U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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WEDNESDAY
APRIL 24, 2019

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The Board convened in the Lamar Ballroom at the Augusta Marriott at the Convention Center located at 2 Tenth Street, Augusta, Georgia, at 8:30 a.m. Eastern Daylight Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN DEMENT
GEORGE FRIEDMAN-JIMENEZ
MAREK MIKULSKI
KENNETH SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
STEVEN MARKOWITZ, Chair
CARRIE REDLICH

CLAIMANT COMMUNITY

KIRK DOMINA
RON MAHS
DURONDA POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

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

MR. FITZGERALD: Good morning everyone. My name is Douglas Fitzgerald and I would like to welcome you to today's meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health. I'm the Board's Designated Federal Officer or DFO.

Before we begin, I'd like to go over some general housekeeping items so to make sure everyone's visit today is safe and comfortable for the next couple of days.

First, restrooms are located to your left down the hall. There's also a restroom downstairs in the lobby area. In case of emergency or if an alarm sounds, please follow the exits that are to your left, to your right, as well as to the back of the room and exit the building.

I'd like to express my appreciation for the work of the Board Members in preparing for this public meeting and for their forthcoming deliberations. I also wish to thank my colleagues at the Department of Labor for all their efforts

in preparing for today's meeting, particularly Carrie Rhoads and our Committee staff; the Alternate DFO who makes this job so much easier for us, as well as our SIDEM contract staff who also do a fantastic job in arranging everyone's travel, preparing briefing books and running these meetings again.

As a DFO, I serve as the liaison between the Department and the Board. I'm responsible for approving meeting agendas and for opening and adjourning meetings while ensuring all conditions of the Federal Advisory Act are met regarding operations of the Board.

I'm also responsible for making the Board's deliberations fall within the parameters outlined in its enabling statute and its charter. Within that context, I work closely with the Board's Chair, Dr. Markowitz, and OWCP to ensure that the Board, as an advisory body to the Secretary, is fulfilling the mandate to advise and is addressing those issues of highest priority and appraisement for the Secretary of Labor who is ultimately

responsible for the administration of the Energy Employees Occupational Illness Compensation Program.

CHAIR MARKOWITZ: This might work a little better.

MR. FITZGERALD: Maybe, okay. All right, I just got the Chairman's microphone and maybe this will work a little better.

So within the context, I work with the Board's Chair, Dr. Markowitz, and OWCP to ensure that the Board, as an advisory body to the Secretary, is fulfilling that mandate to advise, and is addressing those issues of highest priority and of greatest benefit to the Secretary of Labor who is ultimately responsible for the administration of the Energy Employees Occupational Illness Compensation Program.

And finally, I also work with the appropriate Agency officials to ensure that all relevant ethics regulations are satisfied.

Regarding today's meeting, we have a full agenda for the next couple of days, and you

should note that the agenda times are approximate. So we'll try as best as we can to adhere to that timeframe, but we may not be able to actually meet exact times that the agenda lays out.

Copies of all meeting materials and public comments are or will be available on the Board's website under the heading Meetings. The Board's website, I think everyone can find that easily if you just go to the Department of Labor, dol.gov, and go to OWCP, you'll find the Advisory Board's website fairly easily.

There you can find a page that's dedicated to this week's meeting. It contains all materials submitted to us in advance, and you'll find the agenda for today's meeting as well as instructions for participating remotely in both the meeting and the public comment period later this afternoon.

Public comments will begin at 4:30 p.m. And if you have not already scheduled to speak and would like to speak, please follow the Chair's directions prior to the public comment section

later this afternoon if you're participating remotely.

If you are present and would like to speak, please inform Carrie Rhoads, the Alternate DFO, of your interest in speaking.

If you are participating remotely, I want to point out that the telephone numbers and the links to the WebEx sessions are different for today and tomorrow, so please make sure you read those instructions carefully.

If you're joining by WebEx, please note that sessions are for viewing only and will not be interactive. Phones will also be muted during public comment period. That begins at 4:30 this afternoon.

The Chair will also note that the public comment period is not a question-and-answer session but rather an opportunity for the public to provide comments about their own experiences and address any of the issues that the Board is discussing today.

During Board discussions and prior to

the public comment period, I would request that the people in the room remain silent as possible, as quiet as possible since we're recording this meeting to produce transcripts.

If, for any reason, the Board Members require clarification on an issue that requires participation from the public, the Board may request such information through the chair or myself.

The Federal Advisory Committee Act requires that minutes of this meeting be prepared to include a description of the matters discussed during the next several days and any conclusions reached by the Board.

As the Designated Federal Officer, I prepare the minutes and ensure that they're certified by the Board's Chair. The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today per FACA regulations. But if they're available sooner, we'll post them sooner.

Although formal minutes are being

prepared because they're required by the FACA regulations, we'll also be publishing verbatim transcripts which are obviously more detailed in nature, and these transcripts will be available on the Board's website as soon as possible.

I'm looking forward to working with all of you today and hearing your discussions. This week's meeting represents like the third full meeting of the Board since November, so I'd like to acknowledge the Agency's efforts to complete all the internal FACA procedures and public notice requirements to facilitate the Board's ambitious schedule.

I also would like to thank the Energy Program and Director Leiton who is here with us today for being here to lend her knowledge and expertise to the Board's discussions and for providing the case-specific data that will be the substance of much of that discussion.

And on that point, I just want to make sure that everyone is aware that the information that has been provided to the Board Members contains

a lot of personally identifiable information, and please be cognizant of that when you are having discussions and talking about these cases so that you are aware that we have to be very careful about not disclosing information that is personal and proprietary.

And with that, Mr. Chairman, I convene this meeting of the Advisory Board of Toxic Substances Worker Health.

CHAIR MARKOWITZ: Thank you and welcome. Welcome to the Board Members for coming and attending the meeting, and welcome to the public as well, including the public that might be on the phone listening to us or watching through WebEx. Can you hear me in back? Okay.

So I want to thank Doug Fitzgerald and Carrie Rhoads and Kevin Bird for all of the support for this meeting and for our efforts in general.

We were going to -- we went to Savannah River Site and I want to thank DOL and DOE Greg Lewis for arranging for that excellent tour yesterday.

Anyway, when we were driving there and I was driving with Carrie Rhoads, and she was following Doug Fitzgerald in the car and I said to Carrie, I said, don't worry, Doug's not going to lose you because if he lost you, then Doug would have to do all the work that you do by himself. But thank you for -- (Laughter.)

And thank you for the Department of Labor personnel who are here today, Ms. Leiton, Malcolm Nelson, Amanda Fallon, and if there's anybody else.

I think Ms. Leiton will be here throughout the day, but she won't be here tomorrow. So if there are questions that the Board Members have, clarification or whatnot, we should raise them today.

We may have access to John Vance tomorrow. Not quite sure whether we'll need that access, but in any case, just be aware of that because it's very good to have Department of Labor officials from the program in attendance and available by phone, certainly for clarification.

I just want to say that the Board received materials in the last couple of weeks, and people have made efforts to review those materials as much as possible. I suspect we haven't had a complete opportunity to review all the materials, which is just fine.

I want to encourage Board Members to participate in the meeting even if there's some uncertainty about what you've read, or uncertainty about your understanding about what you've read. Because what we want to do is get as much clarification as we can during the meeting, so don't be shy about raising issues, asking questions or the like.

We're going to start with introductions with the Board Members, and then with everybody else in the room actually briefly, and then we'll move onto review of the Agenda.

I'm Steven Markowitz. I'm an occupational medicine physician. I'm an epidemiologist and a professor at the City University of New York, and I run the largest Former

Worker medical screening program with support from the Department of Energy. Mani.

MEMBER BERENJI: Good morning. I'm Mani Berenji, occupational medicine physician at Boston University School of Medicine and assistant professor. Pleasure to be here.

MEMBER DEMENT: I'm John Dement. I'm an industrial hygienist and epidemiologist. I'm at the Duke University Medical Center. I also have participated with the Building Trades Medical Screening Program since about 1998.

MEMBER DOMINA: I'm Kirk Domina. I'm the Employee Health Advocate for the Hanford Atomic Metal Trades Council in Richland, Washington. I'm also a U.S. DMBU (phonetic) member. I'm an active worker. I've been out there 36 years. I guess that's it.

MEMBER SILVER: Ken Silver, Faculty and Environmental Health at the College of Public Health at East Tennessee State University. It feels like a lifetime ago, but I was very closely involved with Los Alamos families in advocating

for the law and making sure the people who spoke out early on got paid under this program.

MEMBER FRIEDMAN-JIMENEZ: I'm George Friedman-Jimenez. I'm an occupational medicine physician and an epidemiologist at New York University School of Medicine, and I run the Occupational Medicine Clinic at Bellevue Hospital in New York City.

MEMBER POPE: Duronda Pope, United Steelworkers Emergency Response Team, but also a former worker of Rocky Flats, 25 years.

MEMBER TEBAY: I'm Calin Tebay. I'm the Hanford Site beryllium heath advocate and the Hanford Workforce Engagement Center representative.

MEMBER REDLICH: I'm Carrie Redlich. I'm an occupational medicine and pulmonary physician on the faculty at Yale of Professional Medicine, and at the Medical School, and I'm director of the Yale Occupational and Environmental Medicine Program.

MEMBER MAHS: Ron Mahs. Approximately

20 years at all three plants at Oak Ridge, and that's about it.

MEMBER MIKULSKI: I'm Marek Mikulski. I'm an occupational epidemiologist with the University of Iowa. I direct the Former Worker program for the former nuclear weapons workers from the State of Iowa.

MS. LEITON: Hi. I'm Rachel Leiton. I'm the Director of the Energy Compensation Program at the Department of Labor.

MS. SPLETT: I'm Gail Splett. I'm with the Department of Energy at the Hanford Site. I'm the EEOICPA program manager there.

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

MS. SLAUGHTER: I'm Jenny Slaughter with United Energy Workers.

MS. SHAVLIN: I'm Sarah Shavlin with United Energy Workers.

MS. JERISON: Deb Jerison, Energy Employees Claims Assistance Project.

MS. BARRIE: Terrie Barrie, ANWAG.

MS. VLIEGER: Faye Vlieger, former member of the Advisory Board on Toxic Substances and Worker Health, charter member of Cold War Patriots, and a worker advocate.

MR. ARTZER: I'm Josh Artzer. I'm the current chairman of the Beryllium Awareness Group out at Hanford, and also the Hanford Workforce Engagement Center Representative.

MS. BUTLER: I'm Debra Butler, manager of the Savannah River Resource Center.

MR. BALLARD: I'm Chris Ballard and I'm with Critical Nurse Staffing, the Vice-President of Regulatory Affairs.

MR. NELSON: Good morning. I'm Malcolm Nelson. I'm the current ombudsman for the Energy Employees Occupational Illness Compensation Program.

MS. FALLON: Good morning. My name is Amanda Fallon. I'm a policy analyst in the Office of the Ombudsman.

CHAIR MARKOWITZ: Pretty exciting agenda, I think. We're going to review the agenda.

Let's just take a look at the agenda. I think members of the public had access to a copy of the agenda from outside, right? Okay.

So we're going to hear from Ms. Leiton regarding relevant update for Board matters and other remarks that she might like to make.

And then Mr. Fitzgerald will go over a few items which are written out on the agenda.

Then Mr. Nelson will give us a summary of the Ombudsman report.

And then I will just briefly go over the items, the Board items, the action items, recommendations and whatnot from our first two meetings, and the DOL responses that we've received to date.

Just a brief update then on the presumption for COPD. And then after lunch -- by the way, times are quite approximate because I really don't know how long conversation will go on for.

So after lunch we will talk about the claims we've received for COPD, and then we will

hear a report from the working group on Parkinson's-related disorders.

We will then discuss some claims in relation to Parkinson's-related disorders. And then we end the day with a public comment period from 4:30 to 6:00 p.m.

Tomorrow, after an introduction, we'll have just a brief discussion. It's 45 minutes for that time, Ken, and we won't need that much time just so you know. It's just going to be a review of the issue of the request from DOL to address, really provide assistance with how to look at non-cancer outcomes of various radiological materials.

We're going to discuss the public comments within the Board, and then we'll have an update on the presumption for solvent-induced hearing loss, have some time to review Board functioning, operation, structure, working groups, committees and the like with ideas to improve things if needed. And then we'll discuss any new issues that arise, and then make a plan for the next

meeting.

So are there any suggestions about this agenda? Any additions? Any items people want to add that aren't covered by the topics? Okay.

So I would like to welcome Ms. Rachel Leiton who's director of EEOICP. I should say welcome back.

MS. LEITON: Can you hear me? All right. Thank you for having me and thank you all for being here. I know that you have put a lot of time and effort into reviewing our cases and reviewing the matters before you, and I know it takes a lot of time so I do appreciate all of your efforts on behalf of our program.

I have been asked to cover a few things, so I'm going to do my best to do that. There was a small list of items for me to cover. I'll be around all day if there are follow-up questions or whatever, and anything you want me to come up and help clarify.

The first thing that I was asked to do is review the changes from the latest procedure

manual chapter which is 3.0. There is a transmittal, that's Transmittal 19-01 that goes through each and every change in quite some detail, so I'm probably not going to read them all.

A lot of them are changes from terminology. We used to have what you call a CE-2 Unit. We now don't have that. It was a unit that was -- well, it was claims examiners in the district office that worked on matters that were, on cases that were in front of the FAB that weren't related to the FAB. It gets a little bit complicated, but so there were some references to that.

We've made some changes to our organizational structure, and I think I've mentioned whether it's here, but we did centralize some of our processes in terms of our medical bills, our home health care, all pre-authorizations, so we created a new Branch of Medical Benefits in National Office. We cover that in 3.0.

I also want to mention that we're probably soon going to have a 3.1, so a lot of that's going to be related to some of the changes that

were made in our regulations.

But I will walk through -- I'm going to give you some of the highlights. This is a 19-page document, so I'm sure you guys can read anything that I don't cover here.

As I said, some of it's just change of terminology, rewording of certain things. The Representative Conflict of Interest Guidance really didn't change, but again, we just kind of reworded it in terms of what we consider a conflict of interest. We have had this in the procedures for quite some time, so it's not really a change.

There is something new in chapter 15 which we added, and that is we included language regarding the evaluation of an opinion of a treating physician. And it's basically in instances where a physician submits an opinion that a toxic substance exposure was a contributory or aggravating factor in the development of claimed illness specific to the individual.

His or her opinion must be determined to be well-rationalized, as that phrase is defined

later in this chapter, before the Part E claim can be accepted. In particular, the physician must offer an interpretation of epidemiological or medical health science data that reasonably supports the opinion presented.

Moreover, the CE must corroborate the factual presentation of information used in the formulation of the opinion, e.g. medical history, verified periods of covered employment, and toxic substance exposure characterization with evidence available in the case file or obtained through the application of program resources such as the SEM or referral to a medical health science expert.

So that is a new section. Chapter 15.13, we added some language regarding the CE's responsibility when a causation opinion of an employee's physician is found to be insufficient. And that's basically -- yes --

CHAIR MARKOWITZ: I'm sorry, before we move on, can I just ask you a question?

MS. LEITON: Absolutely.

CHAIR MARKOWITZ: So this new language

about establishing toxic substance exposure and causation -- so if you could bring that up, Kevin.

MS. LEITON: In the transmittal or the chapter?

CHAIR MARKOWITZ: It's higher up. It precedes what we're looking at on the screen. Okay, that's it. So this language, this isn't entirely new?

MS. LEITON: No, it's just placed in this section. So we've got it in other places pretty much saying similar things, but this puts it in the section, makes it very clear they're supposed to be evaluating for it.

CHAIR MARKOWITZ: So is it new that the treating physician "must offer an interpretation of epidemiologic or medical health science data in support of their opinion." Is that new, because I don't remember seeing that.

MS. LEITON: The language itself might be new. In practice, it's something that we've asked for in training, and in addition, when we say must, we often go back and ask for whatever

information we can get from the treating doctor.

One of the things that we're trying to refocus claims staff on is going back to the treating physician instead of immediately going to a CMC. And so I think this section was put in so that we could kind of drive that focus.

Obviously, we're not going to get perfect reports all the time, so we'll do as much development as we can around that.

CHAIR MARKOWITZ: You know, my concern is, we've discussed this before and I'm sure you're aware of it, which is that the practicing physician who wants to be supportive of the claimant is unlikely, actually, to be versed in epidemiologic or medical health science data in support of their opinion and would probably not have the time to do the research or to provide the reference list for that opinion.

And I understand what the intent is. Maybe in the next version instead of using must, you could soften the language somewhat so that it's suggested that that would be, maybe not an optimal

approach, but to the extent possible, the treating physician should provide that kind of information.

But to make it compulsory is probably overly ambitious, frankly, for what the practitioner can do.

The other question I have is, I was trying to understand what it means that it says, "The CE must corroborate the factual presentation of information used in the formulation of the opinion." So if the physician does an occupational history and gets information about details of their exposure, and that's not -- and the CE then looks at the various sources of exposure information and doesn't fully corroborate that because frankly you have a professional who's interviewing a patient and they're getting additional information.

That information that the physician collects and transmits shouldn't be discounted because the claims examiner can't exactly find a replication of that somewhere else. To me, it's an additional source of information rather than something that necessarily requires compulsory

corroboration. Do you understand my point?

MS. LEITON: Yes, I do. Again, in this language, we're trying to get the claims examiners to review the evidence in the case file. So if we have a statement of accepted facts, we've got an exposure analysis against that report. And if they have questions or issues, to go back to that treating doctor instead of immediately going to a new doctor and saying, here's what we have. You've laid out two years of exposure, we have 10, or whatever it might be. So that's kind of the point of this.

CHAIR MARKOWITZ: Sure.

MEMBER DEMENT: I don't know if this thing is on. I think what Steven's talked about with regard to giving additional information, I think we'll hear that as we go through some of these cases. Because in some instances, in my view the case could have been better developed had either an industrial hygienist or physician really gone through and taken a more detailed history of what actually the individual did at a site.

In some cases, it seems that the SEM sort of pre-empted what was actually in the occupational history itself, and maybe some other pieces of information. So I think it's important that it not be so tightly bound to verification on from site records which sometimes are quite incomplete.

MS. LEITON: Thanks. Okay, the next section that I was going to point out is chapter 15.13(b). We've added some language regarding the CE's responsibility when a causation opinion of an employee's physician is found to be insufficient.

In these situations, the CE is to provide the physician with any employment or scientific evidence that DEEOIC has obtained to establish an accurate factual presentation of exposure.

That's what I was referring to earlier is we're trying to push it back to the treating as much as we can.

We deleted the section about exposure

after 1986 through 1995 because we really want more of a case-by-case assessment of that evidence. I believe that in the prior section it probably talked -- I unfortunately don't have the chapter in front of me -- but it talked a little bit more about the likelihood of exposure during that period of time, and we prefer that they go to an IH for those assessments.

The next section we just edited for clarity. The hearing loss, we edited to clarify the process by which a finding can be made that the job is equivalent to the listed job, and to communicate ways in which an IH and SEM can be used to assist in the adjudication of claims.

The section that is relevant here, the newest section, is after the list of job categories. We basically said employees often present evidence that they were in a labor category that is the equivalent of one of those listed here.

When a claimant makes a claim that a job the employee performed is synonymous to one of the qualifying labor categories listed above,

and the CE conducted some labor category alias search that doesn't provide assistive information, the CE can seek assistance in evaluating the claim through a referral to a SEM mailbox. Our contractors can review the mailbox and provide the claims examiner with additional information, or submission to an IH referral, so we just clarified in the hearing loss presumptions or standards.

We also added a section after the list of toxins. The CE can also use the SEM to identify the employee's potential exposure to one or more of the listed toxic substances. They must carefully screen the evidence to apply appropriate SEM search filters.

This is something that we've been going around training on. Well, we've often trained on it. But using the SEM properly, filtering through the SEM properly to come up with the widest range of exposures that we can. And the claims examiner must look at each one individually to determine what a person might have been exposed to, each labor category in the SEM and then consult with an IH

if there's a question.

CHAIR MARKOWITZ: This is Steve Markowitz. This strikes me as an important change, actually. We've heard repeatedly that if the job title -- with regard to hearing loss -- if the job title isn't on the specific list of 22 job titles, then you can't get compensated for solvent-induced hearing loss.

And this clearly opens the door to equivalent job titles. It actually may even relate to the recommendation of the Board, but I'd have to go back and look at that.

The SEM aliases are expansive but ultimately limited, so this weighing in by the industrial hygienist becomes very important, because the industrial hygienist really can help determine whether the person likely had solvents exposure. So this strikes me as an important change.

I'm still curious about 10 consecutive years of exposure prior to 1990, because the Board has made a recommendation about this. And it's

the 10 consecutive years -- I mean I also wonder about the 1990, but it's the 10 consecutive years. Because that's a foreign notion in occupational medicine that a person has to have continuous exposure.

I really can't think of a condition in which we look at continuous exposure. For a chronic occupational disease, we require continuous exposure over a period of time. Aggregate exposure, cumulative, right, total of 10 years, but that might have occurred over a 15-year period because the person changed jobs for a few years.

So I'm just curious about how intentional it was, the retention of the consecutive years of exposure rather than changing consecutive to another C-word, cumulative, which would better capture I think the occupational medicine knowledge.

MS. LEITON: When our toxicologists, our IH's reviewed this particular standard and through the research, they actually felt or

determined that this was a pretty lax standard for solvents in hearing loss and that we were being generous.

So, I'm not going to debate that right here with you all, but that's the understanding that I was given. In terms of whether it was intentional, it was intentional to do it at consecutive.

And we allowed for the combination of noise and solvents, which was a matter of some debate legally. But we were able to establish the fact that there was some contribution of solvents and noise in the -- we could match that to the standard however in terms of whether or not that's not enough or that we should expand that.

That's something that I've been advised by our scientists isn't currently in the literature that we've reviewed however. Obviously, we will listen to whatever you all propose.

CHAIR MARKOWITZ: Okay. I mean, I don't want to continue this much work. The Board isn't -- I don't think it's our role to weigh in

on generosity or not, but it is our role to weigh in on how compatible the program guidelines is with current occupational medicine thinking. So that's where we're coming from.

MS. LEITON: Sure. Okay, where was I? Okay. Chapter 18, Eligibility Criteria for Non-Cancerous Conditions. This may be a little bit confusing. What we did here, this chapter, this section 18.5(c) has to do with beryllium sensitivity.

And what we did was we took out -- there was in the prior chapter, it said, "If exhaustive efforts produce little or no results, and the evidence of record contains the normal borderline LPT result along with a biopsy of the lung tissue showing the presence of granulomas, the CE may accept the claim."

In the new section, the new chapter, we basically took out that last section that says, "along with biopsy of the lung tissue showing the presence of granulomas, the CE may accept the claim." We're basically saying that if a doctor

says that it's a false-negative and there's evidence of steroid use, we can accept beryllium sensitivity.

We still have the criteria for the biopsy in the next section down regarding established CBD before 1993. So the difference is that for beryllium sensitivity, the doctor can say it's a false-negative. You have steroids. Because beryllium sensitivity, we simply provide benefits for monitoring. CBD is a stricter standard, so we require that biopsy if there's a false-negative and evidence of steroid use.

MEMBER REDLICH: I appreciate the revisions in the language and including steroids as immunosuppressive therapy. There's a number of other agents that are used that are immunosuppressive in the treatment of chronic beryllium disease and other chronic fibrotic lung conditions such as sarcoid.

So in a future revision I think -- and especially with newer immunosuppressive agents, if the wording was simply steroids or other

immunosuppressive medications, that would be more helpful to the physicians.

MS. LEITON: Okay.

MEMBER REDLICH: And I do appreciate because I think this is progress separate from, there are also -- it's acknowledged that the testing on lymphocytes that come from the lung from a lavage are more sensitive than peripheral blood lymphocytes. But that is rarely done now just for multiple reasons, including patient safety.

So the blood test using peripheral blood is not as sensitive as lavage lymphocytes. So you can still have false-negatives even without immunosuppressive therapy.

MS. LEITON: Okay. Thank you. The next section, Exhibit 21-4, this goes into some information about impairment ratings. Basically, we revised it to be a little more description of what we mean by activities of daily living.

We added a section where we basically say reported ADLs must be described in sufficient detail to allow a physician to apply the information

to the assessment of whole person impairment in accordance with the AMA guides.

Basically, when we do impairment evaluations, not all physicians can do them, and so a claimant will go to their treating physician, request that they provide information to us, and we can then send it to a CMC.

So we wanted to make sure that the treating is describing those activities of daily living. That is a critical portion of impairment ratings.

The next section, Chapter 24 on Recommended Decisions, this is really just about formatting cover letters and what to include and what not to include in terms of it. We used to require that the amount of benefits being awarded be in the cover letter. It's not a requirement anymore because it's listed several other places in the recommended decision.

We also deleted the requirement for a wet signature for recommended decisions because a lot of these are being signed digitally. We do

sign -- we physically have our hearing representative sign the final decision since that's the one that goes to court. But for recommended decisions and flexibility issues, we took out that signatory line.

We added here in Chapter 24.10(g), we included language that allows the use of letter decisions to accept additional claims for skin cancers of the same type under parties. So therefore, instead of going through a whole recommended decision process, we've already accepted skin cancer. We would just allow them to send a letter saying we're accepting more skin cancers.

The FAB decisions, this is what I was talking about earlier with regard to the term CE-2. We no longer have these CE-2s. Since our claims have been digitalized, we have a different format for how claims examiners can review cases that are at the FAB when there are other issues at play.

Again, the format of the final decision was changed slightly with regard to what sections

needed to be where in that final decision format. And changes to the reference to CE-2s throughout a lot more of these.

There was a typographical error we changed in reopening. I'll skip to Chapter 29 on Ancillary Medical Services. We added a section on hearing aids just to clarify what's needed when they're billing for hearing aids.

And then in the Home Healthcare section, we deleted the whole Conflict of Interest section because we have it somewhere else, and we referenced the chapter that we talk about conflict of interest there.

Those are the highlights. If you have other questions about this Chapter 3.0, I'm happy to answer them.

CHAIR MARKOWITZ: I have a question. By the way, do you need for the Board Members to identify themselves when we make comments? Whenever possible, okay. It's Steven Markowitz.

I just want to go back to Exhibit 15-4, Section 3(b), about asbestos exposure. And I've

asked Kevin to find Procedure Manual 2.3 version, because that's where the language is, and it's being deleted. So we need to just look at what's being deleted.

So is this the transmittal document or is it -- okay. So if you could go online and look for the procedure manual 2.3.

MS. LEITON: It should be in archives of the procedure manual.

CHAIR MARKOWITZ: So let me -- I'll talk about it briefly while he's looking for it. So this section, if you remember asbestos, the way that the program approached presumption of exposure was that it looked at two periods of time, prior to 1986 and prior to 1996.

So you had this '86 and before, and I can't remember whether it's January 1st, 1986, December 31, 1986, and same for 1995-96. So I'm just going to use shorthand and say '86 and '95-'96.

But there was -- this section that's being deleted specifically refers to a presumption of asbestos exposure between 1986 through 1995.

So what will be retained in 3.0, is being retained in 3.0, is the presumption that there is asbestos exposure for certain job categories prior to or through 1986. Okay? So the insulators, the painters, the pipefitters, the carpenters and the like, mostly construction-maintenance titles, will still be presumed to have significant asbestos exposure through 1986.

However, what's being deleted is any comment -- if I understand it correctly -- is any comment on what happened between 1986 and 1995.

And the old manual said between '86 and '95 that those same labor categories that I mentioned, you know the insulators, painters, et cetera, are presumed to have significant exposure from '86 to '95, but at low levels.

But I think the important thing is they were still presumed to have significant exposures through '95. That their significant exposures continued beyond '86 through '95.

And that all other labor categories --

I'm quoting here from the 2.3 manual, it's Exhibit 15.4 -- actually, let me just hold off a moment because we're almost there. When you get there it's item 3, so you go down another page I think. And you try to read through the superseded -- keep going. It's the next page. Okay, that's it.

So it's that Section B we're looking at which is being deleted. So it pertains to asbestos exposure between 1986 and 1995.

And you can see item B-1 is what I just mentioned, which is the labor categories cited above, have significant exposure but at low levels. And then Item 2 is that all other labor categories are considered to have exposure to asbestos, but the extent of their exposure didn't surpass established occupational safety and health guidelines, and therefore the level of exposure is not considered significant.

So Item B makes partial sense because it removes the presumption that their exposure didn't surpass established occupational safety and health guidelines.

However it does delete the aspect in which these other labor categories are presumed to have exposure to asbestos. That is to say the ones not on the list, but who worked at the facilities, were presumed to have exposure to asbestos.

I'm also concerned in Part 1 where between '86 and through '95 that the group including the painters, the millwrights, the insulators and the like are no longer presumed to have significant exposure to asbestos.

And this is important because when you get to the individual diseases, the asbestosis, mesothelioma and the like, and we can see for instance, we can just scroll down under asbestosis. You see under Part 4(b) it says, Exposure. "The employee was employed in the job that would have brought the employee into contact with significant exposure to asbestos."

So I'm wondering what the thinking here is, and I'm wondering also what the practical significance or implication of removing this whole

time period of presumed exposure to asbestos is?

MS. LEITON: I would like to get back to you. I think that there's probably rationale that maybe it's somewhere else or we have -- I need to find out, and I don't want to mis-speak on the record, so let me get back to you if you don't mind.

CHAIR MARKOWITZ: No, that's fine. Because what the CE is left with in terms of exposure presumption now entirely pertains just to 1986 and before. And so now the guidance, the document is silent on the period after '86, and I'm concerned that may have some important practical implications for evaluation of claims.

So, yes, that would be great if there's some clarification on that, and we may have further comments on that.

MS. LEITON: Okay.

CHAIR MARKOWITZ: Does any Board Member have any comments, something you want to add on this? Okay.

MS. LEITON: I will try to get you something before I leave.

CHAIR MARKOWITZ: Yes, okay.

MS. LEITON: So that's 3.0. Yes?

MEMBER REDLICH: This is Carrie Redlich. I appreciate the changes in 3.0. Just to point out, which I think we did last time, the tables have not yet been updated to reflect some of the changes in the text or the changes that we recommended. They still include things like specific inhalation challenge testing is a way to diagnose occupational asthma which is not available in the United States.

So I would just suggest that a future revision to look at the tables. There are also some other, you know, they're relatively minor suggestions we had made or pointed out. I think they're more than suggestions, but just, you know, factually correct. Such as whether granulomas can be calcified in a patient with sarcoid -- excuse me, with chronic beryllium disease. And they can be calcified.

The current text still says that a calcified granuloma is not characteristic of CBD.

And I think it would just be more medically accurate to remove that sentence.

MS. LEITON: There are various opinions on that, so we have looked at them. We'll look at them again.

MEMBER REDLICH: It was just one example. I think it's definitely improving, but it could still use additional edits.

MS. LEITON: Okay, noted. Thank you.

MEMBER REDLICH: And one of them is just a question. Recognizing that some of our suggestions have been incorporated, I was wondering how has that been transmitted to -- I realize there's a whole education process -- to the CEs and the CMCs that there have been changes, the training materials. So how often are those revised?

MS. LEITON: We're in the process of revising all of our training materials to update them. We have a training lead who's going through them. We were missing one for a while because one of our training leads left, and so we had a gap.

But we're back to revising all the materials, the basic CE materials, making sure they're in line with the current procedures. And so that's where we are right now with that with our modules; revising and updating them.

MEMBER REDLICH: And I realize that's challenging. We would be happy to review the relevant training materials such as related to Part B conditions.

MS. LEITON: Thank you. Okay, the next section, the next part that you wanted me to talk about was the status of the December 10, 2019 data and claims request. This was the one with regard to COPD and Parkinson's. We did get you some information there.

For the other ones, we're going to talk about using a form and getting additional information for those requests. I think Doug's going to talk about that later. If the review of the --

CHAIR MARKOWITZ: We can -- after Doug introduces that form then we can come back to this.

That's fine.

MS. LEITON: Yes. Follow-up on the February 28, 2019 recommendation of asbestos-related disease, asthma, and OHQ, we are still in the process of reviewing those. We got them in March. Our policy branch, our medical science unit have been working on those responses.

We hope to have a draft within the next couple of weeks, but that has to go through clearance which means it has to go through the whole process of going through the Labor Department. So I can't guarantee you a time, but I have hope that it will be within the next month or so.

Follow-up, let's see, review of the DOL responses to the 11/18 requests. So there was a request for information that we provided a response to in February, and you had highlighted some sections. I don't know if you have that up. Do you have that there?

Okay. So the first section has to do with the Bulletin 19-03 which provides guidance to staff about reopening cases as a result of the

presumptions that we changed for causation resulting from the Board's recommendations.

We do have a report on that. We've made it a priority for all of our claims staff to review these cases, and they're 98 percent finished screening and found -- so they looked at different groups. The first group was mesothelioma, ovarian cancer and pleural plaques. The second group was hearing loss, bladder cancer. And the third group was lung cancer.

They have reviewed, as I said 98 percent of all of those groups, and we found about 170 cases that have the potential to be reopened right now.

MEMBER BERENJI: I'm sorry. Can you clarify the denominator, 170 out of what number?

MS. LEITON: Yes. It's actually a pretty small percentage of cases that are going to probably be reopened. We've looked at all the factors. There were about 1900 cases that have been reviewed.

MEMBER BERENJI: And I'm sorry, can you clarify the 170, like what percentage were the

mesothelioma cases?

MS. LEITON: It was pretty even. No, actually, I'm sorry, lung cancer was the highest. There were like 84 of those that were lung cancer; 42 were for hearing loss and bladder cancer; and 43 were for the mesothelioma, ovarian cancer, and pleural plaques in terms of what we have the potential to reopen right now.

MEMBER BERENJI: I'm sorry, that's not very clear. You seem to lump a lot of these various --

MS. LEITON: Yes, we didn't separate them out. We lumped them into three categories: mesothelioma, ovarian cancer, and pleural plaques was one category; hearing loss, bladder cancer was another category; and lung cancer was the third category.

MEMBER BERENJI: Okay. So can you clarify the lung cancer was 84?

MS. LEITON: 84.

MEMBER BERENJI: The hearing loss, bladder cancer was 42.

MS. LEITON: 42.

MEMBER BERENJI: And then the third category?

MS. LEITON: 43. That was the mesothelioma, ovarian cancer, and pleural plaques.

MEMBER BERENJI: Thank you.

MS. LEITON: The process moving forward obviously takes into consideration the new presumptions. The next --

MEMBER REDLICH: Carrie Redlich. On the subject of reopening cases, as you know, we've been given cases to review and had in the past, many of which we agreed with the final adjudication.

For ones that we have questions or disagree with that, have we established any process about whether it's possible for any of those claims to be reopened?

MS. LEITON: Obviously, we'll take whatever input you have and evaluate that. If it looks like a case needs to be reopened, then we'll reopen it.

MEMBER REDLICH: So from the ones that

we had previously reviewed, it's not a large number, but if there are a few cases that we think should be reopened, could we give you --

MS. LEITON: We can look at the cases.

MEMBER REDLICH: Okay.

MEMBER BERENJI: Yes. That would have to be done in some sort of systematic fashion. I mean --

MEMBER REDLICH: Yes, I think that passes and I also think going forward with the cases we were just given. And actually, I think the prior ones since we got rid of them, I actually don't have the identifying information.

MS. LEITON: I don't know what to say to that.

MEMBER REDLICH: Yes, so I think the going forward with the ones that we have now -- we haven't even started to discuss those cases yet.

MR. FITZGERALD: I would say as the DFO, I think when you discover things that are questionable and you bring it to the program's attention, they will give it the due consideration

it should have.

It's just like when we do kind of accountability reviews and we do auditing of our own cases when we look at those things, if things are revealed in that audit process that look incorrect, the program will go back and revisit those things.

So in a sense, that's kind of what you're doing. It's not the primary role of the Board to do that, but to the extent that you find that sort of thing and share it with the program, they will consider the same. And the same when they would do any kind of audit and review of their work.

MEMBER REDLICH: Okay, given that we just got a number of cases to review, it seems like it would be helpful to clarify.

MS. LEITON: Yes, if you see something in a case after you've reviewed it, share it with Doug and he'll share it with us.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: So I have a question.

Steve Markowitz. I'm just going to use approximate numbers. About 1900 claims fell within the areas of the revised causation standards and required review, and roughly 170 of them deemed to be relevant will require further review for possible change in the decision about those claims.

As a suggestion, and it's relevant to what we do, because we've been working on presumptions. And the impact of our recommendations on those presumptions are of interest.

So it would seem to be just as easy, when you look at those data, the 1900, to identify them by individual diagnosis, or the most important diagnosis, say mesothelioma or lung cancer or bladder cancer. The total number that have been reviewed, and then give the total number in which it's been deemed they need further review and reanalysis so they don't -- so the bladder cancer and hearing loss aren't lumped together. Because that -- that doesn't mean anything I don't think.

MS. LEITON: We can probably go back

and do a report. This report came from our claims staff. We had asked them to look at them in stages. So we had to group them so they could look at them in stages, and those are the groups we did that we analyzed them through.

This report just came to me last week. So we can do some further revisions and look at what further reporting we can do.

CHAIR MARKOWITZ: That would be great. By the principal diagnosis, that would be the most sensible. Thank you.

MS. LEITON: Okay. Number 3 highlighted section where you indicated DEEOIC is developing a report that will identify the total number of Part E claims filed with a final decision to accept.

I just got that report yesterday, so we do have a preliminary report on that. I can probably provide it to you. I'd like to do a little bit further QC, but generally we're looking at this by accepted-only cases under Part E, denied-only cases, and accepted and denied cases.

So there are three different categories that we kind of have to look at it through the lens of. Overall, there were about 26 percent of cases referred to an industrial hygienist.

Now that's a little lower than I expected, so I want to double-check those numbers. But you have to consider the fact that a lot of cases are either accepted or denied. They might be denied or accepted for other reasons, so that factors hugely into -- they won't go to an IH if there's no survivorship, for example. But I do have a report that we can probably share with you, once I've done a little bit more investigation on it.

The next section. You highlighted documentation submitted with requests to make changes in how its effects are provided to Dr. Jay Brown, Haz-Map for evaluation. I'm not sure what the question there is.

CHAIR MARKOWITZ: What are we looking at? Do you know which --

MS. LEITON: It's right under --

CHAIR MARKOWITZ: Well, okay. Well, the question about Jay Brown I think is at some point we learned that the program doesn't have a contract with Dr. Brown to work on the SEM or to provide input into the exposure-disease links in the SEM.

But there's references at various points in which it would appear that the program continues to use Dr. Brown, so I just wanted some clarification about that.

MS. LEITON: Well, Dr. Brown still updates his Haz-Map, and we still utilize that information. So we still have the ability to provide him with information that he then uses in Haz-Map that we can correlate with the SEM.

CHAIR MARKOWITZ: I'm sorry, maybe I didn't quite hear everything.

MS. LEITON: So he's still --

CHAIR MARKOWITZ: Is he looking -- do you ask him specific questions about this agent disease links that he weighs in on and helps you and revise the SEM?

MS. LEITON: My understanding is that we provide him with information that he can then use in the Haz-Map and add to his Haz-Map, which we can then add to the SEM.

Now we have other processes in place for adding things to the SEM or through policy changes that we can make of our own volition without the Haz-Map. But that's usually made through a policy determination first and then added to the SEM, so --

CHAIR MARKOWITZ: Okay. Thank you.

MS. LEITON: The second section was also about Dr. Brown, so I think that covers your highlights of this document which was the follow-up.

And the last thing you wanted me to cover was the updates to all prior Board recommendations, 2016 to present, on which new actions have been taken.

So I went through all of the recommendations you made, all of our responses, and one thing that I found was that you all had

done in February of 2018, kind of gone back through all the ones prior to that date. So the '16 recommendations, '17 recommendations, and we went through this back-and-forth.

So that document, the February 16th one really kind of covers the prior recommendations because you went back through them all. Rather than going through them again, I'd rather just cover that document. And then if you have questions about any other ones, I'm happy to answer them. But I just thought that might be the most efficient way to do this.

So in your February 2018 document you went through I think it was 10 different -- nine different recommendations, and kind of gave us responses that we then responded to.

MEMBER BERENJI: I'm sorry, I don't have that document so I'm not sure if that's going to be helpful for me.

MS. LEITON: It's on the website, your website.

CHAIR MARKOWITZ: Yes, maybe we can

just wait a moment until Kevin can find it. It's under the --

MS. LEITON: It's under the recommendations. It's February 16, 2018 response. February 16, 2018. I'm sorry.

CHAIR MARKOWITZ: They're usually organized by meeting date.

MEMBER BERENJI: Right. I was under the assumption that we're going to go through the answers for the most recent meeting, and I'm still, have questions about these.

MS. LEITON: The most recent meeting, we're still evaluating those, so we don't have responses for those. Those need to be cleared. I will have responses once they've been cleared through the Department. So I don't -- I'm not able to respond to those right now.

The request to me was to go through all the previous recommendations, so I thought I'd start with the 2018 document if you still want me to do that.

CHAIR MARKOWITZ: Yes, that's fine.

MS. LEITON: Did you find it? I've gone over my time, so do you want me to continue?

CHAIR MARKOWITZ: That's fine.

MS. LEITON: Okay.

MR. FITZGERALD: I'll yield my time to you.

MS. LEITON: Okay. That's August. August was our response to the February -- yes, yes, that's fine.

So walking through this document, so you provided us the February document that we then responded to in August. I was going to kind of just walk through those.

So the first one is the comments on recommendation incorporating Agency Health Effect Reviews recommended by IOM reporting to the SEM. The Advisory Board recommends that the program apply different data sources for expanding disease exposure links, including the following: IARC, Integrated Risk Information System, and the National Toxicology Program.

So we already used IARC Group 1. With

regard to Causal Group 2(a), we will refer to those when we're talking about aggravation of contribution. We defer to a physician on that rather than incorporating it into the SEM.

With regard to the application of the IRIS and NTP databases, you've suggested a process for evaluating those. We asked for additional information in terms of how to exactly use those in our SEM.

Each database communicates voluminous and complex data on a range of toxic substances and health effect topics. We don't think that adding all of those in the absence of rigorous and comprehensive investigations would be prudent for us. So that was our response here.

I'm not sure how much you want me to read through our responses as go through and try tell you if they're action items, so I just kind of highlighted some sections in this.

CHAIR MARKOWITZ: That's fine. Just a summary of the responses would be good.

MS. LEITON: Okay. You also

recommended that we identify a team that includes individuals with competence in toxicology, occupational medicine, and epidemiology to do a rigorous review.

While I would like to have the resources to do that, and I think we've talked about this before, it's kind of a catch-22 because our mandate is to evaluate claims on a case-by-case basis. We're not a research-centric organization. OWCP was not built to have that sort of a research arm, and so that's where we have -- we don't have the ability to have that rigorous scientific team as part of our organization. It's not the way it's set up.

While I understand and agree that, you know, having such a resource would be helpful, our mandate is and our funding is based on a workers compensation program where we pay for claims examiners and final adjudication branch.

We've been able to have our scientists that we do have, and the contractor to help us with individual case-by-cases. But, in terms of a

research organization, this is not the way we're built.

CHAIR MARKOWITZ: Dr. Friedman-Jiminez?

MEMBER FRIEDMAN-JIMENEZ: Can you hear me? I would consider that part of the clinical practice of occupational medicine. If you get a case, for example, and you have to review 40 articles on COPD and asbestos, that's part of the case. It's not research.

Research is finding new knowledge that hasn't been published, that hasn't been found before. So I would say that's part of the clinical practice of occupational medicine. And occupational physicians should be trained and prepared to do that kind of literature review because that's part of what we do.

It's not in the textbooks. It's not in, you know, a single document. Sometimes you have to do a broad and deep literature review for a single case as part of the clinical care of a patient.

MS. LEITON: I agree.

MEMBER FRIEDMAN-JIMENEZ: Or the evaluation of a case.

MS. LEITON: I agree in terms of what a physician should be doing when they're evaluating the patient for a claim. Our claims examiners aren't in the business of occupational medicine. They're in the business of reviewing factual information that's presented on a claim, so that's what they're trained to do.

In terms of, you know, the case-by-case, yes. We try to obtain as much information as we can on a particular claim from a physician or an authorized rep, or whatever we can obtain from the claimants medically or scientifically. Then we have a contract medical consultant process where we can refer cases out if we can't get information from the treating. We also have our industrial hygienist on a case-by-case basis.

But in terms of generally having, as this suggests, a group of people we can go to, to

provide us with the information that we're talking about here, which is an evaluation of all these different databases and resources that we could use to enter into our SEM, that's the kind of research I'm talking about in terms of doing that in-depth analysis for overall use in the program.

We do as much of that as we can in the creation of the SEM and the contracts that we do have. But again, our focus has to be on adjudicating claims on a case-by-case basis and gathering information on a case-by-case basis. That's what our focus is.

CHAIR MARKOWITZ: This is Steve Markowitz. You know, I think the Department doesn't fully appreciate how difficult your job is. Because, you know, various compensation programs within the Office of Workers Compensation Programs, EEOICP has to take on tens of thousands of different agents and the entire spectrum of occupational disease.

And I know I've said this before, you know, you have black lung which is really, you know,

a very limited set of exposures, a limited industry, limited job titles. FECA I assume mostly deals with traumatic events rather than disease. Longshoremen again probably mostly traumatic events, so-called accidents.

But your job within EEOICP is really unique. And for that matter, I can't think of any other compensation program at the state or federal level that has the challenge that you have.

MS. LEITON: Yes, well thank you for that. I --

CHAIR MARKOWITZ: Well, you can say something, but I do want to make a point.

MS. LEITON: No, I mean I think you're right in that this is new territory for a compensation program. All of the different exposures, trying to come up with assessments, it's a lot. But go ahead and make your point.

CHAIR MARKOWITZ: Well, so for instance, we're happy to provide assistance with Parkinson-related disorders. But that's an example of an issue, you know, we're a Board that

comes and goes, we provide advice and we're happy to do that with respect to that limited issue. But we don't have resources to do much above and beyond that.

And you need that internal capacity. I wish the Haz-Map or some other resource out there was totally up-to-date, an agent disease link that you could rely upon. But such a resource really doesn't exist.

MS. LEITON: True.

CHAIR MARKOWITZ: And so our argument is only that you need a deeper capacity to be able to evaluate, not do research, but to evaluate existing knowledge to make sure the program accurately reflects that existing knowledge.

MS. LEITON: I understand. Okay. I do want to note there with regard to the first one that your latest set of recommendation is more specific, and I wanted to note that is something we're evaluating. With regard to the SEM, I think you've gone into more specifics there, so we will be evaluating that.

The second set of recommendations is the hiring of former DOE workers to administer the OHQ. The Board also requested specific data regarding the work performed by the former DOE workers. I think we provided that data to you and indicated what we can and cannot do with regard to our contractor, and what we can hire for, what we can mandate versus what we can't mandate.

We can put in the contract that we prefer expertise and DOE former workers. But in terms of getting a contract, we are not permitted to mandate that they all be former workers.

Number 3, comments on recommendations, claimant information sent to industrial hygiene and medical consultants. The Advisory Board recommends that the program provide copies of entire case files to subject matter experts, such as industrial hygienists and medical consultants.

The Advisory Board further recommends that the claims examiner map be filed to indicate where relevant information is believed to be.

So I think we've gone back-and-forth

on this over the years. You know, one of the things that we -- one thing that I do want to point out in this response from us is that we indicate that it's important that once a decision on one part of the case is made, it's not re-adjudicated and a referral to a specialist on another issue.

And that -- there's a tendency to do that when you're looking at everything, especially if we've already put in a statement of accepted facts that a case has been accepted for a condition. We can't really go back and re-adjudicate that in a referral.

There's also different types of referrals that require different evidence in payment versus wage loss versus causation determinations. We do try to provide whatever -- all the medical evidence to a physician whenever possible and when it's relevant.

When it's for an impairment evaluation, sometimes there's going to be less information because we're looking at a particular set of facts that need to be reviewed specifically for an

impairment evaluation.

CHAIR MARKOWITZ: Can I just ask a question?

MS. LEITON: Yes.

CHAIR MARKOWITZ: Steve Markowitz. So having recently looked at claims, I don't know how the other Board Members' experience is with looking at claims, but it's not clear to me that the contract medical physician, the CMC, it's not clear to me what pieces of exposure information they get.

They get the IH report, but do they also get the Occupational Health Questionnaire? Or do they get any information that the claimant provides? Do they get an excerpt from the SEM? It's in the overall claims file but, you know, some of those files are 2,000 -- 5,000 pages. So do you know what the CMC gets with reference to the exposure, the various pieces of exposure information?

MS. LEITON: Well, they're supposed to -- usually there's supposed to be an assessment

of the IH, the exposure information that the claims examiner does in the statement of accepted facts that's referred to the physician.

Sometimes there's a separate assessment that is the exposure assessment. If it's a lengthy exposure assessment, the claims examiner will send, quoting the SEM, where these sources are from.

It really depends on the type of referral to the physician, whether it's a causation. If it's not a causation, that information won't necessarily be in there.

But I don't know that every time that we send something to a physician we're including the OHQ. A physician can ask for that in their assessment when they're looking at these cases. But we do try to include our factual assessment of exposure when we refer these to the CMC.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I guess, so along those lines, I think -- and we're just getting into reviewing these cases so it's pretty early. But

certainly a trend that I see in the ones that I've reviewed, and maybe others have seen it as well, is the OHQ is looked at by CE, and many times it doesn't appear that some of the exposures that are actually listed in the OHQ are included in the statement of accepted facts that goes to the CMC.

I don't even think the industrial hygienist necessarily looks at some of that when they're assessing exposures. They're told by the CE to assess exposures largely drawn from the SEM.

In some cases, that's been helpful because the exposure on the OHQ were very vague. I mean it goes both ways. But I guess one of my concerns is the exposure information is not developed.

And it goes back to some of the earlier recommendations is that we feel, and I think this Board feels, has felt, and maybe this Board will have a different feeling that the industrial hygienist particular needs to have access to the claimant to develop the case. And there's some in here which I reviewed that I think, as a

hygienist, if I had a chance to talk to the individual, I could've figured it out whether or not there were actual exposures beyond what may have been in the SEM, or may be in the SEM, but not defined very well.

So see it goes back to, in my opinion, developing the case more broadly. And not all cases, not all claims are going to need that level of detail, but some will. It's sort of developing a triage process to make such a more detailed assessment work.

MS. LEITON: Yes, and we've also been back-and-forth on that particular issue as well. Our, you know, we believe that the claims examiner needs to be the one making the factual determinations. And if the industrial hygienist has questions, they can go back to the CE who can obtain that information.

There is kind of a legal basis for that chain of command or chain of custody of the case that needs to be with the claims examiner from the legal perspective, and that's kind of our struggle.

But I understand what you're saying. We --

MEMBER DEMENT: I'm an industrial hygienist, not a lawyer.

MS. LEITON: I know. I'm aware. So back to our topic. Did you have something else?

CHAIR MARKOWITZ: Just a quick follow-up question. So as a matter of protocol, when the CE sends a statement of accepted facts and a request for industrial hygiene analysis, do they send the OHQ the EE-3, whatever the claimant affidavit, the results of the SEM, are all those pieces sent to the IH? Because the IH needs that in order to do their work.

MS. LEITON: Yes, I believe the OHQ is sent. You know, we do do an assessment, the claims examiners do do an assessment of those that are reported on the OHQ to see how it presents with the other information that we have in the SEM. The SEM is one of the sources that we rely on for that, but we will refer the OHQ to the IH as well.

CHAIR MARKOWITZ: So then the second part of that question then is, when a referral is

made to the CMC, are those same pieces of the exposure data sent to the CMC?

MS. LEITON: Usually once it's reviewed by an industrial hygienist and we've confirmed certain exposure facts, that's what we'll send to the CMC versus the actual OHQ unless the physician wants to see the OHQ.

CHAIR MARKOWITZ: Okay, thank you. Is there a question?

MEMBER MAHS: Yes, Ron Mahs. I had a question when reviewing these cases, it kept coming back to me. Is the IH that's doing these claimants in a remote area, or is he at the site where the claimants are working?

MS. LEITON: We have a contract with the industrial hygienist that we refer these to, and so they have a variety of different experiences in terms of their history and resumes and that. So they're not on site with the DOE facility.

MEMBER MAHS: It seems odd how they get an exposure level without actually seeing the site and knowing what's going on.

MS. LEITON: Well, they're industrial hygienists. They have expertise in this area. That's why they do this for us.

MEMBER REDLICH: I had one related question, just more for the process. And I would second that reviewing some of these claims, that makes me appreciate the challenge of your job. They're really --

MS. LEITON: They're long. Some of them are very --

MEMBER REDLICH: No, and it's just multiple diseases definitely, and physicians are not always helpful in this process, but I think this is a simple question. There were one or two where there had been a hearing and a taped --

MS. LEITON: Transcript.

CHAIR MARKOWITZ: Transcript.

MEMBER REDLICH: -- transcript. How often does that happen, or what stage of the process? Because in just following up on what Dr. Dement said that the worker's description of what they did in that transcript was sometimes helpful.

And I wasn't clear, you know, when and how that happened.

MS. LEITON: So we issue a recommended decision at the district office level, and that is conducted by our claims examiner to develop the case and they do all of the initial development referrals to the IH; to the CMC oftentimes. Once they issue that recommended decision, the claimant has the right to appeal it.

All cases go to our Final Adjudication Branch who issue the final decision on every case, whether it's accepted, denied, whatever. They issue that final decision, which becomes the decision of record.

Before that final decision is issued, a claimant can ask for a hearing with hearing representative. And that's where you'll see the transcripts. They'll meet with them either on the phone or in person and present their arguments.

They can also, claimants can request a review of the written record where they submit additional information in writing. That can be

additional medical reports. It can be whatever. Or they can waive their right to object, and they'll usually do that if they haven't accepted so we can issue a decision quickly.

At that stage, after the hearing, the Final Adjudication Branch hearing representative will review all the evidence and issue a determination. Sometimes that determination is to affirm the recommended decision.

Sometimes if they get additional information that they feel requires more development, they can remand the case back to the district office and say, conduct additional development before we do a final decision. And they'll issue a new recommended decision after that, which will then go back to the FAB.

They can reverse. If there is enough information to accept, then they'll reverse a case. So those are the process stages.

MEMBER REDLICH: Thank you. That was very helpful. I guess there's nothing simple about this process. And just a related question, some

people have had attorneys involved and others have not. How common is that? And the attorneys seemed to be involved in the process of the hearing.

MS. LEITON: Any claimant has the right to an authorized representative. It doesn't have to be a lawyer. It can be somebody that can represent for them. That could be a daughter or something like that. They just have to put it in writing and say this is the person I want representing me.

Some of them will hire attorneys. They don't need to. We'll hold a hearing with the claimants. We try to assist them through the process by talking to them. The claims examiners will talk to them. They can go to the resource center.

So there are a lot of other ways that they can do this alone, but sometimes they do it. I don't have an exact percentage. I think it's probably less than half to have authorized reps, but don't quote me on that because I'm not sure.

MEMBER REDLICH: Thank you. That was

helpful.

MEMBER MIKULSKI: This is Marek Mikulski and this is a question along the lines of the procedures. In looking at the claims that we have received, I've noticed a lack of consistency in referrals to the CMCs and IH. I was wondering if you could comment on at what level the decision is made for referral of the case to CMC and IH?

MS. LEITON: So a claimant --- claims examiner will first develop the case with the claimant and say we need medical information, or we need exposure information. The employment information we go directly to Department of Energy first, and they will provide us with employment information if they have it.

But then we'll go to the claimant, ask them for information. If the claimant comes in and doesn't have a diagnosis for example, that's kind of a nonstarter. We won't really go to a CMC at that point because we don't have a diagnosis on which to base anything.

But if we get a diagnosis, if we get

some indication from the doctor, even if it's, I believe this is related to his work, we'll develop it further to either hopefully go back to the treating doctor, say this is what we know, you've indicated some sort of causal relationship. And if they can't always provide us with information, but we know that there was exposure because we've done exposure assessment, we'll send it to a CMC because their physician couldn't provide us the information.

But there's various stages that we have to go through. First, we determine if there's a diagnosis. We determine if there was covered employment. Then we determine whether there was any exposure, if we have any evidence of exposure. And then it goes to a CMC. So it really depends on at what stage, you know, what the facts of the case are to determine whether it's going to go to a CMC.

It's not a requirement. Sometimes we can get the information from the treating doctor without doing that. But it really depends on the

case.

CHAIR MARKOWITZ: I'm sorry, Ms. Pope.

MEMBER POPE: Duronda Pope. It just seemed like there was some inconsistency in some of the cases that I was reviewing in terms of information from the treating physician was given to the CMC and the IH.

And they looked at this information but it just seemed like there was so much information supporting the fact that there was exposure. The illness was verified and confirmed. But at the final adjudication, it just seemed like it wasn't enough. I just didn't understand, you know, the weight.

MS. LEITON: I would have to see the case. There's so many varieties and variations. If I saw the case to talk through, I could, but, you know. The determination is based on the evidence that's in the case file and the determination by the claims examiner based on the procedures that they follow.

So, you know, in terms of

inconsistencies, once you guys have reviewed these cases and have questions, I can be in a better position to answer those sorts of questions. It's 10:15, you want me to continue?

CHAIR MARKOWITZ: What's the sense? Do we want her to finish this or should we -- why don't we take a break for a few minutes. We will reconvene at 10:30.

(Whereupon, the above-entitled matter went off the record at 10:15 p.m. and resumed at 10:36 a.m.)

CHAIR MARKOWITZ: Okay. We're going to get started again. I think Ms. Leiton was reminding us of our requests and DOL responses -- or our recommendations and DOL responses, so you can continue.

MS. LEITON: Okay. Is it on? How about that?

Okay. So, I was on No. 3. I think we talked about the referrals to the industrial hygienist. I think we've beat that one to death already, unless you have further questions.

Yeah.

MEMBER TEBAY: I'm Calin Tebay.

I -- in reviewing the claims -- and, so you know, just these claims -- working at the HWEC -- for you folks that don't know what the HWEC is, it's the Hanford Workforce Engagement Center -- in a year's time -- and I'll -- this will be relevant here shortly, but in a year's time we've seen 4,000 individuals.

Some of those people are repeat at our facility, and a majority of those are EEOICPA claimants.

And with the new presumption law for the State of Washington, we're starting to see, obviously, more and more go in that direction as well.

So, we review claims on a daily basis and we're getting a lot of folks coming in with denied claims or people that are starting claims.

But when we talk about the CMCs and the IHs, what's concerning for me --- and I think I'm piggybacking onto several earlier comments, but

there seems to be all too consistent reviews by IHs and CMCs almost like the reviews are based on assumption because the information is not in the file.

Often we see the review from the IH say that there is significant exposure. The claims examiner says there's significant exposure.

Yet the IH's response at the end of that review says, there's no exposure at or above an OEL or a PEL; therefore, maybe the condition or disease is not verifiable, it's not confirmed, whatever that term may be.

So, my question is, is that -- we see that often. So; one, I don't believe -- and maybe this is a question solely on the Board -- that just because you're not exposed at or above a PEL, does that eliminate you from having a condition or disease? I don't think so.

Or the fact that just because you were exposed at or above a PEL, that doesn't also confirm that you're going to get a disease or a condition.

So -- but the information I'm more

interested in, is how did the IH come to that review or that piece of information?

Is there something in the file that says that individual was not exposed at or above a PEL or an OEL?

And if it's not in there, then the summary or the remarks, they're based on assumption because we all know that the records, those exposures -- sometimes the exposures these individuals that are exposed to, they're not even monitored for.

So, the actual IH data doesn't even exist to make that kind of a comment. So, that's where I'm confused, right?

I just -- it just, for me, on a daily basis seeing this comment, is really concerning. And that's where I think Ms. Dement earlier talked about the IH involvement with the actual employee.

Now, what we've started doing at the HWEC is telling people that they need to provide a summary of their work history and the actual -- along with the OHQ, provide a summary of their

actual work processes they were involved in because, let's be honest, we can tell you that most folks do not understand the exposures or know exactly all the exposures that were involved in that process.

The IH data is really sketchy for those processes and those jobs. So, I'm really concerned that we don't -- we're missing that piece, right, that link.

And that's not only -- that's not on the DOL, right, or the claims examiner, but it starts at the claimant being able to explain those processes they were involved in; but just because it's not there in the file, doesn't mean it doesn't exist or it didn't happen.

MEMBER DEMENT: I'll follow on with that. This is John.

I fully support what you're saying. And a number of these cases that I reviewed, here's the phraseology: No available evidence, paren, i.e., personal or area industrial hygiene monitoring data, paren close, to support that after

the mid-1990s because exposures would have exceeded existing regulatory standards.

I looked at the file as well in the DAR and whatever came back. There's no data in there to support this statement.

So, if the IH is going to make this statement, he should be required to quote the available data to support it. Otherwise, it's a presumption on his part -- his or her part.

MEMBER TEBAY: We -- just to finish up, we often -- and I don't know how all sites do it, but sometimes when we work in groups, maybe one individual in that group is actually assigned some kind of monitoring equipment, right, a personal monitoring equipment.

Therefore, the rest of the group, if there is an exposure that's concerning that's at an action level, for instance, not even over the regulatory limit, some of the employees aren't even made aware that that level had been reached. Only the employee wearing the actual monitoring in that group was made aware.

So, all of us could be in the same room, you could be wearing the monitor, but none of us would have been notified that those exposures even existed in that process that day.

So, the data doesn't exist when these IHs or these, you know, contracted IHs make these, you know, these summaries or provide these reviews on, really, no IH data.

So, my -- I think it's a little unfair, obviously, that an IH can make an assumption against the claimant, but the -- it doesn't work both ways, right?

So, I'm a little -- that's where my concern lies. And I know that we talked about this and it's going round and round, but ---

CHAIR MARKOWITZ: Thank you.

Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Can you hear me?

Okay. Essentially, what we're talking about is a presumption that there's no exposure. In other words, when you have a workplace where

there are variable levels of, let's say, asbestos and the person is a maintenance worker and you know that the levels are varying from day to day or from month to month by some amount, depending on whether it's disturbed or not, how many people are working in the room, but the industrial hygiene measurements are only done either randomly, very infrequently, or not at all, or done in response to some concern after some cleanup was done.

You don't know what conditions under which the industrial hygiene measurements have been done.

So, essentially, it's a presumption to say that there is no exposure above the standard, and that should be identified as a presumption rather than to say there's no evidence, because you can always say there's no evidence.

So, I think it's a little bit unfair to frame the statement in that way that gives a false scientific credibility to it as if there were data that would find the exposure if it were there, because it's not being done.

We know that the sampling isn't being done very frequently and -- in medicine, we refer to it as "sensitivity."

In other words, if there's a disease, what's the probability that the diagnostic test will find it?

So, in this case, if there's an exposure, what's the probability that industrial hygiene sampling will document it?

It's actually pretty low. So, I would say that that kind of a phrase really should not be acceptable in ---

CHAIR MARKOWITZ: So, let me just jump in.

Circular 15-06 was rescinded and that was stated that there was a presumption that exposures 1995 -- or after 1995 were within the regulatory limits unless there was compelling, probative evidence to the contrary.

And the language that's currently used in the claims that we've all seen by reviewing these claims, it seems to be an extension of that circular

which was rescinded.

So, what's the explanation? I --

MS. LEITON: I'm glad you brought that up.

So, the Circular that told claims examiners not to go to an IH after -- for cases that were after 1995, we rescinded that so that now they go to an IH.

There are going to be presumptions that IHs make without evidence. If you have no evidence that there was any excess, you have no records about the levels of exposure that the person might have had that would be outside of that, then our IHs are going to make some assumptions.

If we didn't have IHs, we'd be denying a lot more cases. 26 percent right now, I can tell you, went to IHs and were accepted after.

So, before you -- Dr. Dement, before you do that, I just did want to point out that in your recommendations back to us when we talked about this asbestos exposure and such, the Board said: The Board has not yet identified surveillance

information that supports use of 2005 as a threshold date for presumed significant exposure -- asbestos exposure. As a default and until such information is identified, the Board recognizes that DOE Order 440.1, issued in 1995, likely served as an important stimulus for change in DOE health and safety policy and procedures. The Board, therefore, agrees to the use of 1995 as a threshold date before which sufficient asbestos exposure occurred among maintenance and construction job titles, assuming the temporal requirements noted above, to meet a presumption of asbestos-related disease.

So, there are going to have to be some asbestos -- there's going to have to be some presumptions made when we don't have evidence to the contrary.

If we have the HWEC information, that's going to help us. The more information we have, the more we can do a better assessment.

But if we didn't have IHs at all, then -- we got the IHs to help the claim move forward. We didn't get the IHs to deny claims. We did it

so that we could make some sort of exposure assessment, in the absence of any, to help these claimants with their claims.

So, you know, this is something we addressed -- this 1995 issue, the Circular issue, we addressed it in our recent response to the Ombudsman's report that you guys probably saw last night.

The one that's posted to the ombudsman's report is from 2015. This issue was addressed there. We discussed the fact that the Circular is one thing, but the threshold is a different thing, and that's why you're still seeing that language.

We still -- we -- that circular required claims examiners to make that assumption in every case without going to an IH. That is a requirement that was lifted.

CHAIR MARKOWITZ: Dr. Dement.

MEMBER DEMENT: I accept, and I think most hygienists would accept, that experience and knowledge of the hygienist needs to be used when

appropriate.

But what I really object to is the statement in here that it makes -- it doesn't -- the hygienist is not being forthright with regard to, I am assuming -- it makes it appear as though there's no exposures -- there actually is exposure information that will support that statement.

What I would like to see is the hygienist just say there's not much with regard to exposure information available; however, in my opinion, or based on my experience, or based on the published literature, exposures after this time frame would likely have been -- likely have been within, you know, regulatory exposure limits, but it doesn't, you know.

To me, when this goes to the CMC, the CMC takes that as a bold statement of fact when actually it's an opinion, a learned opinion, of course, but it's, nonetheless, an opinion.

MS. LEITON: I can look at the language. I'm pretty sure they say "likely would have been," but in terms of -- we can always look

at modification on that language.

I do know that they say some of that language, but we can definitely look at it.

MEMBER TEBAY: With that, it's so important to -- what that language says, because that -- what happens, is you create a waterfall.

The minute that statement is put into place, it changes how the CMC reads it. It changes how -- or the ability for the claimant to respond.

Because once that statement is made that it's somewhat fact that it doesn't exist, you're put in a hole to try and rebut that comment to where if everybody knew that was looking at that claim that the reason they made that statement is because there was none in the file, but doesn't mean it doesn't exist, just means that I'm presuming.

Well, I can rebut, as a claimant, or help claimants rebut the fact that there's a presumption that there was no exposure.

I know claims very well at Hanford that we've used the site occupational medical director

or IH on staff to say, this person working in this process as a sheet metal worker would have been exposed to these -- you know, would have been exposed to A, B, C and D significantly, which changes the whole outcome at that point.

Now, there's still not any IH data to document levels of the exposure, but that changes the fact that the first IH said that it doesn't exist. So, we have to be very careful with that language going forward.

CHAIR MARKOWITZ: Dr. Redlich.

MEMBER REDLICH: Carrie Redlich.

Let me just add one more comment to this whole discussion just from the perspective of a pulmonary or occupational medicine physician, you know, deciding whether the problem is work related, you know.

For the past 30 years, I -- we depend and use industrial hygiene input, but what's frequently most helpful is a knowledgeable -- you know, they're all knowledgeable -- an industrial hygienist who's knowledgeable about that

particular site or process.

And frequently it's qualitative information that is also used in addition to quantitative in terms of, you know, the type of process, if it's spraying, welding, heating, enclosed space, the time period, and that -- and an understanding of the process that's being done.

And somehow that -- and the questionnaires that the workers fill out, or if they've had a transcript, actually provide sometimes more of that information than the SEM report.

But from -- it's almost like it's a higher standard than is the standard of care in which -- in 30 years in my practice, this clinical practice, is almost entirely patients with pulmonary disease with the specific question, is it exposure related.

I think the number of times that there has been quantitative exposure data from that workplace that supported -- and I do not just accept everything.

I have a pretty high threshold, but the times that there's actually quantitative data that supports the exposure is so rare it's -- because that's a -- even in a workplace where sampling is done, as the point's been made, it's so sporadic.

So, we do want industrial hygiene input, but it's frequently more based on a qualitative understanding of the process and the time period and all that information that we've put together.

Unfortunately, most physicians because they know so little about the workplace or exposure data, I think over-interpret sometimes the SEM in a way that it wasn't meant to be interpreted as, like, the definitive word.

CHAIR MARKOWITZ: Okay. Other comments?

Dr. Silver.

MEMBER SILVER: I have an information management question about those nuggets of industrial hygiene data that do exist going back to Calin's example of a group of Hanford workers.

Let's say a couple of them at this moment in time have chronic illnesses, they file claims, they don't have any exposure data, their claims are denied.

A few years go by and finally that one guy who does have evidence of exposure develops a chronic illness. He files a claim.

What happens to that exposure information: A, do you fish it out of his file and post it somewhere so that it can be generally applied to new claims, and; B, will you go back and look at the denied claims of those earlier workers in light of that exposure data?

MS. LEITON: Do you want me to answer that or do you want to have follow-up?

So, I mean, if I have one case that has a certain set of facts and I have another case that has a certain set of facts, I don't have the same claims examiner reviewing every case.

So, I'm not going to know, necessarily, that this person had the exact same fact pattern as this other person and be able to go back to that,

unless there's something I can apply globally in making a presumption that people in this category -- then we can put it in the SEM and we can go back to the SEM and put that change in there.

So, that's the best way that I can do that and go and reopen a case. I can reopen a case at any time if there's new information.

So, if that other guy asked for a reopening and said, "I have this new information," then I can go back to that case file, pull it out and reopen that case and accept it.

But unless there's something I can generalize on and go back and put in the SEM and then reopen that set of cases, which we have been able to do, that's the best we can do when it comes to that scenario.

MEMBER SILVER: So, if I understand, though, on my first point, you routinely fish exposure data out of individual claimant's files and add the information to the SEM?

MS. LEITON: If there's new information that can be added to the SEM, we

absolutely do add it to the SEM.

CHAIR MARKOWITZ: So, do you want to continue with ---

MS. LEITON: Yeah. Sure.

Okay. So, I think we were -- well, we were still on No. 3 and this was with regard to the information sent to the industrial hygienists and the CMC.

Do you have further questions on that one?

Okay. The next one is on presumption for asbestos-related diseases. The advisory board recommends that the program add or modify presumptive standards relating to several asbestos-related diseases, the five conditions of asbestosis, asbestos-related pleural disease, lung cancer, and cancer of the ovary and larynx.

And the Board also recommends applying the presumption to all DOE workers who worked as a maintenance or construction worker.

And it has suggested that the presumption standard use 1995 as a threshold date

before which sufficient exposure occurred.

So, we did make the changes, as you know, and we've been reopening the cases. We made some of the changes.

So, the existing presumption for asbestosis, that the employee must establish diagnosis of asbestosis, significant occupational exposure to asbestos for at least 250 aggregate workdays in a 10-year latency, is what we added.

I note that you guys have more recommendations with regard to asbestos, I believe, in your recent recommendations. So, we'll be looking at those separately.

Lung cancer, we added the presumption as you have suggested. The same for mesothelioma, asbestos-related pleural disease, ovarian cancer and laryngeal cancer.

The labor categories, again, it has been an area we've gone back and forth with you all about in terms of how we characterize them, what we add, what we don't add to that list of presumptions for labor categorizations.

I also want to note that I believe your recent set of recommendations goes into further detail there, so ---

CHAIR MARKOWITZ: That's correct.

MS. LEITON: -- we'll be evaluating those as well.

Let's see. I think that covers that because I'm not going to talk more about the labor categories until we've evaluated your additional information.

No. 5, presumption for work-related asthma. The advisory board recommends language changes to procedural guidance relating to these, the presumption for occupational asthma.

As part of this recommendation, the Board has offered an alternative definition of the term "toxic substance."

Again, you've revisited this toxic substance issue in your most recent recommendation, so we will be addressing those again later.

We did make some changes to the asthma language in our Procedural Manual, but, as Dr.

Redlich points out, maybe not all of them. We can continue to look at that.

Revise recommendation No. 6, presumption for COPD. The advisory board recommends modifications to the presumptive standards for evaluating claims involving COPD. Basically, this is the issue with regards to vapors, gases, dust and fumes.

It also recommends changing the period of exposure necessary to trigger presumption from 20 to five years.

The SEM has some of the health effects, some of the toxic substances that are included in vapors, gases, dust and fumes that are linked to COPD, and I think that's what we mentioned here.

We legally have been having disagreements about the use of that term and how it can fit into our assessments because of various factors and the fact that it's a broad term.

I think that you've also addressed this again in your most recent, so we'll be looking at what you've provided to us there.

CHAIR MARKOWITZ: Right. And we're going to be discussing COPD claims, so some of this will be revisited.

Dr. Friedman-Jimenez, did you want to say something?

MEMBER FRIEDMAN-JIMENEZ: Going back to No. 5, the asthma, what is the language that precludes using the NIH definition of a "toxic substance," which, I think, is quite well-accepted worldwide, the National Institute for Environmental Health Sciences.

What is it that keeps you from being able to accept this really expert body definition of a very fundamental term?

MS. LEITON: The statute, the way that it's written -- my understanding, from discussions with our lawyers -- is that the phrase "toxic substance" comes from the statute and they've defined it a certain way.

So, in order for us to -- so, we, therefore, have to define it the way that we define it.

The statute and the rulemaking, they have the force and effect of law. And so, we can't consider how other entities define "toxic substance" because of the way the law is written.

MEMBER FRIEDMAN-JIMENEZ: I mean, we're not talking about just any other definition. We're talking about the NIH, which was created by Congress --

MS. LEITON: Yeah. Congress created the ---

MEMBER FRIEDMAN-JIMENEZ: -- defining something --

MS. LEITON: -- statute, too, though.

MEMBER FRIEDMAN-JIMENEZ: -- that Congress doesn't have the expertise to overrule, I think.

MS. LEITON: Well ---

MEMBER FRIEDMAN-JIMENEZ: So, I'm just wondering what exactly is the language that prevents you from using this better and more widely accepted definition?

MS. LEITON: It's the language in the

statute. I can provide that to you separately.

CHAIR MARKOWITZ: Thank you.

MS. LEITON: Okay. So, on to No. 7, the OHQ.

CHAIR MARKOWITZ: Right. That was subject that we made a further recommendation about the OHQ.

MS. LEITON: Right.

CHAIR MARKOWITZ: So, you can skip that.

MS. LEITON: And then the last -- I think it's the last one. The last one is the quality assessment.

The Board recommends improvement to the quality of the CMC auditing. We do audits through the medical director as well as accountability reviews.

So, some of the recommendations surround the fact that maybe these CMCs or the way we apply the CMCs aren't being utilized correctly. So, we do have what we have in place currently.

CHAIR MARKOWITZ: That's okay. We

know we're looking at the CMCs ---

MS. LEITON: Yeah. Right.

CHAIR MARKOWITZ: -- when we're reviewing these claims. So, I'm sure we'll have further advice.

MS. LEITON: Okay. So, then I think that that covers it.

CHAIR MARKOWITZ: Okay. Any questions/comments from the Board members?

MS. LEITON: And I am seeking clarification on that issue that you asked me about from the Procedure Manual. I should hopefully have something soon.

CHAIR MARKOWITZ: Okay. Thank you very much.

MS. LEITON: Thank you.

CHAIR MARKOWITZ: Mr. Fitzgerald.

MR. FITZGERALD: I just want to take a couple of minutes to kind of update the Board on the kind of internal ---

CHAIR MARKOWITZ: Excuse me.

Can you hear in the back?

MR. FITZGERALD: Can you hear me?

Can you hear me now?

Okay. All right. I just wanted to update the Board and the public on a couple of, like, internal issues that we're addressing right now.

One, is that the Board's charter, as most of you probably know, is a two-year charter and needs to be renewed every two years. So, this July is when the current charter expires.

We've started the process internally that the FACA -- the Federal Advisory Committee Act -- process within the Department of Labor to issue a new charter. We don't anticipate there being any significant changes to that.

We fully expect the charter to be in place by July when it expires now and I don't think there's anything the Board has to do.

It's just kind of an internal process. I just wanted it to be on record that we have started that process and we expect there will be a new charter in place by July.

Also, as most of you are aware, we are shy one board member with the departure of Dr. Victoria Cassano.

We are actually going to be putting out -- I think, later this week or early next week in the Federal Register Notice, there will be a solicitation going out soliciting a new member for the Board either from the scientific or the medical community.

Because the way our composition of the Board is right now, we can kind of move members around so we can actually entertain the idea of there being a medical person or a scientific person to fill that particular slot.

So, that gives us a little bit more latitude in terms of, you know, the universe of people we can consider.

That nomination period will be open for 30 days. At which time, we will close the nomination process and then start our internal processes for vetting and reviewing the candidates that are being nominated.

And we hope to have somebody in place this summer, so kind of almost in tandem with the charter renewal as well. So, I just wanted to let everyone know that.

The third thing I wanted to -- and the last thing I wanted to just advise the Board about, is that, you know, we -- the Board has been around now for several years and we've gone through kind of like a -- probably a little bit of a learning curve in terms of how the Board requests information from the program.

At the last meeting, there were a number of requests for data and it kind of elevated the issue to the point where we think that it would really help the Board as well as help the program to kind of regularize the process for requesting data, particularly claims information.

The last data request that you all received, you see how voluminous it is and we have to be very concerned about protecting PII and those sorts of things.

So, we've actually created a -- kind

of a very straightforward form that the chairman is going to submit to the program for requesting data, particularly claims data, so that we understand exactly what the purpose is and what the intended use is.

And it will help the program, I think, and the Board work together to make sure that the data requested can be fulfilled.

Sometimes, I think, we do this sort of request on the fly sometimes during board meetings. It's like, well, we should get claims in on that.

And so, it's kind of found in the transcripts of the meetings, so we want to kind of formalize that request process a little bit more so we can actually determine the data that's being requested and then determine a time frame for the delivery of that data to the Board.

And I've talked to the chairman about that and I think we're on the same page with that.

It's a pretty straightforward sort of thing, but I think it will help kind of formalize and kind of, you know, bring more consistency of

data requests from the program.

And those are the three items I just wanted to bring everybody up to speed on. Any questions?

CHAIR MARKOWITZ: So, I think -- this is Steve Markowitz.

I think -- I don't know, Carrie, do you have a copy of that form that -- okay. We're trying to bring that up so people can look at it. You can see what's being requested.

That's fine. We will, I think, be able to complete those forms for -- well, here's a question, actually: We made a data request -- claims request December 10th. So, that's four and a half months ago.

Do you want us to fill out that form for -- with reference to that data request?

MR. FITZGERALD: Yes. In fact, I've asked Carrie to actually do kind of a first -- a first cut at that request based on the commentary that we heard from the last board meeting.

A lot of that -- the request, I think,

was kind of, like, cobbled together in terms of, like, just a general statement, we need this and we need that.

The form will help us kind of, like, break that down into its component parts and so we can address it one at a time.

CHAIR MARKOWITZ: But if we're talking about how to facilitate the process, so we need to know what the -- understand what the challenges are in assimilating the data requests.

And if the problem is lack of specificity on our part, then we need to hear directly from the -- or however you want to handle it, we need to hear where the specific areas of clarity are needed.

The form is not necessarily going to settle that issue because there will be -- there needs to be some back and forth.

MR. FITZGERALD: Yes.

CHAIR MARKOWITZ: And so -- but that back and forth doesn't really happen that much. So, the question is, how can we make that happen

so that we can -- we all can fulfill the request in a more timely fashion.

And then maybe that's a question for Ms. Leiton, I don't know, but I just say, you know, for having submitted a data request four and a half months ago and I haven't received any questions about what particular data we want or -- I don't -- the process is opaque to us.

It's a little frustrating because it doesn't, from our perspective, appear to be all that complicated.

I'm sure it is, but I should say the first board, we made a similar data request and we got data in a much shorter period of time.

And Dr. Dement did some work with this data and they were very illuminating, actually, to our processes.

So, I'm all for a data request form, but I don't think that's going to necessarily solve the problem because there needs to be some iteration, some back and forth, so that we can actually get to the -- a solution.

MR. FITZGERALD: I mean, I would agree and I think that this form actually helps kind of define what those requests are so there can be that kind of back and forth.

I would like the back and forth to be as limited as possible, but right now it isn't really happening in a very formalized way.

But I think that being able to articulate the request will elevate the issue for the program to be able to say, okay, you're asking for this information, either we have the data, or we don't have data, or it's going to be very hard to extract this data, is this what -- really what you need? We might have proxy data that we can substitute for certain things you're asking for.

So, there will be a little bit of back and forth and a little more clarification, I think, of the request. And I think this form will help, you know, facilitate that conversation.

MS. LEITON: This is Rachel.

I think that part of it is to understand what it's going to be used for, how it relates to

the mandate of the Board.

And if we know what it's going to be used for and how -- what you're specifically looking for, we can usually -- we can get the data in a format or in -- the information you're actually trying to get at a little bit easier. So, I think that was kind of the purpose behind it.

I'm hoping that we can work with Carrie to facilitate this next step fairly easily.

And I think that's what Doug was alluding, is that she can help frame what we're looking for in those requests as examples, correct?

So, Carrie will facilitate back and forth, as necessary, for this one and then -- and the additional ones.

CHAIR MARKOWITZ: But let me just say that the time frame has to be appropriate. So, if we submit a request December 10 and 2 weeks later we're asked, "What do you need these data for? How is it relevant to your chartered tasks?" that's fine.

But, frankly, to be asked that four and

a half months later is not so fine. It doesn't really make sense.

So, we just need to shorten the time frames and have whatever back and forth is needed so that we can do the work that we're being asked to do.

MS. LEITON: And I'm sure that in future requests it will be a much faster turnaround.

CHAIR MARKOWITZ: Okay. Normally, we like to get specific and talk about numbers of days and weeks, but we will bypass that for the moment.

So, thank you -- oh, this is the data request form, but you can see just briefly delineation of the requested information is the first item.

So, I guess -- I think that, if I'm reading that correctly, it just asks for some degree of specificity.

The second item is statutory authority. They want us to name what part of the statute, that is to say, which of our four assigned tasks the request relates to.

Whatever -- the third item is supporting rationale. That is to say it supports No. 2. Why it is that what we're requesting is needed to fulfill our function on our chartered mission.

And then No. 4, there's a fourth item, which is intended use. So, it's pretty straightforward and I'm sure we can complete that.

MR. FITZGERALD: And there's also just the appropriate notification about how this information is, you know, protected under the Privacy Act.

So, it's just a good way to document that everybody has been informed about the privacy issues regarding the information that's about to be shared with the Board.

CHAIR MARKOWITZ: Great. Okay. So, let's move on -- oh, so I would like to welcome Mr. Malcolm Nelson, who will present to us the Ombudsman report 2017.

For board members, I just want to point out that sometime, I think, late last night we got

-- I think it was late last night we got a -- the DOL response or comments on the Ombudsman report.

So, I just want to point out to you, in your email, there is some commentary from DOL about the report.

MS. LEITON: (Speaking off mic.)

CHAIR MARKOWITZ: Okay. Anyway, welcome -- welcome back, I should say.

MR. NELSON: Yeah. Good morning and thank you for inviting me.

I am Malcolm Nelson, the current Ombudsman for the Energy Employees Occupational Illness Compensation program.

As I said before, I want to start out by thanking you for inviting me here today, and I also want to commend the Board for its work reviewing many of the complex scientific and medical issues that underlie this program and to put forth recommendations intended to facilitate the claims process.

When I received this invitation, I was faced with a dilemma. And it's a dilemma I have

every time I'm asked to discuss this program.

There's so much I would like to say, and I realize I have a limited amount of time to say it.

Secondly, I'm an attorney. I am an attorney and, you know, in law, a brief can be 50 pages.

I was helped, however, because the Alliance of Nuclear Worker Advocacy Group provided the Board with a letter asking my office to outline certain issues.

These issues included examples surrounding the use of the SEM, issues involving the use of the language similar to the language in the now-rescinded Circular 15-06, and issues surrounding the policy regarding claims for bilateral sensorineural hearing loss.

For the sake of brevity, I'm going to limit my comments to those issues. However, there is one issue I do think -- or, really, two issues I really do think are important that are not related to those.

First, one of the biggest problems we see with this program is that claimants -- there are many claimants who still don't know this program.

And so, one of the things I want to again commend this board, is for your willingness to come to different locations.

And it's always my hope that the publicity or the work being passed around that you're coming to these areas will help pass the word out and disseminate information about this program. So, you know, that's just something I'd like to point out.

Secondly, one of the biggest issues we find, is this is simply a complex program and many of the claimants we encounter simply struggle to understand this program.

There is an encounter I had very early, as the Ombudsman, and it's one that stuck with me ever since.

And in that encounter, someone called me one day to ask about the waiver form that

claimants receive when they receive a recommended decision.

I began to explain the use of that waiver form and, as I was talking, I realized there was just total silence on the other end of the phone.

So, I finally stopped and I asked the claimant "Is there something wrong?" And very hesitantly they said, "I really need you to start with the beginning. You need to explain to me what the word 'waiver' means."

And that's really, I find, the problem with this program, that very often in this program we begin to tell claimants what to do or how to do it and, yet, they need us to start with the beginning.

They need someone to explain to them what a covered illness is. They hear "SEM." They need to understand what is SEM, what is that site exposure matrix. And I think that's one of the biggest problems.

We also see that claimants simply do not understand the claims process. They don't

understand adjudication, in general, or this claims process and specifics.

So, we often find that claimants, you know, we're telling them, "You need to file this paper" or "You need to do this," and they really don't understand how to do that.

One of the biggest issues we have found now is that claimants don't understand how to develop evidence.

Over the years, we've talked to DOL and I will commend them. They now provide claimants with the reports prepared by the specialists. They give claimants those reports when they receive the recommended decision.

But one of the things we found is that claimants have no idea what to do with that decision or those reports. That we often talk to claimants and they have -- and they'll say "I went to my doctor."

And we say, "Well, did you take that report with you to your doctor?"

And they're like "No. Should I have?"

And there's just that problem that claimants simply do not understand how to develop claims or don't understand the claims process.

And this is a problem we really see as we kind of segue into SEM, is that SEM is this tool and it's often mentioned in decisions, it's often mentioned in conversations with claimants, but claimants have no idea what SEM is.

Some of them don't even realize that it's an online tool. And so, you need to start at the beginning and often tell them, "This is an online tool" and to explain to them what it is.

Because we find that although SEM is often mentioned in decisions, claimants just kind of glaze over that because they have no idea what the SEM is.

In fact, one of the -- and then beyond that, what we find is that once claimants get to SEM, if they do get to SEM, we find that claimants have no idea how to navigate SEM.

I can't tell you how many times I've talked to a claimant and they will tell me they

have printed out information from SEM and they now know the toxins they've been exposed to.

And, yet, when we looked at what that claimant has, all they have done is gone to SEM and they have that initial list of all the toxins that were at the facility.

Those claimants don't understand SEM and don't know how to refine the SEM search to start looking at labor categories, buildings and areas and things of that nature.

The other problem we find, as we get into SEM, is that many of the claimants question the accuracy of the information found in SEM, and we've already started to discuss some of that.

But the issues we hear from claimants is that, as I said before, are things that we said before, but different -- similar jobs were called different things at different facilities. So, there is that equivalency issue by claimants.

And so, we always hear claimants say, "Yes, I was a welder, but we did welding differently at my facility."

Or, more importantly, what claimants tell us is that almost everybody's job or everybody's job description has that phrase at the end "other duties as assigned."

And claimants always tell us that they did a lot of other duties as assigned, and those duties simply are not written down anywhere and not recorded.

And so, a big problem for claimants is that there really is no process of really understanding what they do and this turns into an issue with the occupational history questionnaire.

We find that claimants generally take this history questionnaire very early in the claims process and that basically what the claimant is told to do is tell me everything about your job.

And what I find, is that claimants approach that, kind of in my mind, the way you approach your résumé.

You talk about -- you talk a lot about the things you're doing now, but you don't talk so much about the things you used to do years ago.

And so, the problem for claimants is that they've done this occupational history questionnaire and now it's going to be used to make determinations, it's given to the IH or these other specialists in making determinations about their job.

And the argument by the claimants is that as this case starts to get refined, as you begin to identify the specific toxins or as you begin to focus on certain jobs I have, there needs to be some going back to the claimant so that claimant can now provide more detail about those specific issues.

And that's really an issue like, you know, where many claimants say that in addition to -- well, let me move back.

The Board has recommended that claimants -- that industrial hygienists should be able to talk to claimants.

Claimants agree with that, but claimants go a step further and they think that they should be able to talk to all of the specialists

that are going to have input in their claims because claimants feel that they can begin to explain to these specialists the very specific things about their job.

And, as I said before, and especially as the case begins to narrow -- as we begin to narrow the focus of the case, claimants feel that they can provide that detailed information, information you are not going to give in a general conversation about your job, but information you may very well provide when somebody is asking you about your -- this specific job or this specific exposure.

The other problem claimants have, you know, they often point out, is just finding records.

Most claimants, because they worked at these facilities, they never had access to records.

So, there is that question from claimants, you know, "You're telling me I need to support -- you know, need to submit more evidence about my work or my exposures. Where do I find records?"

And for many claimants because they don't have records, they end up having to rely on their own testimony, what is often called "self-reporting evidence," and claimants question the weight that is given to the self-reported testimony.

I hear complaints all the time from claimants suggesting that they took a lot of time talking to their claims examiner, telling them about their job, yet that information is not -- sometimes it's not even mentioned in the decision.

And if it is mentioned in the decision, it's seen not to have had any impact on the decision.

It's often suggested -- I've had it suggested that just because the evidence is not mentioned in the decision does not mean that that evidence wasn't considered.

The problem for claimants, however, is that if the evidence is not addressed in the decision, they don't know if -- first of all, if it was actually reviewed.

And if it was reviewed, they don't

understand why it was not accepted, and that leaves claimant in the position of not knowing what to do next, you know.

I've told -- you know, the claimants tell us "I've told the CE my job. It did not seem to impact the CE. Do I need to tell them more detail? Did they not understand what I said? Do I need to clarify what I said or is it that I need to go get more information?"

The feeling we hear by most claimants is that when it comes to self-reported evidence, that evidence is only going to be accepted if it is supported by other evidence in the record.

And, again, this troubles claimants because self-reported evidence is usually most critical in those instances where there either is no other evidence or where they feel that the evidence in the record is inaccurate.

So, you know -- and claimants also feel that -- there is a concern that claimants have that because they're often talking to a CE who does not fully understand that work, especially does not

understand how that work was done 20, 30, 40 years ago, that they would love to talk to someone who has more experience.

And that's something that claimants often argue, is that when you're talking about this work -- and this goes even in talking to the industrial hygienist or when the industrial hygienist is reviewing the report -- it's not how that work is done today, it's how that work was done 20, 30, 40 years ago.

And not just 20, 30, 40 years ago, but was done in a closed environment behind this gate where oftentimes they were being rushed to do this work.

Claimants tell us that in much of -- they worked in an environment -- many of these claimants tell us they worked in an environment where getting the work done quickly took precedence over following rules and regulations.

And so, claimants say "You have to understand that" -- and that's something I often tell claimants, "I understand."

Very early in my life I worked for five summers for the Central Intelligence Agency. I was a summer employee because my parents worked here.

My job was to install alarm systems. And the things I remember about that is, first of all, working behind that gate there was a whole different world.

You -- we did things behind that gate that we would not do outside of that wall because we knew we were in this insulated world.

Like, I tell people all the time, I was up on aluminum ladders holding a Coca-Cola in my hand and cutting wires -- live wires because that's how you got the job done, you know.

I didn't worry about OSHA coming in and standing over my shoulder because OSHA couldn't get behind that gate.

The other problem I realized was that in my old job, the rule was we -- once I started working on that alarm system, when I left, there had to be a working alarm system.

And I'm here to tell you I cut corners

and everything else to get that alarm system working.

I went to whatever room I had to go into to get that alarm system working and I did whatever I had to do.

And that's what claimants argue about their jobs, is that you look at SEM and SEM has this job -- is based on these job descriptions or these, you know, kind of procedures, and those are the procedures -- those are nice, written procedures.

But on a day-to-day basis, they did not follow those procedures. They were being rushed to get that job done.

And to do that job, they went anywhere and everywhere they had to go and they feel that there's simply not enough consideration to that.

Another issue we often hear from claimants regards smoking history. It's been often suggested that smoking history is not a factor in decisions, yet claimants often come to us with decisions where the CE -- and maybe sometimes the

specialist, the CMC -- has specifically referred to the claimant's smoking history and has concluded that it was the smoking as opposed to these other exposures that caused the claimant's illness.

And claimants just really want a clarification, you know, on exactly what does it mean and what consideration should be given to smoking history in these cases.

When it comes to the language in 15-06 -- and, again, this is something we've already talked to -- it's been noted that -- and I think Ms. Leiton has already said it, that while this circular was rescinded, it does not mean that the use of 1995 as a threshold to indicate general exposures would not have been within regulatory limits, was not a factual statement.

The problem that claimants have is that -- and I think it was a question that one of the board members has already raised, is what is the impact of the fact that your exposures were within regulatory limits.

Under this program, you could be

compensated if your exposures caused, contributed or aggravated your illness.

And I guess the question that claimants have is, are we saying that an illness cannot be contributed to or aggravated by regulatory -- by exposures within regulatory limits? Is that an absolute rule? And that's just the question that claimants have with that issue.

And also, if I can just say from my own experience, when you talk about presumptions, there are both positive presumptions as well as the negative presumptions.

Positive presumptions are those more common presumptions where you assume that if a person has X number of years and has certain exposures, you may presume that their illness was caused by those exposures.

Negative presumptions are not that common where you try to say, "Well, if you don't have this and you don't have this, then you can't have any exposures or your illness cannot be exposed."

Those are fairly rare and really have to be supported by a lot of evidence, at least in my experience.

In this regard, we also see an issue that claimants have -- and, I think, again it's been -- everything I've said has been referred to already, but you see these industrial hygienist report where the industrial hygienist starts out by saying the person had significant exposure; but then they provide a table rating the exposures for various toxic substances.

And those toxic substances they rate by the extent and level of exposure. So, it could be frequent or, you know, not frequent and high or low exposures.

And from that, the CE concludes that the exposure is either caused or not caused -- caused or did not cause the claimant's illness.

And claimants want to know what really are the guidelines that the CE has, and any industrial hygienist has, in determining even though you had a significant exposure, that somehow

this frequent or low -- you know, there's just -- it's really not very clear to claimants, you know.

Most of the claimants we talk to, they -- as soon as they see the word "significant exposure," they're like, "I had significant exposure."

So, what does that "frequent" and "low" mean and how is the CE to apply that in a case?

The hearing loss policy also continues to be a concern for claimants. And here, I must acknowledge that; one, the Board has been -- is already looking at this issue, but claimants question, why, if they do not meet those -- the three criteria that's been outlined by DOL, they are not given an opportunity to at least try to establish that their hearing loss was nevertheless caused, contributed to or aggravated by exposure to the list of specific toxins.

We hear this with a lot of hearing loss claims, but we especially hear it where the decision recognizes that the claimant had exposure to one of the listed toxins and had exposure for ten or

more consecutive years; yet, the claim was denied because the claimant did not work in one of the enumerated job categories.

Over the years, this has troubled claimants who noted that, again, their job was -- that similar jobs did not always go by the same name at different sites, as well as by those who noted that while their job description may not have included work similar to that performed by those in enumerated job categories, they -- these were duties that they were assigned, nevertheless.

So, essentially, claimants question whether the information concerning these job categories was so complete that it absolutely precluded the possibility that someone working in another job category could not have had hearing loss associated with the exposures.

Now, as it's been noted, DOL has just released a new version of a Procedure Manual and this version outlines a procedure for the CE when the claimant makes a claim that the job that the employee performed is synonymous to one of the

qualifying labor categories.

Yet, the concerns raised by claimants still apply to those who do not have the ten consecutive years of employment in a qualifying job category prior to 1999.

Claimants want -- you know, claimants have raised that same question about why must it be ten consecutive years?

Does the medical evidence that exists, is it that clear that a claimant who has accumulative more than ten years, but somehow somewhere had a break, that there can be absolutely no impact to hearing loss?

But we see cases all the time where the claimant had, you know, six, seven years of exposure, then there's a break maybe of six months, maybe a year, two years, and they go back to work for maybe another seven, eight years and claimants just do not understand why that break, six months or whatever it is, is so impactful that it should say that they don't get to proceed with their hearing loss case.

We also hear similar issues about that 1990 date, and we especially hear this from painters.

And painters come to us all the time and try to -- and tell us -- or ask us to try to tell us -- tell them what happened in 1990 that all of a sudden that same paint that they were using that they applied the same way, all of a sudden now it doesn't have an impact on them.

So -- and I think, as it's been said, you know, while this may be a generality or a presumption, claimants feel that they should have the opportunity to rebut their presumption and to show that, in their jobs, there was nothing -- nothing changed in 1990.

Because the Procedure Manual has been revised a couple of times, the approach to hearing loss has changed somewhat.

But one of the things that continues to confuse claimants is that some of the most recent versions, on the one hand, say that a claimant -- that the claims examiner can review or should review

the case even if the claimant does not have -- does not meet the criteria outlined for hearing loss.

But then those provisions of the Procedure Manual go on to say that if the claimant wants to challenge the criteria, the claimant has to show -- and let me try to find my language.

They have to show that -- the claimant has the burden of establishing through the submission of probative scientific evidence, that the criteria used by the program do not represent a reasonable consensus drawn from the body of available scientific data.

First of all, claimants don't -- the way the most recent provisions -- I mean, of the PM about hearing loss have been written, claimants really aren't sure of what they're supposed to do if they want to challenge a hearing loss denial.

But, secondly, to the extent that most of them read this as saying that they have to now show that the criteria is not based on a reasonable -- a reasonable consensus drawn from the body of available scientific data, claimants feel that

that's placing a very high and costly burden on them.

On the one hand, claimants feel that that means that they're going to have to go find specialists who can make -- who can address that, which first means that they're going to have to get all of the evidence or all the data the DOL has relied on.

And, secondly, you know, claimants feel that with the give and take that will often occur when you're debating medical science, that it can get very costly to try and engage with those medical professionals.

I could go on and on -- like I say, I could go on and on, but I'm going to stop here to see if there are any questions that anyone has.

CHAIR MARKOWITZ: Comments? Questions?

Dr. Silver.

MEMBER SILVER: Thank you very much for a concise, punchy, provocative presentation.

Your remarks about smoking set off a

little light bulb for me. One of the COPD cases we received involved a worker whose claim was denied.

Nowhere in the chain of evidence did anyone dispute that she smoked one to two cigarettes a day.

And we all know people like that, right? After a meal, on a break or just part of their daily habit.

Yet, when it came to the CMC's report, there was an elaborate paragraph about the contribution of smoking to COPD, and I began to wonder whether that was a cut-and-paste, boilerplate paragraph that goes into every one of the CMC's opinions on COPD.

Have you seen inappropriate boilerplate language in these claims?

In the Parkinson's case that I looked into, there was an analogous paragraph that was all about the histopathology of Parkinson's and said something about genetic risk for people under 50.

Well, this guy was 82. So, is that going on where --

MR. NELSON: Unfortunately --

MEMBER SILVER: -- there's kind of a mass production event that CMCs are cutting and pasting?

MR. NELSON: Unfortunately, my office, we don't often see a lot of the information in the claim file.

Every case with us is different in terms of how much information we see and are able to review. So, I'm really not in a position to try to say, oh, there's this pattern going on.

What we do have - I mean, we do hear from claimants with very similar - and I hope maybe it's even the same claimant, but we hear from claimants with a similar argument, is that the smoking history that seems to get passed on to the specialist, they take exception with that, you know, they say they may have smoked, you know, a lot of cigarettes in the past, but they often try to stress to the -- you know, in the occupational

history that they had not smoked very heavily in the last 20, 30 years and somehow it all got kind of reduced to a heavy smoking history.

So, I think there are claimants who do challenge the interpretation of their smoking history.

CHAIR MARKOWITZ: Questions? Comments?

Ms. Pope.

MEMBER POPE: Yes, I too want thank you for your support and help with these claimants with their claims.

I also see the similar problems and concerns when claimants are trying to -- the burden of proof is just overwhelming in terms of them supplying all this information, but having an advocate there at the resource center or in the process of these claimants trying to provide all this information, not to mention trying to navigate through the overwhelming process of trying to figure out how to submit this information -- so they're going through the history of their job

description and I notice, during one of the claims that I was reviewing, that the security guard -- he was a security guard, but the CMC had -- seemed like the CMC had this assumption that he was not exposed to the different things that the claimant was saying that he was exposed to like welding fumes and diesel fumes and how he could possibly come down with the types of illness that he had presented to the claim.

But I think it's important to have someone to have some knowledge of that site to add to the claimant's information in order to have a -- for the CMC to have that information in the case to help to support what that claimant is trying to present.

MR. NELSON: It is. I mean, again, you're having this -- what I hear from claimants in the occupational history questionnaire when they're engaged in that, you know, they've been told to talk about their jobs, but, as I said, they have no idea what the -- what anybody wants, you know.

I worked for the Government for 43 years. If you start asking me, you know, I'm sure there's a lot I would just leave out because I have -- you know, there are things I think are important, but, you know, may not be what you're looking for. And that's the problem I think the claimants have at least initially.

And then as the claim goes on, no one ever tells the claimant "Why don't you go back and update your occupational history questionnaire because now you can see that they're focusing on this issue or they're asking you about these dates. Go back and focus on those dates."

One, many claimants don't think about that. That doesn't even enter their minds.

Secondly, a lot of claimants have honestly told me they're afraid to do that because they're afraid if they go back and try to clarify the history questionnaire, they're going to be accused of now trying to make up stuff to get benefits.

So, they feel like they're kind of

caught in this catch 22, but -- you know, and that's why I said many claimants feel if they could talk to the IH, if they could talk to the toxicologist, here is somebody who at least has some expertise in these areas.

And as they begin to talk to them, they can explain, like -- you know, very often the SEM will say this person was not exposed to this toxin.

The claimant can tell you how they -- not only that they were exposed to it, but they will explain to you how they work with it.

And they feel if I can talk to someone who has a basic understanding of this job and how it was carried out, I can explain to them how I can be exposed to this.

CHAIR MARKOWITZ: Well, you know -- Steve Markowitz -- we have from -- even from the previous board, recognized -- as DOL has the limitations of the SEM and have tried to make some recommendations to improve the exposure information available for the decision-makers, including improving the OHQ and encouraging that

the industrial hygienist could speak directly to the claimant. So, those would be concrete ways in which the exposure information could be improved.

I have a question -- and actually it's not about the work of the Board per se, but the first point you raised about people -- claimants not really understanding some of the communication they get and understanding the process.

So, I can express some of the claims I've read that the final decision is pretty comprehensive, actually, not written at the appropriate literacy level for many claimants.

And -- but the cost of being comprehensive and detailed is that it gets into language which is not readily understandable.

Do most people have authorized representatives?

Do the authorized representatives serve that function of translating those kind of communications for people?

Is that part of the system functioning

well?

MR. NELSON: I can only talk about the claimants my office encounters. The majority of the claimants who I -- my office encounters either do not have an authorized rep, or if they have an authorized rep, that authorized rep is a family member who themself really do not understand the program.

But beyond that, another problem that claimants have -- and I'm glad you asked that question. It was something I wanted to say and had forgotten.

The other problem is that even when claimants have an authorized representative, that authorized representative does not always assist the claimant with every issue in the case.

We -- I have a guess as to why, but what we often find is that authorized representatives will help claimants in what I call get the initial benefits, but they tend to drop out of the case when those cases get to issues like medical benefits and billing issues.

And the feeling is the way the statute is written, the statute is very clear that that AR gets paid for certain services and assisting the claimant with billing issues and with home healthcare-type issues, the statute is not clear or doesn't really address how that AR gets paid. So, the ARs just stay away from those issues.

There has also, you know, quite honestly, has been the feeling by many claimants is that because of the way the statute is written, the statute limits the amount of money that an AR will get paid in a case.

And so, that ARs tend to participate or represent claimants in the easier cases and they tend to avoid the complex cases.

So, what we tend to find is that claimants cannot find an AR in the very cases where they most need the help, which are the complicated cases.

And lastly -- I mean, two other things. One, as you realize, under the statute, if the claimant utilizes the services of an AR, the

claimant has to pay that AR.

And many claimants have told us they simply don't have the money to pay the AR, and I know people come back and say, well, you'll get some money from the claim.

And claimant's response to that is, even if they get that money, that money generally does not cover all the costs that they paid on these claims or paid, you know, for their -- on their health so that any money they have, they need for other purposes.

So, many claimants just don't even pursue an AR because they don't want to have to pay.

And lastly, and this is one I talk about. I think it gets overlooked all the time or people don't understand, but the people we -- the majority of these people who worked at these facilities, the generation they come from, they're very proud people and they're very proud about that work that they did at those facilities, and they don't want to fight the government.

And so, they don't want to go get an AR because they interpret going to get an AR as going to get an attorney.

And they see that as fighting the government, and they just don't want to be viewed as fighting the government.

So, all I've got to say, in my experience, a lot of the claimants I encounter do not have an AR.

If they have an AR, as I said, it's a family member or, for whatever reason, they have an AR and, yet, that AR is not helping them with the issues they are having problems with when they come to us.

CHAIR MARKOWITZ: I have one other comment.

MR. NELSON: I --

CHAIR MARKOWITZ: Oh, go ahead. I'm sorry, I didn't meant to cut you off.

MR. NELSON: No, this is something I -- you know, again, as I sit here, I'm thinking of things I was supposed to do and I did not do.

And I -- initially, I was supposed to also introduce Amanda Fallon, who is here from our office as well. I didn't want to have to go back to the office without having done that.

Go ahead. Sorry.

CHAIR MARKOWITZ: That would be unwise, yes.

MR. NELSON: Yes.

CHAIR MARKOWITZ: I was also struck, reading some claims, that the physicians, the CMCs, usually talk about smoking with reference to COPD, and I don't know if DOL is ever going to be able to stop them from doing that.

Maybe later after lunch, Ms. Leiton, if you could address whether DOL actively tells the CMC not to address the role of smoking in, say, COPD or another claim because -- and even if you did, frankly, I would expect the doctors to ignore -- you know, many doctors to ignore that advice because that's what we do, but -- and I can see where that would be confusing to people.

I mean, it was confusing to me because

I'm thinking, well, how does the CMC really thinking about that case -- if they're largely or almost exclusively attributing it to smoking, how are they thinking about the occupational exposures?

So, I appreciate that comment, that potential source of confusion for claimants.

MR. NELSON: Yeah. And just, in general, another issue that often comes up, SEM really only addresses causation.

And so, you know, when the specialist, the industrial hygienist or whatever, when they are looking at SEM, you know, the other question just comes to -- kind of comes to smoking, but all is to what extent are they really evaluating contribution and aggravation?

So, once again, you know, when that doctor is saying it's mostly or due to smoking, they're saying mostly due to smoking, you know, are they just ruling out any contribution or aggravation by these other toxins? And that's always the question that really confuses claimants.

CHAIR MARKOWITZ: Okay. Any other

comments?

Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: When we're talking about contribution to causation of a disease, I think it's completely appropriate to mention smoking and -- when you're talking about COPD, for example.

It probably does contribute to COPD, but that doesn't change, in any way, the contribution of other environmental causes of COPD unless there are epidemiologic data to show that smoking prevents the other exposure from causing COPD, and I haven't seen those kind of data.

So, I think it's pretty benign to mention smoking, but it's not benign to suggest that -- and somehow the smoking history negates the other causation of COPD.

It's the rule, not the exception, that diseases are caused by multiple, different factors.

Sometimes they add together additively, sometimes they multiply. Most often they combine in some way in between those two, but

they should be considered separately.

And I don't think mentioning smoking adds or subtracts from the causation question for the other exposures.

But it is used in that way, in some settings, and I think that's what some of us are objecting to.

CHAIR MARKOWITZ: Yeah, Dr. Silver.

MEMBER SILVER: It's not benign to fail to distinguish between vanishingly low levels of smoking and heavy smoking.

Lord knows dose-relatedness is a big issue when it comes to chemical exposures.

CHAIR MARKOWITZ: Are there any other comments or questions? Otherwise, thank you very much --

MR. NELSON: Thank you.

CHAIR MARKOWITZ: -- for the talk, and you'll be around for the day if people have questions?

MR. NELSON; Yes, I will.

CHAIR MARKOWITZ: Thank you.

So, just a couple of short items before we break for lunch because we've covered these -- the action items from our November 2018 meeting, I think, we've discussed, for the most part.

We've also discussed the data and claims request from December 10, 2018. We did request a large number of claims for multiple conditions.

And when we were asked to try to triage that recently or, you know, in some number of weeks ago -- I can't remember the timing, exactly -- we decided to focus first on Parkinson's Disease and COPD. So, that's where we're at now and we'll continue to pursue those requests.

The issue of COPD -- maybe this is the first meeting, but we don't have a reformulated, revised recommendation for COPD.

It's -- we're at a bit of a stalemate in terms of the way we view it and the way we think the program should accommodate it, but, more importantly, actually we have claims to look at.

And so, we can see actually what sense

our recommendations make vis-a-vis the claims and how the -- how, in the real claims, how COPD is actually considered. And that's what we're doing now by reviewing those claims.

So, we may yet come up with revised recommendation for COPD, but it will be after we review some claims.

Any comments or questions? Otherwise, we are going to break for lunch. It's 12 o'clock. We will resume at 1:00 p.m.

(Whereupon, the above-entitled matter went off the record at 11:59 a.m. and resumed at 1:09 p.m.)

CHAIR MARKOWITZ: Okay. Let's get started. 1:10. I'd like to thank the very faithful public who has stuck around for the afternoon session. Welcome everybody back.

All right. So, our next topic is going to be reviewing some claims on chronic obstructive pulmonary disease, otherwise known as COPD.

But before we look at individual claims, I'd like to open it up for discussion about,

sort of, how we should do this, where we might expect to get to today.

My own feeling is that, you know, we received these claims about two weeks ago. I know that Mr. Domina has been on the road for the last two weeks and probably hasn't had a whole lot of time.

I know that Mr. Mahs has been involved with training activities for the past ten days, and others of us are busy.

So, I'm sure we haven't had the opportunity to review all the claims, even the limited number that we were asked to. So, this is an initial conversation and it will be ongoing.

I think our observation should be considered provisional in that sense. I'm not sure whether we're going to be able to come to any even reasonable consensus about conclusions, so other comments on how you think we should approach this?

Dr. Dement.

MEMBER DEMENT: I guess there might be some individual cases that are worthy of a group

discussion, and likely are, but I think at the end of the day, as we all go through our cases and we get more experience across the board and we get some underlying observations, it might be worthy of each of us to take the time just to jot down talking points about major observations and then come back at a later date and sort of discuss our major observations and we can use cases as examples to support or not support those observations.

CHAIR MARKOWITZ: Okay. Other comments?

Dr. Silver.

MEMBER SILVER: We put a lot of work into recommended presumption for COPD. Even though the Department hasn't accepted it, I think a real important question to ask particularly for the denied cases is, would the outcome had been different had our presumption been accepted by DOL?

Or if it were to be in the future, would it have influenced the outcome of the denied COPD cases, building a record for continuing to debate the issue.

CHAIR MARKOWITZ: Other comments?

While you're thinking, just for the moment, I want to remind the Board about our tasks and how they relate to review of claims so that it's clear what our role is.

The first task is to look at site exposure matrices. Obviously, those are used by the industrial hygienists and maybe the CMCs.

Secondly, we're asked to weigh in on the medical guidance for claims examiners. And this directly pertains to what the claims examiners provide the CMC, certainly, but also I would argue the IHs.

And then, finally, Task 4, and for those members who -- of the Board who are new to this board and weren't on the previous board, we did not really address, on the previous board, Task No. 4, which was to evaluate the work of industrial hygienists, staff physicians and consulting physicians, and reports of such hygienists and physicians, to ensure and hear the key words "quality," "consistency" and "objectivity."

So, when you think -- when we're talking about these claims, focus on the quality. You may not agree with their conclusions, but we would look at the quality of their conclusion regardless, what it's based on.

The objectivity and the consistency across claims, although we're usually dealing with different IHs, different CMCs, and so that's -- can be a little challenging. But in any event, just keep -- bear that in mind when we talk about the claims.

Any other comments?

So, who wants to - I think we should start off with COPD denials. Anybody want to talk about it, walk us through a claim and what they saw and what they found?

Somewhere I have here a list of who was asked to look at what, but I'll be glad to start, but I need the handouts.

So, let me remind people that we do not mention personal identifiers. So, we obviously do not mention the names of the claimants, their

addresses.

We can certainly mention the site because there are a lot of people who worked at each site.

And we don't mention the full claim number because that would identify a person, but we identify claims by the last three or five digits.

And so, what I've done, by way of example, is take a COPD denial and we're going to -- I've taken excerpts from the record, from the files.

And for those of you present who didn't have the opportunity to look or are not involved with reviewing these claims, meaning the members of the public, the files were anywhere from 500 to 5,000 pages long. So, they were quite lengthy.

Some of them highly repetitive, the same documents appeared over and over again. They were not indexed, so you basically scrolled through until you found what you're interested in.

Sometimes there are multiple documents that appear to be the same. Still trying to get

familiar with recommended versus final decisions, but, in any case, took some time to actually identify.

And I'm not sure I, for one, have identified everything in each of those files that I needed to look at, but I made an attempt to do so.

So, the board members are going to be looking at these excerpts from these claims. And as I walk through them, I'm going to explain what they are so that everybody in the room and anybody on the phone can follow us.

So, this was -- the first claim is for someone -- this -- the decision date was March 2019 -- we're trying to avoid precise dates because that's -- could be personally identifiable -- and there is a final decision.

Now, the COPD in this case was diagnosed 2003. So, the person's had COPD for a long time.

And the excerpt from the final decision, first, is that -- this is the communication to the claimant and it says that the

EE-3, the employment history form, indicated that they worked at Oak Ridge at X-10 at K-25 and at Y-12, all three of the DOE facilities.

And that, totally, they were employed from 1977 until -- beyond 2010. So, they were employed for a very long time and they had begun employment a long time ago.

And their job titles were carpenter and machinist. So, we have a long-term carpenter/machinist from Oak Ridge who began work in 1977.

Next page, which is Slide 3, and the final decision mentions the occupational history interview and that they were exposed to -- that that interview indicated they were exposed to beryllium, lead, mercury, nickel, cesium, cobalt, technetium, thorium, uranium, asbestos, silica, fiberglass, wool, mineral wool fibers, PCBs, organic solvents and degreasers.

And then the final decision goes on and talks about the SEM and the fact that those job titles I mentioned, which were carpenter and

machinist, were linked by the SEM to agents that cause COPD; endotoxin, asbestos, chlorine, coal dust, diesel exhaust, phosgene, silica, cement and wood dust.

So, here, the final decision is recognizing that the SEM connected the carpenter/machinist job titles to these COPD-linked exposures.

And then it goes on to -- this is Slide 5 -- saying that the case was referred to an industrial hygienist, and the IH concluded that that person had significant exposure, as a machinist, to endotoxin and, secondly, as a machinist, to endotoxin plus asbestos, diesel engine exhaust and silica.

And the IH further concluded that your exposure to those toxic substances after the mid-1990s would have been within existing regulatory standards.

And then concluded, as well, that working as a carpenter involved significant exposure to asbestos and silica.

And then there's, again, the standard statement that, quote, however, the IH stated that your exposure to those toxins after the mid-1990s would have been within existing regulatory standards, end of quote.

So, the case was referred to a CMC and the CMC decided that the exposure to the SEM-specific COPD agents, right, the ones I mentioned before, which were, you know, cement, chlorine, coal dust, et cetera, diesel exhaust, were not at least as likely as not to be a significant contributing factor.

And the CMC concluded that your long-term exposure to tobacco smoke was responsible for the COPD more than any other substance.

So, here, we actually have a final decision saying that -- quoting the CMC and saying tobacco smoke was responsible and that the occupational agents weren't responsible.

Slide 7 is a handwritten occupational history from the claimant and it's a little hard to make out and I don't want to read the whole thing,

but basically the person talks about their exposure to wood dust, the conditions under which they were exposed.

They removed floor tile, they built forms for pouring concrete, they machine -- worked in a shop machining parts and they described that they breathed in dust on a daily basis, 2000 to 2008.

So, Slide 9 is the occupational health interview and it says, basically, that the person was exposed to asbestos, silica, coal dust, fiberglass, glass wool and the like.

And, in fact, actually, I found an excerpt from the medical examiner at the Y-12 site in which between 1981 and 2000 the person says they were exposed to asbestos, chemicals, dust, noise, gases, acids and the like.

And if you look at the SEM for machinist and carpenter at the Oak Ridge facilities, you actually come up with, under a K-25 machinist, 23 different toxins; for a Y-12 machinist, 102 different toxins; and a carpenter at X-10, 15

different toxins and any number of what they call work processes.

Those aren't all linked to COPD, but it's a listing of the toxins -- toxic substances they were exposed to.

So, 13 just gives you detail on how much time the -- the person was mostly a machinist with limited time -- number of years as a -- well, almost seven years as a carpenter.

The IH report concludes that the -- that his work as a machinist at K-25/Y-12, and carpenter at X-10, was significantly exposed to multiple toxins.

And then provides a table, which we've seen in multiple claims, in which -- and I'm sure others have seen this, in which the list of agents is provided, and then the frequency and the intensity level is estimated by the industrial hygienist.

So, in some cases, it's occasional, some cases it's frequent. Wood dust was frequent, meaning on a daily basis. Endotoxins, frequent.

And the exposure level, say, for wood dust was low to moderate. For endotoxin, diesel exhaust was low to moderate and the like.

And then the IH says there's no available evidence to support that as part of this position after the mid-1990s, his exposures to any of these agents would have exceeded existing regulatory standards.

Then the IH provides references. Actually, I find the references to be interesting, because the first few references are DOL/DOE documents or databases, but the last four references are textbooks.

And I found this repeatedly, I don't know if you've seen this, but the IH routinely cites textbooks.

I know these textbooks, for the most part, and they don't -- they don't provide any sort of specificity for job title and level of exposure.

So, they really are not the source of their knowledge about what kind of level a machinist -- and how frequently a machinist will be exposed.

The IH may be using their own personal expertise, but it's not -- you don't find that in the textbooks, for those of you that are less familiar.

So, I am finishing this. So, only a couple more slides.

So, the CMC report is fascinating because the CMC says the latest CAT scan shows no evidence of interstitial lung disease.

So, for those of you that don't know, interstitial lung disease is like asbestosis. It's not COPD. It's completely different from COPD.

So, the CT scan shows no interstitial lung disease. Quote: in essence, asbestos, cement, endotoxins and silicon dioxide crystalline can be ruled out as agents, as these agents show an interstitial lung disease pattern on chest X-ray.

Do any of the physicians in the room agree with that statement?

So, let me just finish and that is

unusual. And then goes on to say there's no evidence of pleural thickening, which occurs with asbestos or with silica exposure.

The X-ray didn't show rounded opacities in the upper lung zones, which would occur with coal.

Cement dust causes interstitial lung disease, pleural thickening. We don't see that.

Wood dust causes hypersensitivity and pneumonitis and we don't see that.

So, in short, to summarize, we can rule out COPD in relation to these agents because the X-ray doesn't show these other findings of either interstitial lung disease or pleural thickening.

And then he -- she -- I can't remember -- goes on to say, diesel exhaust exposure was only low to moderate and the person was not involved directly in transportation so that this lack of exposure reduces their risk of COPD, ruling out diesel exhaust.

And endotoxin produces interstitial lung disease. On X-ray, that's not present, so

we rule out endotoxin.

And concludes by saying, the most likely cause of the COPD was tobacco abuse. So -- and then there's further language, but essentially it comes to the same conclusion.

So, a long-term carpenter/machinist with a lot of exposures within the SEM are relevant to COPD, the IH concludes that those levels were of significance, and the CMC uses what I regard as unorthodox knowledge to deny the claim, basically.

So, that's -- I don't know if anybody else looked at this claim or has questions about it.

If you're looking at the particular language of the CMC and if that makes -- if I'm wrong and that makes more sense to you than to me, then, you know.

Any comments? Questions?

Yes, Mr. Domina.

MEMBER DOMINA: On the -- I just want to make sure on this Slide 19, it has the guy's

name in it. So, make sure nobody sees that.

CHAIR MARKOWITZ: Okay. Okay. Thank you.

MEMBER DOMINA: This is one that I looked at, you know, and I noticed -- I believe it was in -- let me find it here -- 1987 he was restricted from the carbon graphite shop due to respiratory issues and a rash and swelling of his respiratory passages, that I saw when I went through it.

And I, you know, and so that was -- I mean, because this gentleman was still working as of 2018, you know.

The guy's like 82 years old, but -- yeah, and I saw the same -- like, the smoking thing just like you had mentioned because --

CHAIR MARKOWITZ: Yeah. So, anyway, to me, the air seems to be concentrated, in the CMC's judgment.

And before that, you know, the information moved along in the way that you'd more or less expect.

Comments? Questions?

Otherwise, let's move on to another case. We don't need to go into this level of detail in the cases, but I --

MEMBER SILVER: Yes. Thank you for providing us with a really good template. Some of us probably saw similar leaps in logic, but we doubted whether we were seeing what we thought we saw and organizing into a framework like this should allow us to nail things down the way you've done.

CHAIR MARKOWITZ: Yeah. I'll make one other comment, which is I couldn't tell -- and I think this is true from -- I couldn't tell from the IH report and the CMC report what they actually reviewed.

The IH doesn't list -- and in subsequent claims in the CE when they made the referral and they developed their questions, I don't see a list of what was provided for them to look at.

So, then you don't know what this IH has actually looked at unless they mention it in their report.

The final decision seemed to mention the relevant exposure sources, but more crucial, frankly, is what the IH looked at.

MEMBER REDLICH: Are we not mentioning who the CMC is or --

CHAIR MARKOWITZ: No, I don't see any -- because -- I don't see any problem with that.

Anybody -- Is there any problem with us mentioning - how about the state?

Can we mention the state they live in?

MS. LEITON: That's okay.

CHAIR MARKOWITZ: Well, I think the question is if we see repeated issues with one or two people, right?

MEMBER REDLICH: That has been a pattern.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: So, I thought that it is relevant and that's not providing any information of the patient.

CHAIR MARKOWITZ: Okay.

MR. FITZGERALD: I think it's fair to

raise that with the program independently of the meeting itself.

If you see a pattern, I think that's what the Board here is trying to do, is determine whether there is an ongoing, sort of, pattern of behavior across the CMC community or the IH community that we're trying to remedy in terms of the process versus looking at individuals and calling them out and saying you didn't do this right.

MEMBER REDLICH: And then if there is a CMC that we do identify a pattern that we think is maybe concerning --

MR. FITZGERALD: You should raise it with the program.

MEMBER REDLICH: Okay. And then what would be the process of reviewing that CMC?

MR. FITZGERALD: I would defer to the program on that. But in terms of elevating it to the program, I'd go through the chair to --

MEMBER REDLICH: Okay.

MS. LEITON: We'll look at it.

CHAIR MARKOWITZ: Any other comments or --

MEMBER BERENJI: This is just a general comment. This is Mani Berenji.

At least from a CMC's standpoint, I'm pretty sure I've mentioned this at a previous meeting, but it's very important to have at least some sort of standardization in terms of how these CMCs are collected and identified.

I know they run the gamut, at least based on the cases I reviewed. They were family medicine physicians.

And, again, I feel that there are many competent physicians who are capable of doing this type of work, but making sure that there is some sort of training, at least to be able to complete the review in a systematic matter, you know, taking into account the SEM, but also taking into account a full occupational history.

And at least from my perspective -- and, again, please correct me if I'm wrong -- but it doesn't appear that the CMCs actually meet the

claimants; is that correct?

CHAIR MARKOWITZ: That's correct.

MEMBER BERENJI: So, to me, I mean, I do disability reviews. I always see the claimant because I feel that unless you see the person right in front of you, it's hard to make a real good assessment as to -- first of all, you always want to make sure that the claimant, you know, is forthcoming and you want to make sure that you can verify, at least to the best of your ability, whether the events that transpired actually adds up to the particular exposure.

At least from my perspective and from my experience, it's really important to see these individuals face to face.

I'm not sure if there's any discussion among your colleagues at least with respect to, you know, evaluating CMCs.

Is there any potential for, you know, at least revamping the process or at least having the CMCs meet with these claimants face to face?

MS. LEITON: Do you want me to respond

to that?

CHAIR MARKOWITZ: Sure. Could you?

MS. LEITON: We have a second opinion process where physicians will see claimants, but the amount of cases we refer to a CMC for a record review, we don't have them all over the country to meet with all these claimants.

There's a cadre of physicians in the contract, and so it feasibly is -- would be really, really difficult for us to -- for that to happen.

CHAIR MARKOWITZ: Yes, Mr. Domina.

MEMBER DOMINA: I just -- I was just -- and I'll just defer some of this because, in the State of Washington, we have IMEs and stuff and so there's a process.

So, if you nave X amount of complaints against one, there's a way to do that. And the same thing -- I don't know if this process allows that and the fact that they're not in for life, they got to reapply every three years.

So, is there some kind of a vetting process even though it may be a different contract

or has the contract, on a way to verify, you know, the person has been fully vetted and reapplies or a claimant has a way, you know, if they have a problem with the way it's done.

MS. LEITON: So, there is -- the contract has a vetting process. They have a vetting process for all their physicians when they come on board.

I would have to check on how many times they're recertified annually or whatever it is.

With regard to whether we can -- a claimant can object to what the physician said, they can do that through our appeals process on an individual basis.

With regard to a determination or multiple -- like, when we do audits, if there's a CMC that has multiple or has more than one error in different cases on a regular basis, then we have -- we will meet with the contractor and take whatever steps are necessary.

That may be additional training, it may be worse than that, but there are steps that we

can take with the contractor.

We meet with them on a regular basis. We have teleconference calls with all of our CMCs on a regular basis quarterly, I believe, to talk about new issues, talk about any questions they may have to make sure that they're aware of issues.

While I'm up here, I'll just mention the smoking. We do tell them that smoking is not something they should be taking into consideration, but, again, they're going to take it into consideration as physicians in cases like -- as Dr. Markowitz mentioned.

CHAIR MARKOWITZ: Dr. Berenji.

MEMBER BERENJI: Mani Berenji.

So, again, I apologize if I misunderstand the process when it comes to the industrial hygienist.

These are folks who work with DOE; is that correct?

MS. LEITON: No. The industrial hygienists work for us, for the Department of Labor.

MEMBER BERENJI: Okay. So, I know

that there's a process to identify CMCs.

Has there been any thought about, you know, at least having some sort of industrial hygienist panel at least to be able to review the SEM, go through the occupational health questionnaire?

Because at least based on my review of both the approvals and the denials of the respective claims -- and I know Dr. Dement already alluded to this, but I feel that a lot of times the industrial hygienist is following a boilerplate.

And at least based on my review of the eight cases that I had the opportunity to review, it seems that, you know, that's one data point from this one particular industrial hygienist.

But at least from my perspective, I think it might be something worth considering in the future -- and, again, this is up for debate -- if there is a way to get some sort of consensus among industrial hygienists across the country from different disciplines, you know, both with clinical experiences, industry experiences.

I'm going to leave it up to the Board, but at least from my perspective I think that would be instrumental to provide a counterpoint to the industrial hygienists from your end. Thank you.

MS. LEITON: Okay. I will just say that we have a contract with industrial hygienists.

Every IH report goes through our federal -- we have two federal employees who are industrial hygienists.

You will see the format being repeated because that's what they were taught to do in that format. But aside from that, I'll let you guys --

CHAIR MARKOWITZ: One comment on this case, by the way, the issue of cigarette smoke, it was one thing for the CMC to ascribe it to smoke, but actually in the final decision, which obviously is written by DOL, it said that -- quoting the CMC that it --

MS. LEITON: That's because they're quoting the CMC who provided an opinion on causation and included that as part of his opinion.

Now, if they say significant amount of it is a result of the smoking, it's not something we can ignore, you know.

We -- unless they were -- you know, it's very difficult to separate that out once the physician has already gone there.

CHAIR MARKOWITZ: Well, it makes it look like you were endorsing that and that could be very confusing to a claimant, but I'll move on.

Dr. Silver.

MEMBER SILVER: I think we heard in a previous meeting that the claims examiners are encouraged to limit the number of substances considered to seven substances, and there was a memo in the COPD case that I reviewed spelling that out.

It came from headquarters telling the claims examiner to keep it to seven toxins. And, sure enough, in this case, if you look at Slide 20, it's exactly seven substances.

And if you look back all the way to Slide 8, 10, 11, a few of them bit the dust or fell out

of consideration.

Fiberglass didn't make the cut. Gases didn't make the cut. Beryllium didn't make the cut, mercury and arsenic.

Now, maybe those are not the most relevant substances for COPD, but if we're going to ever have a meeting of the minds of vapors, gases, dust and fumes, you have to relax this seven substances rule, I think.

CHAIR MARKOWITZ: Yeah. I mean, that wasn't the challenge in this case, but I take your point.

Dr. Dement.

MEMBER DEMENT: I think your review of this case points out some interesting issues. When you look at the SEM for this job category, it lists many, many exposures. I think you've listed them on your slide. So, obviously there are many exposures that -- if you meet the job category.

So, the two criteria for the CE to actually refer these exposures to the IH and ultimately to the CMC, one is the job category has

to be right. The other is the claimed disease has to also be in there.

So, only a few of the exposures that this individual would have had even from the SEM, not restricting it to seven, because it would be many more actually even made it to an assessment, when, in fact, I think the majority of the published literature suggests that for COPD we look more broadly at their cumulative exposures to these vapors, gas, dust and fumes.

I guess the other thing, and the clinicians need to answer this, but it relies -- this opinion and some others that I looked at relies heavily on -- either on CT and -- more on chest X-ray changes, a requirement that those actually be present to support an attribution to the exposures.

I'm not aware that that's an actual requirement for COPD. The clinicians can answer that.

CHAIR MARKOWITZ: They're not -- I mean, they're certainly not for the diagnosis of

COPD -- for the diagnosis of other conditions, but I've never read that you need -- any of these other conditions are prerequisites for COPD -- for ascribing COPD to the occupational agent.

MEMBER DEMENT: And, in fact, this is the first place I've ever seen that done.

CHAIR MARKOWITZ: By the way, this was a board certified occupational medicine physician. So, that didn't help us in this one.

Anybody have another COPD denial they want to talk about?

You don't have to do it in this level, but that's -- you shouldn't, actually, because we'll never get through, but -- yeah, George.

MEMBER FRIEDMAN-JIMENEZ: I can present a case quickly that illustrates one point. This is Case No. -- 14286 are the last five digits.

So, a 79-year-old woman worked as an electrical mechanical inspector at the Kansas City plant from 1979 to 1981 -- 1991, 50-pack-year smoker, diagnosed with COPD in 2012 and was agreed to have had significant exposure to asbestos;

however, the question of asbestosis was raised.

She had several X-rays on record and apparently also had a CT scan, but the CT scan was not in the record. And so, the CMC said that it wasn't clear whether she had asbestosis or not.

There was pleural parenchymal scarring mentioned on one of the chest X-rays, but it didn't say "asbestosis."

And so, because there was no CT available, the CMC denied the case and said that we need to have the CT, but the CT had already been done.

So, this raises the question of should a case be pursued and come to a final decision when not all of the medical evidence is present?

In this case, it would have just been a matter of getting the result of a chest CT, which had been done fairly recently.

If that hadn't been done, I would argue that it should even -- there should be a mechanism by which it could be ordered and that the case not be decided until you have a proper evaluation.

And apparently, the CMC just signed off on the case and said there's -- denied it because there was no evidence of asbestosis because there was no chest CT on record.

So, the question is: what is the process by which a necessary diagnostic test can be either gotten -- obtained that's already been done, or ordered, if it hasn't already been done, in order to complete the evaluation for a necessary decision?

This wasn't about asbestosis per se, it was about COPD and whether asbestos contributed to the COPD.

And it's somewhat different literature if someone has asbestosis than if they don't have asbestosis.

And so, it would have been an important thing to have in the record. So, that's the question I wanted to raise with this case.

MS. LEITON: So, this is Rachel.

If it was a CT scan that was referenced -- you said you knew there had been a CT scan --

how did you know that there had been a CT scan?

MEMBER FRIEDMAN-JIMENEZ: It was mentioned in, I think, a PFT report.

MS. LEITON: Okay. So, the CMC, at that point, could have easily gone back to us and said there's reference to a CT scan. We could go to the claimant and ask for it if it had relevance to the question being asked. There is a process for that.

With regard to requesting that a test be done, we run into problems for cases that we haven't accepted yet. We can't guarantee that we're going to pay for that test because they're submitting it.

So, it could be a suggestion that the CMC makes and said, you know, if this person were to have a CT scan, they might be able to verify it, which we could relay to the claimant.

And if the claimant then wanted to go, you know, and get that CT scan on their own, they could, but we couldn't require them to do that or pay for that to be done.

MEMBER FRIEDMAN-JIMENEZ: So, that's really the issue that we're raising here, is how can we make sure that a proper evaluation is done before these decisions are made? Because that does involve paying for the diagnostic testing.

And this is a catch 22 we often run into in occupational medicine. To establish a case, you need to do a test that would need to be paid for by --

MS. LEITON: And if we did accept the case, we could retroactively pay for it, but that's hinging on whether or not we end up accepting the case, because we go retroactive to the date that they file.

We can pay for whatever is related to what we accept, but that's only after the fact and it's only if we accept it.

MR. FITZGERALD: Let me just say that's standard practice in all worker's compensation systems.

We don't generally get -- we generally don't pay for diagnostic testing until a case is

accepted. And that's pretty much common practice in worker's compensation.

MEMBER REDLICH: Yeah, I also -- Carrie Redlich -- I also reviewed this case and I agree. So, I think one issue that has come up sometimes is when the claim is placed for one disease. And, in this case, it was for COPD.

And so, I've got a couple issues. And then there is the evaluation suggests that there may be another occupational relevant disease which is not the one that the claimant had put the claim in for.

And in those situations, I -- usually the CMC's been asked a very specific question, you know.

They've been asked not does the person have a work-related respiratory condition, but do they have work-related -- you know, do their exposures contribute to COPD?

I think an easy solution would be they can answer that question and then is there evidence of any other relevant work-related condition,

because I have seen several where the question was COPD when there was evidence of asbestos pleural plaques or another condition.

In this person, the concern I had is it seems like the diagnosis, from what information we had, was likely COPD.

The smoking history was variable, but the -- this -- it was at this Kansas City plant. And I just quickly Googled what this Kansas City plant did out of curiosity.

I would have called up John Dement and see if he could fill me in on -- because the person was an electrical mechanical inspector from 1979 to '91.

And this plant was made -- I have my little notes here, but it basically was initially, starting in 1942, a Pratt & Whitney plant that made engines and made the non-nuclear warheads.

So, it -- and there was a little other information that it sounded like there was a lot going on in this plant besides asbestos for -- and in the period of time from '79 to '91, it sounded

like there was machining operations to different, you know, plastics and adhesives and a whole range of activities that -- and it was unclear what sort of inspector.

She -- the questionnaire that the person filled out was not that helpful in terms of, you know, had sort of possibly checked off almost every exposure you could have, which -- but there was the question, did you -- should respiratory protection have been provided? The person answered yes.

It seems that some better idea -- somehow the SEM that produced only asbestos as a relevant exposure was what caught my eye.

And knowing more about what was going on in a place that's been -- an old facility doing engine machining -- you know, making engine parts, seemed like there was potential opportunity for exposures beyond asbestos that might be relevant to COPD and hopefully an industrial hygienist would be able to determine that.

CHAIR MARKOWITZ: But there was an IH

report in that case.

MEMBER REDLICH: Yes, but I think it's, again, this issue of the job category. I think a phone call or brief conversation with this person and a better understanding of what their job tasks were -- you know, if the person had only worked there for six months, I'd say let's not spend more time on this. It's unlikely that that's contributing.

But when we have a, you know, 20-year period of time in a, you know, facility like this, it seems that that warrants more attention.

CHAIR MARKOWITZ: Other comments?

Yeah, Calin.

MEMBER TEBAY: This is Calin Tebay.

I'm still -- I want to go back to your -- the lack of the CT or the -- that it was overlooked that the CT existed.

One, this is, Doug, for your information, in worker's comp, often the tests are paid for by worker's comp to aid diagnosis often before the claim is accepted. Not in Department

of Labor, right, but in worker's compensation at the State level.

But in this case, it doesn't really matter for the simple fact that you know going into the claim that you may or may not get reimbursed depending on if the claim is accepted.

So, I don't quite know how we got on the conversation of why it was relevant to if we were going to pay for it or not when the simple fact is everybody knows that you're not going to get reimbursed if the claim is not accepted.

But I go back to the fact that if the doctor recommended denial based on the lack of a CT, why didn't we stop there and say we're missing this CT scan, let's not deny the claim or --

MEMBER REDLICH: Well, I --

MEMBER TEBAY: -- force the person into an appeal process, because appeal processes are almost impossible for a claimant to get through for the simple fact that the time frames are so short often the claim will be recommended denial and denied at the final -- at the FAB before you

can even get an appointment to get that extra scan -- to get a CT scan for a claimant that needs a pulmonologist and needs to get it ordered.

I think -- and I don't know about in anybody else's area, but in our area it can take weeks.

By that time, the recommended decision has been done, the final decision is done, and then you got to appeal the final decision, and then you got to go through the reopening of the claim process to prove that you've -- I mean, so look what -- the waterfall effect of creating or providing a recommended decision or a final decision based on the lack of a test for the claimant to try to go through, then, is nearly impossible to recover once that final decision or recommended decision is made.

The appeal process is not easy at all, and it's not time-friendly to a claimant. So, I guess my point is, is that's a claim where if we know that happens, why doesn't -- why aren't we stopping instead of saying, "Well, you can appeal

it if you can get that test in the time frames we allow you before we provide a final decision."

Because often claims examiners just move right on forward, they don't give you extra time to go get those tests.

And I understand you can't just leave them all hanging, right? You can't just say, "Okay, everybody's got as much as they want to get all the information."

But on the other hand, when you -- you kind of -- it's not okay to deny the claim based on that was overlooked.

MEMBER REDLICH: I just -- one other -- I mean, and this -- one other point I did want to bring up, was that it was a CMC that there has been a pattern of -- I question some of the CMC's decisions.

CHAIR MARKOWITZ: Other comments on this case?

Other COPD denial?

Dr. Dement.

MEMBER DEMENT: Okay. This is a

individual -- a claim of COPD. Worked as a graphic -- worked as a graphic illustrator at Fernald a couple periods of time, '86 to '91 and '92 to '93.

His occupational history questionnaire suggests that he was a photographer who obviously did things -- illustrative photographer, but he actually went into the facilities and did work in the facilities taking photographs of different equipment and operations. So, he had a fair amount of time within the facilities.

Doesn't go into great detail, and at some suggestion, at least, in terms of his work as a photographer, he may have had some other work that's directly related to that particular task.

That wasn't very well-developed either in the occupational history or in the claims process, so basically the process was to go into the SEM and look for this particular job category and some aliases of this job category.

And what they found was the possibility of diesel exposure, I guess, just being around diesel equipment. I don't know exactly how that

would happen, but I guess all of us have some diesel exposure.

Anyway, that was what was established from the SEM. It went to the IH who -- for consideration.

The IH basically said that diesel exposures would have occurred, but back with the same comment about not approaching regulatory limits.

So, this claim was denied and it may well have been appropriate to have denied this claim.

It was -- I think this person was a smoker, but a half pack a day since age 25. That didn't come into the picture, as I could tell, in the final decision to deny.

I guess what I take away from this, is the -- neither the occupational history questionnaire or the development of the case, I think, actually went back to the individual -- allowed the individual to elaborate on exposures that he may have had either going into these

facilities and buildings or as doing the task of processing and developing film as they had on site.

So, it was denied and I think this is one where maybe some additional information would have informed that decision better.

I don't think there's any other points here about this exposure. He had two -- was actually exposed to two incidents at the plant; one for plutonium and hexafluoride.

So, there was an exposure incident while he was actually in the plant doing his work.

CHAIR MARKOWITZ: It sounds like a case where the industrial hygienist couldn't really have used the job title for --- to be very informative about diesel exhaust.

MEMBER DEMENT: No.

CHAIR MARKOWITZ: Right. So, in other words, the only way he could understand potential dose --- or likely dose is through interview.

MEMBER DEMENT: Yes. I don't know --- this is not a job category that if you asked me, do they have diesel exposure, I would have said

yes.

So, for me to have assessed this exposure, I would have had to ask questions, like, how were you exposed to diesel?

CHAIR MARKOWITZ: Right.

MEMBER DEMENT: So, I don't -- to me, it just wasn't developed. The case wasn't developed.

CHAIR MARKOWITZ: Comments? Questions? Other COPD denial cases?

MEMBER MAHS: I have one that was originally a denial and then it was accepted this year.

In 2012 -- this was a 77-year-old former worker at --- I lost it. Pantex, I think it was.

CHAIR MARKOWITZ: I'm sorry, what kind of worker was he?

MEMBER MAHS: He was a truck driver.

CHAIR MARKOWITZ: Okay.

MEMBER MAHS: He was a truck driver at Hanford. He was exposed to arsenic, asbestos, beryllium, diesel exhaust, nickel, silver,

stainless steel, and something else there. I can't read my writing.

He worked 19-plus years as that, but, as a truck driver, even though he was a truck driver, his work assignments included digging, spraying weeds for weeks at a time, digging in the tank farms. So, he was exposed to quite a few different things.

And I think the first time they looked at it, he was just exposed to asbestos, is the only thing they found to start with.

And, anyhow, in 2012 he filed a claim for benefits. He identified chronic COPD and asthma as a medical condition related to your covered employment.

Submitted employment history and they confirmed that he worked at DOE for several different contractors over the years.

And the SEM revealed that he was exposed --- potentially exposed to asbestos, is the only one they found, as for a truck driver.

Medical consult, CMC, to obtain an opinion as to whether it's at least likely as not

to exposure asbestos during your covered employment at Hanford with significant factor in causing or contributing or aggravating. And the CMC reviewed his case and decided it was not at least as likely.

They denied his claim for COPD and asthma in June of 2005. In -- November 2nd, 2017, though, his authorized representative requested a reopening of the claim for COPD and asthma to raise the -- he had additional medical evidence and they said Department of Labor erred when they forwarded the claim to the CMC for review.

She noted that the CMC concluded the medical evidence supported a diagnostic -- diagnosis of asthma, however, it did not support a diagnosis of occupational asthma.

Your authorized representative stated that its referral to the CMC, the DOL should have asked the physician whether occupational exposure to a toxic substance contributed or aggravated, claim. She maintained that this was an error.

The District's order was issued in December 17th, which vacated the final decision

on the 2012 that the condition, COPD only, and not the asthma.

The District office reviewed the source of documents and checked the SEM again. And with the labor category of teamster, the SEM lists COPD as a possible specific health effect of asbestos, diesel exhaust, silicon dioxide and crystalline.

In the IH report, your exposure to asbestos was significant and would have been frequent and at low levels. However, after 1986 through the mid-'90s your exposure would have been occasional, and at very low levels. After the mid-'90s, there's no evidence to support that your exposures would have accepted the existing standards.

I don't know what that had to do with --- exposure to diesel exhaust was significant and would have been frequent and at very low levels through the mid-'90s. And after the mid-'90s, there is no evidence to support your exposure exceeded the standard.

Silicon/crystalline was significant

and would have been frequent and at very low levels also.

In a report dated May 9th, 2018, the CMC concluded that it is at least as likely as not that your exposure to asbestos, diesel exhaust, silicon dioxide during your employment at Hanford was a significant factor contributing to your COPD.

And they recommended acceptance of the case this time in --- I lost the page, but there is also a page where the IH had stated the exposure to diesel exhaust would only be in passing. He was a truck driver.

CHAIR MARKOWITZ: But COPD was accepted, ultimately?

MEMBER MAHS: The second time around, yes.

CHAIR MARKOWITZ: Based on asbestos, diesel exhaust ---

MEMBER MAHS: They added a few more chemicals that he was exposed to and a little more medical evidence.

And the error --- I guess they explained

they reopened it due to a possible error with the CMC report --- or what the CMC received.

CHAIR MARKOWITZ: Comments? Questions?

MEMBER POPE: I had a similar case.

My --- the case that I reviewed was a security guard, 44-year employee, COPD --- was claiming COPD, kidney disease, and those other illnesses were not recognized, but he was originally denied and then it was reversed.

Let's see. Denied in May, reversed in June. The only reason why, I believe, that it was reversed, is because his AR --- his attorney had, at the hearing --- there was a hearing --- had brought up the fact that there was a step that was missed between the information being passed along to the CMC and the step that was missed that they did not confer with the treating physician. And that's a step that was brought forth during the hearing.

Now, had his attorney not brought that information up, I'm sure that this case would have

remained denied.

CHAIR MARKOWITZ: Comments? Questions? Dr. Redlich?

MEMBER REDLICH: Yes, I agree. I also reviewed that case.

CHAIR MARKOWITZ: Use the mic, please.

MEMBER REDLICH: Sorry.

Yes, I also reviewed that case and I agree with Duronda that it was a security guard for 44 years and I --- the two treating physicians and another physician had decided that the COPD was work-related, but --- and gave a rationale for why it was work-related, but then the case was referred to a CMC who decided it was not work-related.

And it was only reversed after a hearing representative and then the final decision was accepted. However, it seemed that --- and this just raised the question of when you refer to a CMC. If you have a treating physician who gives a rational --- you know, that the diagnosis is clear, they give a rational reason for why they

think it was related to the, you know, work exposures, then would that --- did that need to go to a CMC?

And the SEM, I think, again came --- I'm trying to remember this one. I can't read my notes whether --- it was also one when you read the transcript of the description of what this security/police officer did at the Y-12 plant for 40 years, it sounded like there were inhalational exposures, but I don't think the SEM had come up with much.

MS. LEITON: I just wanted to make a comment about that.

I think I mentioned earlier today that we're trying to encourage CEs to go to the treating first -- to follow up with the treating first, before going to a CMC.

And one of the things that we've also reiterated in recent training to them, is that causation is a much different standard than aggravation and contribution.

So, if a treating doctor is coming in

with medical rationale for aggravation/contribution, we're looking at those in a different way than we would if they're just simply trying to say it was caused by. So, we're seeing more of that going back to a treating, clarifying, trying to understand whether they -- you know, whether it's contribution, aggravation, those sorts of things.

I also did want to mention, I looked back at my notes from one of your recommendations early on from the previous board on talking --- the IH having the ability to talk to claims examiners --- I mean, to the claimants. And one of the things we said there, was that we would be able to allow that as long as the claims examiner was involved.

So, I need to look back and see if we actually got specific procedures for that. I'm pretty sure we've advised the IHs, but I'll go back and follow up on that particular issue because it is possible. It's just that we need to have -- make sure that CE is involved.

MEMBER REDLICH: I guess just in terms of some of the themes that we had, this is another example where the occupational questionnaire, the occupational history that his treating physician had, and then his transcript of his hearing, gave, I think, a more accurate picture of his exposures because the SEM came up with no exposures that could cause COPD, but there was a description of welding fumes, unloading coal dust, various other exposures that had not come up in the SEM probably because a security/police officer --- but that his transcript described more accurately what he had done.

And his physician, actually, which is rare, had an occupational history that also described it.

CHAIR MARKOWITZ: Just commenting on the issue of IH interview, we made that recommendation and your response was that the CE should be involved and we absolutely agreed that made sense. And so, we would like to know the progress because that was --- that happened some

time ago.

MS. LEITON: Yes, it did. It might be in there or it might be instructions to our Ihs. I need to check, but I will definitely get back to you.

CHAIR MARKOWITZ: I mean, the IHs presumably are used to not doing that, they're used to --- and it's easier for them just to do a paper review and do what they always do.

So, you may need to encourage, or there are some circumstances that they do this, to get them over that hump.

MS. LEITON: Could I just make one more comment?

I want to go back to something that I --- that Dr. Friedman-Jimenez had mentioned with regard to the definition of toxic substance. I also went back to check on that.

What --- we did define it in the regulations a specific way. The statute doesn't have a definition of it, but the reason that we defined it the way we did is when we got Part E

in 2005, the prior process was for a --- Department of Energy used to have a panel of physicians.

And when they had --- they would refer cases to that panel, and that panel would recommend yes or no on whether or not it was related to exposures. There was a definition used then.

So, when we took over those cases and we got Part E, there was a push to be consistent. They didn't want us to have a different definition than DOE did, because then we would be treating the cases differently.

So, that was the underlying reasons for it being put in the regulations the way it was. I just wanted to clarify that.

MEMBER FRIEDMAN-JIMENEZ: Could I just put in a plug for looking at the definition that the National Toxicology Program has for toxic substance and considering changing your --- since it sounds like you're not bound by law to have that definition that you have, I think it's very, very justifiable to use the NIH definition that the National Toxicology Program has on their website

and have published.

They really know toxicology and they know what a toxic substance is. And I think that's the strongest way to go to make this a --- and if you want to unify the definition, that would be what you want to unify it to, I think, and it makes sense. It's a very well-accepted definition of toxic substance.

CHAIR MARKOWITZ: Yes, let me just comment. Steve Markowitz.

So, you take workers who are operations or production or maintenance or laboratory or construction. The SEM, their occupational health questionnaire are full of toxic substances.

There's no shortage of --- as DOL currently defines. So, there's no shortage of what is called potential exposure to toxic substances for, probably, the vast majority of job titles within the complex.

So, I --- you know, I know this has been an issue we've gone back and forth with, but even on their own terms there's plenty of exposure that

could be used to make decisions.

Dr. Dement?

MEMBER DEMENT: But the real stopping point here is the link to the outcome. They could have the job -- well, there's two places.

Making sure the job is searched with regard to all the different ways it could be called, and there's some --- you know, there's some places where some of these jobs are described in the presumption, for example, there's a list of jobs.

It's not sometimes quite clear how those are mapped back into the specific jobs in the SEM, and I think they should be. So, you have to pass that hurdle.

But, then, in order to get referred for even consideration in some cases, you have to have that disease link, which we've argued for and needs to be expanded.

And in some ways, it does relate to the definition of what toxic substance is, really.

MEMBER REDLICH: Well, other comments? Questions?

MEMBER REDLICH: I just have one other question as far as --- this is Carrie Redlich --- as far as the process, because it seems that there have been a number of claims that eventually get to what appears to be a reasonable, final decision, but, you know, they go through multiple appeals.

And does the Department sort of maybe review those cases and say, you know, what will we learn from this so that moving forward we could have come up with that decision sooner. Because it's a lot of time and money for each one of these denials and appeals and the like.

So, in this case, the hearing representative agreed that the, you know, treating physician had provided a well-rationalized medical opinion, originally, and then agreed that it accepted both claims.

So, is there a process where claims have sort of been reviewed and appealed and then eventually accepted to sort of, you know, as sort of a quality control to look and see whether moving forward that could have been avoided.

MS. LEITON: Well, we have quality control. We have reviews on an annual basis of cases. Some that have been reopened, all final -- or a final decision, samples of final decisions, recommended decisions.

So, there's an audit process, but we also have 400 claims examiners around the country and they're all going to make different --- they're not all going to be exactly the same decisions.

Individual cases are going to then be -- they're always reviewed by a second reviewer. That's when things are caught sometimes that might not have been caught the first time. Some other reasons for reopening a case might be we got new evidence or something changed in the law. So, it's --- we don't have a system for trying to --- since they're all so case-specific, it's really hard to generalize in that manner.

So, we don't have a system like that, but we do --- if things like --- if there are obvious things that a hearing rep will see, oh, and this has been happening more than one time where we can

make note of that, we're small enough to be able to do that and bring it to the attention of policy, but a lot of these are just really case-specific.

MEMBER REDLICH: So, maybe -- after we finish going through, maybe, if we are able to identify some common themes, then that would be potentially something that could be ---

MS. LEITON: You could bring it to our attention.

MEMBER REDLICH: Yes.

MEMBER BERENJI: Right. I'm sorry, this is Mani Berenji. I just wanted to add on to Dr. Redlich's point.

Having some best practices among all the claims examiners, you know, looking at, you know, specific claims with respect to respiratory, with respect to neurologic conditions, I mean, I think this is something that could help educate all the claims examiners.

And looking at, you know, cases that were initially denied, but then approved --- I mean, I feel that there are common themes that could

potentially be identified in trying to ensure that all these cases are reviewed in a timely manner just to improve efficiency. Thanks.

CHAIR MARKOWITZ: I have a COPD denial claim in slide 22 if you want to follow along. I'm going to try to do it a little bit more succinctly.

This was a long-term instrument mechanic at X-10 in Oak Ridge. So, an instrument mechanic, 1967 to, at least, 1986. And this was a recent case. Recently --- final decision March 2019.

So, the occupational health questionnaire lists about 20 different exposures. The SEM identified asbestos as the target toxin of interest.

And interestingly, the --- I looked at the SEM for instrument mechanics at X-10 --- X-10 is Oak Ridge National Laboratory --- and under --- in the SEM it said asbestos, but it also said cadmium as an exposure --- or potential exposure. And then I looked at the SEM for toxic substances related

to COPD and it also listed Cadmium. Cadmium oxide.

So, there was an agent, which however we feel about it, whether cadmium causes COPD, is listed in the SEM as both being a potential exposure of this job title, instrument mechanic, and linked to COPD.

It was never addressed in the claim review. The focus was on asbestos --- by the way, I think asbestos is recurrently the target because the Procedure Manual has some specific guidance on asbestos. And so, it tends to, as a magnet, attract attention even though many of us would think that asbestos is probably the least of the issues with COPD.

In any case, this person worked as an instrument mechanic, 1967 to 1986. What that means, is that he had 20 years of exposure as an instrument mechanic.

And under the Procedure Manual, in that time period, that's a job listing that is said to have significant asbestos exposure.

And by the --- if you look at 34 ---

slide 34, page 17, I took an excerpt from the Procedure Manual and it says, COPD --- this is the exposure presumption.

20 years of exposure, employed -- this is in item 1, employed in any of the labor categories that are listed on Exhibit 15-3 --- 4-3 or whatever. Instrument mechanics are listed and he had aggregate of 20 years of exposure prior to the end of '86.

Now, actually, I'm not recalling all the details. It may be that he --- instrument mechanic wasn't listed. I'd have to check that, but there's a second way in which you can qualify, which is the IH looks at the exposure history. And with the 20 years of significant exposure to asbestos, than that should qualify under this set of presumptions.

In any case, the fact is the person did meet these 20 years and the CE sends it to the IH. The IH confirms it, actually, and the IH conclusion on slide 32 was that, quote, it is highly likely that Claimant X, in his capacity as an instrument

technician at the X-10 plant, was significantly exposed to asbestos. And then goes on to say that it would have been frequent --- that is to say on a daily basis --- between 1967 to 1986.

So, the IH confirms what -- follows the Procedure Manual guidance, returns that to the CE. At that point, that should have been enough to call it --- to accept the claim. They had gone to the IH, the IH, following the Procedure Manual appropriately, kicked it back to the CE with that opinion. The CE instead refers it on to the CMC, and the CMC concludes otherwise that it's not --- it's not connected.

So, the errors here, one, was that cadmium was overlooked despite it being in the SEM. And, secondly, that the Procedure Manual guidance followed by the IH, not followed by the CE.

And then the CMC, I think, didn't consult the Procedure Manual because, frankly, if he had --- it was an occupational medicine physician. If he had, he would have seen that this person should be accepted under -- specifically

under the asbestos guidance.

Are there any other denials?

Yes, Carrie?

MEMBER REDLICH: Yeah. There was one denial that was a secretary at a plant who had also --- it was a denial for COPD. They also had a claim for skin cancer. And it looked like the major concerns were more radiation focus than concerns for COPD. So, I thought it was an appropriate denial.

CHAIR MARKOWITZ: Thank you.

MEMBER DEMENT: Steve, are the references that were included in the IH report the same references that were included in the prior report?

CHAIR MARKOWITZ: Yes. Yes. Yes. There's a definitely cut-and-paste mode of action on the references.

The industrial hygienist is obviously using their own information or their own expertise to make a decision and --- are there any accepted cases that --- Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: There is a denial here that's Case No. 22846. And I'm not going to go through it in detail. I don't think it's a particularly illustrative case except for one thing that we've been talking about, and I'd like to raise this formally as an issue.

This is the statement --- the recurring statement, and I'll quote, there is no available evidence, i.e., personal or area industrial hygiene monitoring data, to support that, as part of this position after the mid-1990s, his exposures would have exceeded existing regulatory standards.

That statement I found so many times in ---

CHAIR MARKOWITZ: It's a chorus, actually. It's the chorus.

MEMBER FRIEDMAN-JIMENEZ: I'm sorry?

CHAIR MARKOWITZ: It's the chorus.

MEMBER FRIEDMAN-JIMENEZ: Yes. Well, I think it's problematic and it overstates the confidence that we actually have in the nonelevated levels, and I see two problems here.

The first problem is that the frequency and the conditions under which sampling is done --- in other words, area or personal measurements of the toxic substance in the workplace are not --- don't necessarily ensure that this is a representative sample, that it's a good estimate of the day-to-day exposures that that worker is going to experience or has experienced over time.

There are not a lot of quantitative samples that are available that have been done. And, John, you know these data probably better than any of us and, please, correct me if I'm wrong on this, but my sense is that there's not a lot of sample size and, also, they're not done necessarily under random timing or conditions or active sampling that would allow us to use those as an estimate of the actual day-to-day exposure. Is that accurate?

MEMBER DEMENT: I think that's accurate. I think --- well, the issues you've discussed, I think, are clear.

I think that the problem --- and we've

discussed this before this morning in here, is that it's a presumption that the IH is making about what the exposures would have been in that time frame without stating his rationale for his decision, really --- his or her decision.

And that, you know, judgment comes into play in all of this, but the basis of the judgment needs to be explained in the process of defining what this is. So, the CMC and the CE knows the limits of confidence they can place on the fact of no exposure.

The other aspect of this, even for a particular job and location, there aren't likely to ever have been very many samples ever taken. And the one thing that's always problematic is taking a job and inferring an individual's exposure from that job itself because we never know how people actually do work. And how they do work is a big factor sometimes.

People doing the same work can have must different exposures. Depends on how they do it.

MEMBER FRIEDMAN-JIMENEZ: Yes, the

inter-worker variability in the exposure may be substantial.

MEMBER DEMENT: Yes.

MEMBER FRIEDMAN-JIMENEZ: So, that's one problem.

The second problem I see is that these standards are regulatory standards. These were developed through a scientific and medical and political and financial process for regulation of groups of people.

And they were developed with, what I would say, is a fairly obsolete concept of single agent causation --- in other words, how much of the substance does it take to cause the disease? Rather than a more modern and scientifically valid, I think, concept of toxic substance of interest being one of a multiple set of component causes that contribute to the causation -- to a sufficient cause of that disease.

And we're understanding, I think, a little better in the last 20 years of epidemiology, how causation works and how the causal mechanisms

work.

And so --- but most regulations don't reflect that kind of concept of causation. And so, the standards have been set for single agent causation rather than contribution to causation of the disease or aggravation of the disease.

And so, they aren't necessarily valid and completely protective standards for that particular disease.

So, I think that this phrase, which --- you know, I have nothing against cut-and-paste. I do it all the time. I think it saves time. It's good. But to use it as sort of a pathway of saying that there's no significant exposure, I think, is -- it's sloppy sometimes and I think it does the whole process injustice. I think it's not appropriate, and it's pervasive. I've seen it in multiple reports, the same exact wording.

I mean, it's -- and I think that we want to strive to be medically and scientifically accurate in this process, and we also want to be

perceived by both Claimants and the Department of Labor as having a fair and unbiased process. And I think this does a real disservice to both, so I would -- I would recommend that that phrase not be used as a standard phrase.

CHAIR MARKOWITZ: But, see, here's the issue. The industrial hygienist doesn't feel comfortable --- I'm thinking the industrial hygienist doesn't feel comfortable with what really went on after '95.

They don't really have data before '95 to support their points of view, right, by and large, because those data don't exist, but they're comfortable in saying there was some level of exposure. Sometimes very low, could be low, could be moderate.

So, they're making their decisions pre-'95 based on --- not on data, but on their knowledge of the facilities, their knowledge of industrial hygiene, their knowledge of what those people do in industry by job title, right? But it's not based on data.

Post-'95 because of DOE Order 440.1 when things were supposed to improve, right? Now they no longer feel comfortable using their own industrial hygiene knowledge and are --- want data which don't exist.

So, what phrase -- what do we think would be an appropriate statement about post-1995 exposures? Something like no data, either personal or area monitoring, exists for this job title or for conditions relevant to this individual that shed any light whatsoever on levels of exposure, period.

In other words, don't frame it in terms of regulatory levels. Don't suggest that the lack of data means there's lack of exposure. Just say, we don't have any data. Is that the solution?

Dr. Dement?

MEMBER DEMENT: Well, I think that's the appropriate approach. I mean, the lack of data doesn't mean there's no exposure so ---

CHAIR MARKOWITZ: Right.

MEMBER DEMENT: The way it's phrased

now, it suggests there actually is data supporting the fact there's no exposure, and I don't think that's what a hygienist really means.

So, yes, I think, you know, a fair presentation of the information would be --- you know, there's no actual exposure information for this particular job site. If they want to refer to, you know, when standards came into place and some published literature about how exposures dropped after implementation of standards, that's fine, but don't make it a statement of fact when it's really not there with the supporting data.

MEMBER FRIEDMAN-JIMENEZ: I think saying, no data, is somewhat overstating the case, also, because they're not clouds of dust visible in the air. That's data, that you can actually not see the dust.

But there are not sufficient data to make a reasonable estimate of what --- a representative estimate, of what the exposures were from day to day, and I think we should be honest about that because we just don't know. And to

suggest that we do know that they were low, I think, is overstating it.

MEMBER DEMENT: Yes. I don't have a problem with saying, you know, conditions approved after 1995 with implementation of this thing that DOE cites. I mean, that's perfectly fine.

MEMBER FRIEDMAN-JIMENEZ: Sure.

MEMBER DEMENT: And we know there's --- you know, things don't happen overnight and changes take time, so ---

CHAIR MARKOWITZ: You know, I ---

MEMBER DEMENT: -- present it as it is.

MEMBER POPE: I think by stating there's no data, though, just means that this claim is even more so denied when you say that there is no data to support your claim of your illness.

CHAIR MARKOWITZ: I agree. I think some CMCs are going to interpret no data, well ---

MEMBER POPE: No data, you know, no help.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I think there may not be area or personal monitoring, but the data that are used are from published, peer-reviewed research that has done studies and found either a disease correlates or actually done air measurements in other settings.

So, I think there are --- there is some information available and I think the industrial hygienist can interpret that information, but we should be honest that this is an opinion of the industrial hygienist based on published studies of other populations or whatever it's based on, but this particular wording I find potentially misleading and potentially biased, and it's perceived by most of us as being boilerplate that's not appropriate.

MEMBER POPE: I think it's kind of one in the same. Low -- referring to it as low doses or no data means denial, to me.

If you're saying your doses are low and environmental --- how they state it, means that there's no data --- it would mean the same thing,

to me, as saying there's no data available.

CHAIR MARKOWITZ: I mean, you know, much of this activity is for the CMC. The CMC is going to look at post-'95 and say, I've got no basis on which to say there was any significant exposure, so I'm going to rule it out. When the fact is we don't know what happened, right?

Dr. Silver?

MEMBER SILVER: Two things. Correct me if I'm wrong, but you have other faculties you can draw upon. The natural history of the disease is sometimes known from other case reports or case series, and sometimes there's a prodromal syndrome that's followed later by the onset of symptoms and it appears classically in persons of a certain age, after a certain duration of time in a profession.

Wouldn't a CMC who was drawing upon everything they learned in school, be able to infer causation even without quantitative industrial hygiene data, in some cases?

MEMBER BERENJI: Not necessarily. I mean, among my own colleagues, and I'm sure my

occupational medicine friends here can opine to this as well, I mean, it runs the full gamut.

I mean, some of my colleagues are very black and white. And obviously to be able to do this type of analysis, you have to look at nuance. And with these cases, there is a lot of nuance and, again, this begs the question --- and I apologize for my ignorance on this front, but at least for the CMCs to be able to do this type of work, there needs to be some sort of guidance document with the, you know, understanding that a lot of times there will not be a sufficient amount of quantitative evidence to be able to make a direct connection.

And I think we have to be able to, you know, make sure that the CMCs are given some sort of, you know, didactic -- a guidance document, at least some sort of basic understanding of the work that they're getting into with the understanding that there may not necessarily be, you know, a slam-dunk connection.

Otherwise, I feel that this is just

going to keep repeating itself. We're going to keep having these conversations. We're going to keep meeting at this table. We're going to see the same pattern.

CHAIR MARKOWITZ: Comments? Questions?

MEMBER BERENJI: Do we have time to discuss one more approval or ---

CHAIR MARKOWITZ: Sure. And then we'll take a break.

MEMBER BERENJI: Okay. So, I actually had a case that was approved, and I thought this was a very good case because, at least from my perspective, everything was done right.

So, let me just go ahead and provide the case ID. Last four digits, 2509. Date of birth, 1930.

So, this was an individual who was working as an installer for telephone lines. And he worked at two different plants.

One was at the Portsmouth GDP, and one was at the GTE -- which I don't know what that stands

for, but these are two different sites in Ohio. And he worked -- at least his work experience was from 1953 to 1992. So, that's over 40-plus years of cumulative exposures.

So, I felt that this case was evaluated right because a lot of things were done systematically, which I thought that was a good thing.

The occupational health questionnaire, I felt that, you know, there was a lot of good text, lot of good pretext information. The SEM did cover a lot of different exposures, including asbestos, cement, arsenic, chromium, silica. And, again, it's not necessarily covering all the potential exposures, but I thought at least compared to the other cases I reviewed, there was a greater capture of exposures.

And then I'm not sure if this is done systematically --- I may have missed how this got done, but there was a connection to the NIOSH radio/epi program. So, I'm not sure how many --- what percentage of the cases are they sent over

to this particular NIOSH program. I'm not sure if there's any data on that, but they actually did dose reconstruction and they actually did do telephone interview, which I thought was good.

So, again, there are cases, at least in this particular instance, where I felt that there was a systematic way of collecting information. The telephone interview, I thought, was appropriate.

And this case ended up getting accepted and I actually thought the CMC did a good job on this one, too. The CMC provided the report stating that the claimant had sustained multiple toxic exposures over the decades.

And the CMC did actually account for the fact that this individual was a smoker. I forget the number of pack per day, but, again, he had actually, you know, used a well-rationalized argument that, even though it was a confounder, just given his breadth of experiences, 40-plus years at these two different plants, you know, he was actually able to come up with a good consensus

that the exposures did explain a lot of his pathology.

And this individual was applying for not only COPD, by the way, but also for -- looks like he had lung cancer because it looks like there's a lung mass excision. And he also had multiple skin cancers.

So, complicated case, lot of different points to cover, but this was actually at least a good example of how incorporating various, different data points from the industrial hygienist, the NIOSH folks --- and I can't belabor this point enough, but actually doing the telephone interview, actually making contact with the claimant, getting the human side of the, kind of, picture, I think, really helps to solidify the case.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I have a question about the case.

Did --- was there chest X-ray or CT data used to support the asbestos exposure in COPD?

MEMBER BERENJI: In this particular

case?

MEMBER DEMENT: Yes.

MEMBER BERENJI: I did see a chest X-ray. I don't recall the CT scan, but I'd probably have to go through the file again.

MEMBER DEMENT: Yes. I had a similar case and --- it won't take me just a moment. I had a similar case and it was an individual who worked at Fernald, you know, laborer and chemical operator for 10 or 12 years and some other work. But anyway, he had multiple claims --- COPD one of them -- but he also claimed for asbestosis and some skin cancers.

Originally, the asbestosis was denied, because he really had pleural changes. And so, that finally was accepted at least for medical monitoring for the pleural changes. And then the COPD came --- case came later and it was actually accepted for COPD, but largely based on the fact that he had chest X-ray changes demonstrating asbestos exposure.

CHAIR MARKOWITZ: Dr.

Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: This is very interesting.

I didn't look at this case, but could you tell us a little more about the dose reconstruction, what they did and how ---

MEMBER BERENJI: I'm going to be honest, I kind of skimmed through the dose reconstruction, but I probably have to go back to do a more detailed analysis.

At least based on my initial review, they were actually able to collect various data points to be able to make a consensus as to understanding the exposures that this particular individual had.

Again, I wish I could kind of explain more of the nuances. I probably have to get back to you on that.

MEMBER FRIEDMAN-JIMENEZ: This was the asbestos dose that the ---

MEMBER BERENJI: I believe this is for asbestos as well as for the arsenic.

MEMBER FRIEDMAN-JIMENEZ: It was for arsenic?

MS. LEITON: The dose reconstruction would have been done on the cancers. NIOSH only does dose reconstruction for cancers, and it's only for Part B cases. And so, that had a Part B component and the ---

MEMBER FRIEDMAN-JIMENEZ: Radiation?

MS. LEITON: Radiation. Radiation for lung cancer. Just radiation for lung cancer --- or for other cancers.

MEMBER FRIEDMAN-JIMENEZ: (Speaking off mic.)

MS. LEITON: No. They don't do the dose reconstructions for ---

MEMBER BERENJI: Oh, really? Okay. I thought that was the case for ---

MS. LEITON: For any of the Part E conditions, just the cancer for radiation.

MEMBER BERENJI: Just for the radiation. Okay. Got it.

(Simultaneous speaking.)

MS. LEITON: There would have been a dose reconstruction for skin cancer and lung cancer probably.

CHAIR MARKOWITZ: One more minute. Just bear with me for one COPD accept. You'll see why I want to mention this case.

Long-term machinist and other job titles, sheet metal laborer at Rocky Flats. This was an accepted COPD case.

The various exposures were recognized by the industrial hygienist as being significant, was not sent to the CMC because the claims examiner looked at the personal physician and the former worker program medical reports.

The personal physician said the COPD was related to work and identified some exposures, ammonia, asbestos, diesel exhaust, endotoxin, but here's, I think, what was the deciding factor.

The former worker program letter, and this is from National Jewish Medical Center, said, quote, in my opinion, it is at least as likely as not that exposure to dust, fumes, gases, vapors

during your work at Rocky Flats aggravated, contributed, or caused your diagnosis of COPD.

And apparently that won the day, so I want to assure you that there is at least one claims examiner out there who is listening to us.

(Laughter.)

CHAIR MARKOWITZ: Let's take a break. We'll be back at 3:00.

(Whereupon, the above-entitled matter went off the record at 2:48 p.m. and resumed at 3:07 p.m.)

CHAIR MARKOWITZ: We are going to get started. Let's get started. Okay, we're next going to switch to Parkinson's Disease. And first we'll -- Marek Mikulski will give us a summary of the work that he and the working group have done on this. And then we will discuss claims for Parkinson's-related illnesses.

MEMBER MIKULSKI: It did work a few minutes ago. Can everybody hear me? Thank you so very much for this opportunity to speak at today's meeting. I wanted to give you a brief

update on Parkinsonism and Parkinson's Disease as it relates to the request the Board has received from the Department of Labor. Let me start with some clarifications in terms of terminology that we're going to be using today here during the presentation.

What is Parkinsonism? Parkinsonism is actually a generic term that is used to describe a group of clinical motor symptoms that include slowness of movement, stiffness and tightness of the limbs, and involuntary shaking movements that are most commonly present in the upper limbs, specifically in the hands and often described as pill-rolling.

Parkinson's Disease is actually the most common cause of all Parkinsonism cases in this country. It is estimated that up to over 2/3 of all Parkinsonism cases are the cases of Parkinson's Disease with some genetic factors that have been identified in the last few years responsible for an early onset of the disease under the age of 50. By rough estimates, these add up to roughly 10

percent of all Parkinson's Disease cases.

There's a whole spectrum of known agent exposures in diseases that present with clinical symptoms of Parkinsonism. And these include response to anti-psychotic and anti-anxiety medications, infectious agents, metabolic disorders, brain injury, as well as some occupational exposures. Studies have also identified cases of Parkinson-mimicking disorders that mimic the clinical symptomatology of the disease. However lack the response to the current available treatment.

From a pathologist standpoint, Parkinsonism is actually a very diverse group of symptoms. It is believed that the hallmark of the disease is the loss of dopaminergic neurons in the part of mid-brain called substantia nigra. This loss of neurons leads to a reduction in levels of dopamine, which is the main chemical neurotransmitter in the dopaminergic system that amongst all controls reward seeking fine muscle movements, as well as addictions. A few in the

last years of research on the molecular level has identified two potential mechanisms involving abnormal accumulation of proteins, alpha-synucleins and tau-proteins that are now believed to be responsible for most of the Parkinsonism and Parkinson's Disease cases.

According to the most recent tenth revision of the medical classification list by the WHO, Parkinsonism and Parkinson's disease are actually coded under the same medical diagnosis code. The difference is beginning with coding of known secondary causes of Parkinsonism. This ICD-10 is somewhat similar to a previous coding list, ICD-9 except for major differences in recently identified causes of Parkinsonism.

Under the previously accepted and used Parkinson's Disease Society brain bank, diagnostic criteria for Parkinson's Disease, Parkinson's Disease is actually a diagnosis of exclusion which is supported by the response to the dopamine replacement therapy. These diagnostic criteria were put in place in late 80s originally for years

in the pathology series studies. But they have been subsequently adopted by the clinical community, as well as research community. These criterias have been widely used in epidemiologic studies that look at rates and potential risk factors of Parkinson's Disease.

The new diagnostic system has been introduced just a few years ago by the International Parkinson and Movement Disorder Society. And it is somewhat similar to the old system as it requires a diagnosis of Parkinsonism first, which is now supported by the Unified Parkinson's Disease Rating Scale. And has been designed to help the physician assess both motor and non-motor symptoms associated with Parkinson's Disease. This new system also introduces two levels of certainty, which are the clinically established diagnosis of Parkinson's Disease that maximizes the specificity of these criteria versus the diagnosis of probable Parkinson's Disease that sort of balances between the sensitivity and specificity.

Parkinson's Disease as I mentioned

before is the most common cause of Parkinsonism, but the exact risk factors are still very poorly understood. Most of the cases are termed idiopathic if no known etiology has been identified. Research studies have focused on identifying personal characteristics that form genetic makeups and markers, but also on exposures that may increase the risk of Parkinson's Disease. Amongst those exposures are exposures that were federally at the DOE side.

PCBs have been widely used throughout the mid-70s due to their excellent physical chemical properties. Used in electrical equipment, starting fluids for fabrication of metal weapons parts, and has components of paints, coatings, adhesives, and gaskets. PCB exposure has been shown to result in decrease in dopamine levels in both animal models and experimental cell lines.

Higher concentrations of PCBs have also been found in pathology series of individuals with Parkinson's Disease as compared to controls. And

a population-based study of mortality experience of workers from three electrical components plants has shown an almost threefold increase in mortality from Parkinson's Disease as an underlying cause of death amongst highly exposed female workers from three electrical capacitor producing plants. This finding was later confirmed in another pathology series that showed marked differences between the concentrations of PCBs in brain tissue of female subjects as compared to controls.

MEMBER BERENJI: I'm sorry. Can I ask a question?

MEMBER MIKULSKI: Sure.

MEMBER BERENJI: Can you back to the previous slide please? So I wasn't sure if you went through that last bullet about the dose reconstruction feasibility study.

MEMBER MIKULSKI: Yes. This is part of the Oak Ridge Reservation health study that was primarily conducted to reconstruct the radiation dose and PCBs have been identified as persisting in the environment with potential sources of

exposure -- historical exposures in all those processes.

MEMBER BERENJI: Is this published or is this just based on --

MEMBER MIKULSKI: This is available as public information. There is no publication as far as I know. But this can be found and I can provide you with references for the initial preliminary reports.

MEMBER BERENJI: Thank you.

MEMBER MIKULSKI: Solvents. Solvents have been extensively used throughout the industry, as well as the Department of Energy complexes primarily as degreasing agents in cleaning parts, machining equipment and in paint thinners. Most commonly solvents used at the DOE complex include the trichloroethylene, toluene, acetone, hexane, and carbon disulfide, which has been previously addressed as potential risk factors for Parkinsonism in the DOL procedure manual.

The majority of the population-based studies to date have not looked at individual --

the effects of individual -- exposure to individual solvents. They were mostly presented as single entity, rather than any specific exposures.

There are a few cluster reports to date. Clusters of Parkinson Disease that present on Doppler evidence of increased risk of Parkinson Disease in those highly exposed to TCE. TCE -- Oh, I'm sorry. TCE exposure has also been shown in animal models to result in loss of dopaminergic neurons and reductions in the levels of dopamine.

A 2012 research from UCS and Parkinson's Institute in California has shown that every exposure to trichloroethylene on at least one hour per week basis may result in sixfold increase in risk of Parkinson's Disease when compared to non-exposed control. And this last study was part of a -- of a World War II Veteran National Academy of Sciences twin study that has been going on since the 1960s. This study was particularly important as it offered advantages in adjusting for different genetic makeup between the individuals exposed to solvents.

Metals have been widely used throughout the whole industry, but the most prevalent, the most common exposures at the DOE complex would have been through metal fumes or metal dusts generated during welding or machining operations. Welders have been at particular risk for exposures to a spectrum of metals in welding fumes including manganese that has been looked as a risk factor for Parkinsonism. And have been addressed in multiple epidemiologic studies before.

An increased risk are iron and copper. Let me start with those two. Iron and copper exposures have been found -- have been linked to reduction in dopamine levels in animal models. In a study from 1997 and 1999, an increased risk of Parkinson's Disease has been found among workers with 20 plus years of occupational exposures to copper and iron/copper combinations.

Finally pesticides. There's been a lot of research interest in pesticide -- in effects of pesticide exposures and the increased risk of Parkinson's Disease amongst the farmers and in

general, in agricultural industry. Pesticides use was not that common at the DOE complex. However, there was a potential for bystander exposure as multiple sites have had farming operations going on during their normal production.

There's several classes of pesticides including insecticides, herbicides, and fungicides have been again linked to reductions in dopamine levels in experimental cell lines, as well as in animal models. Significantly higher concentrations of organochlorides, a class of insecticides have been found alongside the PCBs and brain tissue of patients diagnosed with Parkinson's Disease when compared to non-disease controls. In pooled data analysis -- in meta-analysis studies, the risk for Parkinson's Disease has been shown to be elevated for two classes of pesticides; for insecticides and herbicides, as compared to those never exposed.

I wanted to finish here and open the floor for discussion, questions.

CHAIR MARKOWITZ: Thank you, Marek.

That was great. So perhaps for the benefit of some of the non-physicians in the room, we should just say that there is no particular -- you may have covered this, but maybe I missed it. There's no blood test. There's no urine test. There's no radiology study. There's no way of making the diagnosis while persons -- of Parkinson-related disorders -- while the person's alive, except for the clinical diagnosis. Meaning listening to the patient, doing a physical examination, and seeing how they respond to therapy. Is that right?

MEMBER MIKULSKI: That's correct. There are however several clinical tests that have shown an association with Parkinson's Disease. One of them being the loss of sense of smell has been shown to be present in over 95 percent of every case of Parkinson's Disease.

CHAIR MARKOWITZ: So that means that reasonable doctors can disagree about the diagnosis, particularly when it's relatively early in the course.

MEMBER MIKULSKI: That's correct.

CHAIR MARKOWITZ: Are primary care clinicians able to make the diagnosis of Parkinson's Disease with reasonable accuracy?

MEMBER MIKULSKI: It has been shown that the clinical accuracy is the highest among specialists in movement disorders. Primary care physicians are probably lacking the proper training. And possibly these guidelines that have just been issued have not been updated on the most recent state of knowledge.

CHAIR MARKOWITZ: So Ms. Leiton, can I ask you because you know, we looked at a limited number of -- we're going to discuss those claims, but I'm sure the causation is a question. But is the question of the diagnosis of -- you know, the claims examiner is sitting there looking at medical records making some effort to decide whether to accept the medical diagnosis of Parkinson's Disease. Has that been a problem?

MS. LEITON: Yes. Part of the problem is that it's been called different things. And so we have certain presumptions in the procedure

manual. I think it's for Parkinsonism or Parkinson's Disease. They don't know whether they're synonymous. And then there's, I think one other term that is used for Parkinsonism. And it gets a little confusing for us. That's part of the reason we wanted you guys to kind of help clarify that for us.

I did have a question. You said a specialist in movement, what would that mean for us if we were going to try to, you know, look for a specialist who actually would need to help clarify this? Because, would it be a neurologist?

MEMBER MIKULSKI: It would be a neurologist with training, especially in these last --

MS. LEITON: Wow --

MEMBER MIKULSKI: -- most recent guidelines at this point.

CHAIR MARKOWITZ: But Parkinson's Disease is bread and butter for the average neurologist. Right?

MEMBER MIKULSKI: Yes.

MEMBER REDLICH: My father died of Parkinson's, so I think anyone who's had a relative is going to be more knowledgeable about this disease. There are some cases that are very classic in presentation with the various --

FEMALE PARTICIPANT: Your mic.

MEMBER REDLICH: Oh, I'm sorry. I was just saying that just having a relative who passed away from Parkinson's, I became much more familiar with the disease even though I'm not a neurologist. There's just a wide spectrum of presentations in the realm of different movement disorders. And there's some cases that are sort of quite classic. And then there are others that there's an overlap that may take a neurologist years to diagnose. So it's really more I think a spectrum of diseases. So I'm not surprised that it's challenging to diagnose. Challenging enough that I told Steve, could he please review my Parkinson's cases.

CHAIR MARKOWITZ: Thank you. Dr. Silver?

MEMBER SILVER: A non-physician with

a maybe simplistic question. So if a worker has the three categories of motor symptoms, but their condition does not improve with drug therapy, Levodopa, does that tilt in favor of xenobiotic exposure causing the movement disorders?

MEMBER MIKULSKI: Possibly. I don't think that this would be -- in favor of diagnosing Parkinson's Disease, but definitely some other secondary agents.

CHAIR MARKOWITZ: And that would be categorized as Parkinsonism.

MEMBER MIKULSKI: As a secondary Parkinsonism panel.

MEMBER SILVER: Thank you.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: How strong is the evidence for PCBs? I noticed that you had the PCB slide, the Chorigon study. The numbers were the same for the PCBs and for the organochlorines. Is that for PCBs? And how strong a study is that because there were small

numbers.

MEMBER MIKULSKI: That was actually a pathology series that was a very small case -- a very small study. I believe roughly between ten and 20 cases. And those were actually identified parallel and parallel. So PCBs and organochlorines in the brain tissues and of the same cases of Parkinson's Disease.

MEMBER FRIEDMAN-JIMENEZ: I wasn't able to tell how strong it was from the numbers that you had. The second numbers in the parentheses, were those tissue levels?

MEMBER MIKULSKI: There were no tissue levels.

MEMBER FRIEDMAN-JIMENEZ: What was that 70 to 85 versus 50 to 72?

MEMBER MIKULSKI: Those were the age ranges.

MEMBER FRIEDMAN-JIMENEZ: Oh, those were the age ranges. Okay.

MEMBER MIKULSKI: And the ratio of male to female subjects. They have had -- They've

extended the age range to include younger controls as well. The cases of age of death was anywhere between 70 and mid-80s as I recall. But for the controls, they used several subjects younger than that.

MEMBER BERENJI: I have a question -- I'm sorry.

CHAIR MARKOWITZ: Yes, Dr. Berenji.

MEMBER BERENJI: Do you have any data about the use of imaging, specifically PET imaging to be able to diagnose early signs of Parkinson's? Because I know the data has been equivocal, but I wasn't sure if you had any specific information on that.

MEMBER MIKULSKI: I have not come across any of this.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Another question on manganism. Okay, that's the Parkinson presentation due to manganese. And I've read studies that have found imaging changes in the

globus pallidus on MRI that aren't found in Parkinson's Disease. What's your -- What have you found on that? Is there anything new on that or any developments in imaging that can distinguish manganism from primary Parkinson's Disease?

MEMBER MIKULSKI: I honestly have not looked at the effects of manganese specifically. We assume that since this is also covered under the cards on files and we're not going to do any more research in that area. But certainly this is something to look into in the future. Manganese is a very controversial exposure, at least to say some studies have found a correlation where some others have not. So this is definitely something to be cautious about and possibly look into it in the future.

CHAIR MARKOWITZ: But the DOL approach to this class of disorders is to -- if I understand the procedure manual correctly is to include all the relevant ones with the ICD codes that contain Parkinson as being equivalent. So they don't carve out manganism as a separate diagnosis. If at all,

they're erring on the side of being inclusive -- very inclusive in at least the way the procedure manual reads.

You know the -- I'm having -- I can't -- I'm having a hard time imagining a CMC second guessing the diagnosis of a primary care physician of Parkinson's Disease. A neurologist, that's easy because the neurologist is the expert. The primary care physician has fairly frequent contact with Parkinson's Disease because it's fairly common. They may or may not be correct in the diagnosis. But I'm trying to imagine a CMC doing a paper review being more correct than the primary care doctor who's seeing the patient for this condition. So I'm wondering if you -- what your view of that because you've been thinking more about this than I have.

MEMBER MIKULSKI: I think it all depends on the level of expertise of CMC. Most CMC probably -- most CMCs probably have not had that level of expertise to be able to question the neurological degenerative disorders. I'd

probably caution against using a CMCs opinion as a cardinal or final opinion in making this diagnosis, especially where there is evidence of medical deficits presented and diagnosed by the primary care physician who honestly at this point may not be using the most recent classification as this is so recent. And still operating under the old guidelines, which are perfectly fine in terms of clinical accuracy.

CHAIR MARKOWITZ: Well these guidelines that you went over, the new ones, these are very complicated for the clinician because you have to have certain positive findings. You can't have -- certain findings absolutely rule it out. Other findings serve as red flags and argue against it. It's --

MEMBER MIKULSKI: And another complicating factor here is that these are guidelines formulate by the organization that's specifically interested in erring on the side of diagnosing Parkinson's Disease. As an example, this unified scale of Parkinson's is a scale that

helps assess the both motor and non-motor symptoms of Parkinson's Disease is something that you actually have to purchase before you can start using it. Which sort of shows the direction that this may be going on in terms of clinical diagnosis.

I don't know how well will this be adopted in the future. There's really no say. There are validity studies. Studies that look at the eternal validity of the scale versus the old scale and compared to the gold standards of diagnosis being the pathology series. But I think it's really too early to sort of limit yourself to this -- to this particular one set of criteria that are now being recommended by an organization that is vitally interested in the -- in the potential outcome.

CHAIR MARKOWITZ: Any other comments or questions? Otherwise, we'll move to reviewing the claims for Parkinson's Disease and we can reiterate the same discussion. Yes, Dr. Silver?

MEMBER SILVER: It may be an oversimplification, but for our population of

former workers 70 to 80 years old this 2x2 table is jelling in mind. One row is Parkinson's Disease. The other is secondary Parkinsonism. And the columns are yes job exposures, no job exposures. So Parkinson's Disease could be caused by job exposures.

MEMBER MIKULSKI: Exactly.

MEMBER SILVER: All right? But a lot of it is idiopathic. And then the lower row of the table, Parkinsonism similarly it could be caused by job exposures or maybe drugs, metabolic disorders --

MEMBER MIKULSKI: Exactly.

MEMBER SILVER: -- and infections.

MEMBER MAHS: Anything that can be explained.

CHAIR MARKOWITZ: All right. So let's discuss some Parkinson's-related claims. Anybody want to start?

MEMBER MAHS: Are these accepted or denied?

CHAIR MARKOWITZ: Oh yes, sure. We

can go with either.

MEMBER MAHS: Well since we're here, I've got one on Savannah River that's denied --

CHAIR MARKOWITZ: Oh, hit the mic.

MEMBER MAHS: Since we're here, I have one at Savannah River that was denied. It was a laborist. Worked there a little a little over ten years. Works labor as an inspector. And I'm kind of -- anyhow, she was denied on October 19th. They had her appeal. They denied her claim for Parkinson's Disease and pulmonary fibrosis. Final decision notably does not discuss the testimony provided during the previous hearing in October from her and co-worker concerning the kinds of exposure to toxic substances she experienced at SRS. Further states that after this evidence was submitted, the District Office undertook development of the claim by searching the SEM for potential exposures.

District Office determined at a search in December revealed that a Labor, DI mechanic, and Quality Inspector had potential for exposure

to aluminum, bronze, microtalc, antimony hydride, silica gel, and synthetic vitreous fibers. In December, revealed certain potential exposures to carbon monoxide and stainless steel, which are associated with Parkinson's Disease.

The final decision states these potential exposures were referred to an industrial hygienist to evaluate the nature. He opined that there was significantly exposed to stainless steel. It was highly unlikely that she was exposed to carbon monoxide at a level specified in the procedure manual.

For discussion, her representative respectfully requested to reconsider the final decision denying her claim which is prematurely and erroneously issued. And the denial of her claim denies due process law as discussed above. Neither her nor her attorney, an authorized representative of record, received the recommended decision. In fact, they were not aware of the recommended decision until they received the final decision. So they had no time to find out what

the problem was.

Failing to give notice of the recommended decision, the Department of Labor failed to properly develop her claim of pulmonary fibrosis. And neither the recommended decision, nor the final decision considered the full extent of exposure related to her employment at Savannah River. She was exposed to including asbestos, aluminum, and other metal dust silicone, dioxide including cement dust, coal dust, loading fumes, exhaust fumes.

She had testimony from two different co-workers that she'd worked in the steam plant and was exposed to the coal dust and asbestos and stuff. And it wasn't used in the final recommendation either. The hygiene records from SRS state that as a laborer, she was exposed to cement dust, coal dust, slag, fiberglass, diesel and gasoline exhaust, fumes, asbestos, and coal dust. And that's just about the same thing that the SEM said she could be exposed to.

In addition, she ran a jackhammer that

exposed her to cement dust and diesel exhaust. And again, she was sent to the power house for three years. Her co-workers confirmed it and that testimony was not used, I think I mentioned.

However, chronically daily exposure to dust and fumes for more than ten years employment as a labor mechanic. The most prominent hazards at capacity were her exposure to cement, silicon dioxide, coal dust, asbestos, welding fumes, metal dust, aluminum oxide, which she had chronic exposure and likely some instances of acute or heavy exposure.

Occupational exposure to the discussed toxin substances was most significant risk factor of her development of pneumoconiosis, however you say that, and resulting pulmonary fibrosis. Also my opinion to a reasonable degree of medical certainly, it's at least as likely as not that her occupational exposure to these hazardous chemicals were possibly responsible.

In November 2018, they denied her claim benefit based on Parkinson's Disease, pulmonary

fibrosis and the advice of reconsideration request will be assigned to the Jacksonville office. And again, for the reasons stated below, the Department of Energy verified they worked at the plant. On July 6th, 2017, District Office issued a recommended decision to deny your claim under Part E based on a condition of Parkinson's Disease and pulmonary fibrosis because you failed to submit medical evidence, which I just read.

On February 9th, 2018, FAB issued a remand order that after you submitted additional medical evidence to support that you were diagnosed with pulmonary fibrosis and Parkinson's Disease. Medical evidence you submitted included medical report, which showed a diagnosis, a CT scan, and reviewed by her MD and showed pulmonary fibrosis -- just repeating itself. And they find that your occupational exposure to airborne particulates, dust fumes including coal, dust, and asbestos caused or contributed to your pulmonary fibrosis.

The industrial hygienist on February 27th and May 8th of 2018, the potential exposure

at Savannah Riverside that you have had to carbon monoxide and stainless steel as an EI mechanic from September 23rd '85 to April '92 to aluminum, bronze, microtalc. And as a laborer from February '85 to September '85 to antimony hydride, silica gel, some synthetic vitreous fibers, metallic as an EI mechanic from September '85 to 30th.

He opined that in your job as an EI mechanic you were significantly exposed to stainless steel. Exposure would have been incidental in nature and in passing. Highly unlikely that you were exposed to carbon monoxide at levels specified in the EEOICPA procedure manual. There was no evidence that you were ever rendered unconscious as a result of this exposure to that agent. Do you have to be unconscious to be exposed to carbon monoxide? Pardon?

MS. LEITON: It's in our presumption of carbon monoxide.

MEMBER MAHS: All right. Anyhow, so in the event that you did ask for an revision because of the problems of things that didn't get turned

over or reviewed. And I guess they sent it to the Jacksonville office to see if they're going to review it.

CHAIR MARKOWITZ: Comments, questions? So do they -- Did they accept the medical diagnosis of Parkinson's disorder and the issue was the exposure?

MEMBER MAHS: Yes, well that was her doctor suggesting it was exposure to these fumes.

CHAIR MARKOWITZ: Right. Her doctor said she had Parkinson's?

MEMBER MAHS: Yes.

CHAIR MARKOWITZ: But did the DOL claims process accept the medical diagnosis or is that still in contention or was it --

MEMBER MAHS: That was another part. He did not submit probative scientific evidence of a fully rationalized medical report showing that your occupational exposure to toxic substance at Savannah Riverside was a significant factor and aggravating, contributing, or causing your pulmonary fibrosis and Parkinson's Disease. And

so they deny your claim for benefits based on Parkinson's Disease and pulmonary fibrosis is appropriate. You did not establish that toxic substance exposures was a significant factor in aggravating, contributing to, or causing claimed conditions of Parkinson at least as likely as not.

CHAIR MARKOWITZ: Okay, thanks. Comments, questions?

MEMBER DOMINA: I have a case we can do. It's an accept case. If you still have that handout, if you go to Page 36 or Slide 72. It's not a long case. And it's a chemist actually who worked for 40 years as a chemist at Hanford and PNNL. And was exposed in the IH report to manganese and potassium permanganate at very low to low levels. And the IH concluded that it was highly likely that in his work as a chemist or scientist at Hanford PNNL, he was significantly exposed to multiple toxins, though not after the mid-1990s.

He was a chemist for 40 years beginning in the 1960s -- or in actually 1955, so for a long time. And the referral to the CMC was that his

exposure to manganese or permanganate as a chemist cause, contribute, or aggravate his Parkinson's disorder -- the disease was accepted -- the medical diagnosis was accepted. That wasn't in contest. It was just the question of exposure.

And the CMC said yes, he or she did believe that this person's exposure to manganese permanganate was sufficient. And it was at least as likely as not. And cited some references including several which are specific to Parkinson's Disease and environmental exposures. So a chemist 40 years, named exposure to manganese permanganate, recognized by the IH, recognized by the CMC was approved. So that's an example of an approval for Parkinson's.

CHAIR MARKOWITZ: Yes?

MEMBER FRIEDMAN-JIMENEZ: That was one of the ones you gave me that I looked at also. And I noticed that they also accepted his COPD and his Parkinson's at the same time a few years back. And they deferred his neuropathy and his chronic kidney disease. But also what Dr. Mikulski talked

about earlier, he had a loss of smell since 1995 in which they denied. And so --

CHAIR MARKOWITZ: Yes. You're saying that was part of the Parkinson's -- that's an attribute of Parkinson's Disease.

MEMBER FRIEDMAN-JIMENEZ: It's a supportive criteria for the diagnosis of Parkinson's according to the most recent --

MS. LEITON: This is Rachel and that's part of the reason we need help. Because we don't -- there's not -- That for example is something that we wouldn't have known otherwise. Doctors don't always put it in as a part of Parkinsonism. We've got some of these manganese, carbon monoxide in our procedural manual. But a lot of times they come back and say idiopathic. And you know then -- so those are the jumbles of different issues and problems with he have Parkinsonism, Parkinson's Disease, manganism. All those are kind of jumbled together and they're not as well known. So it's one area of education that would --

MEMBER DOMINA: One other thing on that

case because the guy -- because it showed him from 55 to 65 working for GE and there was no records. I mean the case file is 1,415 pages long. And there's no records from 55 to 65 in his case file. And so for me, that's a little bit troubling on some of the things that maybe they denied him on. Because he also talked about working with beryllium and lead basically daily too. And so, because I went back and skimmed through it again when I couldn't find any 55 to 65 records. I thought that was kind of odd.

CHAIR MARKOWITZ: And this was kidney disease. And what was the other one you said he was --

MEMBER DOMINA: Neuropathy --

CHAIR MARKOWITZ: Neuropathy.

MEMBER DOMINA: -- and his loss of smell, yes.

CHAIR MARKOWITZ: I have to confess, I was focusing on Parkinson's.

MEMBER DOMINA: Well I know, but see for me it's like you know, these four letter words

I can work with. And so it's kind of like you know --

CHAIR MARKOWITZ: I know. You want to address the whole person. I get that.

MEMBER DOMINA: Yes.

CHAIR MARKOWITZ: Other comments, questions? All right, any other cases? Dr. Dement? Oh yes, of course. Dr. Mikulski.

MEMBER MIKULSKI: Yes. So I have a denied case of Parkinson's Disease that looks like it's been in the works for a good decade or so. The Case ID No. is 7158. And this is a 65-year-old gentleman at the time of diagnosis of Parkinson's Disease, now 77, who worked almost 20 years -- non-consecutive years as a project engineer and construction engineer at the Portsmouth GDP.

His initial claim, he has no family history of Parkinson's Disease. His initial claim was denied based on the lack of medical evidence. Further medical evidence was submitted. The claim was accepted for review. And final decision has been the lack of causation given the lack of

information -- specific job information and the SEM.

It looks like the claim examiner had went to great lengths of trying to identify these exposures, but could not find any information in the DOL resources. Accepted the medical condition; however, did not take into consideration the occupational health questionnaire that specifically listed exposures to solvents, metals, and other substances.

Anything else about this claim? There was no referral either to the industrial hygiene or CMC in this case. And the case was basically denied by the FAB decision early, early last year. Hence my series of questions earlier today about the level of decision making in terms of having the CMCs look at the available evidence.

MS. LEITON: So for Parkinsonism, we do have that -- In Exhibit 15.4, we have some very specific criteria that we're looking for. And so that might be part of -- so he didn't have evidence of manganese or carbon monoxide or certain

substances. You said that we couldn't find much either. That may be why it wasn't referred to an IH. There just wasn't enough to refer or it didn't line up with some of our presumptions. So that's one of the variations you'll find.

MS. LEITON: He had a medical diagnosis of Parkinson's Disease from both primary care -- his primary care physician, as well as a second opinion from the neurologist as well.

MS. LEITON: Right. The disease wasn't in question. It was the causation --

CHAIR MARKOWITZ: Yes.

MS. LEITON: -- and exposure.

CHAIR MARKOWITZ: What was his job title?

MEMBER MIKULSKI: Project engineer and construction engineer. It looks like there were several phases -- plant operations. Because he worked at -- he first worked during the main operations. Then during remediation, and finally when the plant was -- when the plant was on cold standby. He was not part of the medical

screenings, so he didn't have any other records available in terms of employment.

But what was really interesting is that his occupational health questionnaire was administered by the Resource Center caseworker. Which my impression from looking at the records, had very little expertise with regards to the specific site. And basically just went over the general categories of exposures and flagged them as he was told.

CHAIR MARKOWITZ: What was that case number?

MEMBER MIKULSKI: 7158.

CHAIR MARKOWITZ: But was there any mention in the SAM analysis or in the occupational health questionnaire of carbon monoxide, any manganese-related -- any steel, any welding, any alloy?

MEMBER MIKULSKI: No. The only mention was of exposure to radiation, as well as solvents, metals, gasses.

CHAIR MARKOWITZ: Because as far as I

can tell --

MEMBER MIKULSKI: It was very general.

CHAIR MARKOWITZ: -- the ballpark of relevant exposures as in the procedure manual or in the SEM if you look up Parkinson's, are those the ones I just mentioned; CO, a bunch of alloys, weldings, various steel materials, and various manganese or elements that contain manganese? And if you don't have one of those exposures, then you know, you're not going to qualify because you don't -- because there's no relationship according to -- is the way the system seems to look at it. Dr. Redlich?

MEMBER REDLICH: You know, this is quite different than the pulmonary cases where we've -- we have, you know, more -- in pulmonary cases where we know that asbestos causes, you know, asbestos and the diseases and causation have been established. So we're just addressing in an individual whether there's, you know, clarification of the disease and if there's sufficient exposure. So it seems here we first

need clarification based on the current literature. And that's what you were trying to do is do we think that any additional categories of exposure should be added to the current list?

And I mean the other thing as far as the respiratory diseases, there may be some disagreement about the -- We have some idea in addition to what exposures will cause which diseases. We also have some idea of the magnitude of exposure or a ballpark. You know, how many years? You know, we know beryllium, you need less -- potentially less exposure than, you know, asbestosis.

So is there -- Do we have a consensus of whether the current list is adequate and whether --

CHAIR MARKOWITZ: For myself, I would say not yet. But we're getting there.

MEMBER MIKULSKI: We're working on it.

CHAIR MARKOWITZ: But I think there are two issues. One's general causation we're trying to address.

MEMBER REDLICH: That's right.

CHAIR MARKOWITZ: And the other is specific causation. How well is the system working as it defines relevant exposures? Which is similar to what the COPD claims review was. So I think it's legitimate that --

(Simultaneous speaking.)

CHAIR MARKOWITZ: -- parallel go to both -- go both ways. Comments, questions on this case? Is there another case? Do you have a case Dr. Dement?

MEMBER DEMENT: I have one that's sort of -- Let me do this again. It's sort of interesting.

CHAIR MARKOWITZ: What number is it?

MEMBER DEMENT: It's 0177.

CHAIR MARKOWITZ: Okay.

MEMBER DEMENT: This is a case of an individual who at the time of his case review was in his mid-70s. Was born in 1940. He had Parkinson's, but several other things that were filed for; hearing loss, some skin cancers, a

thyroid nodule, a lung nodule. And his work history wasn't watched well. He was a pipefitter welder. And that seemed to be well-established. The timeframe, some of it in the early 70s. And then again in the mid-90s. And then a period of '91 to '98, so inclusive.

There was some question. Again his work history, whether or not he had more exposure at Oak Ridge. His OHQ was to work in both X10 and occasionally E5. So but that didn't -- the request for records didn't verify that exposure. But nonetheless, there was a question about it. So he had a long experience of being a pipe fitter/welder. Some of which was at Oak Ridge. Some question about how much time. I think they allotted about eight years.

So the diagnosis of Parkinson's was accepted and that was from the treating doctor. The SEM was consulted. And the exposures that the SEM identified of course were the things that Steven just spoke of. And those were carbon and stainless steel, as well as welding. And specifically use

of manganese growing rods. So that was sent to the IH. He reviewed it and said that he concurred that there would have been exposure to carbon and stainless steel, as well as welding fumes and dust during his work history. He saw the same phrase that we've heard all along with regard to regulatory standards after the mid-90s. So that was per the intake -- the review. It didn't really address the welding and rod issue, which I wondered why. It seems like he should have addressed his use of the welding rod with magnesium. The OHQ listed some other metals, specifically lead and mercury. That weren't addressed in the IH assessment or given to the IH for assessment.

So the claim was actually -- was denied. And the CMCs review of it, he accepted the fact that Parkinson's was diagnosed. Then he opines that it's only linked to high sustained exposures to manganese in particular. And he stated that seven year of work is a relative short duration. And the estimated baseline from low to moderate levels of exposure is not a high dose associated

with the development of Parkinson's.

So here we have a situation where in my view, you have a long-term pipefitter welder. Okay, he has those exposures; some of which are at the DOE side. He would be a case that I think if you were to look at his total work history and review it, you would say yes. When you start separating apart and trying to allocate only a piece of it to the DOE side, then this seems like they're falling apart based on the CMCs review. In my opinion, if I were reviewing this case, I think I would just say his Parkinson's Disease is likely caused by his exposures to these materials. And the DOE side exposures contributed to that outcome. Comments?

MEMBER POPE: And that was an accepted?

CHAIR MARKOWITZ: Denied.

MEMBER POPE: It was denied?

MEMBER BERENJI: I actually had this case as well. And I just wanted to reiterate what Dr. Dement just mentioned. At least from my perspective, I mean I deal with this in my clinical

practice where you're dealing with a particular individual who's, you know, coming in, claiming that he or she had this exposure while working at this particular employer site. But if you take a full comprehensive occupational history, it turns out that they worked at various different locations over a period of decades. So at least in this case, I know he was working at this particular location 1970 to 1973.

I might have missed this. I'm not sure if John may have gotten this. But it would be interesting to be able to parse out what exactly he was doing in those three particular years.

MEMBER DEMENT: I believe in those years he was in the same job category; pipefitter welder. He actually spent a lot of time in the fab shop doing a lot of welding.

CHAIR MARKOWITZ: Right, so at least if -- I'm not sure if that may have made it to this statement of accepted facts or at least made it to the questionnaire, I mean if there's a way where there could be kind of you know, brought up to the

CEs attention, I felt that, that could have helped at least to make a better case for this particular claimant.

MEMBER REDLICH: Yes, during that timeframe in particular -- and I think Kirk has pointed out an important point. You weld. You have a variety of different materials that you weld. The base materials, as well as the welding rods that you use, which contribute to the exposure. Then you turn around and you grind the weld off when you get it down to make it nice and smooth and clean. So there's lot of different exposures, rather than just the welding fumes itself.

CHAIR MARKOWITZ: This is Steve Markowitz. I just want to point out, John, with reference to the welding rods, the SEM under Parkinsonism relates it to a work process which is entitled, "Use manganese-containing welding rods." And lists welding fumes as at least potential exposure to welding fumes as related to Parkinsonism. Comments or questions?

MEMBER SILVER: How old was he when the

disease was diagnosed, do you remember?

MEMBER DEMENT: I don't know if I have it recorded on my notes here. I don't seem to have it on my notes.

MEMBER BERENJI: I don't have it either but I can look that up.

CHAIR MARKOWITZ: Okay, thank you.

MEMBER POPE: I'm just having a problem trying to distinguish between the one that you had Dr. Markowitz and that was accepted right?

CHAIR MARKOWITZ: The chemist?

MEMBER POPE: Yes.

CHAIR MARKOWITZ: The chemist was -- 40 years as a chemist, yes.

MEMBER POPE: Forty years and the welder. So the cases that I looked at with the Parkinson's, a lot of the welders were coming down with Parkinson's and a lot of those cases were denied. But I had a problem trying to distinguish why that yours was accepted and theirs were denied.

MEMBER BERENJI: Again, I think Dr. Dement already mentioned this. But it looks like

it has to do with the number of years that this particular individual is working at the DOE site.

MEMBER DEMENT: Yes, the CMT basically said that the duration/intensity of exposure wasn't enough for him to attribute to the Parkinson's to the DOE site where -- Yes, I did find it --

MEMBER POPE: Maybe that's why it was the chemist.

CHAIR MARKOWITZ: Yes, exactly.

MEMBER POPE: Yes, that was my question.

MEMBER DEMENT: It was based on his treating doctor. He was symptomatic since about 2005. So would have been about 65.

CHAIR MARKOWITZ: Well I have another accept case that might help. But I don't want to move on to it unless -- Well this can brief -- accepted November 2018. And this was a machinist janitor for ten years, machinist for 23 years. And the claims examiner -- Well let me just move straight to the IH report. The IH said highly likely as a machinist to be significantly exposed

to multiple toxins.

And among those toxins, relevant to the issue of Parkinsonism was carbon steel occasional low to moderate, Bonnell occasional low, steel occasional low to moderate. And as machinist 23 years. And the CMC said that's enough. That's enough exposure to manganese and copper. I'm not sure where the copper came in exactly, but I think Marek knows. But in any case, they accepted the case. So there's an example of a different job, the machinist, longer term 23 years. Janitor on top of that, but the steel exposure was probably machinist mostly, which was accepted.

MEMBER POPE: Now is there any connection between -- because everybody's different, right -- as far as the disease taking a short amount of time to develop opposed to somebody that has been exposed over a long period of time?

CHAIR MARKOWITZ: Well I think actually, Steve Markowitz -- I think one of the things we need to do is to look at the

manganese-related and welding-related literature that demonstrates Parkinsonism. And look at duration of people and intensity of exposure -- level of exposure to see what levels it's been documented to be related to Parkinsonism. Because that's where you'd be able to tease out what kind of dose you need.

Because clearly that's what's going on in these -- you know, assuming they're all acting in -- the various CMCs are acting in sync. It's a big assumption, but they're calculating dose. Right? And based on job title, based on different exposures. And we need to figure out, I guess, and help advise on what are the dose circumstances that are appropriate for compensation.

MEMBER MAHS: I've got a short denied and probably rightly so. It was denied twice. A 77-year-old, had been a project engineer. He was denied in 2015 and again in 2018 for basically the same reasons. They didn't provide sufficient medical evidence to show exposure to toxic substance while employed under covered DOE facility

was a significant factor. He was diagnosed with Parkinson's in 2007. And again in 2015, a final decision based on submission of medical evidence. None was submitted that establishes a causal relationship between Parkinson's Disease and exposure. The SEM found no potential link between claim Parkinsonism and any toxins at the Portsmouth Gaseous Diffusion Plant.

And again on December 17th and January 2018, they notified of the evidence required to establish a claim. We had time to come up with more evidence and didn't. In response, they submitted medical evidence that had nothing to do with showing any causal reasons. So they denied the claim again in 2018 for lack of medical evidence. And he was given time to find some.

CHAIR MARKOWITZ: Mani's got another one. Dr. Berenji?

MEMBER BERENJI: Yes. Thank you, Dr. Markowitz. I do have a case. It was actually very interesting because it's gone through multiple iterations over the years. Let me go ahead and

give you the Case ID, last four 2701, date of birth 1943. So this is a gentleman who was initially working as a "cafeteria helper" from 1966 to '68. Then transitioned over to maintenance mechanic. And he was working in that particular function from 1968 through 2000. And he was working at Oak Ridge X-10 was the primary location.

So the occupational health questionnaire revealed a lot of exposures including mercury, lead, arsenic. And then there's a question of trichloroethylene. The SEM was done on this case. And again, I have a hard time reading the SEM. I feel like it kind of -- at least from kind of going through these for the first time, it's very hard to delineate all the various subcategories. But at least I felt that there was a discrepancy between the occupational health questionnaire and the SEM.

So this gentleman had the fortune of having an AR, had legal representation, which I think was helpful in this particular instance. And actually had the benefit of having not one, but

two very good neurologists, at least with respect to the particular diseases in question.

So just to make sure I got the chronology correct. He actually applied for multiple diseases including Parkinson's, neuropathy, hearing loss, restless leg syndrome, insomnia, hypertension. And it's actually interesting that he recently filed for ALS in 2018. And at least based on my review, it looks like there's been a deferred decision on the ALS component of his claim as of March 15th of 2019.

So I actually -- again from a clinical perspective, I felt that the records in this case were very well done. Because I felt that there was actually good treating physician notes. From my perspective, it's excellent to have those resources to really gain a sense as to what this particular individual was exposed to.

So the first neurologist who was assessing this claimant was really evaluating him for peripheral neuropathy. And I believe this was diagnosed in the early 2000s, I might be mistaken,

but that was the general timeline on that front. And he had been seeing this particular claimant for a number of years. And he was really -- you know, he did a full work-up and was able to do the EMGs and all the respective testing.

He then transitioned on to a different neurologist in the mid 2000 teens. And this particular neurologist did an excellent job. He really took the SEM but took it to the next level by correlating with the claimant's clinical manifestations. And he actually made great references. He was able to do an extensive literature review. And he actually put those references in his clinical notes.

So to me, this guy is the gold standard when it comes clinical documentation. And I think this guy is somewhere in Tennessee. But I mean this guy --- at least from a neurologic perspective, this guy should set the standard for occupational neuropathy. I feel he did an outstanding job really getting into the nuts and bolts with respect to carbon steel, looking at the PCBs, n-Hexane.

And he was literally able to find, not only animal studies, but human epidemiological studies that were relevant. And that in conjunction with the fact that this individual had legal representation really kind of helped get his Parkinson's approved. Actually this was recently. This was as of March 15th, 2019.

The thing that really kind of gets interesting is the fact that now he's filing for ALS. So I actually did a literature review earlier today just to kind of see what number of individuals who are identified as having Parkinson's actually have ALS. And right now, I mean the jury's still out. It's a very, very small percentage of folks who actually have the pathophysiology because with the individuals diagnosed with Parkinson's, they have the Lewy bodies. But with the folks identified as having ALS, they actually have what are called Veny bodies. So essentially all these expensive proteins in their brain that accumulate.

So right now, at least based on the most recent EMG that was done, he did have clinical,

as well as diagnostic evidence of having ALS, as well as Parkinson's. But as of March 15th of 2019, the DOL has essentially put the ALS kind of on a deferred bucket, if you will.

So it will be interesting to see what ends up happening at least from the ALS perspective. I'm sure the neurologist is going to provide some excellent resources and evidence. But I feel like this case is very interesting because there's so many different layers to this individual's presentation. And how his pathology has evolved over the years. And combining multiple neurodegenerative diseases really kind of it makes it an interesting case.

CHAIR MARKOWITZ: Was this case then ever sent to the CMC or did the treating physician's report suffice?

MEMBER BERENJI: I believe there was a CMC, but I mean at least from my review, I really honed in on the treating physicians --

CHAIR MARKOWITZ: Right, right.

MEMBER BERENJI: -- because they did

such an excellent job. I mean -- again, I can't remember if there was a CMC involved.

CHAIR MARKOWITZ: Okay, okay. That's fine.

MEMBER BERENJI: In this case, the treating physicians did a stellar job.

CHAIR MARKOWITZ: Comments, questions? Okay, we're going to take a five minute break and we're going to start up at 4:30, public comment. Well probably if it's all right, the public comment period, there aren't that many. How many people, Carrie --

Ms. Rhoads: Four.

CHAIR MARKOWITZ: Four. So it probably won't be all that long. We might consider continuing while we're on this claims review for a little bit, so that we can come to some closure. But we'll decide in a bit. So 4:30, that's seven minutes.

(Whereupon, the above-entitled matter went off the record at 4:22 p.m. and resumed at 4:31 p.m.)

CHAIR MARKOWITZ: Okay, if the board members could take their seats.

OPERATOR: Welcome and thank you for standing by. I'd like to inform all parties that your lines have been placed on a listen only mode. This call is also being recorded. If you disagree, you may disconnect at this time. I would now like to turn the call over to Dr. Steven Markowitz. Thank you and you may begin.

CHAIR MARKOWITZ: Sure, thank you. Welcome to the public comment session. We have four people who -- Excuse me -- five people who have requested time to make comments. So let me give you the orders so you know when to expect to be called to the front. We have two people on the phone. But the first will be -- Hold on, don't come up yet. But the first will be Ms. Terrie Barrie. Second will be Faye Vlieger. Third will be Ms. Vina Colley. Fourth will be Ms. D'Lanie Blaze. And fifth will be Ms. Angel Little.

So just to remind public commenters, it's not really a back and forth question and answer

session. It's really a statement, which we listen carefully to. So welcome, Ms. Barrie. Oh and also I want to say while you're sitting down is please limit your comments to seven to ten minutes.

MS. BARRIE: Good evening, everyone; Dr. Markowitz and members of the Board. It's a pleasure to be here again. And to listen to this wonderful conversation and debates about the issues with the program and your ideas on how to fix it.

My name is Terrie Barrie and I'm a founder member of the Alliance of Nuclear Worker Advocacy Groups. I want to thank you for this opportunity to address the Board. And more importantly to thank you for the dedicated work you put in to try to improve this program. I emphasize the word "try" because you cannot possibly fulfill your duties mandated by Congress if the Department of Labor does not provide you with the necessary tools and documents you need to do the job.

You've asked for a support contractor twice without the response from Department of

Labor. And you know, recently we just learned that the claims that you requested back in December were only provided to you a few weeks ago. I admire you for getting through them so you can have the lively discussion today about the two types of cases.

Which reminds me, do you remember the statement that Ms. Rachel Leiton said to you during the April 26, 2016 meeting? You can find that on Page 92 of the transcript. I quote, "I'm actually really looking forward to having a group of people who have worked there; scientists and doctors, to help us with some of these complicated issues."

And Ms. Hearthway did the same thing on November 14th, 2018. "I commend all of you, the past Board, for your future service, the new members for tackling this area. It's critically important and is a difficult area. It's an ambitious area. But I thank you for your public service on this." And I feel that too. But I can't help but feel that this is nothing more than lip service. You've asked for contractors to help you

review the claims, to help you review the SEM, which still needs, you know, some improvement. And they won't provide it for you -- or to you.

And then the issue today of not getting the claims that you asked for 4-1/2 months ago. And the other problem I have and why I think it's lip service is you've made excellent recommendations, you know, some of which have been accepted. You know, and I appreciate Department of Labor for doing that. But they're relying on their experts -- their internal experts who as far as we know, do not have the qualifications that you have. Sorry, I mean that's the basic fact.

We have well-educated, you know, the PhDs and you know, multiple whatever that word is. I can't think of it offhand. And it just doesn't seem right that they just say well we're going to rely on our experts because they don't agree with you. They do not give you the reasoning behind that, but say our experts don't agree. However, they don't provide you, well here's the science and the medical literature and the studies that

my expert -- our experts found that disagree with you.

And I understand the Department of Labor is practicing due diligence. They should review your recommendations and not just accept them out of hand. That's their responsibility. But they haven't provided the evidence to refute your recommendations and your findings. And I'm sorry, but that's wrong.

The Department of Labor requires you to submit, you know, your authorities. They should have the common courtesy to do the same for you. That way it can be an open debate, you know? The NIOSH Board does this. You know, NIOSH doesn't always agree with the Board's contractor and there's a debate. And the Board comes to a consensus and then makes a recommendation to the secretary. Which the secretary normally accepts.

But there's a debate before that. And I realize that this Board is different than an NIOSH Board, but you're still -- you still operate under

FACA. So there is similarities. You have the same purpose, to advise the secretary. It should operate the same way to a degree.

I was kind of disappointed that during the teleconference of February 28th, that there was no one on the call from the Department of Labor. You had a simple question. There was nobody there to answer it. I could have answered it. I had it up on my screen. But that's not my responsibility. It's the Department of Labor. They should be attending each and every one of these meetings and they should be communicating with you. It's just that simple. I'm sorry.

When they say that we appreciate everything you do, well they need to show it in action. You request materials. If they have an issue with it, they have to come back to you and say what do you mean by this? Why do you need this? And the form is fine, you know, but you can't wait. They're wasting the Board's time and energy. They're wasting tax payers money because the Board cannot get their work done because they're dragging

their feet.

And I don't understand the idea of past Board. It's nonsense to me. Congress is sitting at the Board until 2024. DOL owes it to the stakeholders and the Board an explanation and legal justification why they can interrupt the Board's work every two years. There's no continuity. Thankfully a lot of you have been reappointed. I appreciate that and you can catch the new members up. But you should have been working all this time unless there was cause. But nobody understands why there was a break in the Board's work. There is no such thing going on with the NIOSH Board. It shouldn't happen here. You all have important work to do.

And so please don't get discouraged Board members. It's obvious to us that the Department of Labor is digging in their heels and they're not cooperating as well as they should. I personally think they're being derelict in their responsibilities to the Board for their support.

And normally I would call upon DOL to

improve the relationship with the Board and to attend the Board meetings without a special invitation. And provide resources to the Board when they request it in a timely manner. But I think that request would also fall on deaf ears. If DOL didn't listen to the Board and the hundreds of individuals from the public on the final rules, I doubt they would listen to this request.

So instead, I call upon Congress to intervene. I want Congress to investigate this program, tighten or expand the statute as needed. Hearings need to be held. The workers who develop disabling and often fatal diseases in their work to protect their country deserve nothing less. They were exposed to toxic substances without their knowledge and sometimes without proper protection by the DOE contractors.

I would like to remind Department of Labor that this compensation program was intended to correct the decades of injustice perpetrated against the workers and their survivors. It must return to the congressional intent. And

apparently the only way to get that done is to have Congress involved.

And one thing I forgot to mention that was in the body of this. Since Department of Labor has not provided the Board with their citations of scientific studies that they used to reject some of your recommendations, ANWAG will file a Freedom of Information Act request for that. And I also have here some correspondence between Secretary Acosta -- well ANWAG and Secretary Acosta about providing the Board with what they need if anybody would be interested in that.

So thank you again. And I appreciate the work. Thank you.

CHAIR MARKOWITZ: Thank you. Next is Ms. Faye Vlieger.

MS. VLIEGER: Good afternoon.

CHAIR MARKOWITZ: Good afternoon.

MS. VLIEGER: Good afternoon.

CHAIR MARKOWITZ: Good afternoon.

MS. VLIEGER: As I introduced myself at the beginning of the meeting today, I am Faye

Vlieger, a former Member of the Board, and I work as an advocate under EEOICPA.

I'm disconcerted about the lack of weight and consideration given to the previous Board's recommendations. I would ask the current Board to add to its agenda tomorrow the re-approval of all of the open recommendations sent to the Department of Labor by the previous Board.

I have been instructed that that is allowed and that will ensure that those recommendations are actually looked into and replied to.

Of note and discussed earlier today is the Department of Labor's non-adherence to the recision of Circular 1506, Occupational Toxic Exposure Guidance.

The Circular was rescinded on February 2nd, 2017, the Circular 1704. Despite the revision of Circular 1506, the Department of Labor still uses the language of the Circular to deny claims.

This either represents the cavalier

attitude that the Department of Labor holds for the Board, and the EEOICPA worker claims, or the Department's inability to understand the instructions of the Advisory Board.

While I was on the Advisory Board, myself and other Members worked diligently and succinctly to demonstrate that the language of Circular 1506 was not based in fact.

To that point, it was shown to the Department of Labor that they were not -- that there were not only toxic exposures after the mid-1990s above regulatory standards, but also that there was no evidence to support the Circular in scientific studies.

While I was on the Board, evidence was presented to the Department of Labor that DOE was not consulted in the creation of the Circular. Nor did they provide any input to the Circular's creation.

In addition, DOE's own audits of safety and toxic exposure issues from that period of time show that while it was issued, it issued the

Regulation 440.1 to limit toxic exposures on September of 1995, it was not being instituted or followed.

You remember Mr. Domina's comments that you have to have money to do these things. And while they instituted the rule, there was no money for the instruction, implementation, and the scientific instruments to do it.

This is why the Board proposed that the Circular be rescinded and it supposedly was. But was it? In my opinion, no. Sorry. IH and CMC reports are still using this language as fact and using it to deny claims that you all read in the claims that you were given.

No basis is given for the denial other than that flat statement of fact, which in fact, is not fact. I'm not satisfied with Ms. Leiton's explanation of how the rescission of Circular 1506 did not affect the use of this exclusionary language.

I would like an active question placed before Department of Labor. What exact references

are the IHs and CMCs using to justify these boilerplate statements?

If the scientific evidence is not forthcoming, I would like assurances from the Board and the Department of Labor that all of the claims denied using this language will be re-adjudicated.

I'm also concerned that the selection in which toxics should be evaluated for a claim, are submitted, are shunted and reduced by a small group of contractors who appear to have a conflict of interest. A case in point, is a claim I am currently reviewing.

When the contractor who administers, updates, and manages the site exposure matrix named Paragon was also asked to provide their opinion on which toxin should be sent to the IHS/CMC to be considered for particular claim, Paragon's recommendation was used and the claim was denied.

The issue then becomes that a contractor that sets the list of which toxins are present at a DOE site should not then be allowed to decide which toxins are considered for an

individual claim. It's very much, as I told you before when I was on the Board, like letting the fox watch the hen house.

In conclusion, I want to commend the Board on its continued diligence. I am concerned that the good works and recommendations of the Advisory Board are being ignored, subverted, and sidestepped with Departmental wordsmanship in order to blunt any affect that their decisions would have.

It is disingenuous to the Advisory Board and the affected workers under EEOICPA for the Department of Labor to continue to face claimants with platitudes of support, but when you're out of sight, undermine the program and individual claims. I thank you for the opportunity to present my comments.

CHAIR MARKOWITZ: Thank you. Next we have Ms. Vina Colley on the phone. Ms. Colley?

MS. COLLEY: Here.

CHAIR MARKOWITZ: You're welcome.

MS. COLLEY: Thank you for allowing me

to speak on behalf of National Nuclear Workers for Justice and Portsmouth-Piketon Residents for Environmental Safety and Security. We wanted to ask this Board and DOL, again, to hold a meeting here in Portsmouth, Ohio.

You have a lot to learn about this site. And as I listened today, it's very obvious, that you have not been told about the facility --

(Telephonic interference.)

MS. COLLEY: -- by getting turned down from the SEC site. We were one of --

CHAIR MARKOWITZ: Ms. Colley, hold on, hold on one second because we're getting some feedback. Can you turn your phone down a little bit?

MS. COLLEY: Yes. I can try.

CHAIR MARKOWITZ: Yes, yes, that's better.

MS. COLLEY: Does that help?

CHAIR MARKOWITZ: Yes, that's good.

MS. COLLEY: Portsmouth is one of three sites that was an SEC site. Workers are getting

--

(Telephonic interference.)

CHAIR MARKOWITZ: We're getting some more feedback, actually.

OPERATOR: This is the Operator, do you have, do you have a TV or another phone, or a radio on in your background?

MS. COLLEY: This is the only phone I have.

OPERATOR: Okay.

CHAIR MARKOWITZ: Are you, Ms. Colley, are you on speaker phone?

MS. COLLEY: Yes.

CHAIR MARKOWITZ: Could you just get directly on the phone? Maybe that'll solve it.

MS. COLLEY: Okay. Is that any better?

CHAIR MARKOWITZ: So far, so good.

MS. COLLEY: Okay. I can hear something in the background. I said -- okay. I think I've lost my concentration.

CHAIR MARKOWITZ: That's okay.

MS. COLLEY: Anyway, anyway. We would like to invite the Board to come to Portsmouth, Ohio and the Department of Labor to come and talk to these workers. I don't think they have a true understanding of what Portsmouth is.

We also would like to know if DOE and DOD have turned over the secret documents to help get these claims approved. We just released records about plutonium and transuranics on the site on March 19th, here in a public forum.

Saturday, the Health Department is holding a meeting about neptunium being in the local schools. Many children have died from cancer that attended that school. What happened to the --- we would like to know what has happened to the records that the union put together for the sick workers in the SEM database at Piketon. They worked for hours on what was in each of the buildings.

One big problem is we don't have anyone in the Resource Centers that, that can help put the sick workers claims together before it is turned

in and turn down.

There should be an advocate person there who can help look at these workers' records and make sure that they have their ducks in a row before the claims are turned in.

What happens when consultants are given misinformation? My case, the consultants were told lies about me. One, and I will read you part of this thing that I wrote.

Dr. Dhara, D-H-A-R-A, claimed that I worked at the Paducah Gaseous Diffusion Plant. I have never worked at the Paducah, this Paducah plant. I was employed at Piketon, Ohio.

Dr. Dhara claims I smoke one pack of cigarettes a day for 20 years. I have never smoked cigarettes in my life. And if there is any mention in my medical records stating otherwise, it is false.

Per Dr. Dhara's letter, it states, a Dr. Rhodes' report has, not having any documents on my pulmonary edema. In the absence of a diagnosed documentation, my claim for toxic

exposure could not be verified.

However, I had been treated, and currently still treated for 30-some years for pulmonary edema. Also, Dr. Rhodes' report was declared non credible in 2008 by Dr. Marvin Reznikov, and DOL's third-party Dr. Christopher Vrenenman [sic].

So this is just one example of how our records are being falsified, or not completely given to the CMC to, to give us a proper diagnosis or our claims. We had a fire a couple of weeks ago in the X-320 -- I, I can hear a lot of feedback.

CHAIR MARKOWITZ: No, no. You're going --

MS. COLLEY: Is it still kicking back like this?

CHAIR MARKOWITZ: You're, you're coming through loud and clear.

MS. COLLEY: Okay. I don't know. I think there's one, one, big problem is, we don't have anyone -- okay in the Resource Center, I did that. What happened when the consultant, I did

that one.

We had a fire a couple weeks ago in the X-326 Building. It wasn't reported until our meeting on March 19th. It wasn't reported to the public for almost another week and half.

I'm getting calls from the other employees that are sick from the decommissioning of the plant. Many are hard, past the cut off period. They're reporting that they have kidney and cancer problems already and less, some have been there less than ten years.

The work going on at the plant now is very hazardous because of the holdup material plus possible explosions. These workers need to be covered under the compensation bill. We need someone to sit with us and explain the jobs here, so we can explain the jobs.

You all don't have a clue of the exposure here. Portsmouth is the largest plant in the world. We did weapons-grade material. We are a DOE and DOD facility.

I've listened to your reports today,

and it sounds like reports are being copycat and turned down. I want to remind this Board, that we have some the highest exposure according a DOE report in 1985.

Also, you talked about the PCBs and I submitted a paper on PCBs. In the process building, the PCBs are 290,000 parts per million after an event system. And by the time it reaches the floor, we don't know what kind of chemical you will be getting.

Not only is the PCB oil, PCB oil, but this oil was radioactive. We worked in these buildings for eight hours at a time with no protective equipment. We weren't even told that we were working with radioactive PCB oil.

And there is a Congressional hearing on that oil. We claim this oil, also the electrical equipment, the trichloroethylene. We worked many times beside, beside waters without any protection on.

They should rub, rub the PCB oil with siphons at the facility. I have the name of the

workers. I have the, the results. And most these workers tested high for PCB oil.

I have been fighting for a long, long time. Matter of fact, I was one of the persons who, who broke the story about plutonium being in the gas diffusion plant, at the St. Simon Paducah workers den.

I know that they did release some records for the Paducah facility because I went to Oak Ridge and got all records back in that, that time in 1999.

But Portsmouth has never had their records released and workers are being denied. And I'm even getting people who, who got, who worked there back in the early years that have been denied for breast cancer, lung cancer, and liver cancer.

And this is just one lady with all the illnesses that she had. Her family were turned down for survivor fees. So we, we need to come to Portsmouth.

We need to make you aware of exactly what's going on, the PCB oil. I have three tumors,

a hysterectomy, and one thing after another. I was a healthy person when I went to work there.

And they keep putting on all these stipulations on the compensation bill. And we're all getting turned down. We -- something has to happen. We can't let this continue.

The records that we've released at our meeting, one was forensics, radioactive industry of the public inspection samples. And it was done by Lawrence Livermore National Laboratory. And it talks about Portsmouth and Paducah both having smuts of plutonium and transuranic waste.

Also we have the NIOSH dose reconstruction. And they also submitted that we were exposed to neutrons and radiation in all these process buildings. So we have been under, underestimated for the exposures here and the work that we did.

And it's, it is heartbreaking to watch everyone see their families pass away and still fighting for exposures, for Parkinson's disease, for, for prostate cancer, for -- just about

everything these workers are getting turned down for.

We did have a good result not too long ago here where a widow was finally compensated for Lou Gehrig's disease. So that is one step in the right way. But we're, we're a long ways from doing the right thing and trying to help these workers.

So if you could have a meeting here, we could sit down. We'll take you out there and show you the buildings and all of these 25,000 depleted uranium cylinders that have set on the site that has given off neutron exposures. The asbestos that these buildings are made of --

Are going to put in plutonium, and transuranic, if we don't stop it, and it's on top of our aquifer. And it's the largest aquifer in the Midwest. So many people and many workers have been, been exposed from working here at this site.

There's a lot more that I could tell you. And I did send in and submitted the 297,000 parts per million of the PCB oil that was in the ventilated system. So it is on your webpage, I

saw it.

And we would appreciate it if we could get you to come. And the DOL, I hear they're going to New York to help these workers file their claims. And I think that that's great for the New York workers.

So why aren't they here helping us? Why are they fighting us? Why are they falsifying our records? And the reason that we are -- I heard somebody mention about the data. No data is the reason, Portsmouth and Paducah became the SEC site because they didn't keep data. What data they kept, they shredded, and they falsified our records. And that's why they burned the proof.

It wasn't on us. It was on the Department of Labor. Jim Richardson says that. I have his video tape that says, the burden of proof belongs on them, not us. And now, all of a sudden, it's shifted to the burden of proof on us. Thank you for letting me speak.

CHAIR MARKOWITZ: Thank you, very much. Next is Ms. D'Lanie Blaze, who's on the

phone.

MS. BLAZE: Hi guys. This D'Lanie Blaze.

CHAIR MARKOWITZ: Welcome.

MS. BLAZE: Can everyone hear me okay?

CHAIR MARKOWITZ: Yes. That's fine.

MS. BLAZE: Great. I represent workers of Santa Susana and its associated work sites, Canoga and DeSoto Facilities.

And today, I just want to express concern about the IH reports, which I believe are routinely misinterpreted by CEs and the CMCs who neglect to read the body of the report, and then just base their opinions, or their decisions solely on the IH conclusion that's provided at the end of the document.

I recently reviewed an IH report for a metal fabricator, pipefitter, welder, site remediation worker employed at Santa Susana from 1979 to 2009.

And the IH described his aggressive work processes involving routine and significant

exposures to lead, cadmium, and mercury. All of which have established casual links to chronic kidney disease.

And throughout the discussion of the report, the IH repeatedly acknowledged that the data supported significant pre-1995 exposure. But the boilerplate text of the conclusion contained several problems.

The first was a typo. While the discussion of the documents stated it was highly likely that the employee received significant exposure before 1995, the conclusion stated that it was highly unlikely. And that typo alone changed the course of the claim and its outcome.

So now we're lost in the process of lengthy objections, hearings, and we're awaiting a final decision. But meanwhile, this worker is clearly in need of help and he is deserving of assistance.

The other concerns that I have about the conclusion of the IH report is that there's a table that shows exposure levels to lead, cadmium,

and mercury. But the levels that indicated are inconsistent with the IH's opinions that are provided throughout the body of the report.

And then the conclusion's final statement doesn't even mention pre-1995 exposure. It just implies that only insignificant exposure occurred in passing.

So anyone who actually read the entire three-page IH report would have caught the typo and the inconsistency. But it seems the CE and the CMC only read the conclusion, so it's no surprise that the claim was recommended for denial based on the idea of insignificant exposure.

So in an effort to find some clarity on it, I contacted the IH directly. And I asked for her help. Either helping me understand or if necessary, issuing a correction to that typo in the conclusion.

And that IH confirmed that the employee did have significant pre-1995 exposure that was intended to be acknowledged in IH report. But the IH stated that the conclusion could have been

misinterpreted due to what she called clunky language. Quote, that is just the language they have use.

So I assume that the IH was referring to either the IH contractor or to the national office, whoever comes up with the boilerplate language that's currently used to format these IH reports.

So in this case, the national office confirmed the existence of the typo and verified that the conclusion should have stated that it was highly likely that the employee was significantly exposed.

But then the national office emphasized that the exposure levels are provided in the table, which again, are inconsistent with the rest of the document. They state the exposure was low. And then the national office failed to acknowledge the pre-1995 exposure had been left out of the last paragraph entirely.

So this leaves tremendous room for misinterpretation and for a severely diminished

perception of the worker's exposure, particularly when a CE or CMC only looks at the conclusion.

So obviously, I'm troubled by general laziness that's exhibited by failure to read a three-page IH report, which would have taken about five minutes. This led to further delays for the claimant. The inability to obtain needed help under this program.

And it also led to unnecessary administrative costs for Department of Labor, which included an in-person hearing with a Jacksonville representative who had to fly all the way to Los Angeles in order to hear our case.

Now the national office has made so many changes in this program in order increase expediency. But I fail to see the logic in making a series of bad decisions fast and then having to revisit the issue again with all of the additional wait time and administrative efforts and associated costs, et cetera.

So I'm troubled by the boilerplate language that seems to have been carelessly

constructed and that it requires the IHs to punch in relevant information in several places in an IH report. And that makes it pretty easy to miss a relevant place.

And one missed insertion of copy and pasted text could change the context and the direction of the entire claim, so. And then too, obviously the boilerplate conclusions that omit information about pre-1995 exposure, that's just alarming.

So ultimately, it seems like IH reports are pretty tight and short. And there shouldn't be a need to summarize them. There seems to be no need to add a confusing table. Or even to add a conclusion.

A solution might be to recommend removing the conclusion entirely, which would at least ensure that the CE and the CMC are forced into reading the entire document.

And then it would enable the IH to be thorough one time instead of having to insert little bits and pieces of relevant text in several places

in the report.

Anyway, that's it from me and as always, it's a privilege to address the Board and to represent workers under EEOICPA. Thanks for the opportunity to comment.

CHAIR MARKOWITZ: Our next speaker is Ms. Angel Little.

MS. LITTLE: Good evening, everyone.

CHAIR MARKOWITZ: Good evening.

MS. LITTLE: As you know, I'm an Angel Little and I'm a daughter of a Cold War patriot. His name is Earl A. Brown, Jr. He lives in Knoxville, Tennessee.

He is a Navy veteran retired. Also he is retired from ORNL. Amongst the jobs he had, he initially started as a guard. However, he rose through the ranks always being trained, was trained through the fire safety.

So of course, he was at every plant in Oak Ridge, Tennessee. Upon his retirement, however, he was administration at ORNL, but he was based at Y-12.

My father now suffers with berylliosis. This berylliosis also has damaged several things that are going on with him to include renal failure. He has been approved for berylliosis, however, he was denied for kidney failure.

And that very much distresses me because my father was a very robust man while he was working for the Department. We have talked with several people. We have seen several doctors. He is three days a week in dialysis now.

And we keep seeing, oh he, because he had high blood pressure. But it was okay for him to have high blood pressure when he was working for the Department. It didn't keep him from coming to work every day. It didn't keep him from doing his job every day to protect this United States of America.

It didn't take him anything, but to get up every morning and make sure he was at work every day to support his family, put me through college, support his wife, be her care giver.

But it distresses me that this room is

not full. It distresses me that I, who live here in Augusta, Georgia have to go to Oak Ridge to call people long-distance to make sure that things are taken care of for my father.

He is currently being serviced by a professional case management. And that is a daily chore within itself. I've talked with the people out in Oak Ridge. I've been out there to Oak Ridge.

And I have to run and jump through hoops just to get things taken care of. From picking up his medicines, from making sure he has transportation. I should be case manager. However, I'm not. I'm his daughter, the one that loves him.

Also with all the research and I am just at awe at this Advisory Board and the time that you take to review things. That berylliosis has some effects on your kidney, on your liver. He has neuropathy.

So I'm still trying to figure out, what is the problem that my father is still fighting these days, with my assistance, long distance, 350

miles away in trying to get services for him? I don't know if I need to fly to D.C. with you, which I will. I don't need -- hey, I got gas in the car, I'll do it.

And I teach high school and I teach my students every day. Do what's right. Do for you to make this world a better place. And make sure you get your education because nobody can take that away from you.

However, my father has things that are taking it away from him. He's ill. Just this past week, on Thursday, he had two mini-strokes. And by God's help and the weather we had last weekend, I was able to go 350 miles in less than 5 hours without a ticket.

I was able to get to my father and by God's help and some great neurologist that I'm going to look up again, they changed some medications, they were able to do some assessments, and he is at his house.

Also with my assistance, I got a hospital bed in there. I got everything he needs

in there. But I couldn't get that unless I did it, nobody else. My father is worthy of everything that he deserves. And he deserves more than he's getting from this United States of America.

I am charging you, the Advisory Board to look up Earl A. Brown, Jr. His birthday is October 19, 1936, born in Rockwood, Tennessee. And pull his case file, look at him because he's ill now, and we need help.

Tell me what I need to do. It's not a question and answer session. But I'm here as an advocate. If I don't do it and you don't do it, who's going to do it? I'm available any and every day. My cell phone is 24/7.

My high school students know I have an ill parent, who has recently lost his wife, who is an ill person who worked for the Department of Labor, who worked for the Department of the Navy, who served at the Pentagon, served in Vietnam.

So I think my father deserves more and better, and he shouldn't have to fight, nor I to get the benefits that are due to him. So in

closing, my cell phone number is 706-294-0357. I'm here in Augusta, Georgia. If you need to see me, just call me.

And I have a daughter who would like to know that her grandfather has been done right. That her biology degree that helps me research and help her grandfather is not in vain. That she will not have to go through these things as her grandfather is.

She sees him suffering now. She sees that and it's really, really sad that this Board even has to convene for things like this. It's really sad that family has to be here.

But I appreciate the time, the effort and the knowledge that sits here in this room. And again, I am Angel Little, here in Augusta Georgia and I'd like to thank you.

CHAIR MARKOWITZ: What did you say your cell phone number was?

MS. LITTLE: 706-294-0357.

CHAIR MARKOWITZ: Okay. Thank you.

MS. LITTLE: Thank you.

CHAIR MARKOWITZ: Are there any other people who would like to make a public comment? We do have a little time, so if -- okay, and there's no one else waiting on the phone, right?

Do you want me ask her? Yes.

To the moderator on the phone, is there anyone else in the phone who has somehow communicated that they would like to make a public comment?

OPERATOR: No. Should I let, give them an option on how to do that?

CHAIR MARKOWITZ: Yes.

OPERATOR: If anyone on the phone would like to make a comment, please press star zero.

We have a couple, so one moment, please. The first one is Stephanie Carroll.

You may go ahead. Just one moment please. Let them open their line, one by one. Start with Stephanie Carroll. Comment. Stephanie Carroll, you may go ahead.

MS. CARROLL: Thank you, very much. Thank you. I deeply appreciate the Board and the

opportunity to make a comment. I didn't prepare anything formally.

But just wanted to note, especially for the Board reviewing SEM that being an authorized rep who specializes in beryllium disease, I'm always interested in the documentation proving workers are exposed to beryllium.

And I haven't had as many problems here in the Rocky Flats claims or Nevada Test Site. But I had the opportunity last night to review the SEM for Portsmouth. And I was shocked to see that Portsmouth had three buildings related to beryllium.

And just with a very quick review online, I found formal worker programs, these --

(Telephonic interference.)

MS. CARROLL: -- reports, which showed beryllium in multiple buildings. I think I was at eight or nine buildings that it was in.

And so I was shocked to see the difference between evidence that should be being used for the SEM, and the actual SEM that claims

examiners are using.

Another thing I noticed is that the claimant I was, I was researching on had a job category of welder and maintenance mechanic. He said no exposure to beryllium on any of those job titles. And the buildings he, he was in didn't show exposure to beryllium.

This is the thing, when I read the formal worker program needs assessment, it clearly right of the bat noted that there were beryllium welding rods used late into the 90s. And, and that's not even, you know, documented in the site exposure matrix.

What we've been told by the Department of Labor is that beryllium isn't included throughout SEM related to Part E. But I also show a lot of beryllium exposure in SEM, even as it relates to Part E.

Illnesses related like dermatitis, which known to be related to beryllium, weren't even listed in the Portsmouth SEM. Beryllium has no illness related to its exposure in the SEM there.

So I was shocked to see that and I wanted to note that with the Board. And I appreciate all the work that you're doing. And wish I could attend. Thank you, so much.

CHAIR MARKOWITZ: Thank you. To the moderator, is there another person on the phone who wants to speak?

MR. REAVIS: Yes. This is Rick Reavis. Rick Reavis wants to speak.

CHAIR MARKOWITZ: Go ahead.

MR. REAVIS: Are you, are you talking to Rick Reavis now, Doctor?

CHAIR MARKOWITZ: Yes. We can hear you fine.

MR. REAVIS: Okay. Thank you, very much. I want to thank you. I want to thank everybody else who sat there listening. I want to thank the people that are getting up there talking. It takes a lot to do that.

I want to say that I thoroughly, thoroughly believe in what Terrie Barrie said about Congress needs to look into this program. If you

go back to when program was initiated in 2000, it was to correct a wrong.

Because the government had to admit what they did to these people, exposed them to radiation without their knowledge. It's a terrible thing. So the President wanted to make amends. Initially the program said, if got one of the 22 cancers and worked at one these company, you were to get compensation.

That's turned into a big boondoggle. And if you think of it, in 2003, DOE had that program from 2000 to 2003. And it was so corrupt, and I do mean corrupt, that they had to take it away from DOE and give to DOL.

And for all these years, all the way going to 2019, that's a long time even for the government to try and correct a wrong. I don't think the problem has been corrected. I can tell you, and I am by the way disappointed that I can't ask questions.

Because I have questions I know the answers to. But I get those answers via the

government and DOL, DOE, and NIOSH. And I'd like to ask those questions so they could be answered where people could actually have it on tape.

But one lady was talking about false information. My God, you talk about false information. People need to go look up Texas City Chemical. You're supposed to have 250 days of processing, producing something that emits radiation, was used a bomb, in order to qualify for an SEC.

Texas City Chemical only produced for three months, October, November, December 1953. NIOSH was looking for an SEC for that and in 2008, they said that they could do a dose reconstruction.

And they gave five years time that they said covered for the SEC. Five years. For some reason, in 2010, actually 2009, somebody put a lot of pressure on NIOSH. And the pressure caused them to reevaluate and revisit Texas City Chemical.

Now what they said they could do in five years, to a dose reconstruction, no longer could they do that when reduced it to two years. You would

think the logical thinking that if you reduced it down from five years to two years, you would still be able to do a dose reconstruction.

They come back and they say, well it's because the, the question was asked, what changed? Well there were two different things. And we found out about the, the lawsuit. And we found out there was a bankruptcy. What's bankruptcy got to do with Texas City Chemical and their dose reconstruction?

So anyway, the bottom line is nothing changed. There was nothing changed. But yet they reduced it to two years, gave an SEC for Texas City. Those people got paid. My feeling is that those people should have got paid.

They were lied to like all the other people across this country, thousands of them. And there's many of them that you need 250 days to qualify for an SEC. Well, I've heard of some that had 249, didn't get paid.

Well if you look at Texas City, again, they should have got paid. But they only had 60

days of production. Something's wrong with that. And I, I strongly feel the people should take a look at TCC. Look at the records on TCC, what they did.

Another thing I believe, a lot of people -- I just mentioned, in fact, there's a problem with DOL. There has been a problem with the DOL. It's been ongoing. I got a letter from DOL, 2018, trying to explain away Texas City. They've been --- I've been asking this question for going on nine years. They're trying to explain away. And the best they can ever come up with, is well, you know, it's difficult to explain, one company versus another one.

Well how difficult can it be to explain what the difference is between Texas City and the company my father-in-law worked for, Blockson? And he worked there 25 years and didn't get paid. And people at Texas City, two years, actually three months.

There, you put all this stuff together, and you look at this 2018 letter that I got from

the Department of Labor. And they're saying, well, the difference with Texas City is because we did not have, at that time, in 2010, the information that we had to grant the SEC.

Well, the problem with that is I have numerous records. And I, and I really would like to have people call me just like Angel Little. My cell phone number is 815-791-3991.

Now, Department of Labor told me that they did not have that information. Well, listen, I can go back to 2007, 2008, 2010. I have all kinds of records on Texas City.

I have an ombudsman for the government, I don't want to mention names, but he also agrees something's wrong. They, they pulled out a document, the document received a U308, other domestic sources.

According to the government if there's any problem with the document, the benefit goes to the claimant. Well this document, I counted nine errors, provable errors. But yet, DOL, NIOSH, and Department of Energy from what I've read, all

agree, all agree that this document is good.

If you look at this document for Texas City, I told you that they produced October, November, December 1953. That is correct. And Tom Tomes, I know he's probably sitting there.

He could tell you that Jim Netton asked him that back in 2010. And he said, October, November, December '53. Netton said, is that correct? He said, yes, that's correct. All right.

If you look at this document that is so good, it's got Texas City, nobody mentions that. With the Oversight Committee and all the way up to HHS, I know nothing was told about the document other than the fact that it says, Blockson Chemical quit producing in the 1960.

Yes, indeed it does say that. But it also says that Texas City produced only one month, March 1954. That's just one mistake. There's nine mistakes. If in fact, the government stands by and NIOSH says, best available science, fair, consistent, best available science.

And if there's any problem with the document, then the benefit goes to the claimant. Well how come the benefit didn't go to the claimant in my father-in-law's case? According to the document, it only produced Texas City, one month.

I'll tell you something else about my father-in-law and then I'll wrap it up. And believe me, I got a whole lot more to say so anybody out there listening, please call that number, 815-791-3991.

My father-in-law was also at Pearl Harbor. He survived the West Virginia. I always tell people, what the government couldn't do, or what Japanese couldn't do to my father-in-law, the government did. With that, I'll let you go. You know why. Thank you. Bye.

CHAIR MARKOWITZ: Thank you. There's one more? Okay.

OPERATOR: Yes. We have one more. Ms. Donna Hand.

CHAIR MARKOWITZ: Okay.

OPERATOR: You may go ahead.

MS. HAND: Thank you, very much. I'll try to be brief, and hopefully not take very long. I have some issues that I need to address and in today's talk and everything, it was said, that it was legally use of the term, is broad, when you use vapors, gases, dusts and fumes.

Well the Part E is, is to be broad. And the actual documentation of a toxic substance definition also says, means, any material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature.

And that was in the Federal Registry in 2006 as the goal. And that's what they had decided to use. So if you have vapors, gases, dusts and fumes that is the definition of toxic substance according to their own definition, as well, OSHA.

OSHA has air contaminants. Particulate contaminants include dust, fumes, mists, aerosols, and fibers. Liquids changed into vapors. Vapors are the volatile form of substances. Vapors are the gaseous form of substances. Then they have too much --

(Telephonic interference.)

MS. HAND: -- the degree of worker risk from exposure to any given substance depends on the nature and potency of the toxic effect and the magnitude and duration of exposure.

They also have been, you know, biological hazards. Some of these chemicals react differently once it gets into the body. So these are issues here that should have been addressed.

And back in 2006, they were aware of these issues, but somehow have been forgotten about. In fact, their own D&C Handbook says that the legal standard for acceptance of a claim under the EEOICPA is less than stringent than that of other venues.

Medical opinions are to solidly based on the facts, as accepted by the CE and expressed in the Statement of Accepted Facts, and on the state-of-the-art medical knowledge. They should be as objective as possible.

The appropriate legal requirements, and I quote, a case should be accepted if the

evidence in a particular case shows that there was plausible relationship between the exposure at the workplace and the employee's illness, or in some cases, death.

And that's on Page 7 of their own handbook, D&C Handbook, which is now the Contract Medical Consultants Handbook. They define causation as the legal standard of certainty of causation, falls between the preponderance of evidence and a reasonable suspicion.

So it's greater than a reasonable suspicion, but it's less than more likely than not. Because that's the preponderance of evidence. So you're at least as likely as not, is more than a reasonable suspicion, but less than 50 percent.

The workplace exposure can contribute to an increased risk of an illness. That's acceleration. And contributing, also caused, increased, the likelihood of suffering and harm and results in an earlier onset of a condition, such as person having prostate cancer at an earlier age, than what's normal in the public.

That's on page 9 of the D&C Handbook. Aggravation, defined as worsening of a previous existing disease. It also is whether workplace exposures aggravates a condition that may have remained latent or inactive.

So contributing then, aggravation is not being addressed at all in any of the decisions that the Contract Medical Consultant is supposed to be addressing, as well as, the Case Examiners are supposed to be addressing.

And if the causation standard is more than a reasonable suspicion, but less than 50 percent, that's not a medical certainty standard. That's way less than that for causation.

The Contract Medical Consultants are to consider the nature, frequency, and duration of exposure. As well as the intensity and wrath of exposure, if, if this information is available.

A lot of the regulations have also said that the proof of exposure to toxic substance may be established by the submission of any appropriate document or information that is evidence that such

substance was present at the facility, in which the employee was employed and that the employee came into contact with such substance.

It does not address at all that it has to be a significant level. So if you have significant factor, meaning any factor, and it doesn't, you just have to have the nature, duration, and frequency. That's all that the IH can address.

And all these subjective statements such as smoking and exceeding the regulations, they're not relevant underneath the program. The level is a subjective statement that is not relevant.

And again, even in the AIHA study, A-I-H-A, they have a exposure assessment rating speed. And in there they have a certainty description, that's a Category 3, health effect, you know, substance of the air, but reversible, that's Category 2.

If it's life threatening or disabling injury, that's a Category 4. You know, and they said, this is it. It doesn't have the level. And

they also talk about similar exposure groups.

So if the Industrial Hygiene has similar exposure groups, then they know that every single one of them would be exposed to this chemical during this process, if they did this process, such welders or soldering, et cetera.

So you could have a presumption with the IHs. The IHs and also the Contract Medical Consultants never include or address the skin absorption of these chemicals.

Because you inhale it, you ingest it, you absorb it through your skin, as well as if you had any wounds, it go directly also to the bloodstream.

Basically, the Global Initiative for Chronic Obstructive Lung Disease in their 2018 report, which is their pocket guide, that uses it. Says that, dust and vapors.

So to say that it's a legal constraint to use dust, vapors, and mists for COPD or any pulmonary because it's too broad, well internationally everybody uses that for COPD.

The other issue that I have is that the biokinetics of chronic beryllium disease is not just related to the lung. Chronic beryllium disease includes from the biokinetics of it, the liver and the skeleton, as well as those other organs that -- but that's definitely found that it goes to the liver and the goes to the skeleton. So when you, somebody is accepted for chronic beryllium disease, those two other organs and body systems should be addressed as well.

And it's -- since the Department of Labor has already found consequential illnesses for chronic beryllium disease, that's been determined by their doctor, why should a claimant again go and get their doctor who has nothing, knows nothing about chronic beryllium disease to say that yes, these are consequential illnesses?

These, you know, they've -- these are issues that we're finding more and more of, that you're not using the language or the definition that comes in the statute. Such as the IH says, well the significant high-level, significant

low-level.

Well no, significant means any factor. So if there's any level, that's it. And again, the level, you can address if you have, it's a high uncertainly because of the exposure judgement made without any available exposure monitoring data.

Adverse effects are uncertain because you don't have any information. And that's from the Industrial Hygiene Association, itself. Thank you, again, for your time. If there's anything that I can do to help, or further, you know, I can do that.

I also want to point out that we did request an IH interview on a particular case with occupational disease in the eye. And they refused to let us have that interview with that IH.

When we had the hearing, the claimant told the hearing officer the level of exposure to nitric acid, as well as plutonium oxide directly to his eye.

And in the final decision, the hearing officer said, even though you explained that your

level was higher than the IH, it had no bearing on his decision and he still denied the case. So again, thank you, and have a nice evening.

CHAIR MARKOWITZ: Okay. Thank you, very much. Okay. That ends the public comment session. So we've been here for a while. So maybe we should close for the day and start up again tomorrow at 8:30.

And I think we'll probably start off with how we're going to categorize and organize our claims review and move forward. And then on the Parkinson's disease, how to move forward on the topics that Marek raised.

So, thank you, very much. And the meeting is adjourned for the day.

(Whereupon, the above-entitled matter went off the record at 5:41 p.m.)