the medical review of medical evidence and weighing these conflicting medical opinions.

And then, lastly, any application or guidance relating to assessing that standard of contribution to, or aggravation of, toxic substance exposure.

CHAIR MARKOWITZ: So, thank you.

One comment I would have is that your review addresses, really, two issues. One is, does the claimant actually have the diagnosis. Set aside what caused it, but does that person have the diagnosis? And, secondly, what that disease is caused by.

And so, I was unclear, frankly, from the language in the charter, whether this particular issue actually covered the issue of

causation, contribution, aggravation, in addition to just weighing the medical evidence about coming to the diagnosis. So, I'm glad for some clarification about that. That's useful.

Comments? Questions? Dr. Silver?

MEMBER SILVER: Thank you very much for participating. On page 5, weighing the evidence, the first bullet gives an example.

One physician assumes a higher level of exposure, employment, and a causation analysis than the claimant actually had. So, what's the standard of actuality? The SEM? There is so little industrial hygiene monitoring data, I could see a claimant, a patient, telling the doctor, "Doc, I was covered from head to toe. Whenever we did this certain maintenance procedure, my kids called me the snowman." And the doctor would assume high-level exposure.

(Laughter.)

MEMBER SILVER: You look at the record. That doesn't say anything about the snowman, but the doctor says, "High-level

exposure." What do you compare that to to arrive at actual exposure?

MS. LEITON: I think that that actually is -- it's a really situation, kind of. I mean, you will have claimants that will go in and say, you know, "I was covered in all these things," and the doctor will say, "Well, you said you were. So, I'm going to assume that you were."

We will look at the evidence and say, "Well, actually, this person was employed there for a couple of years. We don't have a lot of evidence of exposure, heavy exposure to certain toxic substances this doctor might have said."

What we would normally do in that circumstance, especially if it was a treating doctor, is go back and say, "Here's the evidence that we have," if we have evidence to the contrary or we have specific evidence we can share with that doctor and say, you know, "This is the amount of exposure." Because oftentimes they'll assume they worked there for 20 years,

when maybe they only worked there for two. That's one kind of very objective thing that we can tell them that we know.

So, we can go back to that treating and say we do know these X, Y, Z facts. That is where either they will come back and say, "Okay, well, that changes my opinion," or they won't come back at all. And maybe at that point we will go to a CMC to say, "Well, this doctor's made these assumptions. Here's what we know. Please provide us an opinion." But we'll first go back to that doctor, if it's their treating, and provide them with more information, if we have it.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Yeah, I'm still a little bit confused about how you determine that one opinion is more correct than the other. But let's say, in the medical opinion the person says a higher level of exposure. If they give you a good rationale for, not even the guy saying that "I was covered in soot from head to toe," but

goes and gives you references of people that worked in that same industry and indicated over a certain period of time or what the dosing was at that point, would that convince you more than the evidence that you are getting from elsewhere?

MS. LEITON: If a doctor is going to come back and talk to that level of detail, oftentimes you might have doctors that actually treat this on a regular basis, people in Hanford or Oak Ridge. If we have that level of information, definitely that report's going to have more probative value than somebody that has no idea or doesn't reference anything at all.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: I have a question about what medical evidence means in this context. So, it seems to me that, in order to make causation decisions, you need evidence about employment, exposure, and then the kind of stuff that doctors normally do; that is, diagnosis.

Are we considering all three of those as being part of medical evidence? I think so,

but I just wanted a clarification on that. Because if a doctor gives a report, presumably, he'll have to talk about all those things.

MS. LEITON: That's what we would hope out of an ideal report, is that the doctor would have those three elements in their reports. And if they don't, that's when we would usually go back and do something about it.

MEMBER BODEN: And there is something else that we haven't talked about yet, that, presumably, you need a doctor's input in also. And that's impairment. And so I'm wondering how you currently get the AMA guide's impairment information from physicians. I mean, most physicians don't use the AMA guides, haven't really been trained to use the AMA guides, and, also, may have to perform tests that wouldn't normally be covered by diagnosis or treatment of disease. And I'm wondering how those tests get paid for.

MS. LEITON: Okay. So, when an individual claimant files for impairment, they

have to make a choice. First, they make a choice whether they want this impairment rating to be done by a physician of their choosing, or whether they want us to have a contract medical consultant who has been trained in the guides to conduct it.

The first thing, if they choose their own treating doctor, is we just require that the doctor certify that they have knowledge of and experience with the guides or hey have some sort of ABIME certification or AADEP certification. So, that's what we first ask.

And in some cases we already know which doctors have that. So, we don't keep asking it every time. And so those doctors that they're going to choose, they're going to have the knowledge to use the guides.

If they don't choose to do that, or they can't find a doctor in their area, we'll have the CMC do it. If we do, then we request certain -- there are certain tests, like, depending on the condition they are claiming, if

it is a lung condition, we are going to require them to have recent PFTs within the last year. And there are certain other tests that we outline for each condition that they are claiming. But then they would submit those results to our CMC who can evaluate them. And if additional information were to be required, that CMC would reach back out.

MEMBER BODEN: And if their insurance coverage doesn't pay for those tests, who would pay for them?

MS. LEITON: We pay for those.

MEMBER BODEN: Okay. Thank you.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: So, just clarification on that last, you only get to the limitations evaluation once you have been accepted, right?

MS. LEITON: Yes.

MEMBER SOKAS: My comment is really just a comment. It's, when I look at the language, I mean, physicians are actively taught in school to couch their language as "this person

may have lost their life due to" or their limb due to the earthquake that just happened. You know, so there is this -- I mean, I'm exaggerating -- but there is this presupposition in scientific research that there's always more information out there. And so you always couch it that way.

So, that's a little concerning, that that language would be a flag, as opposed to definitive, because, actually, people are taught that you are not supposed to come to premature conclusions. And so it's actually in conflict with the way many people are trained.

And in truth, I mean, a lot of the questions you have about getting good information, getting people to answer your phone calls, getting like all of this, it's like, golly, if we could figure that out, we would be in -- you know, it's a real hard nut to crack, as I'm sure you know. But that last bullet was a little concerning.

CHAIR MARKOWITZ: Dr. Friedman-

Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yeah, I want to agree with what Rosie just said. Having taught clinical epidemiology of diagnostic testing for 20 years in the medical school, we really focus on probabilistic diagnosis. And even in mainstream medicine, it's not that common that you get an unequivocal diagnosis or a definitive test or what we would consider completely accurate. In occupational medicine, there's less evidence available. And so we're even farther from these ideals.

So, I agree that setting ideals as the standard to be reached, it's not often going to be reached. In fact, I would expect diagnoses to be couched with words like "probably" or "possibly," and those subjective, non-quantitative terms are about all that we have, because we often don't have exact predictive values for specific tests, especially for causation. So, I think you're setting the standard a little high for your ideal situation.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: I have two comments, one of which is, I disagree with both of you guys, because I actually think they need something they can hang their hat on. And the language that the physician has to use is a little cumbersome, but it's not more likely than not. So that if we figure out a way during this process to let the examining physicians know that they basically have to say that the exposure was a substantial factor, as opposed to causative, I think that's enough of a "may." But it's a question of how to get that into the language. I mean, many treating physicians are not comfortable making a causation statement at all. So, that's a different question.

But the question I had put my flag up for was really now I think there is a lot of overlap between these task and No. 4, because so much of the weighing the medical evidence is using consulting medical physicians, consulting contract, the CMCs. I always forget what that

stands for, consulting medical consultants? I don't know.

(Laughter.)

MEMBER WELCH: Contract medical consultants. Okay, I finally got it.

And I don't know if we want to combine the two. We should probably think about that as a group, because there is the process of getting the diagnosis, and then there is the process of making the causation statement. I'm not sure that getting the diagnosis is all that hard for you guys.

But if you can't, I mean, it's really whether there are records or not, not so much how you necessarily weigh the records. I would imagine it's generally -- and it's easier to get physicians to make a statement about diagnosis that seems probative or definitive.

But, anyway, just at a point, and maybe some guidance from those of you who came up with those four tasks, is there a way -- Congress?

(Laughter.)

MEMBER WELCH: But probably just some advice from within. You know, we're supposed to be doing what you guys need us to do.

MS. LEITON: Yeah. No, I appreciate that. What we will probably do is check with our lawyers to see if there are some distinguishing factors between the third and the fourth items, to just give you guys some clarification.

CHAIR MARKOWITZ: Do you want to respond? Dr. Sokas?

MEMBER SOKAS: Yeah. So, I mean, when I saw the title of "weighing the evidence," again, it's, I think, what you said earlier. I assumed that it was going to be something totally different.

I mean, what you're saying is, how do you evaluate the way the medical people write the information? The weight of evidence that we talked about in the earlier committee was quite different. It was whether this toxic exposure causes this health outcome with what level of

reasonable possibility or probability. And I don't know if that question is getting addressed in the first working group with the SEM. It may not be.

And that's actually a question -- I would go back to, what did Congress mean then? I mean, did they mean what you are describing, or did they mean what the IOM meant when it was talking about weight-of-evidence discussion? And I don't know who wants to take that one.

CHAIR MARKOWITZ: If you want to respond, Dr. Welch, and then we'll move on.

MEMBER WELCH: Well, just that, in the end, what this program is doing is making a decision of whether to compensate somebody for a toxic exposure. So, it would seem that that question of causation would be something within the purview of this Board. And if we were to interpret each of the questions to exclude that, then maybe we're not going to be that valuable.

So, I think that either No. 2 or No. 4 has to address that question of how the system

is using all its available information to come to a causation decision, in my opinion.

MS. LEITON: Right, and I think 4 could do that.

CHAIR MARKOWITZ: Well, Steve Markowitz.

I agree that causation, contribution, aggravation has to be at the heart of what the Board does, because that's the most problematic, difficult issue to address, and probably much of what we have to offer, actually.

And I think weight of evidence means different things in different contexts. In the IOM report, it had to do with, you know, how do you approach the issue of causal criteria? But it means different things in terms of reviewing medical records and deciding what diagnosis people have.

But, Dr. Cassano?

MEMBER CASSANO: Tori Cassano again.

Laurie basically said most of what I wanted to say about having those specifics. When

you look at a claim, that is exactly what you see. But I also agree that most treating physicians don't know how to do that and they're uncomfortable doing it.

So, if the claimant is given some information and is told, "Hey, when you go to your treating physician, see if they can write these statements at less than likely, at least as likely as not," et cetera, as aggravating, causative, et cetera, et cetera, et cetera, that would be very helpful in setting that treating physician up. And if you can't do it, then you have to go to a CMC. But some might actually want to do the research and look at it.

CHAIR MARKOWITZ: Dr. Boden? Oh, yeah, sure. Oh, I'm sorry. Let me say that most people are putting their name placards upright to indicate.

MEMBER REDLICH: Mine is on the floor.

(Laughter.)

CHAIR MARKOWITZ: Okay. It's on the floor, but it is upright. So, I missed that.

(Laughter.)

CHAIR MARKOWITZ: I'm sorry about that.

MEMBER REDLICH: I think I had a related question that I think you were about to answer. So, maybe you should respond.

MS. CHAPPELLE: Actually, that's what I was going to say. When we talked about the Department of Labor having the responsibility of developing the medical evidence, we said that the claims examiner will often reach out to the claimant and explain the deficiencies and what is needed in the medical report. And sometimes if the claimant cannot adequately convey that to the physician, then the claims examiner will call the physician himself, call the treating physician, to try to clarify and explain what it is that we need.

And we do recognize that, you're right, most physicians are taught that they don't want to come out and say, "Well, this is 100 percent caused by," you know, working at a

particular place. So, that's why we do use those terms like "probably" as opposed to "possibly". And, again, using the standard of the "at least as likely as not," and did it contribute to or did it aggravate? And it doesn't have to be a specific, medically-caused condition.

CHAIR MARKOWITZ: I have a question, actually. So, I co-direct one of the former worker medical screening programs. And we've done thousands of exams. And we don't routinely -- we rarely get requests, actually, for our report, our medical reports that we issue. Is that because it's up to the claimants to bring in the report that we give to them to the claims process? Meaning the claimant has to initiate, essentially, that transfer. It just doesn't seem, at least in our program, it's routinely done. I don't know about the other former worker programs. But we almost never get requests from DOL for these reports.

MS. LEITON: Usually, when we ask for DAR records from the Department of Energy, the

former worker programs screening or those reports would be included. Oftentimes, they are included. At least that's our assumption.

CHAIR MARKOWITZ: Let me clarify. So, these are the reports that we --

MS. LEITON: Okay. Well, that's --

MS. CHAPPELLE: You know, from our program, it's my understanding that the worker takes the letter to the resource center. And that is usually the basis of them filing a claim. But I don't know that it --

CHAIR MARKOWITZ: Right. Yeah, just to clarify, the Department of Energy wouldn't have our reports, just because these are individual personal medical records. The only person who gets them is the individual and their physician, if the individual requests it. So, those are the only parties who have it. So, I understand, it's up to the claimant --

MS. LEITON: Yeah, so I was misinformed. I was thinking about DAR records, and they mentioned former worker program, but I

think that's a different piece of the former worker program that we get automatically. So, it would be required that the claimant themselves provide us with that.

CHAIR MARKOWITZ: Thank you. Ms. Vlieger?

MS. CHAPPELLE: I mean, we do see a lot of them in the case files. So, perhaps the claimant is bringing them in, because there are a lot of them in the case files that I've reviewed.

CHAIR MARKOWITZ: I'm glad they end up there, actually.

(Laughter.)

MS. CHAPPELLE: Yes.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: So, a couple of things. I've read a lot of the claimants' records. I talk with a lot of the claimants. And many times, when those reports from the former worker program are presented, the claimant is told, "This will not be accepted as primary evidence. You must get a specialist of the

appropriate system or body part to opine on this."

So, then we run into the problem, particularly with the few number of specialists that will even talk to you for this program, we run into the issue of not having adequate medical insurance for the tests that are required.

And then, if you find a specialist who is willing to do this, the proximity to the worker is usually not there. So, the whole concept of saying that you are accepting the former worker records, I find to not be factual in all cases, or at least in the majority that I have seen.

I guess I go back to in our briefing book this page on weighing evidence. Did this come as kind of a mutation from FECA or another program? What is the basis for these presumptions of what evidence is adequate?

MS. LEITON: We do weigh medical evidence at all four of our -- or at least three of our Office of Workers' Compensation programs.

And so, yes, a lot of that language comes from the years, the hundred years of experience we have had in OWCP with evaluating medical evidence and weighing medical evidence. And that's where a lot of these standards came from.

CHAIR MARKOWITZ: Ms. Pope?

MEMBER POPE: Duronda Pope. I was just trying to envision the claimant submitting this information to their physician, their treating physician, and then how that claim -- the CE calling the physician and asking them, "Did you mean, when you wrote down this diagnosis, did you mean this?" And do they say, "Well, you need to put this information in"?

MS. CHAPPELLE: I don't think it works exactly that way. The idea is that the claimant, the CE is advising the claimant what they need to prove their case, the type of medical evidence that is needed, and if they have medical evidence, for instance, they will tell them, you know, "Well, your doctor needs to at least render an opinion whether or not it is possible," or not

possible, "it's probably or at least as likely as not that your condition is related."

The CE can call the treating physician if the claimant is having a difficult time getting the medical evidence that is necessary. They don't always do that. That is why sometimes they may, and then, sometimes it is just easier to refer them to the contract medical consultant to have them to review all of the medical information that the claimant already has and then render an opinion.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, the way this is focused is you've got these different pieces of medical evidence and you need to figure out how to weigh them. But there is, I think, another way of thinking about the issue of weighing the medical evidence, which is providing a framework for the evidence that you get.

So, we have talked a little bit about the idea of possibly developing presumptions for certain cases. In fact, I think you have

developed some of them. Well, that is a way of -- a presumption can, also, then, be provided to the physician who is treating the person as a way of telling them what you need from them to fulfill your needs for the causation, right?

And there are other things that I think we can probably think about that would help the Department of Labor process the evidence that they are getting. For example, providing the treating physicians with words that, if they use them, won't be helpful and words that, if they use them, will be helpful.

Unless somebody is a professional who does a lot of workers' compensation cases, they are not going to know that they need to use these kinds of words in order to get the response that they think they are going to get for their patient.

So, I think that, as part of this, we want to think about things that your organization can do to help you get the evidence that you can weigh appropriately, and not just passively take

in the evidence and, then, try to figure out what it means.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: I just wanted to have you guys clarify that, if a treating physician doesn't provide a causation statement, then the claims examiner can weigh the evidence and potentially make a decision him or herself or use the consultants? So, getting the information from the treating physician is not necessarily an impediment to the claim. It might make it easier because, then, you don't have to go out to your outside consultants. But you wouldn't turn down a claim because you can't get the physician to give a causation opinion, if you have got the diagnostic information?

MS. LEITON: It depends on what we have in the case file. If we don't have any information at all that would lead to any suggestion of causation, there was a limited amount of exposure, the doctor really might have said something else like "I believe that this is

related to" X, Y, and Z "that isn't related to this," sometimes the word "idiopathic" is an indication; we will follow up on it.

I am not going to tell you that we are not going to deny cases if we don't get enough something at the beginning to lead us in the next direction. But we will, if there is some indication there might be a causation link anywhere in the case, if we can't get it from the treating, we will go to a CMC.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: Just a related question. So, this back-and-forth that might go on between the claims administrator and a physician, is there a standard, templated letter or wording that is used? Because the way the question is framed can very much determine. Like, "Do you think that this was caused by...," or "Do you think that there was a contributing factor?"

I'm just curious, because the doc is likely to get a standard letter that says, you

know, "Your patient has applied for" X. "We would like your opinion on...," and how it is actually worded. Or is this more verbal? If it is written, if there is an example of it --

MS. CHAPPELLE: We do have, when a case first comes in and when a claimant first files the claim, a development letter is sent to the claimant, and it will talk about the employment evidence that is needed, the medical evidence that is needed. And so, that kind of lays out exactly what is needed and it will talk about causation.

MS. LEITON: We do. We have given them examples on many occasions of, "Ask the doctor, is it at least as likely as not a significant factor in causing, contributing to, or aggravating?" That is language we use in our development letters. Sometimes that is to the claimant, but sometimes it is in a letter to the doctor where we say, "We understand you are the treating physician. Here's what we need in this case, and here's the question that we need

answered." We will send that out.

When you say "templates," I mean, we do try to cater our letters to the case at hand. So, I don't have like a form letter that we send out to them, but we do send out those letters. Our procedures lay out that we are supposed to be asking those sorts of questions.

CHAIR MARKOWITZ: Dr. Welch? No? You're done? That's good.

And Dr. Boden is done. That leaves Dr. Silver.

MEMBER SILVER: Do you have any success stories of specialists or GPs who don't have a lot of training in occupational medicine? A typical scenario around one of these DOE sites is a worker goes to see an oncologist, the best in the region. And the oncologist takes off their glasses, puts their pen down, and says, "You're from" fill in the blank, Los Alamos. "You are the fifth person I've seen. This is work-related."

A few weeks or months later, they ask

the doctor for a letter for this program. Frankly, the letter stinks.

(Laughter.)

MEMBER SILVER: Have you cultivated anyone like that who is not an occ doc and brought them along and taught them how to be helpful, and now might be helpful to the medical community saying, "Hey, it's easy. I learned how to do it."?

MS. LEITON: Actually, I think that, since we are not located locally, I believe that some of the advocates have been able to cultivate those relationships with the physicians to help them understand what is needed and provide us with the evidence that we need. Also, we have authorized reps. We have attorneys that have done that and cultivated those relationships, and have been able to get, frankly, you know, some of these doctors who understand the program. And that happens.

MEMBER SILVER: I have worked with primary care folks in Tennessee. There isn't an

occ doc for miles around, at least not one who workers could trust. There are some who come to Tennessee periodically, but on a day-to-day basis I am thinking of a peer education approach.

The primary care or rural practitioners talk to occ docs, and they get kind of overwhelmed with everything they ought to be doing. But from oncologist to oncologist or primary care doc to primary care doc, it might be easier to spread the word of how to get these cases done.

MS. CHAPPELLE: One of the things that we have done, we started back in 2012, was trying to reach out to the medical community, to physicians, to educate them. For instance, we went out to Shiprock and met with the hospital staff there to talk about things that we needed, because that is a very small and closed community. So, we talked about what it is that we need in terms of medical evidence, medical reports.

And we have been trying to expand that

throughout, and we have had several outreach events that we have focused on the physicians, trying to educate them and let them know what it is that we need.

We have what we call an email subscription medical blast that we send out monthly that we will take a specific topic and we talk about it. So, we have some various things, and we are always open to other ideas in terms of trying to reach the medical community, because that is one of the difficult things because they are busy. And so, just trying to get them and get them engaged, to let them know what we need and what would be helpful to the claimants.

CHAIR MARKOWITZ: So, I see there are a couple of more questions. But let me just ask whether, after lunch at 12:45, Ms. Chappelle and Ms. Leiton, are you available to return in case there are additional questions?

MS. LEITON: Sure.

CHAIR MARKOWITZ: Okay. So, that should relieve some of the pressure.

Dr. Cassano, the last question before lunch.

MEMBER CASSANO: I am still a little bit confused between what you stated about the development letter and the fact that you are very specific about the language that is needed by the physician. And then, what you said when you stated, "Well, we explain the deficiencies, and if the claimant can't still explain to the doc," and I don't understand that piece.

If you have gotten something that has been written out very specifically as to what is needed, and if you have explained the deficiencies in a letter, rather than a phone call to the claimant, why there is this seemingly disconnect between what is said to the claimant or written to the claimant? I mean, most of the time, the claimant just brings that letter from the agency to their doc and says, "This is what you have to do." So, I don't understand the disconnect.

MS. LEITON: Usually, that is the

case, you're right. A letter that we send to the claimant saying, "This is the medical evidence we need." They will take it to their physician.

You know, in some cases, the claimant might not take it to their physician, and the physician, therefore, never got this information. We may follow up then and either write to the doctor, forward the letter to the doctor, or call the doctor.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: Okay. Thank you. Thank you.

It is 11:45. We are going to break for lunch. We will be back at 12:45.

(Whereupon, the above-entitled matter went off the record at 11:45 a.m. and resumed at 12:56 p.m.)

CHAIR MARKOWITZ: We are going to get started. It's five of 1:00. We are missing one member, two members. I'm sorry. Three members. But let's get started anyway.

So, we are discussing weighing medical

evidence. We have another 35 minutes, actually, to ask questions or make comments, have discussion.

Anybody have anything they wanted to raise?

(No response.)

CHAIR MARKOWITZ: So, I can start off. I tend to ask "how frequently" questions, like how frequently does this occur, does that occur. I appreciate that that is not necessarily known or looked at.

But I am interested in the use not just of the contract medical physicians, but the second-opinion physicians and the referee specialists. So, the second-opinion physicians, how often do you use them? Under what circumstances do you use them? It is just not clear to me.

MS. LEITON: This is Rachel. So, we use the CMCs a lot more. I don't have numbers for you right now. We might be able to get those figures for you. But we use the CMCs a lot more

because there are more things that we will refer to a CMC. That would be like diagnoses and impairment and clarification on causation, things like that.

We go to a second opinion only when we really feel a physical examination is necessary. So, for example, there is a need for home healthcare, for example, and the treating hasn't really given us enough information to go by, but we know that we can't have a CMC evaluate a patient on an issue like that because they really need to see the patient to know what is going on with them. So, we will refer it to a second opinion if we feel it is necessary at that point. But it is rare that will go to a second opinion.

We will go to a referee when there is a conflict, only when there is a conflict in the evidence. So, let's say we have a treating doctor saying one thing, we have a second opinion saying another thing, and we might need to refer the claimant to another, a third independent doctor who looks at everything, looks at the

patient, and provides us with another opinion. And we can weigh the medical evidence between those three at that point. So, a referee is even more there than a second opinion, but it is occasionally something that we do.

CHAIR MARKOWITZ: And is the issue of causation, aggravation, contribution, is that a main reason for using second opinions or referees? Or is it more diagnosis and impairment?

MS. LEITON: So, I would say second-opinion referees are rarely used for those purposes. I mean, I would say probably aggravation/causation might be a second opinion, but the CMCs are usually used more for all those purposes.

But the impairment, we do have a lot of referrals for impairment because there aren't a lot of doctors out there that do impairments on their own or are qualified to do them. So, a lot of our claimants will opt to get a CMC to do impairment ratings. And so, a lot of our

business is there.

But, again, I don't have the specifics. I might be able to break out the reasons for all that. That would have to be something I would look into.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I have one concern. I think between probably five or six of us we have spent over 100 physician-years trying to teach doctors how to diagnose occupational diseases. And it is very difficult. I think everyone would agree with me it is very difficult, and the vast majority of physicians are not trained in any way to make causation judgments.

And the boards in internal medicine, in pulmonary, I don't think there are ever any questions on causation. And so, I think that the emphasis on board certification may not be in the claimant's favor because that doesn't in any way ensure that those physicians have the proper

knowledge and skills to make these judgments.

There are several specialties that do get trained in that. Occupational medicine is probably the main one, and I think there probably should be more emphasis on using people that have specific formal training in toxicology, epidemiology, and judgment of causation, epidemiology and biostatistics, as well as just the experience doing it. So, that is my concern about the language here in terms of weighing the evidence.

MS. LEITON: I understand your concern. It is really a challenge for us because there aren't a lot of people with those specialties. So, if we don't go to the treating doctor, you know -- and when you say "board-certified," I mean, most of them are board-certified, depending on the specialty, whatever.

I think that, as I said, our first avenue is going to go to a treating because the claimant chose that doctor to be their doctor or they have been treating them for a long time.

And so, our first avenue would be we want to allow them to go to that doctor if that is who they want to go to, instead of saying, "Well, we're going to ignore your doctor altogether and we are just going to go to an occ med doctor that we have contracted with."

That is where it gets a little tricky for us because we don't want to say, "Well, your medical evidence isn't good enough because your doctor isn't trained in doing this." So, that is where our balancing-act hat is with all that.

I don't know if that answers your question, but that is kind of where we are.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Sort of along those lines, though, what is the expertise of your contract medical consultants? Are you going to those who are boarded in the particular body part specialty or disease specialty? Or you are going to people like occupational physicians that have more broad understanding of cause/effect?

MS. LEITON: The majority of our

contractors are occ med doctors, but there are questions that we have sometimes with regard to a cancer diagnosis or a pulmonary condition, CBD issues, that aren't necessarily about causation. And so, we will go to a specialist for those questions.

CHAIR MARKOWITZ: Other questions or comments?

(No response.)

CHAIR MARKOWITZ: So, thank you to Ms. Chappelle and, also, Ms. Leiton on this issue.

We need to form a Committee. There was, I think, some discussion about whether there was a lot of overlap between this task and the fourth task on our list. Maybe we should discuss that for a moment to try to clarify. My preference, I think, is to try to keep two separate Subcommittees, so at least we can make sure at the end of the day we actually respond to DOL's requests of us.

But the one we are discussing now is medical guidance for claims examiners for claims

under this Subtitle with respect to the weighing of the medical evidence of claimants. And the fourth task is, quote, "The work of industrial hygienists and staff physicians and consulting physicians of the Department and reports of such hygienists and physicians to ensure quality, objectivity, and consistency."

I see No. 4 as really focusing on the use of experts and how they operate, how their opinions enter the process, how their opinions are relied upon in the process, and specifically looking at the validity of their work, objectivity, and consistency. So, that is pretty easy for us to at least identify, not easy to do, but easy to identify as a relatively specific thing to look at.

Whereas, this Item No. 2, looking at providing medical guidance for claims examiners, weighing the medical evidence, is a broader issue into which the industrial hygiene and the occupational or the contract medical physicians, whatever, that is a subset. That is a piece of

the weighing of the medical evidence, as defined here, "medical evidence" meaning not just addressing diagnosis, but also aggravation, contribution, and causation.

So, thoughts about that?

Ken?

MEMBER SILVER: I think the intuitive appeal of combining them is that we spent time this morning discussing the Site Exposure Matrix and Haz-Map which not entirely, but they kind of smack of general causation. Can X cause Y on a hypothetical worker who was exposed to X? Whereas, B and C are more specific causation. Does DOL in deciding in a particular case? That is just my intuition on why B and D tend to fit together.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I think there is some overlap in those two, as I think I said to you earlier, between 2 and 4. But I also see them as more distinct tasks. As you just said, I think 2 is a little bit broader in that we are focusing

more on the claims examiner and how they should be looking at the evidence and what that evidence should be. And I think No. 4 is more about where should some experts be inserted into this system.

I think maybe there is a way, obviously, to keep the two Committees separate, but even before it gets to the -- and I don't know if this is allowed -- but even before those two Committees report to the main Committee, maybe they deconflict or combine their recommendations or not and, then, move it forward, because there is some overlap between the two.

CHAIR MARKOWITZ: Other thoughts? Comments?

Dr. Redlich?

MEMBER REDLICH: Well, it just seems that these two activities are so intertwined, but I am not sure it would either create more work or it seems to me that putting them together might make more sense. I mean, I realize that they are separate, but they are so dependent on each other

and the information that exists. Maybe after we learn more about everything, we would at that point decide that there was a need for a smaller group to work on a specific area. But I feel like at least it would be premature.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: I think I might, even though I was the one who suggested combining them, I might say keep them separate and then see if they come together. Because there are many different steps in the process from when the medical diagnosis information starts to come in to when the final adjudication is made. If one group starts with the role of the experts and kind of moves backwards, and one starts with the medical information coming in and moves forwards, you come together where it overlaps. I think it would make sure that everything is getting covered to keep it in two different groups, because there are so many pieces in there.

MEMBER REDLICH: Well, assume there will be fewer pieces when we are done.

(Laughter.)

MEMBER WELCH: Well, or more ways to move quickly through some parts of it anyway.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I think the unifying theme here is judgment of causation, causation used in its broader meaning to include aggravation, contributing to, and what is usually thought of as cause. And then, the two subsets of this are as done by the treating physician, medical practitioners, consultants, and as done by the claims examiners, which the logic is similar, but they are somewhat different processes because there are different information sets available to them.

So, you might think about structuring the Committees both around the concept of judgment of causation, but one focusing on the claims examiners and one focusing on the treating physicians and consultants.

CHAIR MARKOWITZ: Comments?

I agree with you George, that both areas have to address/include aggravation, contribution, and causation. My feeling about Task No. 4 is that that group is likely to zero-in on the experts; whereas, No. 2 is larger and looks at how the claims examiner is going to use that expert information, and how it is integrated with SEM or with other information.

Many of us, being experts, will zero-in on what is easy for us, which is the expertise, right, and then, neglect the process. That is the reason I would like to at least start with two separate Committees, to make sure that the larger process gets sufficient attention.

Ms. Vlieger?

MEMBER VLIEGER: I agree with you, Dr. Markowitz, it needs to be two separate areas. We are dealing with a set of lay people who do not have medical expertise, and we need to provide them the guidance of how to review the things, what is important and what is not. Because what is important to one claims examiner may not

actually seem important to another claims examiner.

And this is not just in reviewing the medical evidence, but it is the evidence of the file that is provided to them from the Document Acquisition Request, called the DAR, and from their records that they provide of their own work experience.

So, I think the guidance to the claims examiners for what they are looking at and whether or not it is relevant, and what the different names could be, because it is different from site to site. There is a lot of jargon, too. And so, I think it is important to keep them separate.

CHAIR MARKOWITZ: So, there are a couple of people with vertical name tags, but --

(Laughter.)

CHAIR MARKOWITZ: Other comments, questions?

(No response.)

CHAIR MARKOWITZ: So, should we move

on this issue of two separate Committees or one Committee, not necessarily for the record, but just to make it clear where people stand? Is there a motion?

MEMBER VLIEGER: I move to keep the Committees separate.

CHAIR MARKOWITZ: Second?

MEMBER BODEN: Second.

CHAIR MARKOWITZ: Oh, Dr. Boden, okay. All right. Any further discussion?

(No response.)

CHAIR MARKOWITZ: So, all in favor of keeping two separate Committees to address B and D raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: So, for the record, it is unanimous, yes. Yes, I think it is almost unanimous, but it is certainly the majority. I can't see everybody's hands.

So, let's form a Committee now. Who is interested in addressing this?

Ms. Vlieger. Let's get this down

here. Okay. We have got Les Boden, Ken Silver, Tori Cassano, Ms. Vlieger.

And do we have anybody who would like to actually chair this Committee? Okay. Thank you, yes.

Again, we have sort of set out the generic agenda for this Committee, as we did for the last one.

We should move on now. We are a little bit ahead, which is great.

I am hoping Mr. Curtis Johnson is here.

We are going to be discussing, while he sets up, we are going to be discussing Area 3, which I will read to you from our charter, which is, "Advise the Secretary of Labor with respect to evidentiary requirements for claims under Subtitle B related to lung disease."

And so, I would like to welcome Mr. Curtis Johnson, who is the Unit Chief of Policy, Regulations, and Procedures in the Division, and welcome back, Mr. Vance.

MR. JOHNSON: Thank you very much. Thank you.

Good afternoon, everyone.

Just a little bit about my background before we get started, my background is pretty much similar to that of John Vance and Rachel Leiton. I started with OWCP in October of 1994 at the FECA office in New York. Since 1996, I worked as a claims adjudicator, as a claims examiner, senior claims examiner, and supervisory claims examiner. In June of 2005, I came to the Energy Program as a hearing representative for the Final Adjudication Branch, worked in that capacity until October of 2013, into the current position that I am working in now.

One issue/concern that I just had the Board -- and I am really relieved to see that Part B is something that the Board is going to initiate or take action on right now -- Part B is really the legacy of our program. As Rachel mentioned in her presentation before, if it wasn't for Part E and the work that we did on

Part E, Part E actually wouldn't have come to our program. So, I am really grateful that the Board is really going to be taking some action immediately to look at the Part B aspects of our claim.

During the EEOICPA 101 presentation yesterday, you were all given the conditions that are covered under Part B. What I am going to do today is talk a little bit more specifically about chronic beryllium disease and silicosis.

Before I start with those particular items, I really need to include one other condition that is covered under Part B, beryllium sensitivity. The reason why it is important to discuss beryllium sensitivity is because there is obviously a link between beryllium sensitivity and chronic beryllium disease and, also, our procedures and our statute really mandate that a discussion of beryllium sensitivity take place.

So, first, we are going to start off with beryllium sensitivity. Basically, beryllium sensitivity is simply an allergic reaction to the

immune system that is the result of the presence of beryllium in either the blood or based on exposure to beryllium.

The requirements for beryllium sensitivity, the exposure requirements, you simply need one day of employment at either a Department of Energy facility or with a covered beryllium vendor.

Mr. Turner, you had an issue earlier today regarding beryllium at the Rocky Flats Plant. I don't know if your question was answered, but let me just reassure you of one thing. The Department of Energy Covered Facility List does acknowledge that beryllium was present at Rocky Flats as well as all Department of Energy facilities. And beryllium was present not only during the operation of the plant, but also during the residual period of the plant and during the decontamination process of the plant.

So, as long as an individual worked at Rocky Flats, as long as they have one day of employment, we know for sure without a doubt that

there is evidence of beryllium exposure. So, I just wanted to make sure that you understand that part of the deal.

As far as diagnostic evidence for beryllium sensitivity, the statute requires one abnormal beryllium test. That test can come in the form of a lymphocyte proliferation test or a lymphocyte transformation test.

Once again, I just want to reiterate that the statute allow one, only one, test, and it only has to be an abnormal test. It doesn't have to be borderline normal. It has to be abnormal.

In addition to the testing that I mentioned, we would also accept beryllium skin patch testing. If there is a positive skin patch test for beryllium, we would accept that as medical evidence as well.

Once we establish the medical, the employment criteria for beryllium sensitivity, if a claim is accepted for beryllium sensitivity, we would pay for medical treatment. Unlike other

Part B conditions where there is lump-sum compensation, we would only pay for medical monitoring for beryllium sensitivity.

Although the requirements for accepting claims for beryllium sensitivity are straightforward, there are still issues and concerns that we would like for the Board to take into consideration.

The first issue that we have is the consistency in testing results from different facilities. This may be simply due to the calibration of equipment or monitoring data, but that sometimes has an issue or concern where one site might consider something normal and another site may not consider something normal. So, that is one issue that we would like for the Board to consider.

Another issue we would like for the Board to consider is what happens in instances when one physician interprets the results of a beryllium test as normal and another physician reviews those tests and finds that they are

abnormal. Once again, this issue might even be related to the calibration or the methods that are used in the testing, but, once again, that is something that we also have a concern and issue about as well.

The next issue that we have is whether or not there is any new scientific data that is used to establish a diagnosis of beryllium sensitivity. The lymphocyte proliferation test is pretty much the gold standard, so to speak, and we know those testing methods are out there. We just don't know if there are any other specific testing mechanisms that are out there that would help us in determining a diagnosis of beryllium sensitivity.

The last item that we have is basically what should we consider as medical monitoring for beryllium sensitivity. We would pay for any treatment that we feel is going to be related to establishing a diagnosis of chronic beryllium disease. That would include any chest x-rays, any lung biopsies, any type of testing

that would be done. We are just interested in seeing if there are any other topics or issues of concern that we should be considering for a medical.

And that is everything for beryllium sensitivity. Before I go on to chronic beryllium disease, are there any questions? Any questions?

CHAIR MARKOWITZ: Yes. Steve Markowitz.

I have a question. I didn't quite understand the last item, definition of beryllium medical monitoring. If people are sensitive now, and their claim is accepted, they are in a monitoring program, which is determined probably mostly by the physicians they are seeing. So, what exactly are you asking for here?

MR. JOHNSON: We are really looking at this point for testing to show whether or not an individual will develop chronic beryllium disease. Beryllium sensitivity is really one of the main monikers that is used to determine whether or not an individual is diagnosed with

chronic beryllium disease or some other form of pulmonary illness. So, at that point, our efforts are really focused on testing to make sure that we detect chronic beryllium disease as soon as possible.

MR. VANCE: Yes, this is John Vance.

The thing that we see with medical monitoring is what are the expected tests and diagnostic regimen to follow for an individual who has been sensitized to beryllium. What is the frequency of that testing?

We really get a wide, diverse range of suggestions about, well, this should be done annually, biannually. And so, you have individuals with beryllium sensitivity going all over the country to different facilities to have different types of tests performed. And so, we take a very liberal approach right now with regard to what is defined as medical monitoring, but we can certainly be looking for, you know, what is a good course of care for somebody with beryllium sensitivity with regard to what do we

mean by medical monitoring. Right now, it is a very broad meaning, and there are lots of different interpretations about what that means.

So, I hope that adds some clarity to that issue.

CHAIR MARKOWITZ: Right. So, you are looking for advice on an appropriate monitoring protocol for progression to disease?

MR. JOHNSON: Correct.

CHAIR MARKOWITZ: Thank you.

MR. JOHNSON: The next condition I am going to talk about is chronic beryllium disease. From a claims adjudication standpoint, chronic beryllium disease is probably one of the, if not the, most difficult claims to adjudicate. Normally, it is claims examiners, when we are establishing a diagnosis for a medical condition, we are normally keying on a specific medical report or some type of specific medical evidence where we could say this is what we are going to use to establish a diagnosis of beryllium sensitivity.

Actually, the way that the statute reads -- and we will go into the specifics a little bit later -- for the Part B aspects of the program, you don't necessarily have to have a diagnosis of chronic beryllium disease per se. It is based on the concept, if it looks like CBD and it talks like CBD, we assume, assumption of causation, that it is CBD.

First of all, the requirements for establishing a diagnosis of chronic beryllium disease, similar to the criteria for beryllium sensitivity, one day of exposure to beryllium at a Department of Energy facility or with a beryllium vendor. Once that information is established, the statute mandates that the criteria are reviewed based on a diagnosis chronic beryllium disease either before or after 1993. Once again, this is something that the statute set in place.

MR. VANCE: Let me interject real quick. Let me make a point of clarification here. When Curtis is talking about a

presumption, what we are talking about is the statute lays out very strict requirements for what constitutes the establishment of chronic beryllium disease. And you will notice I am saying "the establishment of chronic beryllium disease," not necessarily the diagnosis of chronic beryllium disease.

So, I just want to make that clear, that the statute lays out specific diagnostic criteria for establishing chronic beryllium disease, dependent on whether or not an individual has a pre- or post-1993 evidence of a chronic -- there is a test that goes into determine whether you are going to apply the criteria for a pre-1993 standard for chronic beryllium disease or a post-1993 standard. Okay? And we'll talk about that because that is an important function of making a determination of the establishment of chronic beryllium disease.

MR. JOHNSON: For establishing the pre- or post-1993 standard, normally, what we would look at first is the actual claim form

where the claimant will actually identify when they were diagnosed or when they believe that they were diagnosed with the illness. That would be the first marker that we are looking for to determine whether or not we are going to use the pre- or post-1993 standards.

If there is no identifying factor as to when the diagnosis took place, what we would be looking at, we would make a determination based on the medical evidence of when an individual was first treated or received treatment for a chronic respiratory disorder.

If we establish that the treatment took place before 1993, we would use the pre-1993 criteria. If it is established after 1993, we would use the post-1993 criteria.

The pre-1993 criteria, it is based on five particular elements. In order to have an acceptable claim, you must meet three of those particular five elements.

The first element that we are looking at is the characteristics of the chest

radiographs. This includes any chest x-rays, any CT scans, any CAT scans. The claims examiner reviews that particular element, and we are looking for, as John mentioned, we are looking for specific findings or criteria in those chest x-rays.

And what I want to make sure that it is really clear is that this is something where the claims examiner does not make an interpretation on their own. If the evaluation report does not identify these particular items and terms, then we make the determination that this information may need to go to the treating physician to ask whether the characteristics are similar to or found in CBD, or we would go to a CMC to get that information.

There are some target words that we do look at. One of the biggest terms is "non-caseating granulomas". That is one term that we determined that is synonymous or consistent characteristics with chronic beryllium disease. If those findings are noted in the x-ray report,

then the claims examiner should feel comfortable in stating this particular piece of criteria is met.

There are also other conditions. Once again, this is something that really the Board would really, really be able to give us help on: what other characteristics in chest radiographs should we be looking at to establish characteristics of CBD?

MR. VANCE: Yes. So, in the handout -- I think we don't need to re-read each one of these -- but the test for the pre- and the post- are laid out. So, what Curtis is talking about is, you know, this is an interpretation of evidence by a physician looking to the diagnostic test results and applying the criteria from the statute. So, in other words, you know, are we looking at x-ray results that are characteristic with chronic beryllium disease? Again, you are looking at an interpretative question that a physician evaluating the evidence makes an opinion as to whether or not this particular test

is showing you a result that he or she feels is consistent with chronic beryllium disease. And that sort of runs throughout here.

So, the pre-1993 standard is a little bit more generalized; whereas, the post-1993 standard is a little bit more specific as to what evidence needs to exist to establish chronic beryllium disease.

And so, it is not a matter of the CE looking at diagnostic evidence and saying, "Hey, this is characteristic with chronic beryllium disease. It is a physician's determination. So, a physician has to look at this information and make that judgment based on what it is that they have seen or see in the evidence of record.

And then, what the claims examiner is doing is basically saying, do I have the diagnostic results or the interpretation of the evidence that satisfies these three of the five criteria for the pre- or the criteria for the post-? So, they are looking for a physician who has opined on these things and do the diagnostic

test results correspond with what is required by the statute.

And what we have as issues here is, of course, the genuine question that we always have, which is interpretative differential, where you have one physician who can look at it and say, "This is clearly characteristic of chronic beryllium disease." Another physician says, "Well, that really is just characteristics of obstructive pulmonary disease, pulmonary fibrosis." And it is impossible to differentiate between that type of a disease and chronic beryllium disease.

So, what we would be looking for is help in saying, what are the markers that can consistently be seen for chronic beryllium disease? Or is that even possible? Or other types of clarifications for how we can apply the evidence in a way consistently to always say this is what you will see if you are talking about the establishment of chronic beryllium disease. These are the types of diagnostic findings or

other types of x-ray results that you would see with that. It is really a question of what would be the standard of creating consistency in that.

Some of the other quick things are that this test of the pre- or post-1993 standard is dependent on the definition of what we mean by chronic respiratory disorder. Okay? It is purely a definitional question, because the statute basically says that the test is evidence of a chronic respiratory disease prior to 1993. And so, we have to know, well, what does that mean? Does that mean one x-ray result that has an abnormal finding or is it truly a situation where a doctor has identified a chronic disease process?

So, we get questions, you know, where we get claims where people are saying, "Hey, here's my occupational x-ray that was performed in 1974 where it shows a mild restrictive problem." Does that equate into a chronic respiratory disorder that turns the program on having to apply the pre-1993 standard or not?

So, that is one area that I think is really kind of an issue for us to try to figure out how to apply that in a consistent manner that is medically-valid. And we have struggled with that for quite some time.

On your handout, we talk about clarification of the diagnostic interpretative meaning of characteristic of CBD. This also sort of plays into No. 4 there, obtaining clarity on the specific diagnostic markers required for the establishment of chronic beryllium disease, whether it is pre- or post-.

And then, we have in the past had issues with regard to how we look at sarcoidosis and how that can be commonly misinterpreted as CBD. So, in other words, somebody is presenting with pulmonary sarcoidosis. How do you treat that, where a lot of physicians would opine that a diagnosis of pulmonary sarcoidosis in the presence of an exposure to beryllium could actually be masking a true chronic beryllium disease situation.

And then, we also have this question of the beryllium LPT issue, which is that the statute requires the presentation of an abnormal beryllium lymphocytic proliferation test when you are dealing with a post-1993 diagnosis of or the establishment of chronic beryllium disease.

So, we have commonly seen a lot of physicians contesting the use of the beryllium lymphocytic test to do that, and a lot of times that test can be masked by the use of different kinds of steroidal medications and other reasons where you would end up with a situation where a positive or a normal test result is being masked by medication. And can we not create better rules or processes for evaluating that? And what are some of the considerations that can be used to say, in this scenario where you do have a normal BeLPT, you know, a beryllium lymphocytic test, what are the characteristics that would allow us to say that is actually, that is really an abnormal result, due to other factors or other considerations?

MR. JOHNSON: This is Curtis Johnson again.

After the chest radiographs, the next criteria that we look at after the chest radiograph, we look for evidence of restrictive or obstructive lung physiology. This is basically a review of the pulmonary function test. Once again, the interpretation for the pulmonary function test, it specifically has to state that there is either a restrictive disorder, an obstructive lung disorder, or some sort of diffused lung effect. And once again, this is something that the claims examiner does not make that interpretation their own. This actually has to be in the results of the test itself.

Okay. And what we are going to do, we are going to continue on because the next issues that we talk about, the lung pathology, the clinical course, all that information we have really already discussed. And we are going to go through it again in the post-1993 criteria.

MR. VANCE: What we are going to do is I am assuming you guys can read the criteria for the pre- and the post, so we are not going to rehash that whole thing.

What I did want to say is, are there any questions at this point about the Part B CBD criteria?

CHAIR MARKOWITZ: It is Ms. Vlieger.

MEMBER VLIEGER: One of the things that I wrestle with with the medical providers and for the claimants is that the doctors are taught the Beryllium Case Registry criteria as part of their studies. And when it comes to this program, it is more lenient criteria number than Beryllium Case Registry.

And so, is there any explanation given to the CMCs in detail, that they have to acknowledge that they understand there is a difference, and to the medical providers that you are in contact with, that there is a distinct difference between the criteria under this program and what is defined as chronic beryllium

disease under the Beryllium Case Registry criteria?

MR. VANCE: Now, what we would do is communicate and convey the information that is statutorily required under our provision, under our statute. So, in other words, if we are going to be developing a case where we are going out to a treating physician, we are going to say, "This is what our statute stipulates as the requirement." So, therefore, we would be seeking information relating to the statutory requirements. We are not going to go out and compare other types of provisions that may exist with regard to the assessment of chronic beryllium disease.

So, this is what is unique about this particular condition in a Part B claim, is that the statute identifies specific diagnostic criteria. So, any other legal provisions really have no effect on our test for chronic beryllium disease. We have to apply this standard.

And where we can have wiggle room is

the definition of certain things such as, what do you mean by a chronic respiratory disorder for determining whether you are going to apply the pre- or post- standard?

CHAIR MARKOWITZ: I have a question. Steven Markowitz.

So, when you say that a physician -- the claims examiner isn't making the determination of the presence of each of these items? It is from a physician report or the like. Is it the case that the physician has to say that, yes, there are three of these five items present and specify what they are? So, the physician is essentially putting the case together and calling this CBD according to your definition? Or is it that the physician merely needs to indicate that, yes, barometry shows restriction; chest x-ray shows interstitial fibrosis, or whatever?

And then, the claims examiner says, "Yes, I see the physician said restriction. I see basic chest x-ray finding compatible with,

and I see a history of chronic respiratory disorder." And the claims examiner, then, is putting those three pieces together and saying this is CBD?

MR. VANCE: No. It has to be the doctor evaluating the evidence, identifying the characteristics of the test results that are abnormal, and that in the opinion of that physician can be interpreted as being consistent with chronic beryllium disease.

MS. LEITON: But I think the expression, we ask the doctor, "Is this characteristic of...?"

MR. VANCE: Right.

MS. LEITON: And the doctor says yes. Then, we put three pieces together.

MR. VANCE: Right. Well, right. So, what Rachel was saying is that, basically, you know, we will advise the doctor, "These are the requirements." And then, the doctor is going to respond, and we are going to get information relating to different components of the chronic

beryllium disease standard.

As long as the doctor is providing an opinion that is characterizing the interpretation of the test to meet that standard, whatever the criteria around the statute, then, yes, we would have the CE looking at that and accepting that, as long as the doctor has interpreted that evidence in a way that satisfies the statutory requirement.

CHAIR MARKOWITZ: All right. So, the assembling of the pieces, the doctor-certified pieces, can be done by the examiner to include?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: So, basically, the CE is making sure do we have the pieces that allow us to accept it, but the source of that material needs to come from the physician and the interpretation of that evidence needs to be done by the physician.

CHAIR MARKOWITZ: Okay. Thank you.

Dr. Welch?

MEMBER WELCH: Are you still getting claims where the pre-1993 applies?

MS. LEITON: Oh, yes.

MR. VANCE: Oh, yes, I think that is the most common ones we are seeing now. A lot of our cases are -- the pre-standard is a little bit more liberal. So, of course, that is where you are going to have a lot of people trying to persuade the program that that is the applicable standard to apply in their case. So, we see a lot of that. I think a majority of our cases now are more pre-1993 than post-.

MEMBER WELCH: So, are you seeing people who are having their first BeLPT in 2016, and that is positive, but they have a long history of chronic respiratory disease that predates the 1993 date?

MR. VANCE: No. The LPT now is negative, and they are trying to argue that the evidence of a chronic respiratory disorder that started way before 1993 allows for the application of the pre-1993 standard.

Rachel was saying that we are seeing it; we are seeing both, but because it is an easier standard, that is where the claims are going to go to.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: Yes, I understand some of the problems. I am quite familiar with many of the issues around beryllium.

So, in the post-1993, for people who aren't familiar with all of these issues, there are multiple reasons why someone may not end up getting a tissue diagnosis or a lavage in terms of being too sick. There are also reasons why the BeLPT might be false, the blood one might be false or negative, depending on medications or even whether the person had the opportunity to have it done, or if something happened in the sample when it went out to National Jewish.

But how many labs are you using for the tests now?

MR. VANCE: We don't actually specify or prescribe particular testing facilities. And

that relates back to the question or the issue that Curtis was mentioning before.

MEMBER REDLICH: Okay.

MR. VANCE: It is that different testing facilities where claimants can go to may have different standards by which they apply to say this is a normal versus an abnormal test. And so, we end up, you know --

MEMBER REDLICH: Yes. No, I'm aware, yes.

MR. VANCE: So, we don't have specific testing facilities that are utilized by the program. Claimants are free to pick and choose which facilities that they would like to go to.

MEMBER REDLICH: Okay. So, there aren't a ton.

And how strict is this? I was looking for wiggle room in terms of the -- you know, you sort of have the problem, the potential problem, that the pre-1993, since it is three of those five criteria, you don't have to actually have sensitization, and there is a lot of lung disease

in people, given how common COPD and lung disease is. So, I could understand --

MR. VANCE: You're absolutely correct, yes.

MEMBER REDLICH: I understand that.

And then, you have almost the reverse issue with the post-1993 in terms of being maybe overly-strict in that it isn't leaving a lot of leeway in terms of wanting some either lavage or tissue.

MR. VANCE: Right. And that will never change unless they change the law itself. So, what I need to really stress is these can't be changed without a legislative change. These are specifically enumerated in the statute itself, rightly or wrongly.

(Laughter.)

MEMBER REDLICH: Okay. But someone could conceivably write, a physician could give an opinion that they think this is CBD, based on A, B, and C, despite the fact that there was never a biopsy, or not?

MR. VANCE: It depends on the combination. As long as the doctor can provide the information that is statutorily required -- so, in other words, if you have the positive beryllium test and you have a biopsy showing this on the first one that the doctor has interpreted as saying, yes, this is showing a bronchial or interstitial lung tissue problem that they can interpret as being chronic beryllium disease.

MEMBER REDLICH: Okay. But I have just diagnosed CBD without tissue, but that doesn't seem to be in --

MR. VANCE: Yes, and I think the statute allows for that to occur.

MS. LEITON: Blood testing.

MEMBER REDLICH: No, no, but it is lavage.

MR. VANCE: Right. It can be a lung biopsy. It can be a lavage.

MEMBER REDLICH: I know, but that is still an invasive procedure.

MR. VANCE: Oh, yes, and that is one

of the issues that we have on our list --

MEMBER REDLICH: Okay.

MR. VANCE: -- is the fact that that reality exists.

MEMBER REDLICH: Yes, I'm saying I've made the diagnosis absent of those, because one was unable to obtain them. But you are saying that, right now, there isn't wiggle room for that? Okay.

MR. VANCE: No, not under the post-1993 criteria. It basically is exactly this. You have got to meet these criteria. You know, it is just statutorily required.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Could someone, if they don't meet the Part B criteria, pursue it under Part E, a claim for CBD? Or is it excluded under E?

MR. VANCE: No, it would be something we could consider under Part E.

MEMBER WELCH: So, then, your kind of case is where you might have a CT scan that shows

characteristic CBD and you have sensitization. It could potentially go under Part E without a biopsy?

CHAIR MARKOWITZ: So, I have a question. Is this a follow-up?

MEMBER VLIEGER: Yes.

CHAIR MARKOWITZ: Oh, go ahead. Go ahead.

MEMBER VLIEGER: Just a clarification on the information in our briefing book. It doesn't exactly follow the wording from the statute. So, my question is, just for clarification for the other Board members, could you enumerate the quantity of criteria needed under a post-1993 diagnostic definition for the Department?

MR. JOHNSON: First, you would need a diagnosis of beryllium sensitivity. That is No. 1. And the second component is that you would need lung pathology consistent with chronic beryllium disease.

We will come back to it.

CHAIR MARKOWITZ: Steve Markowitz.

Since you have chronic respiratory disorder, so it must be potentially confusing for claims examiners because it encompasses a broad range of illnesses and, also, is a fairly non-specific term. So, is there written guidance for the claims examiners on what is a chronic respiratory disorder or when it needs to have appeared, or the like?

MR. VANCE: Yes. In our Procedure Manual, we define it as a problem that is chronic in nature, which means that it is something that exists for a period of time, that a physician is interpreting as being a chronic disease process.

I am not sure of the exact wording, but we do talk about the fact that, you know, a single diagnostic test may not necessarily establish chronic respiratory disease. It is a question that a physician needs to address.

So, we have that language in our non-cancer condition chapter in our Procedure Manual, and we do try to spell that out. But, again, we

are still left with the question of, is that definition that we have in our procedures too strict, too conservative, or too liberal? And that is why we would certainly be looking for the Board to assist with helping in clarifying that issue, because a lot of people are really concerned about that, simply because, then, that sort of sets in motion whether we are going to apply that pre-1993 standard, which is a little bit more easier to do than the post-.

So, that is the focus of a lot of stakeholders and a lot of claimants, is, how do you want to define that? And the words are "chronic respiratory disorder". So, our program has sort of taken the view that it is something that is diagnosed as a long-term respiratory problem.

CHAIR MARKOWITZ: Thank you.

Dr. Silver?

MEMBER SILVER: If I understood your question a little while ago, there is a Beryllium Case Registry that many of the leading physicians

in this area participate in, and it has certain criteria that are above and beyond DOL's.

I am reminded of an early nuclear worker advocate, before there were many, Bob Alvarez, who at the inception of this program went around the country reinforcing the idea that a program like this is social policy first, informed by science. And the scientists are in the backseat giving a little bit of advice, but Congress decided on a claimant-friendly program.

And one of the things we have been doing all along is reminding people that scientists, when among themselves, can apply their normal standards of proof. But, for a program like this which is mainly social policy, different standards apply.

So, because the group of doctors who do beryllium disease as a specialty is so small, I really think this is an opportunity for us to put out an explicit reminder that, fine, you know, the NIH study section, when you are figuring out who is going to get money to do the

next molecular marker in the Case Registry, apply your sky-high criteria, but a little tap on the shoulder here: when you are seeing people for the purposes of compensation, the standards are different. Is that kind of the issue that you are getting at?

MEMBER VLIEGER: Yes, and then, we see it chronically because physicians aren't taught this standard according to this program. So, they rely on their education, which is what they do; it is their job.

But the requirements under this program, when the worker says, "Well, I think I u qualify," and the doctor goes, "No, that's not what I was taught," that is what they write to.

MEMBER SILVER: Are there specific items that are on the doctors' scientific list of criteria that get injected into determinations for this program inappropriately?

MEMBER VLIEGER: From time to time, the doctors will say, "Well, I'm not going to do a biopsy because I don't think you have it.

Well, that's not required."

And then, on the post-1993 diagnoses, it is not required at all, but the doctors were not trained to opine on something less than definitive evidence from a biopsy or from something, a lavage.

And I agreed with Dr. Redlich; the intrusive procedures in many cases are unwarranted, and in older patients you just can't do them. So, with the post-1993 criteria, which is what we see a lot of from the Hanford site, the doctors don't understand that there is a less-restrictive criteria they can write to.

MEMBER REDLICH: But, actually, the problem is also that the 1993 criteria are actually stricter than the American Thoracic Society recently, or in 2004, came out with official guidelines, and theirs are actually less strict than this 1993 because they leave some wiggle room. What it says is that, basically, a probably diagnosis of CBD can be based on imaging consistent with sarcoidosis or a BAL

lymphocytosis, meaning you could have a positive -- so, it is actually this is a stricter criteria than the current ATS guidelines.

I think that was -- I was involved in reviewing this whole document -- because for physicians seeing these patients, realizing that there are times when one is unable, for various reasons, to get the sampling that would be needed.

And even something like a biopsy, you can have three pathologists look at a biopsy and come up with a different description of that pathology; the same with a CT scan.

CHAIR MARKOWITZ: So, that kind of raises the issue of something you mentioned before, whether Part E might actually solve a little bit of this problem, where the doctors have a different set of criteria for CBD diagnose than the Congress people. If somebody doesn't meet Part B requirements, they don't have the biopsy, and you could under Part E compensate them, do you move them over? Can you move them?

Is that a solution to the problem?

MR. VANCE: Well, this is where it gets fascinating. Under Part E, we do require for a Part E claim for chronic beryllium disease that they have to have a positive beryllium lymphocytic test.

The issue there is that, you know, then you are no longer dealing with a pre- or post- standard anymore. So, you could have someone who is trying to get a claim through on Part B for the pre-1993 standard. But, then, when you flip over, and let's say that gets denied, then you flip over to the E side. They might change the story and say, "Well, it was always chronic obstructive pulmonary disease," and that is where they go with their case. So, it really depends.

So, under Part E, it is a little bit different. This is where you get this differential between what happens under Part B and E, because the standards are different. So, it depends on how an individual is going to

pursue their case.

CHAIR MARKOWITZ: But the post-1993 cases, right, in which there is no biopsy, so it can't go under B, it won't be recognized under B. No biopsy, but Dr. Redlich certifies it is CBD. Could that come under -- this is post-1993 -- could that come under Part E and be compensated?

MR. VANCE: Yes. Yes, it can.

CHAIR MARKOWITZ: Thank you.

MS. LEITON: You can't go backwards, though. You can't go E back to B.

CHAIR MARKOWITZ: Okay. Okay.

MR. VANCE: So, Rachel was just adding an elaboration that it can't go from E to B, but it can go from B to E. I love that combination, by the way, the E-B.

MEMBER REDLICH: So, it solves part of the problem. It solves the scenario of the positive BeLPT where you don't have tissue --

MR. VANCE: Correct.

MEMBER REDLICH: -- where you, let's say, have a CT scan that is classic and a

positive BeLPT and a history of exposure, and it solves that problem.

MR. VANCE: Right.

MEMBER REDLICH: The one problem it doesn't solve is where you might have tissue that is classic and a good exposure story, and the person on a lot of steroids and stuff, and then, they get a BeLPT. So, that little thing isn't solved, but it is solves part of it? Is that right?

MR. VANCE: I think you have a pretty good read on it.

MEMBER REDLICH: There is every combination, permutation of these.

(Laughter.)

MR. VANCE: Right. There's lots of different combinations of how this can play out.

MEMBER REDLICH: Yes.

MR. VANCE: And that is what makes this component of the Part B lung disease, that is what makes it so entertaining, is just there's lots of different issues that are buried in a

very clear statutory provision. And so, that is what we are pointing out here.

MEMBER REDLICH: How many new claims a year do you get?

MR. VANCE: So, the question is how many new claims we get, and I can't answer that.

MEMBER REDLICH: Or getting tortured by the old claims that keep coming back?

MR. VANCE: Yes, we would have to get back to you on that.

MEMBER REDLICH: Okay.

MR. VANCE: I just don't know.

MEMBER REDLICH: I was just trying to get a sense of it, because part of how you address it is really what the magnitude of the problem is.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, you may have answered this, but I can't remember if you did or not. Under Part B, if you have a physician report that meets your criteria, but the physician says it doesn't say that they think

that it is CBD, do you act in a positive way on that claim?

MR. VANCE: Could you restate that? I didn't hear the first part.

MEMBER BODEN: Oh, okay. So, you got a physician's report. The physician gives you a report with specifics that meet your Part B criteria, but they say it doesn't meet their standard for being chronic beryllium disease. Do you pay that claim?

MR. VANCE: Yes, as long as the doctor is fulfilling the requirements of the statute, we will pay it.

MEMBER BODEN: So, even if they say it's not --

MR. VANCE: So, let's say, for example, you have a doctor that says, "The standard that is being applied here is completely wrong. I have no idea what Congress was doing when they put this in here, but I am going to opine that this patient does meet the post-1993 standard," the case will be paid.

MEMBER BODEN: But if they give you the test results that meet the standard --

MR. VANCE: Yes, as long as the standard in the statute is satisfied --

MEMBER BODEN: -- they just don't say it --

MR. VANCE: -- the justification of that from a physician, or whatever their opinion is about that --

MEMBER BODEN: Good.

MR. VANCE: -- it is really sort of inconsequential.

CHAIR MARKOWITZ: Other questions, comments?

Are you moving on to silicosis or --

MR. JOHNSON: When you are ready to.

CHAIR MARKOWITZ: Okay. So, I have a question.

I'm sorry, there are a couple of name cards that are vertical.

There are some proposed rule changes that are relevant to this issue of pre- and post-

1993. I couldn't understand the importance of -- I'm not sure I even understood the change, but I didn't understand the importance of the change. So, what was happening that caused you to propose changes to the regulations and what are these changes exactly?

MR. VANCE: Well, yes, unfortunately, I am not in a position to be able to comment on the regulations at all. I think that is going to be something that you are going to have to deliberate on your own to decide what your feelings are on that issue as a deliberative body.

MEMBER REDLICH: The pre-1993 is much more liberal.

CHAIR MARKOWITZ: Right. No, I get that. Okay, fine. Okay. Thank you. I forgot, actually. Other questions or comments?

(No response.)

CHAIR MARKOWITZ: Okay. So, let's proceed.

MR. JOHNSON: And the last condition

that we are going to talk about is chronic silicosis. Once again, the statute mandates that under Part B chronic silicosis is the only silicosis that is covered.

The exposure requirements are simply an individual must have 250 days of employment during the mining of tunnels or exposure to silica, I should say, 250 days of exposure to silica as a result of mining in the tunnels of a DOE facility in Nebraska -- I'm sorry; in Nebraska? In Nevada or Alaska. Excuse me.

(Laughter.)

MR. JOHNSON: The medical requirements -- and once again, this is strictly for chronic silicosis -- there has to be a latency period of 10 years between the initial date of exposure to silica and the date of diagnosis for chronic silicosis.

As far as the diagnostic criteria goes, what we see mostly is the results of a B-reader chest, a NIOSH B-reader chest x-ray. The results of those x-rays have to note the

existence of pneumoconiosis at a level of 1 over zero or higher. That is what we see in most instances as the determining medical evidence. We would also accept if we receive some sort of pathology or chest x-ray evidence of, evidence consistent with chronic silicosis. We would accept claims for silicosis on that basis as well.

One particular issue that we would like for the Board to consider regarding chronic silicosis is the validity of the B-reader x-rays. The x-ray form itself does not have a particular field, or whatever you want to call it, for a physician to sign the form and identify himself as the actual B-reader. The only requirement is that the physician's initials appear on the form and that the address of the physician appears on the form.

Our question is, how do we determine what the validity of that B-reader's credentials are and how do we actually identify that particular physician as a B-reader physician?

MR. VANCE: This is an issue that just pops up periodically, as far as making sure that we know that that is a valid B-read and that it can be applied in the case. It might not be that complicated, but we just get ourselves into this situation where we get B-reads where there is some question as to whether or not that is a true B-read or is that a reinterpretation of a B-read, or what have you?

So, it is just a question of, what it is that marks a valid B-reading? And that is sort of the issue. Silicosis is not one where we have a lot of issues, and that was one that we looked at. We were trying to look at what are some issues that we could identify for consideration, and that is just one that periodically pops up with discussions with external stakeholders.

Any other questions at this point regarding beryllium sensitivity, chronic beryllium disease, or silicosis?

MEMBER VLIEGER: Dr. Markowitz?

CHAIR MARKOWITZ: Yes?

MEMBER VLIEGER: I know that sites for this, I believe that sites for the silicosis are determined by NIOSH, is that correct?

MR. VANCE: You mean silicosis --

MEMBER VLIEGER: Where silicosis applies? Because silicosis doesn't apply to all of the sites.

MR. VANCE: Well, again, we are talking about Part B lung disease. So, silicosis is specifically named as a statutory provision, and the statute, just like chronic beryllium disease, sets out specific criteria that have to be satisfied.

Under Part E, it can apply to anything. So, silicosis can be claimed and does not have to meet the same standard that exists under Part B.

MEMBER VLIEGER: Okay. And so, the explanation for why some sites that could have silicosis claims at them that are not considered to have silicosis under B, is that still a NIOSH

determination?

MR. VANCE: No. I mean, that is a determination of our normal exposure analysis for a Part E case. In other words, if you are a miner who is filing a claim under Part E, you know, it doesn't matter. Any mine where you are working where there could be silica -- the same thing could be applied at any of the DOE facilities under Part E, you know, where there was a silica exposure and an employee has silicosis.

MEMBER VLIEGER: Okay. Thank you.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: I actually didn't go back and look at the statute, but does the statute say they had to be exposed to silica for an aggregate of 250 days? And how do you accept a demonstration of silica exposure at the site?

MR. VANCE: It is 250 days of exposure, and we just presume that if you were there at one of these sites, you are going to have that exposure.

MEMBER WELCH: Okay.

MR. VANCE: And I think Amchitka Island it is even a lesser standard. I think it is only like one day, were you at Amchitka Island.

MEMBER WELCH: Okay. Okay. Good.

CHAIR MARKOWITZ: Other comments or questions?

(No response.)

CHAIR MARKOWITZ: Okay. Thank you very much, Mr. Vance and Mr. Johnson.

MR. VANCE: Thank you.

CHAIR MARKOWITZ: So, is there any discussion on these issues that the Board would like to have before we designate a Committee, volunteer for a Committee, and the like?

Dr. Cassano?

MEMBER CASSANO: I just have one question on it. They talked about the fact that this was a congressional mandate. And so, I don't know if it is within the purview of the Board that if after deliberation we find that

there is no good way to squeeze this lemon from Part B to Part E, if it is within the purview of the Board to recommend that DOL ask for some statutory relief in changing the standard and the statute.

CHAIR MARKOWITZ: Dr. Welch?

I mean, I think just to comment on that, if we are looking at this issue, these couple of issues, we can make certainly observations about weaknesses or deficiencies. We could probably make some recommendations in general, though not necessarily to the Secretary, about how such a situation might be improved.

Dr. Dement?

MEMBER DEMENT: Yes, it looks like Task No. 3 is very specific to Subpart B. So, we are not dealing with what I think is a much broader issue, and that is all the other lung diseases that occur beyond the very few we discuss here. Where do we get to those? Do we get to those in Task 2? I mean, where does this come in? For example, where do we consider

criteria for COPD?

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Well, I think that in some ways it could go into 1 or 2 because, really, the issue with COPD is how much exposure, what kind of exposures and how much exposure do you need, and what documentation for that do you need, to determine that it is work-related under the statute? I see the discussion of SEM as really the discussion of exposure assessment rather than the SEM as part of that. So, that could go there.

It is kind of where would you put, if we were going to help the agency write a presumption for COPD, where would that go? But that probably goes under 2.

CHAIR MARKOWITZ: Yes. Yes, probably 2.

Dr. Redlich?

MEMBER REDLICH: Well, I was hoping John wouldn't raise that question because I was going to offer to see with the more limited

version of addressing beryllium and sarcoid, but it is --

CHAIR MARKOWITZ: But I think what Dr. Welch was saying is that C is more limited. Subtitle B, lung disease issues. And I think John wanted to make sure that we didn't forget about the rest more than where we were going to put it. It is not going to be in C. So, you shouldn't be discouraged.

(Laughter.)

MEMBER VLIEGER: Dr. Redlich, you could volunteer for more than one Committee.

(Laughter.)

CHAIR MARKOWITZ: Mr. Whitley?

MEMBER WHITLEY: Yes. It is Garry Whitley.

From a medical side of the house, is there anything besides the LPT test that -- I see it is kind of like, he said, the gold standard. But we have people that have eight inconclusives. You never get an abnormal, but they got eight inconclusives. I was just talking to Kirk. He

said they had the same thing, eight or nine times. They never get a negative; they never get a positive. Is there anything else? I mean, I don't know.

MEMBER DEMENT: Yes, people with CBD will never get a positive BeLPT.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Well, it is kind of a technical question. But, if what they are getting is an indeterminate result, then the people at ORISE recommend you do a test with autologous serum, as opposed to just continuing to do the same test. You do a different kind of test. And that should come out positive or negative and not indeterminate. So, those people could talk to the ORISE experts or I can tell you how. Because we have a process where, if we get two indeterminates, we don't run the test again. We do a whole different system.

CHAIR MARKOWITZ: Other comments?

MEMBER REDLICH: I think there have been issues with some of the different labs.

MEMBER WELCH: Yes, that's true.

CHAIR MARKOWITZ: So, who would like to serve on this Committee, besides Dr. Redlich?

MEMBER REDLICH: Laura has a lot of experience.

CHAIR MARKOWITZ: That covers the medical side.

MEMBER REDLICH: Someone on the exposure side, I think. No, I think I would like some input on what issues --

MEMBER DOMINA: Just for your information, back in June of 2008, the Department of Energy told Hanford, "You need to have one beryllium program." We are in 2016 and we are still fighting with the contractors to come up with what that program is going to be.

And we do have a different standard to be more protective for the worker, and that is why I am kind of concerned, based on the rewrite of 10 CFR 850, of doing something here, and then, 850 saying something different. And that is why I asked Pat Worthington yesterday, just like I

did a month ago in Denver, about it, because this rewrite was supposed to come out three years ago. And so, I have a concern with that.

MEMBER REDLICH: Not to keep going on with beryllium, but how many of the actual workers are machinist type? Are there many or not?

MEMBER DOMINA: No.

MEMBER REDLICH: Okay.

MEMBER DOMINA: We have janitors. We get, right now, at Hanford over the last couple of years, we have been getting like three, two to three, four newly-diagnosed workers a month sensitized, some CBD, and these are not long-term workers. These are workers that are 10 to 15 years. Okay?

And that is one of the other issues we are having, especially in the D&D world, where they are saying, you know, that we believe that the exposure that people can get needs to be a lot lower than what it has been previously, because of all the sensitization and the CBD that

we are getting.

CHAIR MARKOWITZ: You know, I think if Ms. Leiton could actually just review the statutory requirements for us, it would help.

MS. LEITON: Sorry, I just want to clarify. Ms. Vlieger made a good observation there, and I apologize that the slides themselves probably should have specifically outlined what is in the statute in terms of pre- and post-.

For post-1993 beryllium disease, the statute requires any of the following: so, it is basically beryllium sensitivity together with lung pathology consistent with chronic beryllium disease, including the three things. And we will replace your slides.

But, first, it is lung biopsy showing granulomas or lymphocytic process consistent with CBD and a CT -- or, no -- a Computerized Axial Tomography scan showing changes consistent with chronic beryllium disease, or pulmonary function or exercise testing showing pulmonary deficits consistent with CBD. So, those are the three.

One of the three, the lung biopsy, the CT scan, or a PT test showing pulmonary deficit consistent with CBD. That is post-1993, and that is where it specifically says it has to be consistent with CBD.

So, our question is, right now, we go to the doctor. The doctor has to come back to us and say, "This lung pathology is consistent with CBD."

MEMBER REDLICH: I get it. We can define that.

MS. LEITON: So, how do we get them to help us do that?

MEMBER REDLICH: That is a fixable problem.

MS. LEITON: So, that is what I am thinking. I just want to make sure, those are the statutes we have to abide by, but we have the wiggle room where, how do we get that definition from the doctor?

So, for pre-1993, you have to have the presence of the history, the epidemiological

evidence, beryllium exposure, which we pretty much assume, and any three of the following criteria: characteristic chest radiograph or Computed Tomography, CT, abnormalities. And I think this is right on the slides, but just to reiterate: restrictive or obstructive lung physiology testing or diffusing lung capacity defect, lung pathology consistent with chronic beryllium disease, clinical course consistent with a chronic respiratory disorder, immunological tests showing beryllium sensitivity, which could be a skin patch or a beryllium blood test preferred.

So, here's where some of this says specifically lung pathology consistent with CBD. But, if you don't have that, if the doctors aren't going to tell you that, this gets back to your point, Dr. Boden, where you said, if the doctor doesn't say that, that you could have three of the other ones, like restrictive lung physiology testing, clinical course consistent with a chronic respiratory disorder, and

immunological tests showing beryllium sensitivity. Those three don't say anything about CBD necessarily.

But, then, you have got the lung pathology consistent with CBD and you have characteristic chest radiograph. What does that mean? How do we define "characteristic"? What do we look for in the reports from the doctor? And how can the doctors help us with those criteria when we are actually trying to outline what that means?

So, that is where we think you guys might be able to really help us figure out, as a claims examiner, what do we say to the doctor? Well, is this characteristic of CBD? Are they going to come back and say, "Yes, it is characteristic of CBD."? That is where the use of the term "CBD" or just "characteristic chest radiograph," where is our wiggle room? What do we really need to be looking at? What specific objective findings can we use to apply these tests?

Now we have procedures; we have ways of doing it now. But this is why I believe that this was one of the topics they wanted the Board to look at, because it is so restrictive, but it is also like, where can we find the middle ground somewhere in these two statutory criteria that we really can't change?

So, I hope that like clarifies.

CHAIR MARKOWITZ: Thank you.

Dr. Welch?

MEMBER WELCH: But now I am a little confused because I think you just said that the post-1993 criteria are completely different than what is written here.

MS. LEITON: Yes.

MEMBER WELCH: Okay. So, I would like this page --

MS. LEITON: I apologize for that. We are going to fix it. We are fixing it.

MEMBER WELCH: -- corrected and replaced in everybody's book.

MS. LEITON: We will. We are doing

it.

MEMBER WELCH: Because if this starts to float, I mean --

MS. LEITON: We will have it replaced by tomorrow.

MEMBER WELCH: Then, you could sometime explain to me how someone could possibly have done that.

MS. LEITON: I think a lot of that came from our Procedure Manual in terms of how we were interpreting some of the tests or what some of the tests mean and what we could be looking at in those test results to come up with pathology or the definition.

So, I will correct that tonight --

MEMBER WELCH: Okay.

MS. LEITON: -- make sure you have the correct page. But I apologize.

MEMBER REDLICH: So, it actually is pretty consistent with the ATS guideline and there is some --

MS. LEITON: But it is still kind of

restrictive.

MEMBER VLIEGER: If I might?

CHAIR MARKOWITZ: Sure.

MEMBER VLIEGER: This just goes to show you the different problems we have when we approach the positions, because they have read an article somewhere; they have read a study that is not accepted yet. It just makes this whole process of CBD claims and the discussion with the medical community and the discussion with the unions about protecting the workers so much more difficult because we don't have a level playing field of understanding.

CHAIR MARKOWITZ: Are there any additional comments or questions on this topic?

On the Committee we have Dr. Redlich, Dr. Welch, and Mr. Domina. And if other volunteers appear, that's great. I see some negotiations over there.

(Laughter.)

CHAIR MARKOWITZ: Okay. So, what we are going to do, we need to set up for the next

session. All right. We are going to take a five-minute break, just so we can set things up. So, please be back in five minutes. Thanks.

(Whereupon, the above-entitled matter went off the record at 2:16 p.m. and resumed at 2:30 p.m.)

CHAIR MARKOWITZ: We are going to start the next session here.

So, this is the Board's opportunity -- we also have a session tomorrow -- to provide DOL with input on proposed changes in regulations. Let me give a little bit of background. The Board knows this because you have participated in our discussions on Subcommittees so far, but I think the other attendees and the public who might be on the phone aren't aware. So, let me just give a little bit of background.

Several weeks ago the Department of Labor reopened the record for comments on the proposed rules. And part of that reopening was essentially an invitation to us to look at the proposed rules and make comments on proposals

that related, in particular, to the Scope of Work that has been assigned to the Board.

The way we went about that was we received a briefing on the phone by the Associate Solicitor -- thank you -- here at the Department of Labor, who essentially just went over the proposed changes with us. It was not a discussion, if you recall. It certainly wasn't a discussion among the Board. It was really just letting us know what the proposed changes were.

We, then, scheduled a number of phone calls and had these transient Subcommittees which were formed not by theme or by particular proposed changes, but just by convenience, who could be on the phone at what time. And so, we had three phone calls, different sized groups among the Board, in which we discussed the proposed changes and ideas about those changes. And each group had a scribe and recorded our thoughts about the proposed changes. There was a lot of similarity among the different groups in terms of the thinking.

Our task now is to look at those changes again and, if we can, come to some consensus about recommendations we would make or input we would make to the Department of Labor about the proposed changes.

The comment period is open until May 9th. So that, essentially, if we don't provide input today or tomorrow, then we are not providing input as a Board, because to meet again as a Board before May 9th by phone requires six weeks' notice, as we know.

(Laughter.)

CHAIR MARKOWITZ: And let me count the days. It is not six weeks until May 9th.

So, that means we basically have today and tomorrow in order to consider changes as a group, as a Board, and then, make recommendations, if we want.

Now I should say that Board members, as individuals, are certainly free to submit comments to the record by May 9th regarding proposed changes. That is apart from your Board

activity. But, as members of the public, they are entitled to do that.

So, if, say, we vote on something and you feel very strongly otherwise, or if there is something that we haven't covered that you think should be covered, by all means, that is up to you whether you want to submit the comment or not.

Another consideration, I would just say that this is a fairly challenging task for us to do in a number of ways. One is the Board, we started talking about these proposed changes before even the Board had met, before we had been oriented by DOL about the program. The education we have gotten over the past day and we will continue to get.

So, the Board has members of varying levels of knowledge about the program. And we are all, though, even those more knowledgeable are still very much getting up-to-speed about this. We are providing input, making changes in a program that we are just learning about. I

consider that to be challenging.

The other aspect is that it is a very compressed timeframe for looking at these changes. We have done what we could to look at the changes considered relevant and are going to provide input, I hope, by consensus.

One piece of the process I neglected to mention is that the Department of Labor did provide us with some unofficial guidance, I would say, about proposed changes that were within the scope of the charter of the Board and those that were not within the scope.

But that was not entirely prescriptive. We could certainly take changes from the second list, the list that was not considered to be within our scope, and move them over to within our scope. It was very clear that we could do that. In fact, we did that. So, that was helpful, but not in any way mandated to us, just to be transparent about the process.

Tony, anything I forgot about the process?

MR. RIOS: No.

CHAIR MARKOWITZ: Okay. So, what we would like to do now is --

MEMBER REDLICH: What has prompted the changes at this time? Or is there some reason for the timing right now?

CHAIR MARKOWITZ: I can't answer that. I don't know the answer to that question. Because of the rules under the Administrative Act regarding the proposed rulemaking process, there can be very limited information that we can at this point get out of DOL about the proposed rules. That is just the matter of what the governing rules are about the rulemaking process.

Now whether DOL can answer that question, I don't know, but I would turn that over to Mr. Rios.

MEMBER REDLICH: When was the last time? How often are these rules changed?

MR. RIOS: Yes. So, we are very much ahead of schedule right now. I had asked that the Associate Solicitor, who gave you all the

briefing -- if you remember, Tom Giblin -- I asked him to be present for this part of the conversation. But, because we are so ahead of schedule and he was scheduled in other meetings, I am trying to pull him out of the meeting that he is in right now. So, he will be here in less than five minutes. He can tell you the Department's position.

CHAIR MARKOWITZ: So, any other comments or questions?

(No response.)

CHAIR MARKOWITZ: All right. So, the way this is going to work is that we are going to identify certain issues. We are going to put them up on the screen. Well, first, we are going to show you the language from the proposed changes. It is in blue, and the black is the current regulations.

We will simply describe what provision we are looking at, so it is understood. Then, each of the three groups from the scribe will give us summary comments about that particular

proposed change. We will have some discussion about that change.

And then, I have taken it upon myself to actually draft, in the interest of time, draft written recommendations based on the three groups' discussions, which we will, then, put on the screen and further discuss, alter, and, ultimately, decide whether we want to endorse those recommendations or not. So, is that reasonably clear?

Now I would say, for the people who are sitting way back, I have asked on the screens for the text to be large as much as possible. You may not be able to see it. You may have to move up, if you want to see it. But, as opposed to maybe some of the other things we have shown on the screen, it will be hard to follow along unless you are able to see what we have on the screen. Okay?

Board members have, if you want, in your books, in your briefing books you have a tracked-change version of the proposed changes.

It is in Section 7. So, if it is any easier, then you can follow along in the written form.

MR. RIOS: Just entering into the room is Tom Giblin, the Associate Solicitor.

Tom, you can have a seat. And if you will hold the microphone, that would be better. Thanks.

MR. GIBLIN: All right.

MR. RIOS: Okay. He is ready for questions. No, I'm kidding.

(Laughter.)

MR. GIBLIN: Fire away. I'll give you my best lawyer answer.

MR. RIOS: Carrie, do you want to ask your question again?

MEMBER REDLICH: Well, I was just wondering what prompted changes at this time.

MR. GIBLIN: Well, the last two changes occurred as a result of statutory changes. You know, we got the EEOICPA statute in 2001 and got Part E in 2004. So, we have been in the program now for close to 10 years. So, it

was a process of going through and looking at our regs again to see what we thought could be changed or needed to be changed. So, it was just good government, I guess would be the best way to describe it.

CHAIR MARKOWITZ: Are there other questions?

(No response.)

CHAIR MARKOWITZ: Let me say -- this is Steve Markowitz -- I mistakenly asked before when you were here about the rationale a certain particular change that was being proposed, and I was told that at this point it really can't be discussed by the Department of Labor. We are free to discuss it among ourselves. So, I just wanted to clarify that point, if there is anything else that I need to know?

MR. GIBLIN: No. I mean, we really, because we are in the open comment period, we really have to stick with providing the information that we have already provided to the public; in particular, the preamble to the NPRM.

That really sets out the basis for the changes.

CHAIR MARKOWITZ: Okay. Thank you.

MR. GIBLIN: Thank you.

CHAIR MARKOWITZ: And another comment I forgot to mention is that we are going to review about 10 proposed changes that we have identified as relevant to us, to our charter. I have invited Board members on other proposed changes over the last few weeks to bring them to our attention, so we could look at them and think about them. That hasn't been done, which is fine. We have until tomorrow, if there are additional changes. I'm not inviting; I'm just saying that that is the timetable. But, again, I would remind you they really have to fall within the scope of what we are supposed to do.

So, let's turn to the first one. I think that probably the easiest way of doing this is if one of us reads, actually. This is on page 40, for those of you looking at the print. It is Section 30.231. It is about approving employment and, ultimately, exposure.

I just want to read the first one. (a), the current language is, quote, "Proof of employment may be established by any trustworthy records that on their face, or in conjunction with other such records, establish that the employee was so employed and the written time periods of such employment."

And so, the new language, which doesn't replace but augments the current language, is, quote, "If the only evidence of covered employment is a written affidavit or a declaration, subject to penalty of perjury by the employee, survivor, or any other person, and DoD or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under Section 30.111."

So, the recorder for each of the

groups, Laurie Welch, maybe you could start?

MEMBER WELCH: Okay. When our little group discussed this, we had some kind of specific concerns, one of which was in the new highlighted evidence. In one place it says, "If the only evidence of covered employment," et cetera, et cetera, "then OWCP will evaluate the probative evidence of the affidavit in conjunction with the other evidence of employment."

So, it is internally inconsistent because it is talking as if there is only an affidavit, but, then, refers to other evidence of employment.

Overall, we understand this change to make a worker's affidavit less valuable or it implies that the affidavit is less valuable by describing it that way. And I think it was this section, of our group, we felt that the claimant's occupational history in affidavit form should be an item that can be used to demonstrate exposure and employment. Essentially, that a

detailed affidavit about employment, job tasks, activities, should be considered a valuable piece of information. And our understanding of this change is it is a way to discount an affidavit if it is the only thing available. That is in (a).

So, do we want to discuss (a)'s --

CHAIR MARKOWITZ: We are just discussing (a).

MEMBER WELCH: -- separately from the SEM groups? Okay.

CHAIR MARKOWITZ: Yes.

Mark?

MEMBER GRIFFON: Yes. Our group, which was me and John Dement and Steve, a very small group, came up with similar stuff.

I mean, one specific question in (a) that we asked for further information was there is also a phrase "another entity" which refers, I think, to -- it says, "DOE or another entity demonstrate or challenge the employment in that time period". And we just wanted to know what "another entity" would be.

And then, defining "probative value," I think that comes up in several sections as we went on. I think that came up again.

And can the OWCP give further guidelines on what elements should be included in an affidavit to improve its utility? So, overlapping, I guess.

MEMBER WELCH: Similar.

MEMBER GRIFFON: Yes.

CHAIR MARKOWITZ: And Ken?

MEMBER SILVER: Yes. We had a fairly large subcommittee. And now, for something completely different, our consensus I think was that the proposed change represents a slight improvement for claimants because consideration of affidavits is made explicit. Affidavits are not mentioned in the old language. It may be that our subcommittee was just kind of finding its legs. This is the first issue we brought up.

CHAIR MARKOWITZ: So, other comments from Board members on this?

(No response.)

CHAIR MARKOWITZ: Actually, if you could switch to the draft recommendation? Let me read this. So, it will give you a moment to understand it.

"The Board finds that the proposed new language is vague and contradictory. The Board recommends that DOL specify what is meant by" -- quote -- "`another entity'" -- end of quote -- "that the term `probative value' may be further defined, and that the term `disagrees' be more readily understandable.

"The Board notes that the proposed new language contradicts Section 30.111(c) in a manner that limits the value of affidavits. If the goal is to increase the likelihood that affidavits are valid, then guidelines on what elements need to be included in an affidavit should be issued to clarify the claimant's task of proving an employment history in the absence of other evidence.

"The Board further recommends that the apparent contradictions in the proposed rule

changes be resolved. That is, the proposed language sets out conditions when the affidavit is" -- quote -- "`the only evidence'" -- end of quote -- "and later states that OWCP will evaluate the" -- quote -- "`affidavit in conjunction with the other evidence of employment.'" End of quote.

So, comments, corrections?

Dr. Redlich?

MEMBER REDLICH: Well, just from an occupational physician point of view and occupational history, especially when you are dealing with many, many years of exposure and more chronic disease, is really considered probably the best available way to assess exposure. So, I wouldn't want any wording that minimized that evidence, as Laura said.

CHAIR MARKOWITZ: If you turn to page 26, I just want to point out 30.111, Section (c), because it is directly relevant to this. Frankly, the new language appears to contradict it. So, let me just read it, although in the

near future there should be some other readers here.

I'm not sure, can you go back? Actually, it is page 26 and it is 30.111(c). Go down a little, a few paragraphs. There, you are almost there. Okay. Let's see. Yes.

So, it says, quote, "Written affidavits or declarations, subject to penalty for perjury by the employee, survivor, or any other person, will be accepted as evidence of employment history and survivor relationship for the purposes of establishing eligibility and may be relied on in determining whether a claim meets the requirements of the Act for benefits if, and only if, such person attests that due diligence was used to obtain records in support of the claim, but that no records exist."

So, this paragraph addresses the value and the conditions under which affidavits will be accepted without really any limitation, except for the fact that the claimant has to exercise due diligence in finding the appropriate records,

unless I misunderstand this paragraph.

And so, the proposed change appears to move away from that and appears to set some optional restrictions on the use of affidavits.

Dr. Boden?

MEMBER BODEN: So, a couple of comments. One is, actually, the last line or two of the proposed change is also odd in that it sort of limits it to ignoring the affidavit rather than saying that they could either approve or disapprove of the affidavit.

I would actually suggest a different approach to this, a simpler approach, that says, maybe with some preamble, that we would suggest that that change be eliminated, and maybe with the same preamble. But it just seems to me, now that we have taken a second look at it, that it really doesn't enhance the ability of DOL to either accept or reject on a reasonable basis the affidavit. But it puts the affidavit in a rather negative light.

CHAIR MARKOWITZ: Other comments,

questions?

Yes, Dr. Cassano.

MEMBER CASSANO: Tori Cassano.

I agree with Dr. Boden and the comment about the internal inconsistency. If they wanted to make any kind of qualification about the affidavit, my suggestion would, basically, be to take out that whole middle part and, essentially, say after "subject to penalty of perjury by the employee," yada, yada, yada, take out all the rest and just say, "then OWCP will evaluate the probative value of the affidavit." Period. And be silent on the biased statement about disagree versus agree or deny versus accept.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: The problem with your suggestion is, then, it is just really clearly in contrast or in opposition to the 30.111(c) because that says an affidavit is sufficient.

MEMBER CASSANO: Yes.

MEMBER WELCH: And then, you're saying OWCP could decide, if it is the only evidence,

that it is not sufficient. So, I think I am coming down to going with Les' suggestion.

I mean, what this is saying is that, if the affidavit is the only evidence and DOE disagrees, then the claims examiner can make some decision. Well, maybe that is okay, I mean if there is contradictory evidence. But it goes on to say "disagrees or cannot concur," you know, which is different. That's different, right, cannot occur or disagree, meaning DOE has no evidence. So, I think the simplest thing would be to eliminate it because, under the statute, the examiners and the agency have the ability to weigh conflicting evidence, if there is conflicting evidence with the affidavit. But we would have to get concurrence on that idea from everybody.

CHAIR MARKOWITZ: So, other comments?

(No response.)

CHAIR MARKOWITZ: So, we need a motion, actually.

MEMBER BODEN: Can you go back to the

original change?

CHAIR MARKOWITZ: Sure.

MEMBER WELCH: Les, if you want to read it, it is in your briefing book.

MEMBER BODEN: I mean, our suggestion.

MEMBER WELCH: Or our suggestion? Yes.

CHAIR MARKOWITZ: The draft recommendation?

MEMBER BODEN: The draft whatever that was called.

MR. RIOS: So, you want what Steve wrote? Okay. That was up there, yes. There it is right there.

MEMBER BODEN: So, I would recommend that we keep the initial paragraph. Well, let's see. Let's read it again. That we keep the initial two sentences of the paragraph and simply say that the Board recommends that the changes -- I'm not quite sure of the wording, but that the changes, recommends that the changes not be made. So, maybe somebody can help me with the wording

on that.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: If you remove the change and go back to the original language, essentially, what it says is, "Proof of employment may be established by any trustworthy records that established that the employee was so employed." It is kind of redundant and it doesn't really say much. And I think that we are trying to give some specificity to it. So, maybe we might want to suggest some more clear way of specifying what kind of records will prove employment.

CHAIR MARKOWITZ: Well, you know, that's really a different issue. The proposed change really focuses on the issue of the affidavit and how they are going to look at the affidavit. It is not on the whole set of sources they go to, which we have heard about, to prove employment.

So, it is recommending detail here on

the other sources is not on the table. I understand your point, and it is in the documentation that DOL provides, but it doesn't relate to the proposed change.

MEMBER FRIEDMAN-JIMENEZ: What I am saying is that we should keep something in it that includes mentioning the affidavit.

MEMBER WELCH: Yes, that's in the previous section, 30.111 and 30.112.

MEMBER FRIEDMAN-JIMENEZ: One eleven.

MEMBER WELCH: And 112.

CHAIR MARKOWITZ: Yes, which is on page 26.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Actually, taking up what was just said and trying to revise what I said before, actually, if you take that first sentence, put a comma after "such employment," and say -- I'm sorry. If you took that first sentence under "Proof of Employment," and put a comma after that first sentence, "including an affidavit as defined under 30.111(c) and 30." --

or whatever else it is. And that is all you need.

MEMBER WELCH: I don't think you need it.

MEMBER CASSANO: I don't know. I think you do because somebody may decide that it is not a trusted record. I don't know.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: So, what this paragraph 30.231 is about is proving employment-related exposure to a toxic substance. That is the heading. So, to do that, first, they have to demonstrate they were employed. And then, they have to demonstrate there was proof of toxic substances.

So, one option for (a) is to refer back to the previous section where it talk about how they demonstrate that they are employed, which would solve what, George, I think you were thinking that first paragraph (a) was a little, the first sentence in (a) was kind of redundant and unnecessary. But it is defined previously,

you know. So, proof of employment may be established as specified under 30.111. Because this paragraph is really, the heading is really about (b), but, obviously, you can't prove toxic exposure unless you first prove that you were employed. I mean, it is stepwise.

CHAIR MARKOWITZ: So, let me ask Mr. Giblin a question here about what we are permitted to do. We're looking at the proposed changes and trying to provide input on specific new language. Are we also permitted to provide input on existing language which is not up for revision or add language such as being proposed here? Add language which is, again, not already in the proposed changes?

MR. GIBLIN: The comments really need to be limited to the proposed changes. I mean, that is the purpose of the exercise under the APA, is that we notify folks of what changes we are making and let people comment on those. If you were to comment on changes that were made and, then, we agreed with them, we would probably

have to go through another rulemaking because, see, people wouldn't have notice that we made the change. And so, it is kind of circular.

MEMBER WELCH: Right. Right. That makes sense.

CHAIR MARKOWITZ: Okay. So, that is very helpful because it restricts our attention to new language. So, that's good.

What are we back to? Take a step back here.

MEMBER REDLICH: Could we just make sure that whatever change, because this is also referred to on page 27, and I'm having a little trouble telling what's new and what's crossed out between the blue color and the line through the blue color. I'm a little confused. But, if someone just can make sure it is consistent?

MR. RIOS: Yes, that is how tracked-changes works.

CHAIR MARKOWITZ: Right. So, looking at this language on page 27, it's Section 30.112, paragraph (3), or I don't know what you call

these subsections. But it contains the same contradictory language; whereas, the only evidence it starts off of is a written affidavit. Then, skipping down, "OWCP will evaluate the probative value of the affidavit in conjunction with other evidence of employment."

Okay. Well, let's decide first on 231(a) and, then, we can go back to that language and provide input.

MEMBER BODEN: I had to write it down first. It is better that way.

So, my suggestion is, going back to the changes that were proposed, the recommendation that we would make is to keep the first two sentences of that recommendation and to follow those sentences with "The Board recommends that the proposed changes not be made."

CHAIR MARKOWITZ: I'm sorry, is that a motion?

MEMBER BODEN: That's motion.

CHAIR MARKOWITZ: Okay. So, I need a second.

(Seconded.)

CHAIR MARKOWITZ: So, discussion?

If you strike the new language, proposed language, then what sense is it to retain the second sentence of that recommendation, that the Board recommends that DOL specify what is meant by another entity --

MEMBER BODEN: No, I'm sorry. I guess I counted the sentences wrong. The first four lines; the first sentence, not the first two sentences.

CHAIR MARKOWITZ: Retain the first sentence?

MEMBER BODEN: No, there are the first two sentences. The first sentence is "The Board finds that the proposed new language is vague and contradictory." Oh, right, and that would be the only sentence that we would keep. And then, we would say, "The Board recommends that the changes not be made."

CHAIR MARKOWITZ: Excuse me. Dr. Welch?

MEMBER WELCH: I think including the first three sentences there, going down through "notes the proposed language contradicts Section 30.111(c)," that is our reason for recommending that the language be eliminated --

MEMBER BODEN: Okay.

MEMBER WELCH: -- is those first three. So, I would do the first three and, then, put your language in.

MEMBER BODEN: I totally agree.

MEMBER WELCH: Friendly amendment to your proposal?

MEMBER BODEN: Friendly, very friendly.

MEMBER WELCH: Okay. Thank you.

(Laughter.)

CHAIR MARKOWITZ: I'm not quite understanding. You would retain the second sentence? "The Board recommends that DOL specify what is meant by `another entity'" and the term "probative value" be further defined?

That is language which the motion is

to eliminate that language. So, it wouldn't make any sense to retain the second sentence.

MEMBER BODEN: Okay. So, the first and the third sentences.

CHAIR MARKOWITZ: Thank you. Okay.

MEMBER BODEN: We got it.

(Laughter.)

CHAIR MARKOWITZ: Yes, Mr. Griffon?

MEMBER GRIFFON: Yes, I just want to bring our attention back to page 27 because, I mean, I just want to be careful what I'm voting on here. I mean, if you go back to the old language, if we are saying we want to eliminate this, we would probably have to do the same thing in this section.

CHAIR MARKOWITZ: Yes.

MEMBER GRIFFON: And so, Section 3 would then read, "If the only evidence for the covered employment is a self-serving affidavit, and DOE or another entity either disagrees or," duh-duh-duh-duh-duh, "then the OWCP may reject the claim based upon a lack of evidence of

covered employment." That's the old language.

CHAIR MARKOWITZ: Okay. So, we will get --

MEMBER GRIFFON: Okay. Okay. All right. All right. We'll get to that.

CHAIR MARKOWITZ: We will get to that.

MEMBER GRIFFON: I just want to make sure we know. Okay.

CHAIR MARKOWITZ: We will get to that next.

MEMBER GRIFFON: All right. Sorry.

MEMBER WELCH: That was my concern over here.

MEMBER GRIFFON: Yes, yes, yes. Okay. Yes.

CHAIR MARKOWITZ: So, if we could go back to the -- question: since retaining the first sentence and the third sentence has something to do with providing some rationale for our recommendation, right, the fourth sentence, should we consider retaining that?

I quote: "If the goal is to increase

the likelihood that affidavits are valid, then the guidelines of what elements need to be included the affidavit should be issued to clarify the claimant's task of proving an employment history in the absence of other evidence." Or is that not really necessary?

Dr. Welch?

MEMBER WELCH: Well, I think we can't do that because that would be adding language to the statute, adding new changes that aren't there.

CHAIR MARKOWITZ: No, I'm sorry. This is part of the --

MEMBER WELCH: Oh, you talking about guidance?

CHAIR MARKOWITZ: -- rationale for our proposal. This would be in line with sentences one and three.

MEMBER WELCH: Right, but it says, it is suggesting guidelines. But I guess the guidelines could be not in the statute.

CHAIR MARKOWITZ: Right.

MEMBER WELCH: Not statutory.

CHAIR MARKOWITZ: Well, it could be procedural, not regulatory.

MEMBER WELCH: Right.

CHAIR MARKOWITZ: We could add, then, procedural guidelines or something, which actually already exist, right, to some extent?

MEMBER WELCH: I think that is reasonable.

CHAIR MARKOWITZ: So, we are on the friendly amendment phase, I think.

MEMBER BODEN: Yes.

CHAIR MARKOWITZ: So, one friendly amendment was to include the first sentence and the third sentence. And the next is to include this sentence which was just highlighted, the fourth sentence, amended to say, then, "procedural guidelines" under what elements, to make it clear that we are not talking about regulatory guidelines. Does that capture it?

MEMBER BODEN: How about just saying, then, "information on what elements need to" --

because procedural guidelines is also maybe, it is not clear what that means.

CHAIR MARKOWITZ: Yes, yes. Okay.

MEMBER SILVER: I think, as someone who has spent time around the Federal Register and administrative law, knows that there are regulations that are binding and, then, there are guidelines, guidance, that are just suggestive. So, I think it is fine the way it is.

CHAIR MARKOWITZ: Any other comments on that sentence?

(No response.)

CHAIR MARKOWITZ: And we look at the next paragraph, which is unnecessary because we are recommending that the whole section be struck. Okay.

So, I am going to just ask Kevin if you could delete the second sentence and the last paragraph? Right. Or you could strike through it, whichever it. You can delete it. Okay. And then, delete the last paragraph. Okay.

Okay. And we can add now Les' motion,

which is, "The Board recommends that" --

MEMBER BODEN: "The proposed changes not be made."

CHAIR MARKOWITZ: Okay.

MEMBER BODEN: "The proposed changes not be made."

CHAIR MARKOWITZ: Okay. So, we're now looking at the language of the motion with its rationale or preamble. Any further comments or discussion on this before we take a vote?

Sure. Mark?

MEMBER GRIFFON: I just have a process question. Do we want to vote on these one at a time or are we going to vote on a set of comments that we're submitting as the Board to DOL? I mean, it might be worth going through all of them and sort of drafting, getting the sense of the Board and, then, saving our votes for tomorrow. That way, we can look over them if we have any final thoughts or deliberations tomorrow. Just a thought, you know --

CHAIR MARKOWITZ: Right, right, right,

right.

MEMBER GRIFFON: -- in terms of process.

CHAIR MARKOWITZ: Right. Yes.

Anybody have any thoughts about that? I think the question is hold off on the vote until tomorrow --

MEMBER GRIFFON: Yes. I guess two questions. One is I don't know if we are going to submit comments from the Board, if I vote on each individual one and I disagree with one, what does that mean?

CHAIR MARKOWITZ: Right, right.

MEMBER GRIFFON: Are we just going to vote on one set of recommendations or are we going to --

CHAIR MARKOWITZ: Right. I think we should vote on them individually because there may be difference of opinions.

MEMBER GRIFFON: But the plan is saving the votes for tomorrow.

CHAIR MARKOWITZ: Right, right.

MEMBER GRIFFON: Getting the sense of our language today and, then, maybe sort of emailing it to everyone, so we can look at it, look it over tonight before we do our final votes.

CHAIR MARKOWITZ: Mr. Rios is simply saying that, yes, we could, when we reconvene tomorrow, go over these and vote. We can't meet tonight and discuss them as the Board.

MEMBER VLIEGER: I think the intent of the comment was assigning us homework tonight, separately and individually in our own little rooms with our own little computers, not to have a meeting. So, I have to contradict the intent that we are going to try to have a meeting.

MR. RIOS: He asked me if that was okay, and I told him as long as you don't go back to the hotel and review these in groups. So, there was no intent behind that.

(Laughter.)

MR. RIOS: It was a response to a question.

CHAIR MARKOWITZ: So, we interrupted the vote or the discussion on this to consider another question. Fine. A question of process. And that is, should we delay votes until tomorrow to give people time to think and consider? Any comments on that?

Yes, Ken?

MEMBER SILVER: Bonus, we get to hear from folks during the public comment period with our draft comments up there.

CHAIR MARKOWITZ: The only thing I would say is that tomorrow we have an hour-and-a-half scheduled for this, beginning at 10:45. So, Ms. Pope is going to be speaking downstairs tomorrow at around 10:40, 10:45, as part of Workers' Memorial Day. There is a half-hour of speeches, and whatnot, in recognition of Workers' Memorial Day between 10:30 and 11:00. And she couldn't attend part of this. And so, if we can afford the time, we will take that half-hour to be downstairs and participate, which would leave -- it's a half-hour -- leave us an hour tomorrow.

So, from my point of view, the only consideration is a practical one. Can we take all the votes tomorrow on all the issues?

Dr. Cassano?

MEMBER CASSANO: Can we split the difference and sort of, if there's still some question, then maybe we will table a vote on any one issue until tomorrow? But, if we are pretty much in concurrence and we feel that we can go to a vote on an issue today, we do that.

CHAIR MARKOWITZ: I do think that there are about 10 items on our list, but many of them are fairly straightforward, on which we could take the vote and not feel a need to think about it, and others on which it would be good to have some time.

So, I guess the proposal, then, is to decide, with each proposed change that we look at, whether we want to discuss it today, settle on language, but, then, vote on it tomorrow.

Les?

MEMBER BODEN: Just one alternate

suggestion, if this would work procedurally, which is, we vote on them today, and if there are any we want to reconsider tomorrow, we bring them up.

CHAIR MARKOWITZ: Well, that is a variation.

(Laughter.)

CHAIR MARKOWITZ: That is noted.

MEMBER BODEN: I just prefer moving along and voting --

CHAIR MARKOWITZ: Right.

MEMBER BODEN: -- on things, but I appreciate the concern.

CHAIR MARKOWITZ: Right, right.

MEMBER BODEN: So, I was just trying to figure it out.

CHAIR MARKOWITZ: Right. Dr. Welch?

MEMBER WELCH: Well, I would want to make some more comments on this tomorrow after I read all the sections before, because I think we are going to have to edit this based on the previous -- what I am just reading now. So, I

would like to hold off on this one, but let's maybe move on.

Some little nuances. I mean, I would still say that we wouldn't want to make the proposed changes, but --

CHAIR MARKOWITZ: Okay.

MEMBER GRIFFON: I think I can live with that compromise, that some might be really straightforward. This one, I want to make sure we have got the language correct, yes. Yes.

CHAIR MARKOWITZ: Okay. So, I guess the motion is whether we vote on them individually, whether we are going to decide them today or tomorrow, right? So, is there any further discussion on that?

(No response.)

CHAIR MARKOWITZ: All in favor of, when we visit each of these proposed changes, that we simultaneously decide whether we are going to vote today or tomorrow. All those in favor of that?

(Show of hands.)

CHAIR MARKOWITZ: Okay, it is in favor. Okay. So now, let's revisit this proposed change. The question, I guess, is, the motion is to --

MEMBER CASSANO: Motion to table.

CHAIR MARKOWITZ: Second?

(Seconded.)

CHAIR MARKOWITZ: Okay. Any further discussion on this?

(No response.)

CHAIR MARKOWITZ: Okay. All those in favor?

(Show of hands.)

CHAIR MARKOWITZ: Okay, it is the majority. All those opposed, I guess? Abstentions?

So, we have this language which we will revisit tomorrow.

Let's move on. Now I think we should go to this page 27, to this language. It is very closely related. It wasn't discussed separately

by each of the committees that met on this. And it is Item No. 3.

Does someone want to read this aloud, just for people in the back who can't see it or people on the phone who don't have access to it?

Dr. Cassano?

MEMBER CASSANO: "If the only evidence of covered employment is" -- and I am going to read the new language, not the old language -- "is a written affidavit or declaration, subject to penalty of perjury by the employee, survivor, or any other person, and DoD or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under Section 30.111."

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: But I think, for

purposes of our work, we need to also read the old language because the old language -- I guess what it is is --

CHAIR MARKOWITZ: Could you read that?

MEMBER WELCH: The way it was read before was, "If the only evidence of covered employment is a self-serving affidavit, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP may reject the claim based on a lack of evidence of covered employment."

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, I have a suggestion about a rewording of the change. All right? Which would be -- and I will read this. So, it starts out the same.

"If the only evidence of covered employment is a" -- cross out "self-serving" -- "written affidavit or declaration, subject to penalty of perjury by the employee, survivor, or any other person," then continue down to "then

OWCP will evaluate the probative value of the affidavit in conjunction" -- well, it can't be in conjunction -- "will evaluate the probative value of the affidavit." Period.

CHAIR MARKOWITZ: Okay.

MEMBER BODEN: So, that is a change. It strikes the "self-serving" from the old language. It includes the declaration subject to the penalty of perjury, and then, it doesn't say that it may determine that it is bad. It just says it will evaluate it, which seems all that is really necessary.

And then, it is consistent, I think, with the change that we recommended in the section that we just discussed.

CHAIR MARKOWITZ: So, I think it is important that we see what Les has proposed. So, I've just asked for this section to be copied, moved over to the draft recommendations, and then, we can review those changes --

MEMBER BODEN: Okay.

CHAIR MARKOWITZ: -- so we can all

look at the language that we are discussing.

MR. RIOS: I would like to make a request. Since you're putting together your write-ups that you are going to submit, as my role as a DFO, I am required to ensure that the Board stays within the objectives and the statutory scope, specifically, the four subject matter areas.

So, if you are going to make any recommendations on a particular reg, I would like for the Chair to describe how the particular reg on which you're going to make a recommendation falls within your statutory authority.

CHAIR MARKOWITZ: You want me to do that now with regard to this proposal, or you are saying in general?

MR. RIOS: So, each one of these, if you can evaluate which of the four subject matter areas it falls under, it would be helpful.

CHAIR MARKOWITZ: Okay. Well, I can tell you this issue of covered employment certainly relates to SEM and it relates to the

evaluation of medical evidence used to judge claims.

MEMBER BODEN: So, would you like me to go over my proposal with you?

So, we start the same. "If the only evidence of covered employment is a" -- cross out "self-serving".

(Pause.)

MEMBER BODEN: Okay. So, "If the only evidence of covered employment is a" -- cross out "self-serving". Then, it would say, "written affidavit or declaration, subject to penalty of perjury by the employee, survivor, or any other person," and then, cross out everything until "then OWCP". "Then, OWCP" -- and then, cross out "may reject the claim based upon a lack of evidence of covered employment". Yes. And then, keep "will evaluate the probative value of the affidavit." Period, and cross out the rest.

That's it.

MEMBER WELCH: Les, weren't you going to leave in the part about the old language, "DOE

or another entity agrees or disagrees"? Because I don't know that we can strike that.

MEMBER BODEN: Oh, no, sorry. I'm sorry.

MEMBER WELCH: I think we have to leave that in because it's not a change. I would love to strike it, but I don't think we can.

(Laughter.)

MEMBER BODEN: Yes, okay. I think we can't. I think you are right. I think we can't strike it, as much as I would like to, yes. Thank you, Laura.

Take out "may reject the claim based on a lack of evidence of covered employment," right.

"Then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment." But it is the only evidence. So, there can't be any other evidence, right? So, take that out. Period.

CHAIR MARKOWITZ: No, you took out not only the citation of the other evidence, you also

took out -- just clarifying whether you meant to do this -- take out the language that says, "may determine that the claimant has not met his or her burden of proof under 30.111."

MEMBER BODEN: Yes, I did, because I think that is -- so, if that is unnecessary because it is already evaluating the probative evidence --

CHAIR MARKOWITZ: Okay.

MEMBER BODEN: -- the probative value --

CHAIR MARKOWITZ: I wasn't asking why. I was just asking --

MEMBER BODEN: Yes, but I do want to say, I actually do want to say why, right? Because this, again, gives it that negative twist, right, that says -- because if it says, "may evaluate the probative evidence," that means it could be good; it could be bad. We'll have to decide. But if you say, "will determine that it hasn't met," then it is pushing you in the direction of, well, it would be bad.

MEMBER CASSANO: Just a friendly amendment which I think might solve the problem of getting the language about 30.111 in there is to say "as it relates to Section 30.111." Because, without that, you don't know what the probative evidence you have there is being used to do.

MEMBER BODEN: Okay. Right. So, we could, then, put back in, "under paragraph 30.111" --

MEMBER CASSANO: Or "as it relates to 30.111".

MEMBER BODEN: Well, I think we should leave their language as much as possible.

MEMBER CASSANO: Okay.

MEMBER BODEN: So, that is their language.

So, it would read then, "the probative value of the affidavit"

MEMBER WELCH: "Under" --

MEMBER BODEN: -- "under paragraph" or "Section 30.111".

MEMBER WELCH: Yes.

MEMBER BODEN: I am just trying to keep their language as much as we can.

CHAIR MARKOWITZ: Okay. So, we need a motion. We will discuss this some more, but we do need a motion around this.

Yes?

MEMBER WELCH: One little amendment. We have to reference where we are editing the document because we didn't have that in our -- I mean, this isn't a heading that we had before. So, we have to be sure to add the 30.112 --

MEMBER BODEN: .112.

MEMBER WELCH: -- heading there.

MEMBER BODEN: Yes, yes. So, I think we replaced the 30.231(b) there with 30.112.

MEMBER WELCH: But it has a different title, too.

MEMBER BODEN: Right.

CHAIR MARKOWITZ: 30.112(b)(3), right?

MEMBER BODEN: Yes, (b)(3).

CHAIR MARKOWITZ: And if you just take

out the title, I'll replace it.

MEMBER WELCH: Okay. Yes. Okay. And do you want to highlight it, so you remember that you need to change it?

CHAIR MARKOWITZ: Sure.

MEMBER BODEN: Just delete it.

CHAIR MARKOWITZ: You can delete that, but just highlight the 30.112(b). Okay. Thanks.

So, I'm sorry, what is the motion?

MEMBER CASSANO: The motion is to accept the proposed language unless there is a motion to table, I guess, first.

CHAIR MARKOWITZ: Okay. The motion is to recommend this language with the changes, right?

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: Okay. Is there a second?

(Seconded.)

CHAIR MARKOWITZ: Okay. So now, discussion? Further discussion?

(No response.)

CHAIR MARKOWITZ: Okay. So now, let's decide whether we want to vote on this today or tomorrow. Is there a motion to table this until tomorrow, as in the previous one?

I'm sorry, I'm not making myself clear. We have a motion. We can vote on this proposed change or we can table the vote and vote on it tomorrow.

And my question is whether you want to vote on now or whether you want to table it and vote on it tomorrow.

MEMBER TURNER: I was thinking about earlier we had made mention that we ought to let the public have their comments and, then, we can kind of get some more thoughts and vote on it tomorrow.

MEMBER VLIEGER: Dr. Markowitz, I move that we table it until tomorrow.

MEMBER TURNER: Second.

CHAIR MARKOWITZ: Okay. So, the motion is to table. Fine. Any discussion on that motion?

(No response.)

CHAIR MARKOWITZ: If not, let's vote on whether -- the motion is to table the vote on this particular recommendation until tomorrow. All those in favor raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: All those opposed? And any abstentions?

Okay. So, that passes. So, that is tabled. Let's move on to the next. We finished the first one. That's good.

(Laughter.)

CHAIR MARKOWITZ: The first is the toughest or maybe the second. I'm not sure. Maybe the third. But they do get easier; I will say that.

Anyway, this is the following item. It is on page 40, for the Board members, if you are looking at the print copy. Otherwise, it is coming up on the screen. It is proof of exposure to a toxic substance. If you are online or on the phone, it is Item (b) under 30.231.

And I think, again, it would probably help if we have someone read this.

MEMBER CASSANO: I will be the designated reader then.

CHAIR MARKOWITZ: Okay.

MEMBER CASSANO: And I'll read both languages, old and new, if it makes any sense.

"Proof of exposure to a toxic substance may be established by the submission of an appropriate document or information that is evidence that such substance was present at the facility" -- strike "in which"; substitute "where" -- "the employee was employed and that the employee came into contact with such substance." Strike "OWC Site Exposure Matrices," is stricken out. And then, "Information from the following sources may be -- strike out "used to provide" and substitute "considered" -- "as probative factual evidence" -- strike out "that" -- "for purposes of establishing an employee's exposure to a toxic substance". And then, it says, "was present at a DOE facility or a RECA

Section 5 facility".

Do you want me to go through the 1, 2, and 3?

CHAIR MARKOWITZ: Yes.

MEMBER CASSANO: No. 1, "To the extent" -- and this is new language -- "To the extent practicable and appropriate from DOE, a DOE-sponsored Former Worker Program, or an entity that acted as a contractor or subcontractor to DOE;"

Two, "OWPC Site Exposure Matrices;"

Or, three, "any other entity deemed by OWPC to be a reliable source of information necessary to establish that the employee was exposed to a toxic substance at a DOE facility or RECA Section 5 facility."

CHAIR MARKOWITZ: Okay. So, we have just the comments from each of the three groups.

Laura, do you want to go first?

MEMBER WELCH: Sure. Our discussion, what I would summarize from our discussion was that we were unhappy with the vague -- Item No. 3

seemed to be vague, and we wanted the whole Committee to discuss it.

My opinion, now that I am reading it, the fact that it is very open, which is a good thing, but it allows other sources to come in. So, I personally don't have the same concern we had when we discussed it on the phone.

CHAIR MARKOWITZ: Mark?

MEMBER GRIFFON: Yes, we had the same comment, although I think we also said that guidelines, either regulatory or procedural guidelines, should be established to identify what other reliable sources of information might be. And in my own opinion on that, it might be better to put that sort of in a procedure, rather than a regulation, because it might be involved; it is probably going to change anyway.

CHAIR MARKOWITZ: Ken?

MEMBER SILVER: Before the meeting, I grabbed the law dictionary off the shelf and saw that the word "entity" doesn't apply to individuals. But, as a group, our recommendation

was in (b)(3) to drop the word "entity". So, it reads, "any other source of information deemed reliable".

CHAIR MARKOWITZ: Okay. So, if you could put up the draft recommendation, which is what I drafted from the various subcommittee comments?

I forgot to say, are there other comments at this point that people wanted to make?

(No response.)

CHAIR MARKOWITZ: Okay. Yes, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: A very quick grammatical question. After Item 1, is it understood that there is an "or" there?

CHAIR MARKOWITZ: Yes, I don't know. I don't know the answer to that.

I neglected to say why the Board is justified in looking at this proposed change in terms of our mandate, and this particular issue of proof of exposure to toxic substances relates

to (a) and (b) really, both the Site Exposure Matrices, because this is the information that is used, well, it actually specifies Site Exposure Matrices, but also the medical values which includes information about exposures.

So, let me read this language of this draft recommendation.

"The Board recommends that DOL change," quote, "`entity'", end of quote, "to", quote, "`entity or other information source'", end of quote, "guidelines (regulations or procedures) on how OWCP determines reliability of the sources of information should be established. The occupational history from the claimant or an affidavit with relevant exposure information from a coworker should be considered evidence of exposure. In addition, exposure information obtained from an occupational or other health provider who is not affiliated with a Former Worker Program should be accepted."

So, let me comment on this, actually. The changes recommended under this section expand

and specify the sources of information used to obtain evidence of exposure. The old language is less specific and the new language now goes and lists the sources of information for proof of exposure. Those that are listed are DOE, the Former Worker Program, other entities that were contractors or subcontractors of DOE. It adds the Site Exposure Matrices, and then, it adds any other entity deemed by OWCP to be a reliable source of information.

It doesn't, however, recognize that the claimant himself and coworkers have this exposure information. That is actually where we normally get it from in conducting an occupational medicine evaluation. So, I understand that there may be a wish to complement that information with other sources, but its absence here I think is problematic.

And then, the last sentence of this recommendation relates to naming other health providers other than those at the Former Worker Program as having useful information.

Dr. Boden?

MEMBER BODEN: I like this. I wonder if -- and this is sort of my thinking, trying to think like a lawyer, which is hard for me -- whether saying "should be considered as evidence" should be changed to "may be considered as probative", which is what the rest of the language is. I don't know for sure, but saying "should be considered as evidence" means that you take it as valid in all circumstances, which may be limiting.

CHAIR MARKOWITZ: So, I have to ask Mr. Giblin a question I have already asked, but appear to have forgotten the answer. This recommendation, this draft recommendation, actually proposes new language. For instance, it revises "entity" to "entity or other information source". That would be new proposed change in the regulation. And at this point, you can't add that language to the regulation, can you?

MR. GIBLIN: I am not quite sure I understand your question, but looking at this

change here --

MEMBER WELCH: Right now, it says "entity".

MR. GIBLIN: You can change, you can suggest changes to the language, yes, within the -- yes, you certainly can.

CHAIR MARKOWITZ: So, we are not limited to revisions or suggested deletions of the new language or reversals of struck language?

MR. GIBLIN: No, you're not.

CHAIR MARKOWITZ: Okay. Thank you.

Dr. Welch?

MEMBER WELCH: I think one way to format those insertions of specific other information sources would to be add them in the numbered list. Because says, "Information from the following sources may be considered as probative factual value." And so, we have one, two, three. So, in between two and three, we could insert "the activation list of the claimant, an affidavit of relevant exposure information", and sort of add those to the list.

Then, we are basically using the language that is already proposed in the statute.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I would recommend that we do that as an "e.g." rather than as examples. Because if you put it in as the list, then if it is not on the list, then it is excluded. So, in parentheses, we could say "e.g.", such-and-such and such-and-such.

CHAIR MARKOWITZ: Dr. Dement, do you have a comment on Dr. Cassano's remark?

MEMBER DEMENT: If I can get the microphone on.

(Laughter.)

MEMBER DEMENT: It's hard to see the light. Yes, it's on. Button-pushing 101 is not my forte.

(Laughter.)

CHAIR MARKOWITZ: I think it seems to be limited to this side of the room.

(Laughter.)

MEMBER DEMENT: Yes, we are very

limited on this side.

(Laughter.)

CHAIR MARKOWITZ: Okay. Dr. Dement has the floor.

MEMBER DEMENT: I think we cover that concern in not using "e.g.". I think it would actually be more prescriptive in the list because at the end we have other information. With this change from "entity" to "other sources of information", I think we have covered that well.

CHAIR MARKOWITZ: Yes, personally, the "e.g." is "for example". That seems quite optional. It doesn't have the weight that actually naming/listing does. So, I would agree with that.

Other comments, suggestions?

Yes, Dr. Silver?

MEMBER SILVER: Maybe during the public comment period the folks who have worked as Authorized Representatives can tell us -- I don't know. I thought about when I started on this work and had some interactions, pro bono

only. I am sure I earned a reputation with people who work in the district offices as being a long list of adjectives, unreliable maybe being one of them. But I was supplying really good information from old DOE reports, from peer-reviewed journal articles, from the things that a document hound comes up with.

So, is it the provider of the information or is it the information itself? And I just want to make sure our formulation doesn't impair the ability of self-taught Authorized Representatives to deliver smoking-gun documentation.

CHAIR MARKOWITZ: Additional comments? Yes, Dr. Boden?

MEMBER BODEN: Hopefully, just to respond to Ken's comment, maybe what we want to say is "any other information deemed by OWCP to be reliable" rather than to name the source of the information. I think that is a good point. What is a reliable source of information?

CHAIR MARKOWITZ: Okay. So, you are

going to need to propose some language that modifies what we are looking at to accommodate that.

Let me ask a question of Dr. Welch. You thought that it would be more effective if we actually provided the language of Item No. 4, the occupational history or affidavit from the claimant or coworker; No. 5, any other health provider.

Do you think that it is necessary or preferred that we provide that language as opposed to what we are looking at now in which we say that we recommend that these sources be included among the sources?

MEMBER WELCH: Well, I think if we put it in a paragraph the way we have it now, we have to be careful about the terms that we use when we describe it, such as "should be considered", "the occupational history or affidavit should be considered evidence of exposure". Do we need to say, "considered probative evidence of exposure"? And then, in the last sentence, it says, "should

be accepted", but "accepted" is not a term that is used in that paragraph.

So, I was thinking if we specifically said insert these as part of the list --

CHAIR MARKOWITZ: Right, right.

MEMBER WELCH: -- then we are using -- we don't have to try to match the language where we are making some mistake that makes these sound less valuable, like just an add-on.

CHAIR MARKOWITZ: Okay. Okay.

MEMBER WELCH: And it wouldn't be four, five, six. The No. 3 would be the last one.

CHAIR MARKOWITZ: Right. I get that. I get that, yes. Yes

MEMBER WELCH: So, it would be we would move down the numbering.

CHAIR MARKOWITZ: Okay. So, yes, Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: The language "should be considered evidence of exposure" might be misconstrued as saying, "should be considered

sufficient evidence of exposure", which it is really not. And that could cause them to say, "Let's just delete it." So, maybe we should say, "should be considered sources of probative evidence of exposure", or something like that. So that they are included among the sources --

CHAIR MARKOWITZ: Right.

MEMBER FRIEDMAN-JIMENEZ: -- but we're not saying that that is automatically proving exposure.

CHAIR MARKOWITZ: So, the recommendation is that we add, as an item number, a new Item No. 3, the occupational history obtained from the claimant or an affidavit of the claimant containing the same information. And then, add a new Item No. 4, which would be "information from occupational and other health provider who is not affiliated with the Former Worker Program". Those enter the list.

What precedes that is this language, George. "The following sources" -- quote -- "may be considered as probative factual evidence for

the purposes of establishing an employee's exposure to a toxic substance at a DOE facility". So, that is the language that would apply to these new items on the list. And I think that addresses your concern.

MEMBER FRIEDMAN-JIMENEZ: Yes.

CHAIR MARKOWITZ: Okay. Okay.

MEMBER CASSANO: Just a question. So, the recommendation is to add those two as Items 3 and Items 4 and keep current Item No. 3 as Item 5?

CHAIR MARKOWITZ: Correct.

MEMBER CASSANO: Okay. Then, I'm cool with that.

CHAIR MARKOWITZ: Okay.

MEMBER GRIFFON: Just one more clarification, Steve. When you say, "occupational history from the claimant", are you talking specifically about the occupational history questionnaire that they do through the Resource Center or any occupational -- because I think that might, well, in my opinion, that ought

to be listed, the occupational history questionnaire.

CHAIR MARKOWITZ: You want to list that specific --

MEMBER GRIFFON: Well, maybe not.

CHAIR MARKOWITZ: Right.

MEMBER GRIFFON: I'm asking, what did you mean by your language?

CHAIR MARKOWITZ: Right, right.

Well, here I'm a little lost because the answer really depends on how the program operates, because you have the occupational health questionnaire and, then, the history questionnaire and, then, you probably have some supplemental affidavits that are sometimes submitted --

MEMBER GRIFFON: Yes, right.

CHAIR MARKOWITZ: -- by either the claimant or coworkers, right? So, all that information should enter into the calculations.

I can come up with some language tonight that we can look at tomorrow. It will

say something like "occupational history information obtained from either the occupational history questionnaire or comparable affidavit", or something like that, something that is general enough to include all sources.

Yes, Dr. Boden?

MEMBER BODEN: So, I have some specific language to address Ken's concern.

CHAIR MARKOWITZ: Okay.

MEMBER BODEN: This is what is currently No. 3 and now is going to be No. 6 or 7, or whatever it is. And it would state, "any other information deemed by OWCP to be reliable for purposes of establishing that the employee was exposed to a toxic substance at a DOE facility", et cetera. So, it removes "source", but keeps "information", essentially.

CHAIR MARKOWITZ: So, you're replacing the language --

MEMBER BODEN: Yes.

CHAIR MARKOWITZ: -- the existing language of three? Is that what you are saying?

MEMBER BODEN: Right. I'm replacing it. Essentially, it has to be somewhat reformulated to give the idea that it is information rather than source.

CHAIR MARKOWITZ: Right, right. So, you can get his language on the draft recommendation.

MEMBER BODEN: So, I will say it slowly. It is "any other information" -- oh, sorry.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: I mean, I actually think it is okay to have "reliable sources" because really what is above there are sources of information. So, if something comes from the Former Worker Program, this is saying it's a source that can be used, and you don't necessarily have to independently assess the value of the information.

Now what you are suggesting is that, in addition to sources and information, some information itself can be of probative factual

value. But I don't I necessarily want to take out the "other entity deemed to be a reliable source of information", because it is sort of like, you know, an affidavit from an industrial hygienist who used to work at the plant. Okay? So, they could deem that to be a reliable source of information. I guess that is what I am saying. It is like there is an advantage to saying "sources", and it seems like that is what this paragraph is about. It is how the information gets into the program.

I mean, I don't know that I'm saying I don't agree with your changes, but I don't think it is that simple. What do you think, Ken?

MEMBER SILVER: I think there are highly incentivized, increasingly sophisticated Authorized Representatives who aren't part of an entity who hit the stacks and know every document archived in the public arena, laid down by CDC over the years, whomever, and that is where they find reliable information.

And the District Office may have them,

you know, on sort of a black list, and they shouldn't be judged because of their past battles with the District Office; a four-square piece of paper should be judged.

CHAIR MARKOWITZ: But what if you just took the existing language that says, "any other entity deemed by OWCP to be reliable" and say, "any other entity or information source which provides information that is deemed to be reliable by OWCP"? Would that combine the two thoughts?

MEMBER CASSANO: Yes, I think it is almost too complicated at that point. I think just basically saying, "any other entity or source of information deemed reliable by OWCP", which is what we have originally --

MEMBER BODEN: But that is what Steve just said.

MEMBER CASSANO: Yes. Okay.

MEMBER SILVER: That's cool, yes.

MEMBER CASSANO: No, he added in a different source of information deemed reliable.

MEMBER BODEN: Oh, I see.

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: We have to see the change. If you could scroll up a little bit, just so we can see? Okay.

So, I think the language was "any other entity or source deemed by OWCP to provide information that is reliable". Okay. So, that switches it. What is reliable is the information, not the source. So, if you could, "any other entity or source that is deemed by OWCP to provide information that is reliable".

MEMBER WELCH: Or "to provide reliable information"?

CHAIR MARKOWITZ: Yes, "to provide reliable information". That's fine. And then, you can take out "necessary". Okay.

Does that now capture it? Okay. So, any other?

(No response.)

CHAIR MARKOWITZ: Again, on listing the occupational history and the other

occupational health provider, I will refashion the language into a list, so it mimics what is in the current proposed changes.

Any other changes?

(No response.)

CHAIR MARKOWITZ: Okay. So, is there a motion to table a vote on this proposal until tomorrow?

(Motion.)

CHAIR MARKOWITZ: And is there a second?

(Seconded.)

CHAIR MARKOWITZ: Okay. Any further discussion?

(No response.)

CHAIR MARKOWITZ: So, all those in favor of tabling the vote on this until tomorrow?

(Show of hands.)

CHAIR MARKOWITZ: All those opposed? And any abstentions? Thank you.

Okay. So, let me just say it is four o'clock. We are going to have a public comment

period at five o'clock. We are going to take a break. The question is, when do you want to take that break? Do you want to take it right before the public comment period or do you want to take it now?

Yes, okay. We are going to take a break now. Be back in 15 minutes. Thank you. 4:15.

(Whereupon, the above-entitled matter went off the record at 3:59 p.m. and resumed at 4:17 p.m.)

CHAIR MARKOWITZ: We are now going to focus on the next proposed change which is Section -- it's on page 40, for those of you who have the written document. It is being brought up on the screens. And it's Section 30.232.

This falls within the scope of the Board's mandate because this issue addresses the question of causation, the connection between exposure and disease, and that clearly fits within at least (a) and (b) of our assigned tasks.

So, Section 20.232, and the title of the Section is "How does a claimant establish that the employee has been diagnosed with a covered illness or sustained an injury, illness, impairment, or disease as a consequence of a covered illness?"

So, Tori is going to read. Large sections of this are struck out. We are not going to read the sections that are struck out, just for the sake of time. You can see the section there, and if you scroll down on the next page, it continues and new language is what we will read.

MEMBER CASSANO: So, the new language reads, "To establish that the employee has been diagnosed with the covered illnesses required under Section 30.230(d), the employee or his or her survivors must provide the following:

"(1) Written medical evidence containing a physician's diagnosis of the employee's covered illness (as that term is defined in Section 30.5(s)) and the physician's

reasoning for his or her opinion regarding causation, and

"(2) Any other evidence OWCP may deem necessary to show that the employee has or had an illness that resulted from an exposure to a toxic substance while working at either a DOE facility or a RECA Section 5 facility." Period.

CHAIR MARKOWITZ: So now, the reports from the various subcommittees.

Ken, do you want to go first this time?

MEMBER SILVER: Sure. Our subcommittee felt that the phrase "any other evidence OWCP may deem necessary" should be removed, feeling that it is overly-broad, not necessary, and could form the basis for adversarial interactions between OWCP and claimants.

Further suggestion to consider replacing the phrase "physician's reasoning" with "physician's rationale".

I'll leave it at that.

CHAIR MARKOWITZ: Okay. Mark?

MEMBER GRIFFON: We had a similar comment on that and said this is too vague, asking, also, is there where OWCP may ask for a second opinion?

And the second comment we had was asking for a written opinion, including the, quote, "the physician's reasoning for his or her opinion regarding causation", end quote, puts too great of an onus on the claimant at this stage of the claim's process, as many conditions will have been diagnosed by a general practitioner who may be incapable or unwilling to provide the report being required.

CHAIR MARKOWITZ: Thank you.

Laurie?

MEMBER WELCH: Yes, our group had a similar assessment to what Mark had just said. We were under the impression that this change was saying that all new claims or incoming claims now require a written physician opinion on causation from the person's treating physician, when the

practice has been that the claims examiners could award, could determine if it was a covered illness using other information without the treating physician's opinion on causation.

And so, again thinking that this is a burden on the claimant, and it also seems to be a really big change to the process, as the way the whole program has been running, the way our group understood the change.

CHAIR MARKOWITZ: Okay. Comments from other Board members?

(No response.)

CHAIR MARKOWITZ: So, if you could bring up the draft recommendation? Let me read this.

"The Board recommends that DOL remove the requirement that the claimant must produce written medical evidence where a physician describes the" -- quote -- "`reasoning for his her opinion regarding causation'" End of quote. "The Board believes that sufficient expertise in the causation of occupational illness is unlikely

to be available in DOE communities, and the time commitment for physicians to produce such a documented report makes this requirement unrealistic and places too great a burden on the claimants.

"In addition, the Board is concerned that" -- quote -- "`any other evidence the OWCP may deem necessary'" -- end of quote -- "is overly-broad, unnecessary, and may form the basis for adversarial interactions between OWCP and claimants."

Comments?

(No response.)

CHAIR MARKOWITZ: It's late, but we've got to get there. We've got to get there.

(Laughter.)

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: So, what is our recommendation? I mean, are we recommending the language that has been proposed be removed and the existing language retained? I guess the concern at this point of the process of filing a

claim, a lot of times it is simply a diagnosis of a disease and may or may not have all this other written opinions, which will be developed as the claims process goes forward. Frankly, I don't see the reasoning for the changes.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Yes. In looking at the old language, I mean, that seems incredibly onerous. I think the piece about -- I don't think requiring the written medical evidence with the rationale, as I look at this from writing a regulation, I don't think that basically says, if it is not there, the claim is going to be immediately denied. They are still going to develop it.

But I think if you remove that, then there is no basis for the treating physician to even try to give a rationale. And so, I have got mixed emotions on that first one. I fully agree with the fact that the second one is way too broad and could be horribly interpreted.

But I think we need to include -- and

maybe the answer is to say, "and where possible, the physician's reasoning or rationale" or "where applicable". Because they are going to have to develop a medical opinion. I mean, that is the whole point. You've still got to get to less than likely, at least as likely or not, or more than likely. And if we remove this, then there is no a priori need for the treating physician to even try to do it.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Well, I think you can run a really adequate comp program and never get a causation opinion from the treating physician. So, I guess I disagree. I mean, if they can do it, fine. But most of them don't know how, and if they are going to do it, they are going write language that is not probative.

I mean, what was there before basically said the claimant provides information for the physician that could provide information on the diagnosis, and some other source brings in an occupational history. And then, OWCP asks for

other information.

But if what you get is all the right inputs, then the claims examiner with the consultant can make the causation decision. So, you don't have to have the treating physician.

And the way it is written now, it says the claimant must provide.

CHAIR MARKOWITZ: You are talking about the proposed language?

MEMBER WELCH: The proposed language is the claimant must provide. So, if they don't provide a physician's diagnosis and the physician's reasoning, you're done. That's the way this is written now.

CHAIR MARKOWITZ: I agree.

Other comments?

Dr. Boden?

MEMBER BODEN: I think there is another problem with this, in that the Act does not require, as we have talked about before, causation, right? It requires whatever the words are, aggravated, contributed to, et cetera, et

cetera. So, an opinion on causation is not required by the Act.

CHAIR MARKOWITZ: But that specific point can be addressed simply by replacing "causation" with "aggravation, contribution, and causation", if I get your point correct.

MEMBER BODEN: Right. I guess what I am saying is, however we decide to address this, we ought to in our reasoning include the fact that this is overly-restrictive because --

CHAIR MARKOWITZ: By discussing only causation?

MEMBER BODEN: By discussing only causation.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: Just in general, many of the points that we are bringing up relate to the tasks that we were asked to address on this. So, is there an urgency to change the rules now? It just seems like the order of this is sort of reversed.

(Laughter.)

MEMBER REDLICH: I mean I am just confused.

CHAIR MARKOWITZ: Okay. The timetable is not of our making. The question is whether we can contribute something really.

MEMBER REDLICH: Okay, but can it be postponed --

PARTICIPANT: No.

MEMBER REDLICH: -- or just the wheels have to turn? Okay. Okay.

CHAIR MARKOWITZ: Other comments?

MEMBER CASSANO: Just one, and I don't know if it would be acceptable because this is not language that was changed. But, if you go to Part A, if you go to the subtitle under A, changing one word and making the changes about causation in there would make this acceptable. And instead of saying "must", you could put "should". And then, it would not be a dead-end and they would still continue to develop it.

I mean, this is from somebody that writes this stuff, wrote this stuff. I have real

problems taking that whole requirement out because I really think, No. 1, it will never go through and, No. 2, basically, then all you need is a diagnosis from an EHR or a medical record. And there is nothing that says that a physician has to at least address the concept of the effect of the exposure on the medical condition. And I think that weakens things a lot.

And I am trying not to be hard-hearted here. I am trying to look at this from a practical perspective of somebody who is going to be looking at this regulation and making a decision.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: One thing I think would be useful for our Board to do, or to make recommendations for, is to help OWCP develop presumptions for some of the common illnesses. So, if there were a presumption of how you are diagnosed with asbestos-related disease, you wouldn't need the treating physician's opinion. So, we don't want to end up requiring that in all

the cases anyway.

Like I said, I mean, there's a lot to -- I'm familiar with the trust funds that administer asbestos claims, for example, and they don't require physicians' opinions. They require these 10 pieces of information that, then, lead to presumption in 90 percent of the cases that come in. But we already discussed that particular point. But I think we should be careful about requiring an opinion from the treating physician.

CHAIR MARKOWITZ: So, Dr. Whitley?

MEMBER WHITLEY: Why couldn't you just stop it after 30.5(s)? Written evidence, you know, containing physician's diagnosis of employee's covered illness as divined by 30.5(s). Why do you need that other part in there?

MEMBER FRIEDMAN-JIMENEZ: It's implied.

MEMBER WHITLEY: That he has to give the opinion?

MEMBER BODEN: I have a proposal.

CHAIR MARKOWITZ: Okay. Yes, Dr. Boden.

MEMBER BODEN: Yes. My proposal is that we have a preamble that I think includes the stuff that is up there and, also, includes some language about the causation of illness being too limiting, and then, says that something to the effect that we don't think the changes should be made.

That is, I don't know if people object to anything in the original language. It would seem to be much less restrictive. But, then, that's fine. Then, we should talk about that.

Go ahead.

MEMBER POPE: As Garry was stating, I don't see what is wrong with stopping right there after the 30.5(s).

CHAIR MARKOWITZ: So, I understand that suggestion. Do you mean to suggest that the physician should be addressing the issue of aggravation, contribution, or causation? Or are you simply saying that the physician should

simply provide evidence for the medical diagnosis, what the disease is? It is the latter one, right? The "covered" part is misleading in that sense, though.

Yes, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: The original language, in the first paragraph, paragraph 1, the last sentence, it says, "and to the extent practicable, a copy of the diagnosis and summary of the information upon which the diagnosis is based". That phrase "and to the extent practicable" I think gives the leeway that, if they can't find a physician that is willing to comment or state their opinion on causality, then it is not going to throw out the case. It will just have to go to the contracted medical -- the CMC.

But, if we just stop it after 30.5(s), then that still will require them to give an opinion because it says, "covered illness". And covered illness is defined as an illness that is caused by the toxic exposure. So, that would

imply that the physician would still have to give his opinion or her opinion on why it was a covered illness.

So, I think adding that phrase "to the extent practicable" gives that degree of flexibility, and maybe we should suggest that they do that.

CHAIR MARKOWITZ: If you could remove the word "covered", that would address that concern.

MEMBER FRIEDMAN-JIMENEZ: Remove the word "covered"?

CHAIR MARKOWITZ: Yes. I am just saying if we remove the word "covered" in 30.5(s), it is clear that the interest is in the diagnosis, not the causation aspect.

MEMBER REDLICH: But, then, the next part of the sentence it goes on and says it again. In No. (2)(b), it is restated. It is sort of repetitive. Or is that something different?

CHAIR MARKOWITZ: That's a

consequential -- yes, it is a different category than this issue.

MEMBER WELCH: So, Carrie, it says, "an injury, illness, impairment, or disease sustains the consequence of a covered illness".

MEMBER REDLICH: Oh, I'm sorry.

MEMBER WELCH: Yes.

MEMBER REDLICH: I'm sorry.

MEMBER CASSANO: Okay. Take the word "covered" out and strike the end of it on "the physician's reasoning" or put "to the extent practicable, the physician's reasoning".

MEMBER BODEN: I don't think you can take the word "covered" out because that just says that the physician has diagnosed you with some illness. I mean, it could be the flu that you had last week, right? I mean, it sort of doesn't make any sense in this context.

MEMBER CASSANO: But Part E is any illness anyway. So, under Part E, any illness is covered. So, I would just take out --

MEMBER BODEN: Is that right?

CHAIR MARKOWITZ: So, Dr. Welch?

MEMBER WELCH: I think if you leave the word "covered illness", that means a specific condition that has been established to be caused by toxic exposures. So, I think we might want to try as best we can within this language to separate the medical diagnosis, the diagnosis of a specific medical condition, from the determination of work-relatedness or toxic-relatedness. "Covered illness" puts them both in one phrase.

So, if what we want the physician to provide is documentation that supports the specific diagnosis, the specific medical diagnosis, you could make that, you know, "written medical evidence containing a physician's medical diagnosis for the illness that is claimed", or however. Or just leave it that way. But, in a way, that is what the old language did.

MEMBER CASSANO: Yes, but it just went on and on and on. The old language is "and",

"and", "and". So, they had to provide all of that. It wasn't "or".

MEMBER WELCH: But it is not providing very much, in my opinion. I mean, that is something that the advocates could weigh-in on because they have dealt with that. But it is providing the name and address of the physician who can provide the diagnosis, a medical release for other records, an occupational history, and other things OWCP asks for.

CHAIR MARKOWITZ: Mr. Giblin?

MR. GIBLIN: Yes. Just to clarify, and you can see this in the preamble, this used to be for Part D, which is no longer in existence. And that is why we had all the language that was in there. So, that is why it is being replaced. This is now for establishing a covered illness for Part E. So, I just wanted you to understand what prompted this change.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: If we go back to the definition -- and that's on page 15 -- "covered

illness means, under Part E of the Act relating to exposures, at a DOE facility or a RECA Section 5 facility, an illness or death resulting from exposures to a toxic substance."

So, it has got a slightly different definitive term under these rules than commonly what you would think. "Covered" means you are covered by insurance. This means an illness that will be considered. Now that is my opinion of what it means.

CHAIR MARKOWITZ: So, let me summarize where I think we are at and see if we can direct things. It seems that there is some agreement that the absolute requirement that the claimant produce a physician's report that contains a rationale around causation, aggravation, and attribution, the requirement meaning must produce is excessive, right?

We also seem to agree that, if the treating physician or examining physician can produce such a rationalized report, that that would be useful to the process. And so,

therefore, it should be permitted, perhaps even encouraged, right?

So, we are in agreement about those points, right? Now we just have to come up with language.

(Laughter.)

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Carrie had her hand up first.

CHAIR MARKOWITZ: Yes, Carrie?

MEMBER REDLICH: I guess while we are on this sort of wording, every time it refers to cause or resulting from the toxic exposure, previously, we have been told that that could be a contributing factor and not simply caused by. And so, is that just implied in all the wording every time it is used? All it needs to be is stated once, that that is the implication.

CHAIR MARKOWITZ: Yes. No, I think we should point it out whenever we see it, actually. It would probably be helpful. But I agree with

you.

Okay. So, other comments? I need some specific suggestions now on what we are going to propose around the language, either the new language or the old language, that consensus that I described just now.

MEMBER WHITLEY: I think since it is part of the definition, that you leave the "covered" in there and just say, "written medical evidence containing physician's diagnosis of the employee's covered illness as 30.5", just like it is, and stop.

CHAIR MARKOWITZ: Well, that to me implies that the claimant has to produce a report from a physician that not only gives a diagnosis, but the reason why it is a covered illness. So, it is a backdoor into the issue of causation. And so, that is why. But, if you take out "covered", all you are left with is the doctor just has to produce a diagnosis, period.

MEMBER WHITLEY: That will work.

(Laughter.)

CHAIR MARKOWITZ: George?

MEMBER FRIEDMAN-JIMENEZ: It seems to me that the fundamental problem is that, as I understand it, the process is either a treating physician provides the rationale for causation, and causation meaning cause including exacerbation, aggravation, or contribution, or the CMC provides it. Is that correct? Or am I wrong on that?

CHAIR MARKOWITZ: Yes, the --

MEMBER FRIEDMAN-JIMENEZ: If the treating physician doesn't provide it, who does? The CMC?

CHAIR MARKOWITZ: Or whatever, right. You know, there are various routes.

MEMBER WELCH: It is my understanding there are certain circumstances that the claims examiner can accept a claim without sending it to the CMC, if there is strong evidence and there is a presumption or a procedure that allows that. So, not everything has to have a written physician opinion that summarizes it.

Toxicologists might. The industrial hygienists might.

MEMBER FRIEDMAN-JIMENEZ: Because this paragraph is entitled, "How does a claimant establish that the employee has been diagnosed with a covered illness?" And so, that has to be established somehow. Now you are saying there are three ways, the treating physician or the CMC or the claims examiner, is that right? So, those are the only three ways that it can get established?

CHAIR MARKOWITZ: Well, there may be other ways. But go ahead. Continue making your point.

MEMBER FRIEDMAN-JIMENEZ: So, the best that I can see, using a combination of the previous language and the current proposed language, is to just add in the phrase "to the extent practicable", which they had in the previous language, and use that to sort of soften the requirement. And then, if they can't find a physician that they can produce or is willing to

state that they think that it was a causation, then the CMC or the claims examiner will do it.

But we can't just take it all out, and then, it won't be recommending any way for the claimant to prove that it was caused.

CHAIR MARKOWITZ: So, to say that the claimant must provide to the extent practicable leans on the side of the claimant is expected to produce such a report. I mean, that is the way I would interpret that.

So, I don't think that is the sense of what we are discussing here. I think the sense is that, when it is possible, the claimant may produce -- it will help his case, right? -- may produce such a reasoned report, right, but must produce evidence of the diagnosis? So, the "must" applies to the underlying diagnosis, and the "may" applies to the rationale of the physician that this is occupationally-related, right?

MEMBER CASSANO: So, it might be appropriate, instead of saying, "to the extent

practicable", to say, "and, if possible, a physician's rationale relating the medical condition to a toxic exposure", whatever the language is about substantially affect and causative and aggravated, and all that sort of stuff. And I can work on language, if you like, tonight, with Laurie's permission.

CHAIR MARKOWITZ: But my question is whether we should or are advocating striking the old language as is proposed and, then, tweaking the current language to soften it, so that it is not an absolute requirement, or are we talking about maybe deleting, suggesting deleting the new language and going back to the old language? Because that is like a big dividing line.

MEMBER CASSANO: No.

CHAIR MARKOWITZ: I'm sorry, I said, "A or B?", and you said no.

(Laughter.)

MEMBER WELCH: Do not go back to the old one.

CHAIR MARKOWITZ: You do not want the

old? So, agree with striking the old language. So, the sense is we should tweak the proposed language to soften it, essentially. Let's not do that right now. Vickie, you could do that. And we will, then, appear tomorrow morning with language that reflects that sentiment.

We don't have a proposal to vote on. We don't have the language. So, there is no motion to, there is no proposal to vote on, if I've even got that right.

Okay. We only have a few more minutes, but we have an easy one coming up. So, let's deal with it.

(Laughter.)

CHAIR MARKOWITZ: No, I knew the other ones were hard. So, this is page 39. Let me say this is Section -- it is 39 at the bottom -- it is Section 30.230(d)(2)(3).

And this, by the way, this is not a change, a proposed change by DOL. This is us noticing that there is a phrase which says, quote, "caused or aggravated", end of quote, but

it is missing "contributed". So, this gets back to the point that Dr. Redlich was raising.

MEMBER REDLICH: Consistency.

CHAIR MARKOWITZ: Yes. Okay. So, the proposal is -- now this is not a proposed change by DOL. So, this is us adding our two cents to the process, and I don't know where that fits into the NPRM, but here it is.

(Laughter.)

CHAIR MARKOWITZ: By the way, I should say that this is relevant to the Board's scope because it addresses A and B, which relates to really causation and aggravation and contribution to a work-related illness.

So, I'm reading. "The Board notes the phrase `an opinion of a qualified physician's expertise in treating, diagnosing, and researching the illness claimed to be caused or aggravated by the alleged exposure' and differs from a phrase, actually, about 10 lines, which was, quote, "was a significant factor in aggravating, contributing to, or causing the

illness". End of quote. And it should be made consistent with that language.

So, we don't have to go through the subcommittees here because we all agreed on this one. But any comments on this?

(No response.)

CHAIR MARKOWITZ: Okay. So, do I have a motion?

MEMBER VLIEGER: So moved.

CHAIR MARKOWITZ: Okay. Second?

(Seconded.)

CHAIR MARKOWITZ: Okay. Any discussion?

(No response.)

CHAIR MARKOWITZ: Okay. All those in favor of this raise your hand.

(Show of hands.)

CHAIR MARKOWITZ: All those opposed? And any abstentions?

Okay. So, we need to break at five of 5:00. I recommend that, just for a few minutes before the public comment period, I do think we

should, however, start the next one because we are short of time tomorrow.

So, let me point this out. This is on page 54. It has to do with the requirements about changing physicians. Okay, I'm sorry, it is page 55. It is Section 30.405, Item (b) and (c).

If you could bring that up? And, Tori, if you could read this?

MEMBER CASSANO: Oh, I'm sorry, I forgot my job. So, both sections at the same time, (b) and (c)?

CHAIR MARKOWITZ: Yes.

MEMBER CASSANO: Okay. "After selecting a treating physician, may an employee choose to be treated by another physician instead?"

Item (b) says, "OWCP will approve the request if it determines that the reasons submitted are" -- cross out "sufficient"; add "credible" -- "and supported by probative factual and/or medical evidence, as appropriate.

Requests that are often approved include those for transfer of care from a general practitioner to a physician who specializes in treating the occupational illness or covered illness, covered by EEOICPA, or the need for a new physician when an employee has moved."

And (c), strike out "If a claimant disagrees with the decision of...," and "then OWCP" -- this is not going to make any sense -- strike out that -- "insufficient reasons for...." Basically, it says OWCP may deny the requested change of physician if it determines that the reasons submitted are not both credible and supported by probative evidence.

"If a claimant disagrees with such an informal denial, he or she may utilize the adjudicatory process described in Subpart (d) of this part."

CHAIR MARKOWITZ: And that last paragraph that she read was the new proposed language, to make it clear.

MEMBER CASSANO: Right.

CHAIR MARKOWITZ: Can we hear from the subcommittees first?

Mark, do you want to go first?

MEMBER GRIFFON: Sure. Subpart (b), we basically said that the new language we didn't think clarified or further added anything to the original phrase. This notion of medical evidence seemed like an implausible requirement.

And for Section (c), we said it seemed okay. The change, the proposed changes seemed okay.

CHAIR MARKOWITZ: Laurie?

MEMBER WELCH: We pretty much agreed with what Mark said. We couldn't understand what would be medical evidence, factual medical evidence that would support the change of a physician. And all the physicians couldn't figure out what that was talking about.

(Laughter.)

MEMBER WELCH: So, it really doesn't make any sense. We would go back to the old language in (b) and, also, take out that

"credible and supported by probative evidence" in (c).

(c) sort of repeats (b), except that it says the claimant has the right to appeal the decision or disagree with the decision using the adjudicatory process. So, I don't think it is necessary to insert that new language. I would go back to the old (c), just to be able to get rid of the probative evidence.

We think that the claimants should be able to change physicians if they don't like the physician they are being treated with, and that is not probative evidence. They just might want to see somebody else. I think it is within OWCP's authority probably to limit the number of times that happens without having to write it into the statute.

MEMBER SILVER: Our group did not like the phrase "credible and supported by probative" in (c), vague and unnecessary. Overall, too much emphasis on medical necessity while lacking specificity.

Further suggestion that there should be a specified period of time within which OWCP approves or denies the request, say two weeks from receipt. Otherwise, it is considered approved.

And special concern about changing oncologists. Imagine that.

CHAIR MARKOWITZ: So, let me just address a point that I forgot to address, which was how is this issue relevant to our mandate. The past (b) and (c) for us relate to the collection and use of medical evidence in either establishing claims or related to Subpart B or Subpart E.

And the issue of which physician that the claimant uses has to do with who they go to for evidence of either consequential illness or issues of impairment. And so, there is some relation, I think, to the scope of what we have been asked to do.

Okay. Let me lead and, then, we are going to stop for a break and continue tomorrow.

But let me read draft language that reflects the sentiment of the various subcommittees.

"The Board notes that the added language does not clarify what the claimants need to produce and finds it implausible that claimants can provide medical or factual evidence in support of a request to change physicians. The Board recommends that claimants be permitted to change physicians without requesting permission from OWCP."

So, that is a clear statement, and then, whether people divulge from that or from that statement, we can discuss tomorrow. Okay?

So, let me call for a break now. And then, we will reconvene just a minute before 5:00 because, then, we have got to start the public comment period. Thank you.

(Whereupon, the above-entitled matter went off the record at 4:56 p.m. and resumed at 5:02 p.m.)

CHAIR MARKOWITZ: Thank you. We will now begin the public comment section. We have

eight speakers, all of whom are here in person. So, there are none on the phone who will be speaking.

Almost all of our time has been requested, actually. So, I don't think we are going to have any extra time to accommodate additional speakers.

Apparently, I have to turn it over to the moderator now. So, can Terrie Barrie come forward?

MS. BARRIE: Thank you. Thank you again for giving me time to make a few comments tonight to the Board. I have to commend you. Your work so far is astounding, and I thank you for this.

One thing I would like to remind you, especially for the people who aren't very familiar with this program, Congress enacted this program to take the burden of proof off the claimants. Okay? The records aren't there. There needs to be some kind of assumption that they were exposed to the toxic soup I mentioned

yesterday.

I have four more remarks here. This is just kind of bringing up things I noticed between yesterday and today.

Probative evidence -- nope, I'm sorry. There was a discussion about the development of claims by the claims examiners and that the claims examiners, if the claimant doesn't provide medical evidence, that the claims examiner will help the claimant develop the medical evidence or whatever is needed to support the claim.

In the regulations today, it does say that each and every criteria must be met by the claimant and be provided by the claimant for the claim to be processed, basically. So, I am not sure how that fits with what was said today. I have never heard -- and you could probably poll the Authorized Reps who are here today -- of claims examiners actually calling the claimant and saying, "We need this piece of paper" or "We need that." They might say, "You don't have sufficient evidence," but I don't think they are

very specific on, "Well, you need to get me this test for your heart disease or you PFT." But, like I said, check with the other ones.

We heard a lot yesterday and today about the weight given to the personal physicians' reports. I think yesterday it was said that the wage loss claims, the Department of Labor actually relies on the personal physician since they know how much they can work and, you know, they actually do the physical evaluation.

I know of two instances of wage loss claims where the personal physician's letter, whether it was well-rationalized or not, one was actually rejected outright. And the other one was completely ignored. It was never given any weight whatsoever. And, you know, both of those claims have been denied.

So, maybe what you heard is what the ideal is, but when it translates down to the individual CEs, that is not always what is happening. So, I am hopeful that when the Board gets a chance to take a review of some of these

claims, they can audit that or check it out to see if it is prevalent, if it is common, or if these two claims were unique.

This also applies when it comes to personal physicians. I was really happy when somebody talked about having a template for the personal physicians to follow, because they are not familiar with the program. It saves a lot of time for them if they know what the Department of Labor requires.

Well, this has been tried by -- and please don't think that I am a front for the home healthcare people -- but this was tried by home healthcare agencies. They knew what the Department of Labor requires to approve home healthcare, and they developed a letter. It has been circulated for other physicians to use.

I didn't see that as a bad thing. I mean, as long as the information provided by the physician is true and accurate, there is nothing wrong with that. But the Department of Labor, there was a big fuss about that during our Denver

meeting. So, they didn't seem to be very appreciative of having the same type of letter submitted from different doctors from across the country.

But that doesn't mean that those letters are fraudulent. Okay? It is just an easy way to get the necessary care to these workers.

And when it comes to home healthcare, like I said, I am not a front. I don't get paid by them. I work with every person who tries to help the workers.

The reason you need home healthcare, I am going to read you just a short email I got from a spouse. It says, "Sorry, I did not get you the facts last night. It was a downhill day. I had to bathe, shave, and dress my husband. He fell on me. He pinned me between the floor, sofa, and coffee table."

Now, if this worker had home healthcare because of a covered disease -- and, apparently, he did not -- there would have been

someone there to help the spouse. Okay.

All medical things that the worker needs is covered by this program and needs to be given to the workers who are covered.

And I think that is all I have for tonight. Again, I thank you very much.

CHAIR MARKOWITZ: Thank you.

Next will be Deb Jerison who has requested 10 minutes.

As we are approaching the time limit, I may -- I haven't done this so far -- but I may just give you a little bit of notice.

MS. JERISON: Please do.

I had two things I wanted to speak to today. I'm really glad that you are taking a look at Final Circular 1505. I'm not going to get into it in a lot of detail, but I did have some information I had come up with that I thought could be useful. I will leave the full report.

But the average compensation paid to each worker before Final Circular 1505 came out,

I think it was December of 2014, the average compensation was $157,861. Now there was only eight months of data I had after that document was released or the Circular came out, but the average compensation that was paid to each worker after the Circular came out was $17,743. Seventy-two percent of the cases were approved before Final Circular 1505 was released. Sixty-five percent were approved after the release of it.

Final Circular 1505 only has 57 jobs that are covered in that Circular. Before that, there were 123 jobs with approved claims before that. Those jobs were self-reported, so there could be some discrepancies there.

But I also wanted to speak a little bit about the rules and some of the changes, if I can get to the right version. I was really happy that you're getting a chance to review the rules and you are doing a great job. The discussion was really interesting to listen to.

I think there may be more time that is

needed than doing it before early May. A lot of the implications of these changes aren't immediately obvious, and it will take a lot of work to truly understand how the changes will impact the sick workers. I encourage you to talk to advocates, if you need any on-the-ground kind of information.

EECAP has already made several detailed public comments on the rules changes, but here is some additional information on several sections.

Section 30.5(x) restricts the definition of who is eligible for EEOICPA by removing workers who provided delivery and removal of goods from the premises of a DOE facility. A look at previous claims shows that around 1,080 claims filed for people delivering or removing goods have been adjudicated, with 347 of those claims being approved and 589 being denied. These previously-approved claims have paid $77,739,510 in compensation and $14,058,821 in medical benefits to these sick workers. It

seems arbitrary and capricious to restrict eligibilities for workers transporting goods so late in the program's history.

Then, 30.205 and 30.206 redefine who is covered for beryllium claims by removing the phase "or a facility owned, operated, or occupied by a beryllium vendor", unquote, and changing it to "a facility owned and operated by a beryllium vendor".

A review of the current beryllium vendors shows this wording would remove 80 percent of them from EEOICPA. Of the current 75 beryllium vendor sites, only 15 of them are a facility owned and operated by a beryllium vendor.

30.230 and 30.5(w) offer different dates, August 13th and January 1st, 1942, to be used as the earliest any claimant can claim coverage under EEOICPA. The Einstein-Szilard letter to President Roosevelt recommending the U.S. begin the nuclear program was dated August 2nd, 1939. According to DOE's Manhattan District

history, Book 1, Volume 1, a memo dated February 20th, 1940, discussed the first transfer of funds for the Manhattan Project. I suggest either of these dates would be better than DOL's suggested dates if it is appropriate to dictate a start date to eligibility.

In reviewing the data, there have been 251 claims filed with Employment between January 1939 and August 1942. Of those claims, 124 were approved and 96 were denied. Setting a 1942 employment start date is inequitable for the claimants with work in the early years who haven't filed claims yet.

Just a mention on Section 30.231. I would just like to note that I provided district offices specific DOE document proving exposure for claims, and these have always been considered irrelevant and non-probative by the CEs.

30.232(b) requires a fully-rationalized medical report. We got into this quite a bit. Doctors who have written these reports say that such a report takes between six

and ten hours to write. Sometimes that is with grad students. However, most doctors don't have the experience, let alone the time, to provide a report that meets the EEOIC's requirements. This means many valid claims are denied. This is a major stumbling block for most claimants, and the CMC reports just don't always stack up, either.

EECAP investigated Parkinson's disease claims from June 27th, 2006 through February 2014, and found that no personal physicians' reports led to any claims approval. In October 2014, DEEOIC finally approved one Parkinson's claim based on a non-DOL physician's letter, and that is the one that took grad students. This claim is especially interesting because DEEOIC had previously denied it numerous times based on CMC reports. It took 10 years.

The first report came from a Dr. Hunt in 2008. Two reports, then, came from a Dr. Orgel. One in 2013 came from a Dr. Gresh. Between the letters from Dr. Orgel and Dr. Gresh, an independent physician that the claimant had to

pay to do the letter provided a report recommending the claim be approved, which DEEOIC found not probative enough, partly because of spelling and cut-and-paste errors. Unlike the letter from Dr. Orgel, the claims examiner did not ask this doctor for a clarification. In many ways, this letter was more detailed than the CMC reports.

DOL's document recommendation proposed changes not within the scope of the Advisory Board discusses changes in Section 30.70 to 30.726. And OWCP states that these changes are being made to conform to the existing FECA regulatory schemes.

EEOICPA and FECA are very different programs. EEOICPA is a remedial statute and must be interpreted more liberally than FECA, which is not remedial. While I know it is a pain for OWCP to have to administer these two programs differently, it is improper to cut claimants' benefits and increase the claimants' burden of proof for their administrative convenience.

Also, Section 30.805 increases the sick worker's burden of proof for wage loss and adds a threat of discontinuing the claim when a person cannot meet any step. As of July 2015, only 1,210 wage loss claims have been paid. So, I even wonder why this change would be necessary.

CHAIR MARKOWITZ: I'm sorry, one more minute, if you would.

MS. JERISON: I'm sorry?

CHAIR MARKOWITZ: One more minute, if you would.

MS. JERISON: Okay. For additional comments on EECAP's proposed rules changes, you can check the Radioactive Daughter Blog.

Thank you.

CHAIR MARKOWITZ: Thank you.

Next we will hear from Ms. Stephanie Carroll, who has requested 10 minutes.

MS. CARROLL: Thank you.

It was hard to prepare for this because I had so many different things I wanted to make comments on today.

But what I would like to say is this program was intended to be fair and equitable, and the claims should have a uniform application of the law.

CHAIR MARKOWITZ: Hand it to her.

MS. CARROLL: Okay. Hello. Okay.

Anyway, it was intended to have a uniform application of the law.

I also believe, because I am a specialist in chronic beryllium disease, that Congress intended for the program to establish chronic beryllium disease, to establish beryllium sensitivity. Beryllium sensitization is established by one abnormal beryllium blood test or a lavage showing a positive response. That is not the current medical diagnostic criteria. You could not get a doctor to say that someone has a diagnosis of beryllium sensitization with one beryllium blood test.

Beryllium sensitization is a beryllium illness under the program, along with chronic beryllium disease and any other illnesses that

are consequential to those first two illnesses. So, they should be looked at the same. They are kind of put together in the Act.

So, what is happening now is a huge change in the program when it comes to chronic beryllium disease. Now it looks like, page 32 of the new rules, they are asking for -- well, let me just tell you what is happening, once I look at my notes. I can't even think.

Anyway, as it used to be and what I thought that Congress demanded was, yes, medical evidence is needed to establish CBD, medical evidence being a pulmonary function test showing obstruction and, yes, I agree, a physician should weigh-in on if there is obstruction found on a pulmonary function test. But I don't think any physician can write a well-rationalized medical report describing how they came to the conclusion that this person meets the current diagnostic criteria, medical diagnostic criteria, for chronic beryllium disease. And that is what is being asked.

A physician cannot write that if they are going by current medical diagnostic criteria. The only way you can establish chronic beryllium disease is to see if they meet the medical requirements. You know, they have got specific findings on CT. That's okay to have a doctor review the CT exam and see if there are granulomas found, honeycombing, ground glass, any other number of other things that are listed in the Procedure Manual.

If a physician finds those, well, has findings of those criteria, of course, it would be on the report. So, there is your weighing-in of the medical professionals.

But it is up to the claims examiners, and they have it in the Procedure Manual, the list of criteria that they have to meet to establish chronic beryllium disease. And this isn't happening right now.

I literally am one of the only people that gets chronic beryllium disease approved in this program. Now, if you want data, this is

what you ask for. You ask for the V81.4 Diagnostic Code. That is beryllium sensitization, and that starts our poor beryllium workers on this journey of being monitored for beryllium sensitization and getting an enormous amount of invasive diagnostic tests that never actually meet the current medical diagnostic requirements to establish CBD.

So, people are not getting diagnosed with CBD anymore, since about 2006. So, lots of beryllium sensitization, so the stats will look like you have got a lot of people being approved under Part B for beryllium. No, not for chronic beryllium disease.

Now, when it looks like people aren't being diagnosed with CBD, people onsite may assume, oh, some of these safety measures might be working now because nobody is getting diagnosed anymore. There's 300 people sensitized at Rocky Flats. There has probably been 80 people approved under the program. And when you are sensitized, Lee Newman said in 1992,

sensitization is preclinical chronic beryllium disease. You have the illness when you are sensitized.

So, my workers are going through this monitoring, and they are getting yearly or every-other-year CT scans, PFTs, chest x-rays, exercise tests, no matter how sick they are, and they always qualify for a lavage biopsy, always. It doesn't matter what the tests say or what their health issues are. And they continue to not get diagnosed.

Now I'm so worried about the fact that even I may not be able to get people diagnosed anymore, because what is going to happen is they are now asking for, even if a doctor says the CT scan is consistent with CBD, I was just told they are not going to accept that, even though it is mandated; it is in the law that they should accept that statement. Now they are going to want a well-rationalized letter to explain how this doctor came up with that statement. And that is outrageous, and I'm telling you, nobody

else is getting people approved for this illness.

This Act came about, first and foremost, for chronic beryllium disease. This is what drove this Act, and it is being ignored and nobody is getting diagnosed. And it is very sad. People beryllium sensitized, never smoked, have pulmonary fibrosis, positive B-reads, findings on CT scans that are consistent with CBD, obstruction. They are on oxygen 24 hours a day, and they are not getting even a statement that says that their clinical findings are consistent with CBD.

But they are contributing a lot of their specimens to research. So, that is, I guess, one of the good things to come out of this, if you can call is that.

So, I really want to stress that the beryllium disease issue needs to be covered. And the rule on page 32 actually says -- it has always been if you were treated, tested, or diagnosed with a chronic respiratory disorder, you would fit into the pre-1993 CBD.

Arbitrarily, about a year-and-a-half ago, the program decided to get rid of -- not test it anymore. You got treated or diagnosed with a chronic respiratory disorder. And then, they decided you had to be diagnosed and have long-term treatment for a chronic respiratory disorder prior to 1993.

These arbitrary new policies really affect people's ability to get approved and get recognition for an occupational illness they are suffering from. Now it looks like you are going to have a chronic respiratory disorder, No. 2 on page 32, "If the earliest dated medical evidence shows that the employee was either treated for or diagnosed" -- we got "tested" out of there -- with a chronic respiratory disorder on or after 1993, "the criteria set forth of this section must be used." So now, you have to have a chronic respiratory disorder before you can even use post-1993 CBD criteria? I don't know where that came from.

So, well, I wish you all had more

time. I think it is absolutely outrageous and un-American to not allow this Board to have more time to look at these rules. I think it is just outrageous.

CHAIR MARKOWITZ: I'm sorry, one more minute.

MS. CARROLL: Yes. I am just so pleased that you are here, and you give me hope. So, thank you very much.

CHAIR MARKOWITZ: Thank you.

So, I would like to welcome Jeanne Cisco. Ms. Cisco has requested 10 minutes.

Welcome, Jeanne.

MS. CISCO: Thank you. Hi.

Is it on?

I'm Jeanne Cisco from Portsmouth. I've worked at a gaseous diffusion plant for over 41 years, and I am here to talk to you about the SEM and some of the things collectively that the Worker Health Protection Program Coordinators came up with that we would like to have you look up.

We think that the Department of Labor needs to have transparency when chemicals and other items are added or removed from the SEM, as well as an auditing process of the addition and deletion to the SEM, with the rationale and documentation used to justify the action.

At Portsmouth, I submitted probably -- I don't know -- thousands of chemicals in 2011. Many claims were processed up to that point, but very few chemicals were on the SEM there. We got the list of MSDS sheets from the current contractor in 2011 and submitted those.

The Department of Labor came back. They said they needed to know where they were at, what buildings and departments, in order to put them in. To make a long story short, I worked with the Department of Labor for over a year trying to get those chemicals added to the SEM, and I got a statement from the contractor to prove that those chemicals -- it is difficult for the Department of Labor to put into that SEM the chemicals in what building and what department

because the processes are not identified -- okay? -- well enough. And I heard today they don't have those resources. I heard the Department of Labor say that.

That is essential for someone who is filing a claim to get the right -- well, for one, we were never monitored for chemical exposures at Portsmouth ever. Okay? So, how could they tell the frequency, duration, all those things on exposures, and then, the Department of Labor has to use the SEM that does not describe the work processes and the many classifications that go into these chemicals. That's impossible for anyone to do that with what they are doing today.

I just think that I was involved in the beginning, when this program started, when they came to Portsmouth and they asked on the different processes. And I can remember looking at the retirees answering the questions on radiation, and I'm thinking chemicals. But, you know, they never told us the chemicals. We did not have a need to know.

We now at Portsmouth at a list of MSDS sheets. Not all of those were added. Some have been removed. They are not assigned to the proper classifications. I have a letter from the plant that I submitted and did not get a response on, and it basically states what I'm telling you. All classifications worked in buildings together around those chemicals, and my guess is it's that way throughout the industry.

One thing that concerned me today that I heard is that you're thinking about presumption and you're going to use scientific research on the chemicals. And to try to help this process along, I want you to understand that in the nuclear industry you can't use typical other scientific facts. You need to know what we did and the specific chemicals and things that we had to use.

Now DOE does not release everything; they can't for national security, but there are ways to find out those things. You can get on the Manhattan Project website. They release

important things daily or often. They just released on nickel dust that is not in our SEM. It should be in there. It wouldn't be hard to win a COPD claim if that was in our SEM, and probably throughout the industry.

So, the Coordinators felt that, when you add something or delete something, we should know what it is and why. And when we propose to add something to it like our independent investigations by NIOSH -- Ken spoke today on some language that you're starting to write there or suggest. The Department of Labor should accept those types of reports. They are done by NIOSH. They are done by OSHA. They are done by credible agencies that describe the processes in these plants.

We have Site Profiles. Okay? That was come up with to help for Subtitle B. And they could use those. There's a lot of information in those on the processes and the chemicals.

Okay. Several of the reviews that I

have read have suggested that the Department of Labor incorporate other databases. All of that should be done, in my opinion.

Like I said, the processes, my coworker will cover that a little better.

Once you even submit into the SEM the chemicals, they never get to the classification because there is the break. You've got the processes and the classifications, and many worked in this, and the SEM doesn't capture that. So, you have got your work cut out for you.

I think that the Department of Labor would welcome any and all information that they could get. DOE has a Computerized Accident Injury Reporting System, CAIRS I think, that was mentioned today.

You have many people at these sites that would help in any way we can to help make this better for the sick people. Something that bothered me is that they did not go back prior to 2011 and review the people whose claims went through. If there's any changes, I think that

that needs to be looked at and made retroactive back to any improvements to the program.

I think another area was medical guidance for the claims examiners.

CHAIR MARKOWITZ: One second. One more minute. Okay?

MS. CISCO: One minute?

CHAIR MARKOWITZ: Yes.

MS. CISCO: Okay. Medical guidance for the claims examiners; health physics people, they only had two across all of the DOE complexes. So, how many claims went there? They didn't.

I can't do this under pressure. I'll submit more later.

CHAIR MARKOWITZ: Okay.

MS. CISCO: The health physicists I don't think were used, District Medical Consultants. Usually, the Former Worker Program medical reports and a personal physician's report that uses the proper language of cause, contributed to, or aggravated, that was spelled

out. That's ignored and it is sent to the CMC, and then, they make a ruling.

CHAIR MARKOWITZ: So, thank you.

I might add that there is another public comment period tomorrow, and there may be time on the schedule if you want to cover additional points, just so you know.

Thank you.

Next is Paige Gibson who has requested five minutes.

MS. GIBSON: As he stated, my name is Paige Gibson. I worked at the Mound Miamisburg Plant for 13 years. My father worked there for 23 years.

While I was at Mound, I was a decon B worker. I was the Health and Safety Rep for the Union, and I taught HAZWOPER. I am currently a nurse and a Coordinator for the WHPP program, and, proudly, a worker advocate.

As Jeanne stated, I am going to cover some other points that the Coordinators were concerned about and that we're facing every day

out there.

First of all, there should be user-friendly published guidelines on what happens during the claim process. From my understanding today and from other issues, the claims examiners are gods in the process of a person's claim. This person who has a high school education and two months of in-house training is making medical decisions and denying or agreeing with a claimant.

When they say that we have to have or we should have a doctor's diagnosis on a covered condition, it is you have to. The claims examiner will tell you, "You have to supply me with more likely than not." The explanation is a bonus, if you can get a doctor to do that. But sending a template with my workers to the doctors that says, "Please have your doctor say that you are more likely than not got this disease because you were exposed to toxins at Mound," or at GE, or one of the subcontractors in my area, the doctors don't have a clue what is at Mound. We,

as workers, didn't have a clue until recently.

Mound is closed, and they have access to me or to a reading room that gives them access to the exposures, because the majority of them don't use the computer. They haven't, unless you walk them step by step, they don't use computers. So, you have to provide that for them.

When you talk to them to get your claim going in your regional office -- Portsmouth would be ours -- the job classification, I don't exist according to DOL. There is no such thing as a decontamination worker B. And then, I became a demolition technician. I didn't exist at Mound. So, I don't have a record.

And I love the fact that DOE is working with DOL now to get our records. There is a problem with that, though. Our incident records aren't there. They for Mound were buried. For others, they just were destroyed and never made it into our files. Our exposures aren't there.

So, if they don't exist and DOL is not

recognizing my affidavit or other workers' affidavits, how are they going to know? And that is the crux of those affidavits. All along, up until yesterday, I thought they were great. I knew that on the worker's occupational history that was taken that you could put down dead people because they didn't call them. The claims examiners never called them to get any more information.

So, I submitted affidavits, thinking that these would hold value, and they don't. They are ignored because they aren't proven by DOE records which don't exist. It's a quandary that every worker advocate faces out there.

Job classifications don't exist. We don't have doctors who are willing to get involved or have the experience or knowledge of these sites.

I tell my workers, when they go to get their letter, there's three things. It is not tell your doctor. It is not workman's comp. It's not a lawsuit. And nobody will call them.

Just sign the letter. And we get letters. And it is a shame that you have to tell a doctor that, but I understand the process of lawsuits and whatnot.

Another big concern across the nation, not just at Mound, unless there is an SEC in place, is that somehow DOE decided that January 1st, 1980, all sites became safe. I process hundreds of claims, either as an Authorized Rep or as just helping or as a witness, and 1980 is the cutoff date. I can't figure out why. It is through Circular 1506 that it is mentioned. There is mention of 1995 and the Tiger Teams coming into place.

A real quick story about Tiger Teams. The first six months I was at Mound, they said, "Tiger Team is coming. Overtime." Great. So, our bosses would take us around to buildings and labs and say, "Everything in there in the dumpster." It was a brand-new camera still in the box. "Hey, if you're throwing this away, can I have it?" "No, no, throw it away. Throw it

away."

Chemicals that were stacked high, throw them away. One jug, that's it. Throw them away. And I could never understand why, until later, that we don't want the Tiger Team to have find you, and then, the contractor has to pay. It wasn't a surprise like OSHA shows up. Tiger Team let the company know, "We're coming." So, all these things disappeared.

CHAIR MARKOWITZ: Excuse me. One more minute.

MS. GIBSON: Okay. Just to state that the 1980 date is very important. In the 1980s is when Reagan took over; Star Wars was big, and there was a boon in hiring in the DOE complex. The effect on thousands and thousands of people not being process through the claims because they started after that date has got to be changed.

Exposures happened after that date, accidents, and people are sick. And those dates and the job classifications have to be changed.

I thank you. I think you guys are

doing a wonderful job. You've jumped off running at this Board, and I appreciate your work. Thank you.

CHAIR MARKOWITZ: Thank you.

Next we'll hear from Donna Hand, who has requested five minutes.

MS. HAND: Okay. In the very beginning, we were talking about weighing medical evidence and the physicians had to have a definitive everything. Again, I remember we go back to the statute and the regulations, and it says it is not that high of a standard. Congressional intent and findings have stated you're not going that high of a standard; there's not medical certainty.

So, that "maybe", "probability", you know "plausible", those wordings can be used by the physicians and should still be accepted underneath this program, because that still fits that standard that Congress in the statute and in the regulations, at the Secretary's discretion in 2006, used. So, that part there.

Also, the case examiners, they write what they call a Statement of Accepted Facts. The Statement of Accepted Facts is, then, being sent to the contract medical consultants, along with the specific questions, not general questions, specific questions.

With that Statement of Accepted Facts, they said, "We have accepted their employment. We have accepted the exposure here. We have accepted the medical evidence."

Why can't these Statements of Accepted Facts also be sent to the treating physician? Also, why can't that standard of aggravating, contributing, causing also be sent, along with the definitions that are used to the treating physician? That would help explain a little bit more of, oh, yes, I can say that. I can't say with medical certainty because that is really what causation is. I can't say. I don't know what specific chemical it was.

But if all I have to say, was it plausible, yes, I can do that. You have already

determined he was exposed to this chemical, this chemical, and this chemical. And I know that that chemical does it. Yes, I can say that then.

But that is not what is done. In other words, the treating physician sees the medical part, the diagnostic, you know, the pulmonary function test, the lab work. You know, they see that.

The contract medical consultants just see what the Department of Labor has sent to them, which is we have accepted this medical condition. How much of it, you know, they don't know. So, was it a progressive disease? Was it slowly? Was it mild at first and, then, severe now? They didn't see any of that.

So, why can't that Statement of Accepted Facts, which whether the CMC agrees with or not, they still have to accept it, everything, be sent to both the treating physician, instead of a verbal phone call and say, "Hey, we don't understand. This is our issue. But this is what we have accepted. This is the criteria of our

program. Can you give us an opinion now?"

Again, the statute did state that the Secretary can use physicians to help determine Part E. However, those physicians are to be experts in treating or researching in that particular issue. So, it is just pulmonology, or whatever. So, if you are not treating it, you are not researching it, you are not writing it, you're really not considered an expert to the Secretary. Really, it wobbles down to the final decision, no matter what, is the Secretary's decision, which is, again, the DEEOIC.

Again, experts can only issue opinions within their own field. So, if you are an IH, you can only address, you know, whatever IH can address. They cannot address the medical. They can't address the legal. A medical can't address the legal. So, you can do it as a personal opinion, but you can't do it as an expert opinion.

Interpretative questions, you know, and administrative questions and legal questions,

it all comes down to specifically Part B, chronic beryllium disease. It is established.

And in the very beginning of the program, since 2004, they have said that the pre-1993, you can use that if it was treated for, tested for, or diagnosed with a chronic respiratory condition before 1993. Then, you use that criteria.

However, the chest x-rays, the pulmonary function tests can all be after that. And they have issued decisions of that. So, you can have a pulmonary function test from work showing a mild obstruction. Okay, that meets the pre-1993 criteria. Then, you can have the chest x-ray in 2000. You can the rest of it, the other two criteria. So, you can have all the three criterias later on. It doesn't have to.

And there have been several, several decisions from 2004 on doing that. Then, all of a sudden, in September of 2015, they changed their policy.

And the skin patch test, I agree we

need to have more non-invasive tests to do chronic beryllium disease. The skin patch test is being done for people that have exposure to hip replacements. The Mayo Clinic, Johns Hopkins, and several of them, have done the metal testing for the hip replacements, and they did it with a skin patch test. And it is more accurate than the allergic patch test where you do the prick on the back, everything. So, why isn't there something like that for beryllium?

Again, the main thing is the reports. Like I've used chronic -- the Collaborative on Health and the Environment.

CHAIR MARKOWITZ: One more minute.

MS. HAND: Okay. And in that report, you know, it says the causes for COPD, and it has strong and it has good and it has limited. This evidence has been turned down. I've established that, well, this is proof that there has been peer-reviewed studies, but they won't accept it.

There are other languages, you know, and the World Health Organization has defined

chronic respiratory diseases and lists allergic rhinitis as a chronic respiratory disease. They won't accept that.

I've listed -- in the DMC Handbook, OWCP has a list of reference materials that they approved for their contract medical consultants to use. I've used those same reference materials. They said, "No. Won't use them. Won't accept them."

So, again, thank you so much, and discuss more tomorrow.

CHAIR MARKOWITZ: Okay. Thank you very much.

Tim Larew, who has requested three minutes.

MR. LAREW: Thank you, Dr. Markowitz.

My name is Tim Larew. I serve as Chairperson for Cold War Patriots, a national association of more than 36,000 former and current nuclear complex workers and their families, as well as miners, millers, and transporters. Our mission at Cold War Patriots

is to connect the men and women of our nuclear complex and their families to the information and resources they may need if they suffered a work-related illness, and honor them for their sacrifice and their service.

The enactment of this Advisory Board has been a long-time legislative goal of our organization, and we are encouraged by your efforts on behalf of the worker community that you have begun here in our nation's capital this week.

Over the past several years, I have had the privilege of meeting the several thousand former nuclear complex workers and hundreds of EEOICPA claimants that have been approved and hundreds more that have been denied.

The message I convey to you on their behalf today is this: any nuclear complex worker would gladly forego the compensation and medical benefits provided by EEOICPA if they could simply be restored to good health. Since this is not possible, these sick former workers do ask that

the intent of the law to provide compassionate compensation and medical benefits in a timely manner be respected and honored by all those entrusted with faithful administration of the Act.

You on this Board will now play a very significant role as you apply your individual skills and experiences in fulfilling the promise of EEOICPA. Cold War Patriots welcomes the good work you are now undertaking, and we will support you fully in your important mission.

Thank you.

CHAIR MARKOWITZ: Thank you.

Next, actually, our last speaker is going to be Mr. Hugh Stephens, who has requested five minutes.

MR. STEPHENS: Thank you, Dr. Markowitz.

I just wanted to say a few words about causation. We have been talking about causation in the program. One thing I want to say is, first of all, the normal causation standard,

preponderance of the evidence, is applicable in the program for most things; if you need to supply a birth certificate to show that you are a survivor, for example.

So, the preponderance of the evidence is the typical standard and it is at work within the program. I think, under Part B and E, the idea is that we need a reduced standard, the 50/50 standard, the tie-goes-to-the-runner standard, because of the lack of evidence and the difficulty that you run into determining whether radiation caused your cancer or whether your exposure to occupational hazardous substances in your occupation caused your illness.

And so, when you look at causation under Part B, we have the 50/50 standard. And so, under Part B, if the dose reconstruction shows that radiation is at least as likely as not to have caused your cancer, then you are paid.

The causation standard under Part E that we have talked a lot about includes contribution and aggravation, and so, is a

further reduced standard. And it is a more typical standard that you run into in the workers' compensation context, the idea being that workers should be compensated more liberally probably than in the civil litigation system. And so, I think we can all agree that Part E is a reduced standard.

But, when it comes to radiation and whether it is considered under Part E as a potential hazardous substance causing, contributing to, or aggravating a cancer or another illness -- and I think there is increasing evidence that radiation can cause, can be a contributing cause of both malignancies and other types of illnesses or conditions. And we have been able to have at least one claim approved where radiation was identified, in addition to asbestos, as potentially contributing to a claim for cancer.

And so, I think this is becoming more important. And what I would like to throw out there as just the idea is, when they determine

that radiation is at least as likely as not, and that is defined as causing your cancer or enough to consider it to have caused your cancer, the problem is they are also in this program treating that same evidence, the fact that you did not reach the 50-percent threshold in the dose reconstruction, as meaning that radiation did not contribute to or aggravate, primarily contribute to.

And I think there is within the program this conflation of the idea of contribution into causation, because I think there is a sense that, if it doesn't cause it, how can it contribute to it?

But we know that there are contributory portions of the process. I think we are understanding the process of how cancer comes about better and how radiation might play a role in the many steps leading up to cancer.

And so, one thing we can consider is maybe for my clients I would prefer that the threshold be 1 percent. If you have 1 percent

probability of causation, you ought to get paid under Part E, even though you fail under Part B.

For the Department of Labor, who knows what it is? But somewhere between 1 percent and 49.9 percent, we might have -- there is a reduced standard. And so, under Part E, we should consider at what point with significant radioactive radiation exposure acknowledged in the dose reconstruction, when could it be considered to have contributed?

With that, I will let everybody go home. Thank you very much. I appreciate all your work.

CHAIR MARKOWITZ: Thank you.

And this concludes our public comment session. It also concludes day two. We will meet tomorrow morning at 8:30. Thank you.

(Whereupon, the above-entitled matter went off the record at 6:01 p.m.)

Q

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Meeting of the Advisory Board on Toxic Substances and Worker Health

Before: US DOL

Date: 04-27-16

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter