U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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WEDNESDAY
MAY 8, 2024

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The Advisory Board met at the Comfort Inn Oak Ridge-Knoxville, 433 South Rutgers Avenue, Oak Ridge, Tennessee, at 9:00 a.m., Dr. Steven Markowitz, Chair, presiding.

SCIENTIFIC COMMUNITY

AARON BOWMAN
MARK CATLIN
GEORGE FRIEDMAN-JIMENEZ

MEDICAL COMMUNITY

MARIANNE CLOEREN*
STEVEN MARKOWITZ, Chair
MAREK MIKULSKI
KEVIN VLAHOVICH

CLAIMANT COMMUNITY

JIM H. KEY
GAIL SPLETT
DIANNE WHITTEN
KIRK DOMINA

DESIGNATED FEDERAL OFFICIAL

RYAN JANSEN

ALSO PRESENT
TYLER BAILEY, Southwest Nuclear Advocates*
KEVIN BIRD, SIDEM
REGINA GRIEGO, DOE
JOHN HOVINGA, Paragon*
DEB JERISON, Energy Employees Claimant Assistance Project
JOSH NOVACK, DOL
CARRIE RHOADS, DOL
CALIN TEBAY, Hanford Workforce Engagement Center
PETER TURCIC, Paragon*
JOHN VANCE, DOL
FAYE VLIEGER, Alliance of Nuclear Worker Advocacy Groups (ANWAG)*

*Present via videoconference

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9:00 a.m.

MR. JANSEN: Good morning, everyone. My name is Ryan Jansen and I'm the Designated Federal Officer for the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

I would like to welcome you to today's meeting of the Advisory Board here in Oak Ridge, Tennessee. Today is Wednesday, May 8, 2024, and we are scheduled to meet from 9:00 a.m. to 5:00 p.m. Eastern Time.

At the outset, I'd like to express my appreciation for the hard work of the Board members in preparing for this meeting and their forthcoming deliberations. I'd also like to thank Carrie Rhodes from the Department of Labor and Kevin Bird, our logistics contractor, who are both with me here today for their work organizing this meeting.

The Board's website which can be found at

dol.gov/owcep/energy/regs/compliance/advisorybo

ard.htm has a page dedicated to this meeting. The page contains all materials submitted to us in advance of the meeting and we'll include any materials that are provided by our presenters throughout the day and a half. There you can also find today's agenda as well as instructions for participating remotely in both the meeting and the public comment period later today.

If any of the virtual participants have technical difficulties during this meeting, please email us at energyadvisoryboard@dol.gov. If you are joining by WebEx, please note that outside of the public comment period this afternoon, this session is for viewing only and microphones will be muted for non-advisory board members. So, the public may listen in, but not participate in the Board's discussion during the meeting.

If you are participating remotely and wish to provide a public comment, please email energyadvisoryboard@dol.gov and request to make a comment. Be sure to include your name in the request. If you are participating remotely and

need to provide your public comment via telephone, not WebEx, please include the phone number that you will be dialing in from so that we can unmute your line when it is your turn to make a public comment.

The public comment period begins at 4:15 p.m. Eastern Time this afternoon. Please note that the public comment period isn't a question and answer session, but rather an opportunity for the public to provide comments about the topics being discussed and considered by the Board.

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 through myself.

A transcript and minutes will be prepared from today's meeting. As the Designated Federal Officer, I see that the minutes are prepared and ensure that they are certified by the Chair.

The minutes of today's meeting will be available on the Board's website no later than 90 calendar days from today, but if they're available sooner, they'll be posted sooner. Although formal minutes will be prepared according to the regulations, we also prepare verbatim transcripts and they should be available on the Board's website within 30 days.

During the discussion today, please speak clearly enough for the transcriber to understand. When you begin speaking, especially at the start of the meeting, make sure that you state your name so that it's clear who is saying what. Also, I would like to ask that our transcriber please let us if you have trouble hearing anyone or any of the information that is being provided.

I'd also like to mention that the terms of the 12 current board members expire in July 2024. As such, we have invited interested parties to submit nominations for individuals to serve on the Board. Membership is balanced between the

scientific, medical and claimant communities and current board members may be renominated and reappointed. Nominations for individuals to serve on the Board must be submitted by May 17, 2024. For further information, including details about how to submit nominations and what materials are needed, please visit the Board's website.

As always, I would like to remind advisory board members that there are some materials that have been provided to you in your capacity as Special Government Employees and members of the Board, which are not suitable for public disclosure and cannot be shared or discussed publicly, including during this meeting. Please be aware of this throughout the discussions today. Materials can be discussed in a general way, which does not include any personally identifiable information or PII, such as names, addresses or a doctor's name if we are discussing a case.

I'm looking forward to working with everyone at this meeting and hearing the discussions over the next day and a half. With

that, I convene this meeting of the Advisory Board on Toxic Substances and Worker Health and I will turn it over to Dr. Markowitz for introductions.

CHAIR MARKOWITZ: Good morning, everybody. I echo Mr. Jansen's welcome, thank everyone for attending. Dr. Cloeren, we can or we could see you a few minutes ago, oh yes, we can see you. We encourage you to actively participate in today's meeting.

We may not be able to see any indication that you want to speak, so just do what you usually do and just jump in and interrupt us and we'll be happy to accommodate you.

(Laughter.)

I'd like to start off thanking numerous people mainly because I always forget to thank people at the end of the meeting, so I want to start off with the thank yous. In particular, I want to thank Gina Griego from the Department of Energy for the tour that we had yesterday, excellent tour. We had gone on a tour of Oak Ridge six or seven years ago that was also excellent and yesterday's

tour was, I think, totally different from the tour we did six or seven years ago, so we continue to learn about the sites. It was terrific.

I want to thank the people who make this meeting possible, including I want to start off with Kevin and his group, Stefan, Tom and Matt because I especially always forget to thank Kevin and his group, so thanks a lot for making it happen. So far so good, Kevin, thanks.

(Laughter.)

Also, of course, Mr. Jansen, Carrie Rhodes for all the work that they do to help us communicate to the Department of Labor. I thank Mr. Vance, Mr. Novack for appearing in person here today to get some back and forth clarification. We may ask direct questions your way and if the answers aren't immediately available that's fine, we understand that. It is quite useful to have you here to be able to clarify how the Board views things, thinks about things and the complicated program that you run.

I want to thank members of the public

who are here or online. I know that Mr. Jansen gave you the website address, but I never find that to be terribly useful. I have to say if you just use your search engine and look for ABTSWH and labor, those two words that you will find us. If you just put in ABTSWH, you will end up with a K-pop group from Korea so you need to add the word labor to find us. When you find us, you'll see all the things that we posted for today's meeting, some of which we're going to be referring to today, so I encourage you do that.

Let's do introductions. I want to remind board members when you want to speak, indicate that by raising your name board. My name is Steven Markowitz. I'm an occupational medicine physician epidemiologist, Chair of the Board since 2016 and for the purposes of DOE/DOL, have been directing or co-directing the largest Former Worker DOE medical screening program in the country since 1998, now at 14 sites in the complex. Mr. Domina.

MEMBER DOMINA: My name is Kirk Domina.

I worked at Hanford for 38 years as a reactor operator, nuclear chemical operator and the last 14 years, I was the employee health advocate for the Hanford Atomic Metal Trades Council. We represented 14 different affiliates and a former USW member.

MEMBER WHITTEN: Good morning, Dianne Whitten. I am radcon tech by trade. I am a member of the Hanford Atomic Metal Trades Council. I'm the current health advocate for HAMTC and I am NRRPT certified.

CHAIR MARKOWITZ: Go ahead, Mr. Catlin.

MEMBER CATLIN: Hi, I'm Mark Catlin. I'm a retired industrial hygienist. In 2018, I retired as Health and Safety Director for the Service Employees International Union, but before that, I did a lot of work with the building trades at a number of the DOE sites.

CHAIR MARKOWITZ: Dr. Vlahovich.

MEMBER VLAHOVICH: Good morning, my name is Kevin Vlahovich. I am an occupational

medicine --

CHAIR MARKOWITZ: You know, Kevin, you may need to speak into the mic.

MEMBER VLAHOVICH: I'm an occupational medicine physician and I'm the Director of Employee Occupational Health Services at the University of New Mexico.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Good morning, Jim Key, 49-year plus Cold War veteran, employed at the Paducah Gaseous Diffusion Plant 35 years and the depleted uranium hexafluoride facility to current. Having been on the ground at the inception of the federal investigation at Paducah in 1999, provided Congressional testimony, lobbying for the creation of EEOICPA, represent the labor claimant community and perform as a coordinator for the worker health protection program in the Paducah region.

CHAIR MARKOWITZ: Okay, Ms. Splett.

MEMBER SPLETT: My name is Gail Splett. I'm a retired bureaucrat from the Department of Energy. I worked 45 years at Hanford including

Freedom of Information/Privacy Act officer, tech info officer, litigation manager, records officer and finally, the EEOICPA program manager for Hanford and the Former Workers Program manager at Hanford.

CHAIR MARKOWITZ: Welcome. Let me just say that actually, Ms. Splett, there are probably other people here who aspire to your position as a retired bureaucrat, so welcome.

(Laughter.)

CHAIR MARKOWITZ: Dr. Bowman.

MEMBER BOWMAN: Thank you and good morning. My name is Aaron Bowman, I am a professor as well as interim dean of the College of Health & Human Sciences at Purdue University. I am a molecular toxicologist. My research focuses in the area of neurotoxicology. This is my second term on the Board. Thank you.

CHAIR MARKOWITZ: Great. Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Good morning. I'm George Friedman-Jimenez. I'm an

occupational medicine physician and an epidemiologist. I'm the Director of the Occupational Medicine Clinic at Bellevue Hospital in New York City. I've seen many, many thousands of patients with work-related exposures and diseases. I'm now moving from clinical to epidemiology role and I'm interested in causation and I'll be talking about that tomorrow.

CHAIR MARKOWITZ: Great. Dr. Mikulski.

MEMBER MIKULSKI: Good morning. My name's Marek Mikulski. I'm an occupational epidemiologist with the University of Iowa Occupational & Environmental Health and I also direct one of the Former Worker Programs with two sites in Iowa.

CHAIR MARKOWITZ: Okay. Welcome. Let's review the agenda -- oh yes, I'm sorry, Dr. Cloeren, sorry, would you introduce yourself please?

MEMBER CLOEREN: Hi. My name's Marianne Cloeren. I'm an Associate Professor of

Medicine, specialist in both internal medicine and occupational medicine. I'm at the University of Maryland School of Medicine and I serve as the National Medical Director along with a couple other physicians for the Building Trades National Medical Screening Program. Thank you.

CHAIR MARKOWITZ: So, if it's possible on the video to show Dr. Cloeren and the other folks more prominently then we'll be able to see when she wants to make a comment. Okay, let's review the agenda quickly.

As always, the time slots allocated to various agenda items is flexible because we never know how long the discussion will last on any given topic, but that's the way it goes.

We're going to start off with an update on policy and program by Mr. Vance and Mr. Novack, Department of Labor. Then we're going to talk about the recommendation that the Board made last time relating to industrial hygiene, a request that we made for information regarding industrial hygiene and the responses from the Department of

Labor. After which, we will take a short break and then talk about the recommendation the Board made last time regarding the contract consulting medical physicians, medical consultants, otherwise known as CMCs. Then, we also had submitted an information request regarding the CMCs, which we'll discuss.

After lunch, we're going to dive into the Site Exposure Matrices, a working group of the Board, nicely attended a meeting with Paragon, the contractor in Ohio, a couple of months ago and so we're going to discuss that and what we learned and questions that arose from that. After which, we will switch to Parkinson's disorders and address a task that the Board took on at the last meeting about the integration of Parkinson's disorders in the Site Exposure Matrices.

We'll then talk about our recommendation regarding the program's treatment of terminally ill claimants and the response from the Department. A very short discussion about IARC 2A, these are probable human carcinogens and

how they're treated under the SEM. We will then discuss the response to our information request regarding claims review.

Then, we have a public comment period. So, we welcome members of the public to make comments. Carrie, what do we have so far? Anybody sign up? Two? Okay, so two people so far, we have a 45-minute session dedicated to that and so I encourage people who want to make public comments, if you want to write those comments, all the better and you can submit those to our website. Remember, just Google "ABTSWH" and "labor" and you will find our website.

You know, I forgot to introduce the members of the public who are here. So, we have a couple moments and we have a mic in back. If you wouldn't mind just stating your name and, if you want to, any association with DOE, DOL.

MR. TEBAY: Calin Tebay, Hanford Workforce Engagement Center.

MS. ROBSON: Christy Robson. I work with attorney John Agee.

MS. McGHEE: Amanda McGhee. I'm an RN with the Building Trades Medical Screening Program.

MS. HILL: I'm Betsey Hill, also an RN with the Building Trades Medical Screening Program.

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

MS. HAMILTON: Jenni Hamilton. I'm Senior Program Analyst for the Department of Energy here in Oak Ridge and we have at our organization, one of the highest numbers of EEOICPA claims within the nation for the Department of Energy. We want to make that program as good as it can be and continue it to make it better for all the claimants because we personally feel they gave their lives for the missions that we had here in Oak Ridge.

MS. HENDERSON: I'm Wensday Henderson and I'm the Task Lead over EEOICPA program with FOIA and Privacy activities for the CSC.

MS. GRIEGO: Good morning, everyone. I'm Regina Griego. I'm the DOE Program Manager

for EEOICPA.

CHAIR MARKOWITZ: And then, Mr. Vance and Mr. Novack.

MR. NOVACK: Yeah, hi. My name's Josh Novack. I am with the Energy Program for DOL. I am a Unit Supervisor for the Policy Unit.

MR. VANCE: Good morning, everybody. My name is John Vance. I'm the Policy Branch Chief overseeing the medical health science unit and also a group of our policy analysts within the Department of Labor.

CHAIR MARKOWITZ: Great. Thank you. Let me review tomorrow's agenda actually so I don't have to do it tomorrow. We're going to address the issue of hearing loss, a discussion of that tomorrow first thing. Then, we'll follow up on items that arise today, for instance, the idea of making any new recommendations arise today, it may be useful to draft those if they're not already drafted overnight and then we can review them tomorrow as opposed to us writing them from scratch as a group, which is always a challenging

process.

Then, we'll discuss the quality assurance process -- more the results actually of the program. There's some documents we have which are not available to the public, so we're going to, if anything, only speak about them in general, but we can discuss in general about those issues. We will review public comments tomorrow, those that are made today and those that have been submitted. I remind board members to look at our website to look, there have been two or three written comments so far.

We'll follow up and make plans for (audio interference) anything with kind of a hand off agenda for the next Board term, because we don't know the composition of that Board and we want to leave topics either done or in a state that can be easily picked up by the next Board. Any comments, changes on the agenda? Okay, great.

Let's get started with industrial hygiene. The working group that works on this, we have both the industrial hygiene recommendation

that we made last time and then we also have an information request. Dr. Cloeren, are you going to lead this discussion on this topic?

(Simultaneous speaking.)

MEMBER CLOEREN: I can. I didn't prepare any slides, Dr. Markowitz, but I can off of the many written documents that --

(Simultaneous speaking.)

CHAIR MARKOWITZ: Yeah that's fine, that's fine.

MEMBER BOWMAN: Steve, I was just noting in the agenda the Program and Policy Update by Mr. Vance.

CHAIR MARKOWITZ: Oh yeah, of course. Yeah.

MEMBER CLOEREN: Oh, yeah, yeah, yeah.

MR. VANCE: I was hoping I'd get out of this.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Hold on, hold on. I was trying to let Mr. Vance off the hook, but --

(Laughter.)

CHAIR MARKOWITZ: Dr. Bowman jumped in. Okay, go ahead, Mr. Vance and Mr. Novack.

MR. VANCE: Josh and I going to try to be quick so you can get right to Dr. Cloeren. She might have a moment now to think about this because I'm sure she was caught off guard thinking, oh, I've got to go now.

CHAIR MARKOWITZ: No, you have 40 minutes, so we're good.

MR. VANCE: All right, well, good morning, everyone. Again, my name is John Vance. I'm with the Department of Labor and Josh and I are going to provide a host of information about just some things that the program has been up to. We'll talk about our statistics. We're going to talk about some of our priorities with some IT modernization and also some outreach and other types of policy updates for everybody.

I'm going to start with some claim numbers. I'm going to throw statistics at everybody. We are still looking at a pretty good

intake process for our claim numbers. When I've been looking at the weekly tallies, we're running between 200 and 250, and maybe even sometimes even up into 300 new claims a week. I asked our resource centers to provide some data for us for the period of January 1st through April 19th. The resource center reported 4,138 claim intake, so that's a pretty good number of incoming cases. Representing in that, we had first-time filers 1,639 new filers during that period of time.

I'm always kind of curious where these claims are coming from. I can tell you that New Mexico seems to be the state with the highest number of claims. When I've looked into it, we just have some very prolific authorized representatives who are filing claims. So, New Mexico is our most busy resource center in Espanola.

Dr. Markowitz, I know you always like hearing about our occupational history questionnaire process and for the Board, we completed during that same period, January 1st through April 19th, 1,644 occupational history

questionnaires. I did ask the resource center manager to give me any feedback about how well it was working and were there any issues that they were aware of. The answer was it's working fine. They think it is a much better information collection process. They use an electronic record keeping kind of process for that and that process is very effective and efficient so they didn't really have any negative feedback or any thoughts about that.

I've actually seen a lot of the new Occupational History Questionnaires in cases that we review in Policy. I can say that they do contain a lot more detail specific to the employee compared to the prior versions, so that continues to work well. I have not heard of any issues that we have had with regard to that for improvements, so I'll leave that there.

For a little bit of a change up, I did ask when I was communicating with our resource centers just to give me some stories that I could share with the Board about different things that

they've been up to. Just recent things that were positives and I got some really interesting stories. I heard of one where there was a gentleman that was experiencing some medical bill processing problems with regard to getting coverage for an assisted living facility. The resource center did one on one engagement with that person to try to work through with our medical billing process to get a 53,000 dollar reimbursement for assisted living, which had been apparently held up due to some billing process issues, but the resource centers helped and we were able to reimburse that amount. This individual had previously paid that for assisted living and with the approval of their claim, we were able to work through and get that reimbursement done.

I know the Board will be discussing terminal patients. The resource center in Espanola had a claimant who had filed a claim with a life expectancy of days to weeks. The resource center worked directly with the district office to obtain all the information to a recommended

decision issued immediately after we had received the information about terminal status. The district office was able to issue a recommendation the day after they had been notified of the status of the patient. A final decision from our Final Adjudication Branch was issued on that same day. The next day, the resource center facilitated the completion of the necessary paperwork to get the payment processed and we were able to get 150,000-dollar payment out under Part B and a 250,000-dollar payment to this employee within days of the final decision being issued.

That's not the only instance that we have of those kind of situations where we have terminal patients that come in and we have to basically short-circuit the entire process to get our claims processed quickly, so that occurs fairly frequently. We do have a specialized process to expedite those type of cases.

Then the resource center also had another situation they just said that it had someone who was in a CVS. They were having a real

struggle getting the CVS pharmacist to figure out how to enroll or deal with whatever paperwork was needed to get a payment taken care of. The resource center intervened, coordinated with our medical bill processing unit to get a 1,333-dollar payment processed as the claimant was standing there at CVS. These are just some stories that I got from the resource centers about some of their work activities supporting our claimants.

Just for numerical numbers on compensation payments for the first quarter or the first part of this year, so it's our fiscal year, October 1, 2023 through I'm sorry this may be old information, hold on. Well, it's a lot, let's just say that. I'm looking at the dates here and I'm like that date doesn't look right. We're looking at pretty substantial amounts of money being paid out, continuing to be paid out under both Parts B and E. I'm thinking that's 2024 instead of 2023, but I'm not going to commit to anything, but we're looking at pretty substantial amount of money still being paid out under both Parts B and E. Part E

is really the one where the most compensation is being paid out as of right now vastly exceeding what we're paying in Part B funds.

For fiscal year 2023, we reported this out before and I think it's important to share with the Board. One of the highest expense categories for medical benefits by this program is home and residential healthcare. It is by far the greatest category of expenses paid by the program with regard to medical benefits paid to employees suffering through occupational illnesses. For fiscal 2023, we paid in excess of 1.1 billion dollars just in home healthcare expenses representing payments for approximately 12,000 individuals so it's a pretty extensive amount of work. It's a pretty extensive amount of cost, but it reflects the program's interest in making sure that individuals that are suffering from some of these really debilitating diseases are getting the type of medical care they need in home.

As a consequence of that, we've seen a dramatic increase in our efforts deal with these

claims for ancillary medical benefits like home and residential healthcare. Our staff dedicated to that has really expanded. We have an entire contingent of medical benefit examiners that are dedicated solely to looking at the medical necessity of ancillary benefits. That would include home and residential healthcare, durable medical equipment, home modifications or any other types of specialized services that are being prescribed by physicians. Their role in that unit is to evaluate the medical need for those types of services.

For second quarter FY 2024, second quarter operational plan goals, for all the bureaucrats in the room, right, Gail, the government operates with lots of standards that we have to perform with regard to metrics of performance. These are things to ensure that we're moving cases along and that we are ensuring timely completion and adjudication of cases.

I'm going to run through some of the statistics. Initial processing of claims, again

this is for the second quarter, we completed initial processing on Part B and E claims within 145 days. The standard that we met was 93.4 percent are completed within 145 days and 98 percent are completed within 200 days.

Completed final decisions, this is after we have actually issued a recommendation on a claim where we received a waiver. We're completing those within 30 days, 98 percent of the time.

Final decisions based on a review of the written record, this could be a situation where someone is requesting a review of a case or has not waived their objections to a decision. So the hearing representative in the case is just conducting a review of the written record. We're completing those within 75 days, 97 percent of the time.

Final decisions after a hearing request within 145 days, we're actually at 100 percent on those. I know that that is something that our final adjudication branch is very interested in

maintaining that, simply making sure that the hearings occur, we're able to address those hearings and get a decision out the door, so that's really good work by our final adjudication branch.

Once we've made a decision and we're making an award of lump sum compensation, we're making those payments within 14 days, 99 percent of the time.

Another statistic for the Board for our industrial hygienists, they're completing their review of cases within 30 days of referral, 99 percent of the time. The number I have here for the second quarter was 1,235 cases that they've looked at so keep that in mind as you're discussing the IH production.

For the Site Exposure Matrices, I know that several of you are very interested in that, I've got some information from our SEM contract manager. We continue to make up dates to the Site Exposure Matrices. As you know, it's a resource that continues to evolve as new information becomes

available. There have been 30 data set updates to 30 sites since the last report with our last meeting. I'm not going to run through all of this, but major updates have occurred for 18 sites Brookhaven, Iowa Ordnance Plant, Pacific Proving Ground, Paducah, several sites that are associated with Sandia and some uranium mills have also been updated. We'll continue to do the updates on those.

The next public freeze where we do the freeze of the internal system of Site Exposure Matrices for classification review and then public release is going to occur on May 16th, so that's coming up very soon. I participated in the meeting in Columbus with some of the Board members. I thought it went very well. We will have Pete Turcic and a colleague of his this afternoon available to talk about any of the issues that you have with or follow up questions with regard to the Site Exposure Matrices.

We also obtained, very quickly, a response to some questions that have been submitted

by the Board. Paragon worked very quickly with our contract manager to get those responses together, went through our clearance process in phenomenally fast time, so that was really good. I'd say I would reserve any questions about that document for the Paragon discussion because they're at the ones that prepared that and then the Department of Labor reviewed it and agreed to that response.

IT and ECS initiatives for the Board, we have continued to expand our available forms that are available to the public electronically. We have a new travel reimbursement form that has been cleared for use and that's now available. It makes it much more easy and it allows a claimant to provide a lot more information about the number of trips they are claiming. The old form apparently did not contain as much space for claiming as many trips and now it's been expanded. We've also allowed for electronic submission of claims for impairment and wage loss. This would be for recurring claims. Those are now available

electronically for digital signature through our electronic document portal.

Josh is going to talk in more detail, but I thought I'd mention it. We are going through the very laborious process of getting an OMB clearance for a new form. It is going to be our EE-1A. This is going to be a form dedicated to consequential illness claims. We have seen a really dramatic increase in those types of claims associated with existing cases, so we're going through the machinations of working with our internal OWCP clearance officials and OMB to get that form. Just for entertain purposes, what we have to do for these forms, which if anybody ever has worked in the federal government or worked with forms, be thankful that you may not have ever had that experience, I think is the best way or just understand what I have to go through and Josh has been exposed to. It's not fun. We have to do all kinds of burden analysis. We have to do all kinds of public notice. One of the processes that we

have to go through is we had to do a 60-day Federal Register Notice giving the public time to comment about the estimate of our burden, how much effort is taken to complete the form. Sixty days' worth of time for the public to comment about that, how many comments do you think we received? Anybody want to fashion a guess? Zero.

Now, OMB then requires after this public comment period that we go out and get more public comments. We have to go out and Josh coordinated on this. We have to go interview people and ask them what they think about the burden analysis directly. So, we asked some internal staff. We asked an external representative and they had how many comments? None. So, anyway that's the bureaucracy Gail was talking about, so that's how that works. It's kind of a fun process, but we're excited to get that in place. That's moving as quickly as we possibly can. I think the next stage is going to be going to OMB to actually get their review and make sure that they agree with our burden analysis that no one had any concerns

about.

Internally, with our staff, we have been initiating a lot of efforts with our staff to have all of these different resources that we have to be single sign-on rather than having lots of different password access to the different resources that we have and so we've been really moving quickly to do that. That has been a very well received improvement to our internal processes and so our staff are very excited about that.

Those are the updates I have. I think I'm going to look at Josh. He's going to talk about outreach and some of our policy updates.

MR. NOVACK: Thanks, John. Josh Novack here, again, Unit Supervisor in the Policy Department for DEEOIC.

I'm going to continue with a number of different updates that we have going on in our program including, as John mentioned, outreach. We continue to be dedicated to making as many communities as possible knowledgeable about our

program and getting on the road. Our Program Director, Rachel Pond, right now is at an outreach event in Kansas, which I think is going well so far.

We do outreach in a number of different ways. We have a joint outreach task group which is comprised of our office as well as DOE, HHS, the Ombudsman's Office for NIOSH as well as the Ombudsman's Office in DOL. We go out there in the field and provide overviews of all of our programs and our roles in the adjudication of the claims as well as be able to meet one on one with claimants that come in and help them with any case issues that they have.

For the remainder of this fiscal year, we plan to hold additional joint outreach task group events in Kansas City, Missouri, and then we have a three-day tour of New Mexico with groups going to Gallup, New Mexico; Grants, New Mexico; and, Albuquerque, New Mexico. I know that we have a robust outreach section on our website so you can go to our website at any time and see what our

outreach calendar is and we also have an email distribution list which I recommend anyone to sign up for if they are curious about our outreach events.

We also hold smaller in-person outreach events held usually by a couple of claims examiners in our resource centers being able to focus one on one with individuals that have questions about their program and also be able to go to different locations where we may have an underserved population and be able to meet their needs directly face to face.

In conjunction with going out on the road, we also have a robust webinar series. We do webinars from January through October, usually 10 webinars a year. Also, some of them are with the Joint Outreach Task Group and they have their ability to provide updates. We kind of focus these webinars in individual adjudication functions that we believe our claimant population, our stakeholders, are interested in and these include industrial hygienist referrals, a look at our

medical benefit authorizations. We also have a kind of state of DEEOIC, where we have our Director and our Deputy Director and our Branch Chiefs at times as well, come in and give an update about what are some of the major changes that we are undergoing and also a little look back at some of the things that we hang our hat on over the last year.

Again, we work with NIOSH on one webinar on RECA. We have a webinar in which we go through our website and we show all of the tools and resources that are available on our website and we do a webinar on the roles of our research centers, our claims examiners, our hearing reps and our medical benefits examiners. Then, also a pretty comprehensive webinar on our claims process.

Within national office a few years ago, we established a large customer experience team. I think there's three people now and their main focus is to do a customer feedback collection and kind of get an understanding of what our claimant

population goes through at different touch points in the process of adjudication. We'll send surveys on claims development, on kind of where their mindset is when they receive a recommended decision or a final decision or medical benefits. So, our customer experience team is continuing to reach out to our claimant population to kind of understand some of the, they call them, pain points and bright spots, things that are hard and things that they enjoy that our program does.

I know right now there's a government-wide initiative in understanding people's trust with the government. I know our customer experience team right now is focused on creating surveys in order to gauge and understand our claimants' trust with the process and then evaluate those surveys and those responses to see if there's anything that our program can do in order to gain more of their trust and make our program easier to understand.

Also within our customer experience team, we have one person who specializes in

focusing on our website to make sure our website is clear and understandable and accessible to all. They are always analyzing every document before we put it on to make sure that it's 508-compliant. We also put our feedback surveys on our website and we do robust data updates every single Monday of our program statistics, which you can find on that.

As part of these outreach events, our customer experience team also does focus groups. They'll take a group of 11 people and ask them questions. Our next focus group is going to be held during our July Authorized Representative Workshop, which is a time for authorized representatives to meet in a certain location and have individual deep dives into the adjudication process so they can bring knowledge back to the communities and the claimants that they serve in order to help better understand and guide their claimants through the process.

Quality control is also something that's very important to us. We have a dedicated

quality review and analysis team. They are continuously reviewing DEEOIC adjudication functions to ensure our staff is completing adjudication in a consistent manner, all based on the regulations, policies and procedures.

Also, within quality control and I know that we have a session devoted to it is our CMC and our IH Quality Assurance Surveillance Program Audits. These audits are conducted quarterly by policy analysis within the Policy Group. What we're looking at are two things. One of them is if the contractor performance is meeting the standards of the contract. Then at the same time, we also review the referrals that our claims examiners are making for the CMC and IH to ensure that they are providing the information that the CMCs and the IHs need in order to answer the questions and make sure that the questions that are being asked are being answered in a concise and well-rationalized manner.

Now, I'm going to talk a little bit about Procedure Manual updates. Our internal goal

here is to update the Procedure Manual continuously throughout the year with two major publications per fiscal year. Right now, we are gearing up to release PM version 8.1, that's in its final clearance process right now and John can tell you how bureaucratic that process is as well. It's going to provide updated guidance in several different areas and I know the Board has been provided a copy of the draft transmittal for evaluation as well.

I'm going to touch on a just a couple of the main points that are going to be in this Procedure Manual update. We're going to replace wording about the OWCP 957, which is the Medical Travel Refund Request, and that's actually split now into a form OWCP 957A and 957B, which John mentioned you can file online as well. The 957A is for Medical Travel Refund Requests and the 957B is for Travel Refund Requests.

We're incorporating a change in the Federal Register Notice that brought in scope of coverage for the beryllium vendor sites. If

claims staff identify claimed employment at a statutory beryllium vendor and there's questions about whether or not that could be a covered facility, we allow the claims examiners to refer those questions to the national office and our Policy Unit will take a look at that.

Most of these updates are actually based on feedback of our internal claims staff in ways that we can improve the Procedure Manual to help ensure that there's a clear delineation of the roles and responsibilities sometimes between claims examiners and medical benefits examiners. One of the updates we made is to increase coordination between our medical benefits examiners and our claims examiners in how they handle organ transplant approvals. We go in and we define the roles, specifically who accepts the case, who does the coding of it and who does the notification to the claimant when a case is accepted or denied.

We have new instructions for making referrals to a CMC regarding identification of

specified cancers. We provide additional details about the documentation required for health physicist referral. We incorporate previously published bulletins into our Procedure Manual, that's Bulletin 2401, which is the updated criterion for beryllium sensitivity and Bulletin 2402, which is related to the categorization of basal cell carcinoma and squamous cell carcinoma.

We also provide an update to procedures for tracking a tort or state workers compensation surplus, specifically just removing language that involves paper files, which have all been imaged into our system at this point.

I was going to mention the EE-1A, but I think John did a good job speaking about it so I have nothing additional to add there. That's the end.

MR. VANCE: The one thing I wanted to add was in the Procedure Manual update and I'm fairly certain the Board is aware of this, but there was a statutory change at the end of last year regarding the -- actually it spoke to one of the

recommendations the Board had made about borderline BELPT testing, qualifying for coverage under our statute. Congress did pass an amendment to the statute that added a criteria for allowance of the acceptance of three borderline tests that are conducted within three years that would allow us to accept a case under those criteria. That's what that update to the Procedure Manual is. In fact, we issued an interim bulletin notifying our staff of that change early in the year and then the bulletin is now being incorporated into our Procedure Manual.

In conjunction with that, I thought I would also highlight the fact that we are revisiting previously denied chronic beryllium disease and sensitivity cases looking for any cases that could potentially qualify under that new standard. It was a pretty sizable chunk of claims that we're going back to revisit. I don't have the statistics on where they are with that, but we are revisiting those cases as part of our programmatic initiative looking for cases that are

potentially qualified for that.

I think that wraps up our comments. If there are any questions at this point, I think we have more time or, Steve, I defer it back to you.

CHAIR MARKOWITZ: Okay. Ms. Rhoads, if you could compile an action list for the meeting. Let me just ask a specific question and then we'll get to the Board members about the last topic. The requirement of only abnormal beryllium LPTs, lymphocyte proliferation tests, that there be three within a three-year period. I know that the number of three borderline tests was specified in the congressional legislation, was the finding that those tests occur within a three-year period, was that also specified in the legislation or is that a matter of Policy Department?

MR. VANCE: I believe it was specified and enumerated in the actual language that it had to be three within three years.

CHAIR MARKOWITZ: Okay, thanks. After your retrospective look, if you could provide

the information about the results of that look, that would be very useful. Mr. Domina.

MEMBER DOMINA: Yes, I had a question about the three within three years, because if I remember correctly when I read it, it was like one a year.

MR. VANCE: Yes. We're interpreting it as three within three years, so in whatever sequence that occurs.

MEMBER DOMINA: Okay, well, the other issue is the issue of trying to get those paid for and even get them scheduled, like for a former worker, there's no mechanism for that. That's a huge problem. I mean if you test positive after you go out and I know logistically for New Mexico it's always been a problem trying to get them to National Jewish or ORAU, it's an act of God to try and get that done. The three in three years, I don't care if you do them three in three months, whatever it is, but once you're out the door, it's a problem. Some of these sites from talking to other members they put it on their personal

insurance and the contractors are reimbursing them and that's not the way all this program is supposed to be set up for this or CFR 10 -- or 850. So, I'm trying to figure out when that was written in on this new update and how they expect this to happen.

MR. VANCE: I can't really tell you the intent of the United States Congress. They write the laws and we administer them, so the statute is permitting us to accept a claim when an individual presents three abnormal tests within a three-year period. However that is facilitated, and I understand and hear what you're saying about the challenges in getting those tests. That is going to be on the claimant or their authorized representative or any Former Worker Screening Program, if they're conducting those tests and have done it in the past, where they have the three abnormal tests and are filing a claim.

If you have not filed a claim and if you have a history of seeing borderline tests and you've got three, or you have two and you're scheduled to do another one, that's just the

reality of the situation. We can't facilitate getting those tests, we can only deal with it once they are shown as being borderline results within that standard that's set by Congress.

MEMBER DOMINA: I understand that, but under the Former Worker Program it's going to end up being three in nine years. That's my issue.

CHAIR MARKOWITZ: Steve Markowitz, let me comment on that. Actually because there are three Former Worker Programs represented here, Dr. Cloeren, Dr. Mikulski and myself. We do have a meeting coming up of the Former Worker Programs in early June. We need to add this to discussion because for those who don't know this, the beryllium lymphocyte proliferation tests, the lab alone costs 275 dollars roughly per test. In the Former Worker Program, it's generally scheduled every three years, one test every three years, so we may need to consider changing our protocol to accommodate this legislative requirement. We'll raise that at our June meeting with the two other Former Worker Programs, we'll raise it and see

perhaps if we can change the national medical protocol to satisfy this. That's for former workers, for current workers that's really up to the Department of Energy and the contractors and it's something that somehow needs to be raised as an issue. Other comments specifically on this issue of beryllium? Then other comments, questions for Mr. Vance or Mr. Novack?

Oh, I have some questions. Well, first of all, thank you for a terrific report. It's great to hear that the revised Occupational Health Questionnaire is so useful and also I think you said it's electronic at this point. Does that mean that some of the data on the OHQ is searchable in order to better understand who is submitting claims these days?

MR. VANCE: I think what they're meaning is, is that they collect the information and input it into electronic form, which is then converted to PDF for uploading to the OIS case records. So, we're not maintaining them within the case adjudication system, the resource centers

are collecting these electronically and that's just facilitating the submission of the form with all the information to our electronic imaging system.

CHAIR MARKOWITZ: The reason, for the Board, that I asked that question is because the OHQ has information about site, years, and job titles. I don't know that we've ever been able to get or the DOL was ever to produce any information about claims by job titles, something that the Board might be conceivably interested in in the future, but we don't need to pursue this now because we don't, I think, have a particular request, but it provides a possible opportunity to understand better who is submitting claims in terms of sites, job titles, years, etc.

A third of all claims are new and it sounds like you're getting roughly 10 to 15,000 claims per year, so that makes somewhere between 3,500, 4,500 claims are new and you're doing something like in the most recent quarter, 1,200 IH reports. It sounds like the majority of new

claims, the vast majority of new claims, are submitted to the industrial hygienist for report. Is that true that most new claims the CEs are sending the exposure information to IHs to produce a report?

MR. VANCE: I don't have specific data so it's all anecdotal, but I would say a lot of the claims that we are seeing under the Part E provision of our statute, once they've gotten through the initial evaluation of covered employment and verification of the diagnosis of whatever condition is being claimed. They're establishing an exposure to something that's either identified in the Site Exposure Matrices as a health effect, or there is an argument being presented on behalf of the claimant by a physician, that those would be submitted to an industrial hygienist for some sort of exposure characterization of either the toxic substances that are identified through the SEM analysis by the claims examiner or are being referenced by a physician in some sort of epidemiological

causation argument being presented in a case for cause, contribute or aggravate.

CHAIR MARKOWITZ: Okay. The issue of consequential conditions is really interesting, but these are conditions I presume, and correct me if I'm wrong, but these are accepted claims if a claimant has a condition that is accepted and then they develop a second condition that is claimed to be related to the first accepted condition. So, consequential conditions aren't something that occupational medicine doctors normally deal with because we deal with causation impairment, but not subsequent causation, related causation, of a consequential condition. I don't know how many of those -- I know you were working on defining with the new form what a consequential condition is, but I don't know how many of them are going to go to CMCs, many of them may be resolved without going to CMCs, but you may need to train the contractor and orient the CMCs as to how you look at consequential conditions. It's not something we automatically do and it's not

something that we have a clearly defined framework at present.

When I say we I mean speaking in the occupational medicine community, and the occ med docs here can you dispute me if I'm wrong here, but it's not something we have a framework to really deal with in a standardized way. If that becomes an important issue for the CMCs, then you're going to need to orient them as to how you look at consequential conditions and what goes into that.

MEMBER CLOEREN: If I can jump in.

CHAIR MARKOWITZ: Yeah, sure, Dr. Cloeren.

MEMBER CLOEREN: You know it might be my familiarity with FECA, but I'm quite familiar with the term and the reasoning and I think maybe that word is not used in all workers compensation jurisdictions, but I think the concept, the principle, of a consequential condition is probably familiar to anyone that's treating workers compensation conditions. I agree with you, I think having some guidance in making the

assessment would be a very good idea.

I love the idea of a new form because I think it's a little bit tricky spelling out how something is connected and I think having a mechanism for somebody to make that argument would be very helpful.

MR. VANCE: This is John Vance. I'd just like to remind the Board members, there is an entire chapter within our staff Procedure Manual discussing the process by which we evaluate consequential illness claims, the definition that we apply to that term and that's what guides our staff assessment for consequential illness claims. It can be a very open to interpretation kind of situation and that's the struggle we're dealing with right now is just the propensity of a lot of physicians to make arguments connecting conditions to something else. Some of those you would look at and say that makes perfect sense. If you have a pulmonary disease and that's affecting some other system directly, that makes perfect sense. But then we were starting to see a lot of claims that

are a little bit more challenging from the novel arguments that pulmonary disease is affecting something like osteoarthritis or spinal stenosis or degenerative disc disease, but you're seeing those kinds of arguments presented to us. Then we're left sort of questioning the convincing quality and the compelling argument being made by that physician to link those two things and that drives a lot of our CMC referrals, asking about does that make sense, does there seem to be some sort of justification for that kind of an opinion. It is a very challenging area for us.

CHAIR MARKOWITZ: Steve Markowitz. When you do the quality assurance review every quarter and you divide the CMC reports into different categories, do the reviews of the consequential conditions fall within the causation category?

MR. VANCE: I don't know if they're picked up. I know that we've seen them. Because what they're pulling in is whatever the coding is for the type of referral. So, if it's a causation

opinion and there is a question about a consequential illness, if it's coded like that, that's going to show up for the auditor to review. I personally think that I have seen them in there, but it's not a specific category in the audit that we do, but if it does appear in one of the sampled cases, that's what would be reviewed as part of the quality assurance evaluation of that CMC.

CHAIR MARKOWITZ: Ms. Rhoads, if you could just add the issue of consequential conditions because it's something, I think, that it's within the realm of the mission of the Advisory Board to weigh in on this. We're going to develop, I think, a request on whatever data and it may be prospective because you don't have it in place, but whatever data you have on consequential conditions, the frequency, the outcomes, types of conditions and the like. I think we'll get back to you on that because, as you say, it's an increasingly important issue and we may be able to be helpful with respect to that. Other comments or questions from the Board? Yes.

MEMBER WHITTEN: Dianne Whitten. Mr. Vance, you noted that there's -- on the SEM report, you said that there's 18 sites with major updates coming out in two weeks. Can you tell us what is a "major update"?

MR. VANCE: I think that the way that I would characterize that is that there's been a substantial increase in the information available about either work processes, area building data, or relational connections between certain toxins and labor categories. I'm sure that we could produce some sort of summary of what those changes are. And what I meant was that the changes have occurred. As you know, we have two variance of the Site Exposure Matrices. We have our internal staff version and we have the public version.

As far as the two week -- the two week thing, that is actually what's happening is our internal version is being frozen. That then is submitted to the Department of Energy for a classification review. Once that is done, we then update the public version.

So these changes that have been occurring to these sites are ongoing real time. So as Paragon is in a position to update a site profile, they will do it for the internal version. All of those updates will then be reflected in the public version once it's been released to the public -- you know, once it's gone through the process and released to the public.

MEMBER WHITTEN: Okay.

MR. VANCE: Okay?

MEMBER WHITTEN: So you'll get us the summary of those changes?

MR. VANCE: Yeah.

CHAIR MARKOWITZ: And Ms. Rhoads, if I could just request that you resend the transmittal document that described the updates and the procedure manual, which we did receive a while ago, but we received a number of things in the interim. And some of us may not, you know, have those changes readily available. So that would be useful. We could look at it overnight.

I want to thank you for the JOTG and

the webinars because I think they're really very useful. And you've had significant attendance. Right?

MR. VANCE: Yes. I just want to reiterate what Josh said. So if anybody's interested in those webinars, I think they're put out on their notice on the email distribution for our policy and procedure updates. And I know I specifically highlighted the event that we had earlier in the year with our industrial hygienist. So we did have our two industrial hygienists talking about their role and their function. And I know that several board members attended, so you can get a sense of what was involved with those webinars. So if you're not signed up for that, I'm sure Carrie can send out the link to the registration for the email distribution on those.

CHAIR MARKOWITZ: And I'm sure you've done one on how to use the SEM. Right?

MR. VANCE: I've personally done it multiple times, yes.

CHAIR MARKOWITZ: Okay.

MR. VANCE: So yes.

CHAIR MARKOWITZ: Yeah. By the way, is there a video for new users on how to get into the SEM and use it?

MR. VANCE: There is a -- If you go to the -- I think it's in the outreach site, there's actually -- when you do a -- You can do a Google search too for the Site Exposure Matrices. Go to that link and I think that there is a SEM training link and you can walk through the steps for how to access it, use it, how it's arranged, and the utility of it for assisting with case adjudication.

CHAIR MARKOWITZ: Okay, thanks. Okay, so let's move on to the next agenda item. It's 10 o'clock. Thank you by the way very much.

MR. VANCE: Thank you.

CHAIR MARKOWITZ: Oh, and Ms. Griego, you want to make a comment from the Department of Energy.

MS. GRIEGO: I do. Thank you. Sorry, Dr. Markowitz. I had a conversation with the

Board, John. And I mentioned that we had that workshop back in August between Department of Labor and our EEOICPA POCs and the occupational history questionnaire was raised as to whether or not Labor can continue or at least, you know, send that questionnaire to Department of Energy when they make the record request. There's not consistency right now. So some CEs may send it. Some others -- Some of -- I mean a lot of times, we don't get it. And in the procedure manual, there's no clear guidance as to whether or not they need to send that questionnaire to Energy. So remember, we're just making that recommendation because I think it would be helpful if we had that info.

CHAIR MARKOWITZ: Okay, thank you. Yeah, Mr. Key.

MEMBER KEY: Yeah. John, we're still having problems with the hearing update. I think it was over a year ago that the Department made that revision. We are having claimants still being denied apparently, the CEs have not been educated on the revision and creating more backlog

and problems. And we need to ensure that all CEs are aware of that revision and incorporate it in their decision making.

CHAIR MARKOWITZ: Other comments? Okay, so let's move on to the next agenda item, which is to address the industrial hygiene recommendation that the Board made and also the information request. So we received a response from the Department on March 21 of this year on our industrial hygiene recommendation from the last meeting. And on April 5th, a response to our information request regarding the industrial hygiene. So Dr. Cloeren.

MEMBER CLOEREN: Marianne Cloeren from the University of Maryland. I'm going to try to share my screen so we can just sort of walk through the important parts of the document if that's okay if this works. You should see my screen.

CHAIR MARKOWITZ: Yes.

MEMBER CLOEREN: All right, awesome. Okay. All right, so the first document that I have open is the -- the recommendations and

response related to -- these are the two requests basically that the industrial hygienist report all -- they describe all reported exposures that were found in each of the data sources. That was one of the recommendations. Because right now what typically happens in an industrial hygiene report is a statement to the effect that I reviewed -- I reviewed the OHQ. I reviewed the DAR. I reviewed this, this, and this and kind of a statement that you know, there's nothing that was -- you know, nothing useful found in there. But it doesn't actually state -- it may not even state that, just that it was reviewed.

And then they go on to describe what they think the exposures were, but it's not always clear that the only real source of information was the Site Exposure Matrix. So we thought that -- that really understanding the sources of data, including -- especially anything from the Department of Energy that would describe, you know, what was actually going on at that site, you know, for somebody in that job, which is you know, kind

of closer to -- closer to the truth maybe then the Site Exposure Matrix, which pulls together a lot of more general information.

So you know, here's the statement of what typically is in the -- the IH report. So the request -- we felt that the statements like this could kind of bias the user of the report into thinking that there was useful information in things other than Site Exposure Matrix and often there's not. So our request was basically that the IH consultant should be instructed to describe all the information that was available for the IH review, including what was, you know, summarized and what was in the OHQ interview if they performed it. Any exposure information, you know, from the physician, anything from the daily site. And if there's nothing specific available outside what's in the SEN, that the IH report should state that explicitly. And we think this is more fair and transparent.

And the response from -- the response from the Department was an agreement to work with

the IH contractor, so we thank you for that, to develop feasible changes that would better communicate the examination of case-specific exposure data. So we look forward to hearing more about that.

The second part of our recommendation is highlighted here in blue, was that -- a recommendation to routinely provide the occupational history questionnaire to the -- to the contract medical consultant if they're asked to evaluate claims. And our feeling here was that Occupational Medicine physicians are trained to evaluate, you know, such history. Perhaps not all the CMCs are Occupational Medicine, but in any event, the Department did not agree with sharing the OHQ itself. But I think that if the industrial hygienist can summarize what was in the OHQ and comment on it, you know, that gets us part of the way there.

Do we want to discuss this, Dr. Markowitz before we move on to the other document?

CHAIR MARKOWITZ: Well, this is part

of the issue of whether the OHQ is provided to the CMC. Right?

MEMBER CLOEREN: Correct.

CHAIR MARKOWITZ: Yeah. So yeah, continue. There is a -- Dr. Bowman has a comment, but I think it can probably wait until you, Dr. Cloeren finish this -- this paragraph.

MEMBER CLOEREN: Oh, this is all I have to say on this one basically. So we have partial agreement, including -- and most important thing is agreement to be more explicit about what was -- what exposure information was reviewed. What was found in the data sources other than the SEM. I think that would be a big improvement when that happens. I'm not sure what the next steps are with the Department of Labor and working with the industrial hygiene contractors to develop that and how the Board can be of assistance in that.

CHAIR MARKOWITZ: Yeah. So Ms. Rhoads, if you could add that to our list to learn the results of that interaction between the program and the IHs, the contractor. Dr. Bowman.

MEMBER BOWMAN: Yes, thank you. I was just going to -- on this response, document to our request, I was just going to mention that I concur with Dr. Cloeren in terms of the response for the second question about providing the OHQ. That while I'm uncertain that an unvalidated OHQ to a physician would in fact invite assumptions by the physician that -- that all the information there was validated, which was the basis of the -- of the Department not agreeing with that request.

I do also agree with Dr. Cloeren that if those reports now do explicitly mention or address all of the relevant exposure information, including those on the OHQ that this mitigates the need for that -- that second aspect as Dr. Cloeren mentioned. Nonetheless, there are potential -- there is potential value in providing that OHQ for example to, if something was inadvertently missed. And I would think that a trained physician would be able to consider both the OHQ in the context of the IH report.

CHAIR MARKOWITZ: Thank you. So let

me make -- Steve Markowitz, let me make a comment. I think absolutely that the CMC should get the OHQ and any affidavit that the claimant submits about their exposures because that is the primary data. That is the closest we can get in the process to a physician actually discussing -- understanding directly from the claimant their own report about what happened to them during their life working at the Department of Energy.

So the idea -- I'm looking at the language here for instance that -- It says, if you can show six lines up. This is quoting now. "Providing unvalidated OHQ information to the physician would invite the physician to rely on unproven or inaccurate exposure data to inform their opinion..." I think, you know, the CMC getting the industrial hygiene report is a great thing, to get input from an exposure expert. But I can tell you, and you know, the other physicians here can comment, you know, when we see a person who has exposures and a health condition that may be related to work, we almost never get input from

industrial hygienists because most clinics don't have an industrial hygienist who interview everybody -- all the patients who come in.

And otherwise, industrial hygiene distillation or understanding of what happened to that person just isn't available. So we routinely make decisions about causation without having the industrial hygiene input. I think getting the industrial hygiene input is a wonderful addition, but it's by no means a substitute for hearing directly from the claimant about what happened to them. And the OHQ and any affidavit about their exposures is the way to get that. So I feel strongly that an OHQ should be provided to the CMC directly.

Now the issue of unvalidated -- that it contains unvalidated information or that it is "unproven" or "inaccurate" exposure data, well my response to that is that it is the perception of the claimant about what happened to them. They were there at the time and they are in the best position of reporting their own perceptions about

what happened to them. What job they had. What tasks they had. How they interacted with toxic materials. Whether that was dust in the air. Whether they were using PPE, most likely not, et cetera. And that is the primary information. I don't even know frankly how one would "validate, approve, or establish" the accuracy or inaccuracy of that experience because that was their experience.

And so I'm all in favor of the IH as the expert, looking at all the available information and giving their opinion. I think it adds a nice and very useful layer of information to the CMC decision making. But that it doesn't by any means substitute and should not deny the opportunity for that physician to get primary data directly from the claimant. I realize I'm repeating myself here a couple of times because I think it's a really important point. So comments or questions, Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: I want to concur with Dr. Markowitz, Dr. Cloeren, and Dr.

Bowman. I think that it is an important part of the record, the OHQ. You know, what we've always taught medical students -- and we write our notes in the form of so subjective, objective, assessment, and plan. And this is part of the subjective experience of the claimant. And it's a clear omission if that's not available to the physician. Physicians are trained to think in terms of, you know, what is the validity of this piece of evidence, whether it's a diagnostic test imaging or a patient's subjective report of their symptoms. That's what we do all the time. And I think not allowing the physician who's making the causation judgement to judge whether the evidence in the -- in the OHQ is valid or not is really hampering their ability to make an overall good judgement.

This is a judgement thing. It's not something that there's an objective measurement of exposure. The SEM doesn't even have quantitative measurements at one point in time, not to mention at every point in time. It's just

not possible. So the subjective evidence is an important part of the overall body of evidence.

MR. VANCE: And I'm going to add a wrinkle to this discussion. Okay? Because yeah --

CHAIR MARKOWITZ: This is John Vance by the way.

MR. VANCE: Yeah, this is John Vance. So one of the things that you need to keep in mind is that this is a process by which we evaluate evidence. All right? And there's a weighing methodology that the claims examiner has to apply. All right? So think of this question and then how would you deal with it as a claims examiner? So let's say you provide that occupational history questionnaire along with the industrial hygienist assessment to a physician, the physician chooses to ignore what the industrial hygienist is saying and go with what the claimant is saying. The claims examiner is going to look at that and say who has more credibility in establishing the appropriate level of exposure?

So if the physician is choosing to not accept what the industrial hygienist is saying and go with the claimants position, the claims examiner is sort of stuck in a situation with well, what do I do? And what they're trained in these situations is to say whose got the most authority to decide that question? And in this particular situation, it would be the industrial hygienist. So you also have to be aware of that process in our case adjudication sequence. How do you deal with these conflicts that might exist if you provide that kind of -- and I agree 100 percent -- very subjective information and a physician chooses to go with something that is provided by a claimant who is maybe amplifying information for their claim in such a way that doesn't mesh with the reality that an industrial hygienist looking at it would say is reasonable.

So you have to be conscious of that reality in our case adjudication process. And how do you deal with those contradictions that will occur? So I'm just -- I'm just adding that as

something that you're thinking about.

CHAIR MARKOWITZ: Yeah, Steve Markowitz. There are a number of people who want to make comments. Let me just -- thank you for raising that because that was the next --

MR. VANCE: Yeah.

CHAIR MARKOWITZ: -- sort of issue, which is what do you do with discrepancies between the IH report and the claimant? First of all, let me just say that I don't understand your use of the word "amplifying", but I don't really want to get into that.

Let me give you my view on this. This is a continuation of my previous comment. The ultimate -- in my view, the ultimate decision maker about the significance of the exposure to relation of disease is the physician, is the CMC. And they have enough expertise in exposure to understand exposure. So they sit there and they will weigh the IH expertise embodied in their report and they will weigh the OHQ or whatever affidavit of that exposure is. And then they will make their own

judgement decision about that.

So it's not -- And I understand there can be a discrepancy between what the claimant says and what the IH says. And the physician will be there and say yeah, I understand that. I'm going to weigh those inputs and then make my own decision. And then the claims examiner says okay, fine. That's what the CMC concluded looking at all available information, so anyway. Mr. Domina.

MEMBER DOMINA: Kirk Domina. I agree that it should be the physician because as being a worker anytime -- well 99 percent of the time, we don't have IH. And it's always, they go in after the fact. I've been involved with situations with people shoulder-to-should in a circle around a pit with lapel samplers, area monitoring, and still somebody ends up with ingestion of a radioactive and nothing shows up on any monitoring. And so the IH stuff wouldn't help you to begin with. And so you have to look at over history, we were never monitored. Yeah, they might do some of that now, but still, with our tank farms for instance at

Hanford, stuff happens daily with people being exposed. And it doesn't matter if IH is there or not. And so to -- when they put "not significant" and the guy is bleeding out of his nose or mouth or both, there's an issue like the members up here have said. The doctor needs to have higher credibility or however you want to word it because I'm not a wordsmith guy, the final say.

CHAIR MARKOWITZ: Mr. Catlin.

MEMBER CATLIN: Thank you. Mark Catlin. I guess as we discussed, the industrial hygienist having described in their report more of the detail of what they've looked at so the CMC can see that and the claims examiner can see that. It would seem to me that if the IH reviewed the OHQ and had some concern that there was information they didn't think was what was really happening -- if they had some question about the claim, then they should make that directly in their analysis that goes on so that -- so that everybody following it can see exactly what they're -- what they're disputing from the worker questionnaire to what

they're saying they think is reality.

Because I would imagine that most of the time they're going -- their answer is going to be well, we don't have any data in the SEN or anywhere else, but it could have happened that way. It's possible. And that would make it more clear to me because the reviews that we've done is often, there's a very broad statement that the IH has said there's like not significant exposure. It didn't happen.

And it's way too broad and we're trying to get this much more narrowed, I think. So I would say that if at a minimum, I think the OHQ should go to the CMCs, but I think there ought to be a specific requirement that the industrial hygiene review specifically mention if there's something in the OHQ that isn't -- that they think is invalid or is not -- shouldn't be considered that they specifically say that so then it can be discussed later.

MR. VANCE: Let me just add to that. I understand everybody's talking in the context

of our contract medical consultants, but these IH referrals and these IH reports are also provided to claimant physicians as well who may or may not have Occupational Medicine experience. So I just wanted to make that point as well. While many of our CMCs that are looking at causation are specialists in specific fields of medicine including Occupational Medicine, a lot of the physicians we deal with in the broader claimant population may not be Occupational Medicine specialists. So I just wanted to make that point as well.

CHAIR MARKOWITZ: Yeah, that's a good point. Steve Markowitz. Yeah, Dr. Vlahovich.

MEMBER VLAHOVICH: Kevin Vlahovich. I would just agree with all my colleagues here that it would be good to have the IH report, as well as the OHQ. And if there's a discrepancy or the CMC decides to weigh one over the other, that they provide a decent rationale for that, that the claims examiner could evaluate.

CHAIR MARKOWITZ: Other comments?

MEMBER CLOEREN: My hand's up.

CHAIR MARKOWITZ: Oh, yeah. Dr. Cloeren, I'm sorry. Go ahead.

MEMBER CLOEREN: That's okay. You know, a lot of thought on I think it's very unlikely that you would see very many cases where a physician just out of hand rejects the industrial hygiene opinion and goes in favor of the claimant's story. But I think it would be -- That might be an indication for an interview. And so maybe the -- and since the industrial hygienist had the opportunity to interview the claimant anyway, maybe it would be a useful procedure in those rare cases that the claims examiner and the industrial hygienist, maybe even with the doctor, interview the person submitting the claim.

CHAIR MARKOWITZ: Other comments or questions? Let me just make one final comment. One advantage to I think the CMC having access to the OHQ is that assuming -- in the instances in which the claim is denied, the letter that communicates that decision could state that yes,

the examining -- the expert physician would look at this -- looked at industrial hygiene input, but also looked directly at what the claimant said in their OHQ. Looked at that. Looked at all available information and you know, made this recommendation of denial -- not recommendation, but guidance or decision or judgement about denial. And that would help communicate to the claimant that they're being heard, you know, by multiple parties as part of the process.

Okay, so let's -- I think there's also an information request regarding the IH. I'm not sure we've covered that. Yeah, Dr. Cloeren.

MEMBER CLOEREN: Marianne Cloeren here from University of Maryland. So another related request was that we had the opportunity to have a group of us from the Board meet with a representative group of industrial hygienists employed by the Department of Labor to perform this work to just talk through with them the questions that follow, you know, how they're actually using available data, you know, in conjunction with their

own expertise to apply the manual -- procedure manual required exposure designations. You know, how our previous modification -- yeah, proposed modifications to their reporting affects their workload. How to make a determination about the level of exposure. How they apply exposure determinations when it's not a dosed response kind of a toxic model, but something that is not really dose related like allergy or sensitization. And then, you know, considerations of how the terminology related to significant retrievement, you know, beating around for the last couple of years.

And so the Department responded to each of these questions, but our request was actually for a discussion with the industrial hygienists about how they address these things. And kind of the bottom line to the request is at the bottom that it's a maybe that if we could help develop a clear framework for the discussion in advance with agreement to discuss pre-submitted questions or lines of inquiry that we may be able to get such

a discussion. So I guess this is a to-do for us to help -- to propose such a framework with pre-submitted questions, which I think we already have five pre-submitted questions.

CHAIR MARKOWITZ: So yeah, Mr. Catlin.

MEMBER CATLIN: No. As we start to discuss this, I think -- I know I participated in the webinar that the IH's did. I found it incredibly helpful. And so the possibility of having a back and forth discussion with them, I think would be incredibly valuable for us on the Board.

MR. VANCE: Yeah. This is John Vance. I agree. After our meeting in Columbus with the Board members, I felt that, that was very useful and it was -- and we agreed that it was something that we thought could be replicated for the industrial hygienists. So our response is exactly -- exactly that. That we think it would be useful as long as we have a clear understanding about an agenda and the questions that would be presented. And our group of industrial hygienists is our two

internal federal industrial hygienists, yeah.

CHAIR MARKOWITZ: So those are the national office IH's. Right?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay. So the question for the Board members who have been thinking about this. Most of -- I mean the IH reports are really done by the contractor industrial hygienists. And those are then, I believe reviewed by the national office IH's. So the question I have is the Board request to also include one or more industrial hygienists from the contractor in this discussion or limit it to the federal IH's?

MEMBER CLOEREN: I think our intention when we drafted this is that we would include the contract -- you know, at least the representative sample of the contract industrial hygienists as well if that's possible.

CHAIR MARKOWITZ: Yeah. Yeah. Steve Markowitz. Let me just say that I think that would be really useful because those are the people who

are actually writing the reports. So to be able to understand how they think about things and how they regard -- how they define the word "incidental" for example would be really useful.

Mr. Catlin, did you want to make a comment?

MEMBER CATLIN: Yeah, I just -- in thinking about that, I agree with the idea of talking to the -- to the contract IH's. I thought the webinar gave me the sense that if we could have a conversation maybe first with the national office two IH's that, that might be a good start. And then follow that up with a -- with a discussion with the contract IH's.

(Simultaneous speaking.)

MEMBER CLOEREN: I'm sorry to interrupt, but are there recordings of the webinar because is missed it.

MR. VANCE: No, we don't do recordings.

MEMBER CLOEREN: Okay.

MR. VANCE: But the presentations that

are -- that are done, the actual PowerPoint presentations are available.

CHAIR MARKOWITZ: Steve Markowitz. So how should we proceed? I know that the Department wants a written description of kind of the kinds of things we're interested in. Which board members actually would want to participate in this? I see Mr. Catlin and I see Dr. Bowman, and there may be others. So we'll define this afterwards. So we'll submit, I guess in the information request mode, some of the details. And if there aren't sufficient details in there about what the request is, then just -- I'm addressing this to Mr. Vance, Mr. Novack -- just give us feedback about that. And we can provide you with additional information.

Dr. Cloeren, was there any other aspect of this that you -- of this response to the information request that you wanted to focus on or review?

MEMBER CLOEREN: No. I mean, I think it's positive and it's moving in the right

direction and I'm happy.

CHAIR MARKOWITZ: Okay. Kevin, if you could just scroll up to the second page, Item No. 3. Yeah. Oh, great. Okay. Okay, Doc. Thank you. So I just want to point out the Board has previously discussed this. This is a question and response to a question: "How they make determination and exposure was incidental or was more than incidental, but less than significant." So this is a really important distinction made. And I think kind of really introduced in the last couple of years in the program.

And then there's a detailed response that we don't need to discuss, but I just want to point out that there's, from the Department, an effort to list the factors that go into their decision making about incidental versus significant. So it's worth for board members to take a look at this because this really, I think goes to the heart of a question that we've had for a couple of meetings. We don't need to review it here. I just want to point it out as a matter of

emphasis. Dr. Bowman.

MEMBER BOWMAN: Yes, thank you. Aaron Bowman. I did want to -- I had reviewed this response and including Item No. 3. I thought that the information that is used all seemed very reasonable to me. And I believe meets our standard of practice for assessment of exposures. But what I thought was not in the response that would potentially be something that would come out in a conversation is despite this, I think good list of information that informs the determination, what the Board was really interested in asking is what is that dividing line between what defines incidental and what defines any level of significance? And that is absent from this answer, but is probably something that there's not a simple text-based answer they could give.

And that's where the conversation, I think would be important. And so I think that's the reason why having that conversation is so essential. And since it's the contract IH's that actually are making that determination, that's why

at some point, whether or not it's the first or subsequent meeting, having a representative sample of those contractors would help the Board to understand -- to understand this better.

I wanted to also comment if there was no other -- in response to No. 2, whether or not the recommended templated table, how that was working out. I was very pleased to see that it's not had a significant negative impact on workload. That it's not hindered the timely completion of reports. And in fact, that it appears to be a useful addition, the templated form. So I was happy to see that. I had some other comments and a few other responses, but I see Kirk's card went up, so maybe we want to talk about these before moving on.

CHAIR MARKOWITZ: Mr. Domina, do you want to comment on something that Dr. Bowman said?

MEMBER DOMINA: Well, under No. 3 if you could scroll down to some of those bullets -- a couple of those bullets, I've got a problem with some of those answers about when you're in

production and it says information about an employee's training or certification to work with a particular material, let's be out there on a back shift on a week on the graveyard if something goes south, none of that crap counts. You know? And then trying to put that onto the worker that it's his fault that he was exposed to something when it's all hands on deck, that's very, very -- I can't think of the right word. I mean -- And then about protective measures and occupational safety protocols, there was none. And everybody in this room knows that.

CHAIR MARKOWITZ: Okay, thank you. Dr. Bowman.

MEMBER BOWMAN: I was just going to say in consideration and of this bullet, at least I wasn't reading into it that the weight of that bullet, I think, Mr. Domina, you might agree, that if a worker was not trained on something and was there, that the information about the lack of training would be helpful. And so I looked at that as just one element of the totality of evidence

from which an IH might make a determination. So I thought that little training is an element of it. And I would think as well, the conditions on the ground, which are in fact are covered by other bullets here should also inform that decision. So I think as long -- as long as it's not over weighted in a way as I think you were describing, that it can be an important part of the determination.

MEMBER DOMINA: Kirk Domina. Because the difference today compared to when we were operating in my opinion, some of this stuff that you would not go do. But back when we were operating, crap happens. You get after it because of the implications can be a lot worse if you don't.

CHAIR MARKOWITZ: This is Steve Markowitz. The way I interpret this list we're looking at is that this is the universe of things we would take into consideration. And the knowledge that in my instances, perhaps most, we don't have a lot of this information actually with

respect to individual claims. I mean if it exists, we'll look at it. So the question is, you know, where the rubber meets the road. And that's where I think we need to interact with the industrial hygienists to see how much of this they actually use -- actually have with respect to individual claims.

I have a practical question. This Board's term ends mid-July and at that point, a new board takes over, presumably at the next board meeting the Fall of October or November. So this meeting with the industrial hygienists if there's turnover in the Board, you know, when should we try to schedule this meeting? Particularly, we're talking about two -- maybe two meetings initially with the national office IH's and subsequently with the contractor IH's. So the question is should this request -- should this meeting occur in the next two months during this board term or be scheduled for the early Fall before the next board meeting?

MEMBER BOWMAN: This is Aaron Bowman.

I would think for continuity, it would be important to happen potentially after the new board is in place so the Board members are part of that interview and then is no longer a board member. I don't know if the continuity and the information would be disrupted. So I would lean towards it being after.

CHAIR MARKOWITZ: All right, okay. Any other input into this? Yeah, so we'll figure this out and make it part of the request. And if anybody has any further thoughts, they can send it in by email or over the next day and a half, that would be great.

So Dr. Cloeren or anybody else on the Board, anything else on this agenda topic?

MEMBER CLOEREN: Not from me. Aaron, did you -- Dr. Bowman, did you have something else that you wanted to say about this?

MEMBER BOWMAN: Oh, I was just going to -- just in putting some context into what else might be a part of those questions in a conversation with the IH. I thought there was also elements

of the response for items No. 4 and No. 5 relating to one, the role or lack thereof of dose responses and effects of chemicals on health like comparing allergies or sensitization versus more direct toxic effects.

I thought there was -- there is room for more understanding of that response as well in that conversation. As well as in Item 5, sort of the difference between what incidental and significance might mean to different groups. I think that as well is a -- is something that would be included in that conversation. Just to point out when we do this, I think we might highlight the elements of Item 4 and No. 5, as well as 3 that we talked about would be a part of that conversation.

CHAIR MARKOWITZ: Yeah. Steve Markowitz. So I would ask the working group actually to try to be as detailed and specific and possible in this information request thinking that, you know, we are handing this over to a new board -- a new board term. And there needs to be

as much continuity as possible. So we need any detail. Speaking of which, who is on this working group by the way? Mr. Catlin, Dr. Cloeren is, and --

(Simultaneous speaking.)

MEMBER CLOEREN: Dr. Bowman and Van Dyke.

CHAIR MARKOWITZ: Okay. And Dr. Bowman and Dr. Van Dyke's not here today, so we'll see about that. Okay, great.

MEMBER BOWMAN: Dr. Markowitz, as a point of clarity just so I understand sort of the transition from the current board to the new board --

CHAIR MARKOWITZ: Right.

MEMBER BOWMAN: -- if a recommendation or request is made from the current board, that information is then available or sent to the incoming board. Is that -- I'm just trying to understand.

CHAIR MARKOWITZ: Yeah.

MEMBER BOWMAN: I just want to make

sure that the nature of the request and it seems like we're communicating with ourselves as a board, as well as the Department and I'm just trying to understand how that happens.

CHAIR MARKOWITZ: Yeah. Well, you know, the Board -- this Board still exists until mid-July. We're going to shape this -- submit this request prior to the expiration of this board. So we will, you know, still control that and try to be as detailed and helpful as possible. Does that answer your question?

MEMBER BOWMAN: I guess it does in part. The Board coming in would then have access to all those -- all the information of the current Board?

CHAIR MARKOWITZ: That's a question I think for Mr. Vance.

MR. VANCE: The answer is yes. If the Board makes a formal recommendation to the Department of Labor, we're going to respond regardless of who's on the Board. So it takes a while for us to respond, but we have a timeframe

for that. If the Board submits a formal request for information, we're going to respond to that and it will become a part of the official record for this Board or the next Board. And I know that Carrie will maintain that information because some of it's not available for public dissemination, but it will be available for the Board, whether it's this current Board or any future Board.

CHAIR MARKOWITZ: Okay, great. Thank you. Okay. So Dr. Cloeren, we now see you on big screen I'm happy to say. Uh oh. We just lost you on the big screen. Now we're back to some standard slide. So it's a quarter of 11:00. I think we should take our break now before we start into the next topic. So let us come back at 11 o'clock.

(Whereupon, the above-entitled matter went off the record at 10:43 a.m. and resumed at 11:02 a.m.)

CHAIR MARKOWITZ: Okay. So next we're going to discuss the recommendation and information request that the Board made with respect to the contract medical consultant. Mr.

Vance, is that what CMC stands for, contract medical consultant?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Thanks. I reserve the right to botch that any number of times -- any number of times today. Okay, so hopefully everybody on line can see the slides.

Next slide. So first, we'll deal with the information request. For those of you online if you want to actually find this request and the responses, this is -- this is from an excerpt from our web page with an arrow pointing out. And the briefing book material is where you can find the longer version of what we're going to summarize here.

Next slide. By way of reminding the Board why we're talking about this, these are the six charter tasks of the Board given to us by, I guess Congress actually or maybe the Department, whichever -- the Department from Congress. But in any case, No. 2 and No. 4 are the tasks that we -- under which we requested this information

and provided this guidance. And I don't think I need to read this. But just to establish why it is that we're talking about these things.

Next slide. So we asked for some information about the CMCs. This is really interesting and actually, you know, the Board's been going on for quite some time. It made me wonder what took us so long to ask for this information. But very interesting, the contractor has 338 CMCs actively under contract. Many specialties, 32 specialties in Medicine and related disciplines. And I put the most common ones, are in Occupational Medicine and Cancer. And the third is in Ophthalmology, which I found a little surprising. And of those 338 CMCs, 97 of them produced reports for this program in a recent year. So a fair number of CMCs are involved in this.

Next slide. And then over a four year period of the CMC reports, a total of 8,860 reports or 22 -- roughly 2,200 per year. So a lot of CMC activity, an important part of the program. And

then it's broken down by different types of reports. And this is -- this is interesting because we never quite knew the balance of the relative CMC requests, but over three quarters are for causation analysis. And the majority of the rest are for impairment. And some are -- the diagnosis, that has to do with clarifying the diagnosis. I guess the claims examiner is a little bit unclear about what the medical diagnosis is and asks the CMC to weigh in. And there are various medical specialties, I think which would be especially useful for that.

Next slide. And then of these 8,000+ reports in this four year period, 2020 to 2023, causation was as I said more than three quarters, 6,800 reports done by 90 CMCs. So a large number of CMCs involved. But interestingly, there are a few -- relatively few CMCs, which really bear the burden of -- or have the opportunity to produce reports. And there are four CMCs who are producing over 500 reports each. I think that's over a four year period. And they account for almost 40

percent of all the reports. And then if you look at the top ten, you know, most frequently involved CMCs, those producing over 200 reports in this time period, it's almost two thirds.

So a lot of the CMCs, but it really -- much of the work really focuses on a handful or two handfuls of CMCs. So that's -- I find that interesting, particularly if you think about assessing the quality of the CMC report. It would seem disproportionately important to assess the quality of the most frequently used CMCs because they're the ones with the most impact on the program.

Next slide. And then for impairment, 1,200 reports in this four year period, 13 CMCs including one actually who did almost 400 reports, so very influential in the process. I'm not suggesting there's anything wrong -- improper or wrong about this, I'm just saying that this is -- this is the way that it's been structured by the contractors. Fair enough. And then four of the 13 also did a lot of reports and account for three

quarters.

Next slide. We asked whether the Department has information on the CMC opinion outcome. For instance, in causation when the CMC makes their -- experiences their opinion whether their opinion is about lack of causation or yes, there is causation because it would be -- it would be interesting to look at that by the most frequent CMCs. You'd expect, you know, roughly similar percentages of causation, yes vs. no according to different CMCs. Anyway, that information is not available. So the only way to get that information would be to look at a sample of claims by CMCs and then just look at what their ultimate, you know, recommendation or opinion is on a set of given claims. That is something that the Board could do or the Board could request.

And then the claims examiners have asked for clarification from the CMCs in less than 2 percent of their reports. And that's interesting because that means that the CMC product has clarified the decision making for the claims

examiner without further back and forth with the CMC. I think there's a mechanism if the claims examiner is still undecided after receiving a CMC report, they can ask for a referral report. They can go back to a separate CMC, I think, to get an additional opinion, but that occurs with some frequency, but that's not what we're discussing here. We're discussing when the CMC issues a report, it's been -- it's been pretty clear for the claims examiners.

So any comments from board members on these data that -- this information that we've gotten from the Department?

And by the way, Dr. Cloeren, just so you know, for some reason we can't see you anymore. Oh, there we go. You're back. Great. Okay. Is your hand up? No, okay.

MEMBER CLOEREN: The data is very interesting.

CHAIR MARKOWITZ: Yeah.

MEMBER CLOEREN: It's very like the concentration of reports done by a small group.

CHAIR MARKOWITZ: Yeah.

MEMBER MIKULSKI: Just curious.

CHAIR MARKOWITZ: Yeah, Dr. Mikulski.

MEMBER MIKULSKI: Just curious, the majority of those reports, those -- yes, it's -- that's on. Do you know the distribution of specialties and those most --

MR. VANCE: Yes. If you go back to our written response, I think there's a chart that breaks down the actual numbers per specialization. So in the actual written response we provided to the Board, it's a pretty extensive chart if I recall correctly. So that would be our --

CHAIR MARKOWITZ: Right. Yeah, this is -- I don't know -- We don't really have access, but almost all the causation reports are done by occ med physicians.

MR. VANCE: It's in our February 29th response to the Board.

CHAIR MARKOWITZ: Right. Right. Yeah. And the very active CMCs in causation are almost all Occupational Medicine physicians with

the exception of one Pulmonary physician who does a lot of causation reports. But otherwise, they're all -- I'm sorry, there are two Pulmonary physicians who are quite activity on causation reports. The rest are Occupational Medicine physicians who are doing the vast majority.

MEMBER MIKULSKI: So the next question. Are any of those impairment ratings done by the same physician that does the -- that opines originally on causation?

MR. VANCE: I don't know. I don't have a clear answer for you, but I don't think there would -- that would occur simply because the -- the causation and the impairment are two completely different topics. I know that our contractor tends to utilize the people that have the requisite training and certification to do the impairment rating assessments. And that might not necessarily be one of the Occupational Medicine specialists. So I can't commit to any firm answer, but I can say unlikely that it would occur because it's two different topics. More of it would be

occurring at different temporal points in the case. Causation would be something that would be pre-adjudication and impairment assessment would be after we've accepted a case and they're assessing whole person impairment.

CHAIR MARKOWITZ: Yeah. Dr. Vlahovich.

MEMBER VLAHOVICH: Kevin Vlahovich. That's a very small number that were asked for clarification. Do you know what the most common reason for a clarification would be?

MR. VANCE: It can be really anything. I mean when we do our assessment and auditing for that, it's generally going to be something where the physician has provided some sort of contradictory information that's not very clear. Or the ones I've seen are where they're rendering an opinion and it's like -- it's describing something that's not very clear. Like no, I disagree with this and they don't really explain it. So then we go back and say can you all elaborate? Or it could very well be that there's

some new information that came in, we're going back and asking for the doctor, hey, we've now received this. Can you also now consider that information as well?

CHAIR MARKOWITZ: So what we have on the -- Steve Markowitz, what we have on the screen here actually is part of the response from the Department of Labor dated February 29, 2024. And it shows you the different types of service, so most of them are -- These are CMC reports, most are causation. The next is impairment as I mentioned before. And then you get the clarification of diagnosis type of report. And then some referee causation. There is where it's still not clear to the claims examiner the issues of causation. So they refer to a second CMC, but you can see 268 compared to 6,530 reports, it's really a small percentage that go to referee. And then there's two second opinion and then a few wage loss reviews.

But if you could actually scroll down, Kevin, because there's a big table that addresses

individual CMCs and their contribution. And just to really give people an understanding. So here you see by individual CMC during this four year period, how many reports they did. And you can see in the second column is their specialty and then the various types of reports. So if you scroll down a little bit, Kevin, you'll come to some of the -- Okay, here we go. So CMC 15 did 741 causation reports and I think the fourth column is impairment. I'm sorry, no, it's clarification. The impairment is the sixth column. So that person also did 34 impairment -- We can't see the -- That's okay. Just keep scrolling down just to give a sense of the concentration. CMC 23 did 336 causation reports to occ med doc. Scroll down further please, Kevin. And you'll see there's a Pulmonary physician who appears, CMC 45 Pulmonary physician produced 368 causation reports and also a lot of clarification of diagnoses reports.

Okay, any other comment or questions from this? Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: George Friedman-Jimenez. Quick question. The 6,530 filed for causation, is there a database that has information on those reports? And could we find out what information you do have so that the Board could put together a reasonable request for a study that we could do to look at the causation decision so we know what data are available that we could work with?

MR. VANCE: Yeah. This is John Vance. Yeah, we don't maintain a database exclusive to the CMC reports that are generated by QTC. We would have to do it through some sort of mechanism of evaluating cases and then determining which cases had a CMC opinion during what timeframe? And then extracting those from the files. Those could be produced for the Board, but it would have to be a discussion about the specific parameters of what it is that you're looking for. And then figuring out with our data analytics folks what we could do to produce that information.

MEMBER FRIEDMAN-JIMENEZ: So could you

give us a general idea what type of information you have that we could request?

MR. VANCE: I mean so if you're talking about our case adjudication management system and our OWCP Imaging System, what we could do is we could identify cases where there has been a CMC review. We could identify that case and obtain either the case file for the Board or we could produce the report associated with cases that meet particular parameters. And the Board has asked for that kind of thing in the past and we produced that. It just depends on the parameters that you're looking for. But if you're asking if we maintain the central database of the CMC-produced reports, we do not. And QTC does not maintain that either. This information is just their statistics on what they've produced, but they wouldn't maintain those reports either.

MEMBER FRIEDMAN-JIMENEZ: Thanks.

MR. VANCE: Okay.

MEMBER CLOEREN: I have a question.

CHAIR MARKOWITZ: Yeah, sure. Go

ahead, Dr. Cloeren.

MEMBER CLOEREN: Yes, Marianne Cloeren. I have a question about the referee process in the FECA program, at least the way it used to work when I was working with it. Referees were done by impartial docs that were outside of the second opinion contractor. And they typically were done if there was a difference in opinion between the treating doctor and the Department of Labor's contract doctor. They would go to a referee that was outside of the contractor group. And I think there's something to be said for that. I'm curious whether, I guess one, the reason for the referee does tend to be a conflict between the QTC contract medical consultant and a treating doc or maybe a Former Worker Program doc or you know, something outside the Department of Labor. That's the first question.

And the second, whether you've looked at the way the referees have gone? In what percent of the time do they agree with other, you know, the CMC doc versus going the way of the outside

doc in case there is some kind of a bias coming from the same company?

MR. VANCE: Yeah. This is John Vance. We don't use referees that are outside the contract. So keep in mind, each one of the CMCs is basically their own independent contractor to QTC. So we feel like that produces enough objectivity to allow us to have a referee who is disconnected from the initial conflict. And the only reason that you would get referee would be a disagreement between a claimant's position and an initial contract medical consultant. And that disagreement has been evaluated by the claims examiner and they're unable to clearly weigh one opinion as having greater probative value or not. And so therefore they seek out the opinion of a referee.

The referee would just be another CMC physician in whatever specialty they feel best responds to the issue under contention. That doctor would have no connection with the case. They wouldn't allow a referee that's been involved

with that case in the past to be rendering an opinion to resolve a conflict of medical opinion. But it would be done under that QTC contract, so that referee will just be another doctor in the contract that can conduct the referee evaluation.

Then your second part of the question was speaking to an analysis of the referee opinions. And the answer is we've never conducted any kind of analysis to determine what the percentile of agreement with a claimant physician or a CMC has been in the past. It's really going to depend on the circumstances of the issue under contention and the facts of the case and the interpretation of the referee to the competing physicians of the doctors that had been in conflict.

MEMBER CLOEREN: So would it be possible to get a report of the ultimate decision in cases that went to the referee, so we could see sort of the breakdown of accepted versus denied? Because I think we could then make assumptions about which doctor was saying what.

MR. VANCE: We can always get any kind of information. It's just a matter of how it -- how the question is formulated and what specifically you'd be looking for. But yes, it would be very similar to what I was just discussing before. We would have to identify the cases that had a referee medical examination performed. We would have to identify and extract those reports out of our imaging system to produce them for the Board. So you would just want to know, you know, what was the outcome. And then we could assemble those reports. So it would just be an information request from the Board asking for referees based on whatever parameters that you wanted to include.

MEMBER CLOEREN: Okay, thank you.

CHAIR MARKOWITZ: So Steve Markowitz. So Dr. Cloeren, should we add this to not making a decision necessarily about an information request, but do you want to add this to our kind of list of things we're going to at least think about in the future?

MEMBER CLOEREN: I think it's worth

having just a simple breakdown of accepted versus denied in the cases that went for referee. Because if it's like 99 percent denied, then it may be worth kind of looking at them, but it probably isn't going to be that.

CHAIR MARKOWITZ: Right. Or one could look at a sample of the -- we're looking at over this four year period, 268 referee causation opinions. A sample could be looked at for what's going on.

MEMBER CLOEREN: A sample would make more sense once we have kind of the numbers.

CHAIR MARKOWITZ: Yeah.

MEMBER CLOEREN: Because you know, if it's something reasonable -- you know, something we decide is kind of like reasonable, that there's no reflection of organizational bias, I guess, then there may not be a need to review the samples.

CHAIR MARKOWITZ: Yeah, okay. I mean it's interesting because the decision maker here, I think is the claims examiner as to whether a referee. And so it depends on the claims examiner

understanding of the first CMC report and whether -- whether they want to then ask for a referee report. So it would definitely be a select population, yeah. Okay. Anything else?

MEMBER CLOEREN: Yep. Cases in which the -- it was questionable enough that the claims examiner couldn't assign, you know, that this is the best probative value or whatever the words are. You know, that this one makes the best case. That this is the most persuasive opinion and so they want to have a third doc kind of be the tiebreaker. So they are kind of special cases. I think most of the time the claims examiner would be able to make a decision, you know, just based on what's in front of them.

CHAIR MARKOWITZ: Okay, so let's move on. If you could go back to the slides, Kevin. So the Board made a recommendation at our last meeting regarding these contract medical consultants. And I'm just waiting a moment. Yeah, there we go. If you could -- Yeah. And it should be the next slide. And to summarize the

recommendation, it was that we recommended that there be peer review of a quarterly sample of the CMC report. Peer review meaning review by physicians or healthcare providers to examine the validity of the CMC reports. Again, a sample of them. And that, that peer review be conducted by a small panel of experts who have specific expertise in causation and impairment.

Just to remind the Board and others, Occupational Medicine, a very broad discipline. I've been doing it for a long time. I have no expertise in impairment. You would not want me to review a person's file to determine their impairment. I'm not really trained in doing that. There are impairment docs among Occupational Medicine physicians and others who are expert in that. So the idea that an Occupational Medicine expert covers all areas, you wouldn't want me as your corporate medical director because I don't know what they do. You wouldn't want me operating your occupational injury clinic because I don't really know how to treat patients for acute

injuries.

On the other hand, there are occ med docs who specialize in causation of diseases, rather than injury. So this recommendation had to do with finding some physician experts in these particular areas to help with review of the quality of the -- sample of the quality of the CMC reports. So this recommendation was not accepted by the Department.

Next slide. I would say it was -- We were -- We were gently rejected because using a phrase from the response, the "The Department is committed to working with the Board to determine a process to review medical opinions." So I interpret that as the door isn't entirely closed. And that's in part why we're resuming this discussion about this.

So I want to go point by point for Board input into the remainder -- Next slide please -- the Department's response -- to see whether there's any room for a discussion about this. First -- Their first point is that the CMCs are experts.

They're board certified. They're required to be board certified in their 30 odd specialties, so that's a good thing. And to the way of default thinking as a board certified expert in -- board certified physician in a given area that they're expected to produce an accurate opinion. And that's a fair way to approach the issue.

Secondly, the claims examiners can judge whether medical reports have well rationalized opinions. The quotes here are from the letter, but it's also from the procedural manual. And that they -- the claims examiners can tell which letters "offer a compelling justification." And if we could go to the next slide, I just want to complete the response and then we can go back and discuss the individual points.

The third point is that given variation in legitimate medical opinion, identifying a correct opinion can be challenging. How does an expert panel differentiate between an incorrect versus a normal variant opinion. Normal variant

opinion is opinion kind of within the broad range of what, you know, how doctors consider a thing and they're legitimate differences of opinion. So how do you figure out whether a CMC report is outside of that range of sort of normal variation and is producing an opinion that really doesn't correspond with what we know about the given problem.

And then finally, the Department of Labor requests examples from the Board that a problem exists within the CMC reports kind of proves to us there's a problem there that we need to address.

So let's go back to the previous slide and I want to open the floor up to discussion from board members about -- about these points and then we'll move to the next slide and discuss those points. By the way, Dr. Friedman-Jimenez, your card is up. So George, if you want to put your card down. Otherwise, I'll be constantly calling on you. Oh, yeah. Go ahead, Dr. Vlahovich.

MEMBER VLAHOVICH: Kevin Vlahovich.

So the CMCs are experts and board certified. As Dr. Markowitz said, if you choose an Occupational Medicine physicians, that's a broad category and I might not know anything about eyes. Fortunately there are ophthalmologists who get called on. But I think it would be important to review that and make sure that even though they're Occupational Health, that it's the appropriate field.

CHAIR MARKOWITZ: Steve Markowitz. So Point number 2 here is something I really get stuck on, which is the claims examiners who have expertise in various areas are generally, don't have health backgrounds, much less a position or advanced practitioner.

And that the claims examiners can accurately judge whether the medical report they get, whether it's CMC or from, for that matter a person physician is expressing a well rationalized opinion.

That they can figure out whether that rationale that's provided actually accords with accepted medical opinion or not. I don't see how

a non-trained, non-medical person can do that all the time.

I can see how they can recognize that there's more than just a simple expression of opinion. I can see how they can look at the various elements of that opinion, and whether it makes some sense. The chest x-rays showed so and so, and it's compatible with the results of the spirometry. And all that is sensibly related to exposure to X.

But whether that physician is actually saying the right thing or not, I don't really get how a claims examiner can really do that, can decide whether a justification is compelling or not.

So if there are other Board members who can help me understand this, because I've gotten stuck on this in the past. And I think it's interesting. Because we'll get into the quality assessment process a little bit, to the extent that we can.

And so clearly there's a lot of attention paid to quality. But there's this

omission about, in the various aspects of quality that just, there's this hole that just isn't really filled.

And I'm, so I don't really understand the program's approach to why this is an opinion. By the way, which I should say, I'll show a little bit.

There was a previous attempt actually by the Department to address this. But anyway, open the floor for comments or questions, or -- Okay. That's good. I clearly am solving all the problems here. Oh, Doctor, Mr. Key.

MEMBER KEY: Yes. Dr. Markowitz, I totally agree with you. We've had cases where a claimant has had well rationalized opinions by their either personal physician or a occ med doctor, with medical evidence and articles submitted.

And the claims examiner has remanded the case or denied the case. And issues a remand without any direction of what the next step the claimant needs to do in order to process their claim, and appeal that decision.

So, yes. I totally agree. They are not trained, in my opinion, nor am I to take a well rationalized doctor's opinion on a claim with related nationally recognized articles through the medical community and deny it. Thank you.

CHAIR MARKOWITZ: Ms. Whitten.

MEMBER WHITTEN: Dianne Whitten. I totally agree with you. I've seen several examples from claimants that have brought me their decision letters, and from files we've reviewed in the past as Board members that it didn't appear to me that the CEs had the knowledge, and education, and training to make those kind of decisions, and to disregard the claimant's doctor's claims about the evidence of exposure and causation.

CHAIR MARKOWITZ: Thank you. Could you put up the next slide, Kevin? So, moving on to the points here. Given the variation in legitimate medical opinion, you know, how would an expert panel actually differentiate between an incorrect opinion and something that falls within accepted variation?

Any comments on this? Dr. Vlahovich.

MEMBER VLAHOVICH: Kevin Vlahovich. In reviewing some of these reports it would be important to look at any citations that are produced. Because you could rationalize anything with cherry picking citations.

So making sure that they're from legitimate sources, and they're well established opinions would be an important part of the review.

CHAIR MARKOWITZ: Other comments? Dr. Bowman.

MEMBER BOWMAN: I'm just going to comment that in general this issue raised here in Point 3 that's on the Board, about how to distinguish.

The most in general across the, sort of the scientific and from what I've seen medical, a peer review system is identified as the most accepted method with which to validate accuracy, and importance in impact of work, and so forth.

And so I don't know of a better mechanism designed beyond peer review that would be

definitively better in discerning whether or not opinions expressed represent a, within a normal range, or would be accepted by the community at large, or are unitary opinions that would differ from the community.

So I think peer review, the suggestion we made of peer review is the best suggestion to do, to evaluate this.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: I concur that peer review is the best we got. It's not perfect. It's not even very good sometimes. But it is the best that we have.

And, you know, you're looking at American science, not to be a fanboy for the NIH. But peer reviewed science in the United States is really top notch.

And one of the main reasons is because of the peer review, where you have a group of people that know about a subject talking, arguing, having different opinions, bringing out the strength and

weaknesses of each argument, and coming to sometimes a consensus, sometimes a, you know, a five/four decision.

But the peer review process has a long track record of approaching the truth better than other systems. So I agree with that.

The call for an objective measure of accuracy, I think, you know, this is an admirable request. And I think there is a way to do this. You may not want to hear what I have to say.

But the objective measure of whether the CMCs are over calling causation or under calling causation on a given outcome could be approached epidemiologically.

In other words, we have measures of the prevalency incidents of certain diseases, and of what percent are work related. And these have been studied epidemiologically again, you know, with imperfections in all the methods, the measurement of exposure, and the statistical methods.

But we have some reasonable estimates that are objective. They do meet that criterion

that they're objective.

We could compare, or you could compare the expected prevalence of a certain outcome with the prevalence that you're seeing in your population of how ever many hundred thousand workers.

And you know something about their exposures. Maybe not as much as the epidemiologic studies, maybe more. But you could come up with an objective measure.

But I would hazard a guess that in many of the outcomes you're going to find that you're compensating a much lower percentage than have been estimated epidemiologically.

We've seen this in New York City with occupational asthma. The last recorded year there were 24 cases of occupational asthma in New York City that were compensated by Workers Compensation. And epidemiology predicted 5,000 to 10,000, you know.

And they're just not being recognized. They're being denied in compensation. There's

all kinds of problems. So you'd have to deal with methodologic issues.

But there is an objective way to do this. It would be a big ongoing study, sort of a machine learning process that you could with the data that you have.

It would probably be relatively expensive. And you'd run the risk of finding out that you're compensating a much smaller fraction of the cases that are out there than what you had expected. But there are objective ways of doing this.

But next to that I think the expert panel is the best way to go about, where you have an expert in toxicology, an expert in occupational medicine, and expert in industrial hygiene, exposure measurement, all sitting together and discussing a particular case.

Obviously not for every case, but for the ones that are problematic, for which there's a disagreement, or some issue in the causation judgment.

So that's why I think we recommended an expert panel. You know, they're not going to be able to say it's absolutely right or it's absolutely wrong in an individual case.

You could do it epidemiologically, as I said. Big project. But in an individual case I think the expert panel could judge these individual cases.

In New York we have this, the Workers Comp Board has an expert review panel that does review individual cases that they send to a so-called impartial specialist, who's hired to settle the cases where the Judge, and the treating physician, and the independent medical examiner are unable to come to a conclusion.

And it's worked fairly well. You know, nothing's going to be perfect. And ultimately prevention is the answer, rather than compensation. But that's a whole other Board, other discussion.

So that's my opinion. I think that you can approach it. And that's why the Board has suggested the peer review expert panel process.

Now we don't have the data for Number 4 to say how big a problem, or even if a problem exists. You know, we've, the small number of cases I've reviewed, many of them have been great. I mean, the well rationalized opinion did agree with what I thought about the case, you know.

There have been a few that there were errors that we could identify in, you know, information that was not considered, or something like that. But I think it would be useful for us to do an ongoing case review with this question in mind. You know, is there a problem? And if there is, how big is it or how small is it?

And I think we could use this small expert panel that you have on the Board to do such a very small case review just to estimate, is there a problem, and if so what is the magnitude of it?

CHAIR MARKOWITZ: Steve Markowitz. You know, I don't think the issue requires a special survey. I think it should be built into ongoing quality assessments.

It just, it may or may not be an issue

now, seeing an X number of claims. But should be looked at just as part of the normal, the assessment quality in many different respects, and properly so. And this aspect of a claim should be subject to regular, you know, quality review.

Let me just say one other thing, and then turn it over to Dr. Bowman. Actually, I think there's a different, more kind of practical scheme that could be used.

If you had two experts, let's say you assembled a panel of two. And they were causation. And they reviewed whatever, 20, 30 claims on a quarterly basis, right.

And you have, and they get different cases, each of those two get different cases. And Expert number 1 disagrees with the CMC opinion.

And so who's right? I mean, is it the expert or it the CMC? Well, I guess you could default and say the expert's right. But let's go, let's try to see if we can get beyond that.

Suppose you took that same case and gave it to the second expert, but didn't tell the second

expert that this was subject to dispute. It was part of your normally quarterly review. You're going to look at this additional case.

And so let's say the two experts disagree. So now you've got two experts disagreeing with each other, right. And so meaning one of them agrees with the CMC. Okay, fine. So then you would say okay the CMC did find because you've got two out of three.

Or two experts agree the CMC was incorrect here. And then you understand the, then you have a different conclusion.

So that's not as developed as Dr. Friedman-Jimenez's scheme. But it is a practical way I think of resolving the issue of, how do you make a decision at the end of the day about who's right, which I think has been raised before with, to us.

As far as providing examples I look back. You know, we reviewed claims over the years. And then we returned those discs to Ms. Rhoads, who faithfully destroyed them.

And so I have a couple of cases from my notes I think I could turn over, which I think, where I think we, the CMCs had a problem.

I would say that even if, frankly we reviewed a limited number of cases. We, historically the Board requested resources to review a larger number of cases. But that resources didn't, weren't eventually provided.

So we don't know how big the issue is. But again, I think even if we never found a problem this should still be part of the quality assessment process.

And if you go to the next slide. So this is, I found this in an old, I was updating my slides for this presentation. And I found this slide.

Actually this is from 2018/19. And this is a previous quality assessment process that the program had. So the medical director's quality reviews for five quarter period, okay. So it's, you know, one year three months, 2018/2019.

Reviewed 50 CMC reports per quarter.

And you can see that in causation they really didn't find a problem. Impairment there was a, actually in all the other categories there were significant problems. And many of them, in fairness were minor.

And when you get into the detail of how the policy branch dealt with them, they were minor problems, and not important problems. So I don't want to suggest that there was a big problem in these other things.

But there was virtually no problem detected in causation. And I have to say that my interpretation of that was not that there was no problem, but that it was quite likely that the assessor actually didn't have that expertise in causation. And they did have that expertise in impairment. And so the causation really wasn't getting an expert review in this mechanism.

So the program reinvented their quality assessment process in ensuing years. But omitted this medical oversight or medical review of the CMC products.

And without commenting on the medical director's capabilities or performance, I think it was a mistake to omit this medical component. It was a challenge perhaps to figure out how to do it. Because, you know, they weren't going to assign this role to the medical director. There was, whatever.

But this function of expert medical review of the CMC, which was there, was omitted from the reinvented assessment process. And I think our recommendation has to do with how to correct that basically.

Additional comments at this point? Dr. Bowman?

MEMBER BOWMAN: There was actually an extension of what you had brought up. On one hand, in the absence of such a peer review it might not be possible for us to get an overall sense of systemic.

So there's a certain quality control. And including this as part of the quality control is important to be able to develop and build

confidence of the veracity of the CRC reports.

Steven, you had mentioned a potential alternative approach to us, like a standing Board of peer reviewers, which was as I understood it a, basically a blinded second CMC assessment. Blind to the fact that another CMC assessment was occurring.

I think that might be worth some further discussion by the Board. Imagine a case where one in 50 causations was blindly reviewed by two other contract CMCs.

Some low frequency, you know, might be only 100, 150 cases over a period of five years. But in those cases you could get estimates of the percentage of time there is any disagreement at all.

And that would give data on this. And they'd be blinded to, it wouldn't be a new panel. It wouldn't be a new mechanism. You just send the case to three instead of one some tiny fraction of the time to do random sampling.

And depending on how that comes out,

you know, it might take three or four years to see how that's coming out to maybe get some early data to the Board on that. A decision could be made whether or not a more extensive or less extensive QC would be needed.

I think it would have relatively minimal costs in terms of the fraction of total reviews being done anyway. So I just wanted to emphasize that, this alternative idea that you had mentioned.

And second, that I think there could be value to that, as well as ease of implementation.

CHAIR MARKOWITZ: Interesting. One final point I wanted to just raise was, in the most recent quality assessment surveillance report -- I'm going to speak broadly, because I don't really know how much of this can be shared publicly.

But they did a review of for the, I think final quarter, or some quarter in 2023 of CMC reports. And there were 50, the plan is 50 reports per quarter. And then are reviewed ten of each different type of reports.

So that, the types of reports are, there

are five different types of reports. So there's essentially ten causation, ten impairment, ten what's called supplement, ten file review, et cetera. So that's ten reports in a quarter reviewed for causation.

So if you have a, and of those ten five are denials and five are accepted. So you have five denied CM reports, which led to denial. Five per quarter you're really not going to detect the problem, no matter what quality assessment process you use, if the problem is, only occurs ten or 20 percent of the time.

So if it's only, you know, one out of every five reports, or one out of every ten CMC reports that's problematic, if you only review five per quarter you just aren't, you're not going to find it.

So it's just, they need to be reconsideration of, as of the number or the weighting within the 50. Because three-quarters of the CMC reports are causation. And only 20 percent of the quarterly review is devoted to

causation.

So there's a, this is almost a separate issue from redesigning the assessment of experts. But there needs to be consideration of re-weighting the, what kinds of claims for CMC reports are reviewed.

In fact, it's not clear to me how they found ten supplemental and ten file review reports, or ten second medical opinion or referee opinion reports to review.

Because if we actually, we don't need to do this. But you go back to the numbers of those types of reports there weren't, didn't even appear to be that many of those types of reports that were being completed.

But in any case, that may be something we might want to separately recommend, is the question of the, of what percentage of, how the distribution of reports in their quality assessment process.

So we may come back to that tomorrow. We'll see. Okay.

MR. VANCE: Dr. Markowitz, let me, this is John Vance. Let me just add a couple of comments just as I'm listening to the discussion.

The Board has also been provided with, I know that this is part of our contract performance management documentation, which can't be released publicly.

We've also provided the Board with the audit manuals that are used for those. So that actually explains sort of the rationale and the methodology that's applied.

And I do know the Board has looked at this in the past. Because we've adjusted our selection process to be more, towards a more equitable distribution of the cases, based on a prior Board's input. So just be aware of that fact.

CHAIR MARKOWITZ: Okay.

MR. VANCE: So that document exists. And if you're looking at the criteria that are applied to the CMC assessment, that's explained in that CMC audit performance manual that's available to the Board.

But again, that's for the Board's use only. It's not a publicly available document. But that would be something that also would --

CHAIR MARKOWITZ: Okay.

MR. VANCE: -- probably be worth a look.

CHAIR MARKOWITZ: So, Ms. Rhoads, if you could find that and send that to us, that would be -- But just on the face of it, I mean, we'll look at that.

But on the face of it we see that three-quarters of the CMC reports are for causation. And 20 percent of the quality review are for causation. And you don't need to answer this. But if you can, fine, if not, later.

Why is there such a disproportionate percentage of quality reviews given the overwhelming majority of the fact that the reports are for causation?

MR. VANCE: I think it's partially due to a legacy of how we've done it in the past. This is done under a contract performance management process.

But we also have a separate quality assurance process that's done on a recurring real time basis by an entire dedicated group of staff that are looking at these.

Now, they're not focusing specifically on CMC reviews. But they're looking at the underlying justification and support for decision outcomes. And they would look at that entire process as part of that separate review.

So we have two mechanisms looking at CMC reports. It's our recurring quality assurance team looking at these cases, and then our contract evaluation.

And our contract evaluation's looking at five categories of cases. We got causation, impairment, supplementals, and file reviews. So the file reviews will actually capture some of those causation opinions as well.

But I will point out that none of the questions that we look at from an audit standpoint asks whether or not the auditor feels that the answer that the CMC provided is correct.

It's, did the doctor provide an ample justification or a compelling justification for whatever opinion that they're offering? And it doesn't produce any kind of contradictions in the manner in which the doctor is presenting their opinion.

CHAIR MARKOWITZ: Okay. So we're approaching lunch time. And I don't know if the rain is letting up or not. But any -- Oh, Dr. Bowman.

MEMBER BOWMAN: In this context of the conversation about the quality of, I guess the medical accuracy of the CMC reports, are we, as a Board are we concerned more with the quality in random sampling of individual cases, and ascertaining the percentage of individual cases for which there might be concern, or might not be a concern?

Or are we talking about the review of individual CMCs to ensure that the quality of the CMCs are in general okay? Because I think that might shape how we think about this recommendation

of peer review.

CHAIR MARKOWITZ: Well, Steve Markowitz. My comment on that is, when the Department eventually accepts our concept of peer review of CMC reports we will help them figure that out.

No. I don't mean to trivialize the question. It's important. And they would require different scheme, different numbers to approach. Really interesting question.

If you think about, you know, even from the contractor point of view, how do you, you know, manage your CMCs, and identify, you know, the ones that, you know, aren't performing well? That would be, you know, a challenge. I mean, it's solvable. But it would be a challenge of how you approach that.

Dr. Cloeren, I wanted to give you a chance to have the last word.

MEMBER CLOEREN: I agree that a process is needed. And you don't need to show that there's a problem to have a quality process.

CHAIR MARKOWITZ: Yes.

MEMBER CLOEREN: And I think that the quality process should reflect the distribution of work performed.

CHAIR MARKOWITZ: Okay. So it's noontime. We're going to break for an hour for lunch. We'll resume at 1 o'clock with a very exciting discussion about the site exposure matrices. So stay tuned.

(Whereupon, the above-entitled matter went off the record at 11:58 a.m. and resumed at 1:04 p.m.)

CHAIR MARKOWITZ: Okay. Let's resume. Steven Markowitz. It's five after 1:00 p.m. So our first agenda item for this afternoon is to discuss the site exposure matrices.

This is going to be led by the Site Exposure Matrices Working Group, some of whom attended a meeting with Paragon and Department of Labor in Ohio in March.

I just want to thank the Department for arranging for that, supporting that. A very

productive visit, which we'll hear about. So take it away, group.

MEMBER WHITTEN: This is Dianne Whitten. I just want to thank the Department and Paragon for allowing us to meet with them in person last month.

I feel it was a very productive meeting, with a lot of questions answered, open dialogue. Gail's going to go over some of the highlights for us.

MEMBER SPLETT: This is Gail Splett. Again, I'd like to reiterate the same thing. We appreciated the opportunity to meet in person.

We went in with some examples that we had come up with. And some of the, I think all the Board members have seen the internal report that we did.

We found maybe 15, 20 --

CHAIR MARKOWITZ: Sorry to interrupt. I just want to, I think we should introduce. We have some guests who are online with us as part of this discussion. So if you wouldn't mind, I

think from Paragon. If you wouldn't mind introducing yourselves. Sorry to interrupt, Gail.

MEMBER SPLETT: No. No problem.

MR. TURCIC: Pete Turcic. I'm the project director for Paragon.

CHAIR MARKOWITZ: You're muted.

MR. TURCIC: Am I still muted?

MEMBER SPLETT: Got you now.

CHAIR MARKOWITZ: We got you, Pete.

MR. TURCIC: Okay. Pete Turcic. I'm the project manager for Paragon. And John Hovinga, John, you on?

MR. HOVINGA: Yes. John Hovinga, Paragon, and probably the senior researcher with Paragon.

CHAIR MARKOWITZ: Okay. Thank you.

MEMBER SPLETT: So one of the issues that we've identified is a particular example that we had come up with and discussed our November meeting, which has to do with K-25, a labor category, which included groundskeeper as an alias, as we discover later.

It had 63 chemical hazards identified in 2021. But in 2022 only 21 chemicals. So we asked for an explanation from Paragon, and they did provide that. That they bifurcated and took groundskeeper category and made it a standalone category. And with it, it took 42 chemicals, which explained why the toxicity came down in the next year.

Unfortunately there's nowhere in the SEM that identifies that. Only by asking Paragon specifically did we know that. And that was just one example.

There were buildings also identified that only had a building number and a building title, but showing no labor categories and no toxic materials. And we were not told that the Department of Energy had provided building listings, but there were no toxic materials or work categories, or anything identified.

And I did discuss with Gregg Lewis a couple of weeks ago. He said, no one has ever come back and asked for that information. So we'll

address that a little bit.

Dr. Cloeren, are you online? I see you. Can you address --

MEMBER CLOEREN: Yes, I am.

MEMBER SPLETT: Can you address the chemical hazards that were explicitly removed and why?

MEMBER CLOEREN: Yes. So I don't have the, this is Marianne Cloeren from the University of Maryland. I don't have the state of the IOM report. But there was a review by the Institute of Medicine of the programs that had, and actually Paragon may do a better job of explaining the background of this than I will.

But as I understand it, and correct me if I'm wrong, they found that a lot of these chemicals that were in the Site Exposure Matrix were mixtures of things, for example cleaning agents, which included like many different kinds of chemicals.

And that, you know, to try to be complete all of those were being listed. But that may have

been, that may have inadvertently listed some things that were possibly minor ingredients, also ingredients that may change over time.

And so the IOM recommendation was to not be using, not be listing the individual kind of elements or components of these kind of mixtures, and instead to use the mixture names and the, what's the, I can't think of the word I'm looking for, but other versions of the name, of the mixtures, with the understanding that what's in them may change over time. John, you might want to correct me. Did I get that right?

MEMBER SPLETT: I think you did. Thank you. And again, I think the relevant point is that when those chemicals were removed and put into the generic chemical title, that there's no documentation in the I, and again I'm saying the IAS, the Internet Accessible SEM.

So that anyone searching that's not intuitively obvious or in any way marked. And that was a concern, and one of the things that we'll have some follow-on.

We very nicely got some things from the Department of Labor on Monday. And we'll talk about that in just a few minutes, addressing some of that.

All of these changes seem logical to us. But again, the issue was there's no way to appear to track those changes. And we reached out to ask.

I think the working group, we should talk about the things that we though, the bulleted items, one through ten or 11. You want to talk about those, Dianne, Kirk, Aaron, Jim?

The first, well, Kirk, I'll kick you off. How's that sound? The first one is about the communication with the stakeholders, including union reps. You felt that was an issue.

MEMBER DOMINA: Yes. This is Kirk Domina. Part of it they discuss how they have to get stuff from the Department of Energy. Well, we don't work for the Department of Energy. We work for contractors that work, that have a contract with them.

And so a lot of this stuff the Department of Energy probably would not have. They need to go to the individual unions to get that information with the different, you know, people that were involved. Because they're not going to have it, you know.

MEMBER SPLETT: The next, one of the next ones that I think --

CHAIR MARKOWITZ: I'm sorry. Just a point of clarification. Steve Markowitz. Go to the unions or the contractors?

MEMBER DOMINA: Well both. Because a lot of times with contractors changing, you know, the constant is the workers are there for years, and years. Or a lot of times the contractor may change in five years or ten. And so you have continuity with the workers, where you don't with the contractors.

MEMBER CLOEREN: Kirk, I think you made the point at the meeting also that jobs may have varied a little bit by union contract. And so a job description that would include certain tasks

at one place may, based on agreements with the trade union, well not trade union, the union may have included different tasks at other places. Is that accurate?

MEMBER DOMINA: Yes. This is Kirk Domina. That's correct because of jurisdiction and work assignment where they could tell you, you're going to do this where it may not be your jurisdiction. And that causes conflict because you have to do it or you could lose a job over it.

MEMBER CLOEREN: But that would be another reason to include communication with the unions I guess.

MEMBER DOMINA: Right. With the workers, yes. With the workers.

CHAIR MARKOWITZ: Ms. Splett, there are a couple of people who want to, I think maybe make comments. Can we --

MEMBER SPLETT: I apologize --

(Simultaneous speaking.)

CHAIR MARKOWITZ: No problem. But you want to come in on what we're talking about, right?

Go ahead, Mr. Catlin.

MEMBER CATLIN: No. Just a follow-up question for Kirk. So the contact with unions, the locals would then have detailed records for members on where they worked, who they worked for? Yes. That would be additional site information? Is that what you're --

MEMBER DOMINA: Well they wouldn't maybe necessarily have where they worked at. But the fact that they have the knowledge of what was there, and what processes they used, this or that chemical. They may or may not know. But it's to I guess cut down on, because DOE doesn't necessarily have them, you know.

And to me it cuts down on the bureaucracy of having to go through this agency to that agency, and trying to get the, what people were using. Because nobody's come to the workers in I don't know how long, you know. It's been years.

MEMBER CATLIN: Yes.

MEMBER DOMINA: Probably 20.

MEMBER CATLIN: Yes. So it would be

possible for the local unions to identify like old, long time members who would have that kind of historical knowledge, and have them be subject matter experts on that site, on those issues?

MEMBER DOMINA: Correct.

MEMBER CATLIN: Yes. Okay.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Yes. Jim Key. Yes. I agree with Kirk, especially for the, I want to point out the SECs of the original legislation. The reason they were at that point in time designated special cohort was the fact that there was no documentation at these three gaseous diffusion sites.

When a claimant files a claim, more times than not a IH report on that claim will say no documentation. Well, that's exactly right. We did not have industrial hygiene technicians at the site. Had one person over the IH Department and one over the Health Physics Department up until the mid to late '90s.

So there was no monitoring going on,

nothing. The historical knowledge that we spoke about, Kirk was mentioning, of the workers themselves, yes, if the Department of Energy and Labor aren't going to communicate, then there is a resource from this of those mature workers, and the job scopes and chemicals that they used, which is not recorded again. Because we had no IH.

CHAIR MARKOWITZ: Ms. Splett.

MEMBER SPLETT: A couple more items. The second two have to do with the Department of Energy, one of which is the concerns that the group had about the lag time between new information being updated to the SEM, and the clearance process at DOE.

And one of the questions that was asked, instead of waiting six months is it possible for the Department of Energy to do that every two months? And we did provide that question to the Department of Energy. And I don't know, Gina, if you want to address that later on, or if you're prepared to address it at all.

MS. GRIEGO: I can address it. We're

aware of your request. And we've reached out to our Office of Classification, because those are the ones that actually handled it at headquarters. And so they're discussing it.

But again, I think it depends on how much information they'll have to review. I mean, if it's a limited amount of information that's one thing. But if it's a lot of information two months might be a little bit --

MEMBER SPLETT: My assumption would it be the same amount of information cut in thirds. I mean, if you do this much in six months, you do a third of that. But, you know, appreciate that. And we did want to get you that information so you didn't get caught cold.

MS. GRIEGO: Yes.

MEMBER SPLETT: And so I think the Board will wait for some info back through Labor, Mr. Vance?

MR. VANCE: It would probably come, if it's a question directed to the Department of Energy, then the Department of Energy can respond.

If it's a question directed to the Department of Labor we would respond.

MEMBER SPLETT: So I'm not sure who we're requesting that from.

MS. GRIEGO: But there's process on both sides, right. So Labor's going to have to get their spreadsheets together, provide it to us. And I know they're doing constant, you know, research. So it would also be their ability to provide the information to us. But --

CHAIR MARKOWITZ: I need a input from our designated federal officials. We're advisory to the Department of Labor, to the Secretary. And if this is a information request or somehow input that is more directed to Department of Energy, over which we have no --

MEMBER SPLETT: I guess --

CHAIR MARKOWITZ: -- jurisdiction. How do we proceed?

MR. JANSEN: I don't recall that coming up in the past. But that's something we can definitely check with SOL Counsel to see what the

appropriate mechanism for submitting that type or request, or even if there is a mechanism for doing that.

MEMBER SPLETT: I would assume we could have --

MR. TURCIC: Dr. Markowitz.

CHAIR MARKOWITZ: Yes.

MR. TURCIC: Pete Turcic. Could I add something here? Because I think there's some confusion on when and how, and how long the classification reviews take place.

CHAIR MARKOWITZ: Sure.

MR. TURCIC: The classification reviews occur when we are updating the public SEM, which is twice a year. And so what happens is we do that, we send that information of all the changes during that six month period to the Department of Energy Office of Classification.

They normally turn those around in about two weeks, three weeks at the most. And so the information is reviewed. The reason it's six months is we update the public SEM twice a year.

It doesn't six months for DOE to review, to do the classification review of our updates.

CHAIR MARKOWITZ: And just a quick follow-up question. Steve Markowitz. Mr. Turcic, so during that six month period, throughout that period you're accumulating variably, but you're accumulating additional documents, information from the Department of Energy that go into this every six month change, right?

MR. TURCIC: No. No, no. Let me explain the process. When we get, we get information from the sites. We don't, when we say DOE, DOE, Gina's office will give us a point of contact for each site. And we'll work with those site contacts. And that's who provides the information to us.

Once we get that information we update that specific site profile. So we update the profiles. And then once every six months that, those are the profiles that are used by Department of Labor, the claims examiners. They have access to that as soon as we update the SEM.

Then what, then twice a year we update the public SEM. And match all the changes made in that six months. So that's, that could be, you know, 20 sites have been updated. And that's what goes to Department of Energy for classification review.

It's, they review, the classification review is based on the changes made to SEM to ensure that there are no mosaic effects or any other problems from the classification.

MEMBER SPLETT: I guess the people on the subcommittee had concerns that six months seemed like a long time. And if there was any way to shorten that process.

So someone looking from the outside was only seeing information two months out of date instead of six months out of date. That that would be preferable if that was feasible, both on the Department of Labor, obviously then working with the Department of Energy. So that was what that concern is.

The next concern relating --

CHAIR MARKOWITZ: I'm sorry. This is Steve Markowitz. Let me just pursue that for a moment. So, Mr. Turcic, the changes that you submit on an ongoing or continuous basis to the internal SEM --

MR. TURCIC: Right.

CHAIR MARKOWITZ: -- the DOL SEM. That's not every six months. That's on a more regular, more frequent basis?

MR. TURCIC: Yes. That's constant.

CHAIR MARKOWITZ: Okay. And does that have to go through classification review?

MR. TURCIC: No. And the reason is the agreements with DOE, since that is for Government use only.

CHAIR MARKOWITZ: So the --

MR. TURCIC: It's official use only at that point. But the classification review occurs when we make it public.

CHAIR MARKOWITZ: So, Mr. Vance, does that mean that when the claims examiner is consulting the internal SEM, right, not the public

but the DOL private SEM, that they have access to the most up to date information from Paragon?

MR. VANCE: Yes. This is John Vance. Yes. Because what Mr. Turcic is saying is that as they go through their document evaluation and determine that there's information that needs to be populated into the Site Exposure Matrices, once that occurs it becomes immediately available to the claims examiner.

That information is then presented to the public every six months as part of that case freeze that we're talking about. And I think the next one's coming up May 16th. So that is on a six month cycle.

Now if the Board would recommend that that occur on a more frequent basis that would have to be where we need to coordinate with the Department of Energy to find out what would be feasible for doing that.

CHAIR MARKOWITZ: Okay. Thank you. Ms. Splett.

MEMBER SPLETT: Thank you. The next

issue has to do, and we brought it up a couple of times is, the responsibility for identifying new buildings, or buildings whose status has changed. And I'll go back to the Plutonium Finishing Plant at Hanford, which still is showing as operational. But it's slab on grade.

And whether that's a DOL, DOE, whose responsibility that is, I don't think it's ever really been defined. I mean, I think that was consensus. But it's probably something in the process that does need to be defined. Any comments from any Board members?

MEMBER WHITTEN: This is Dianne Whitten. Yes. I believe that Paragon told us there's actually no formal process to send updated facility information from DOE to Paragon. They rely solely on the claims examiners and the public input through the SEM mailbox.

MR. TURCIC: That's not true. That is not true. The information is provided, when we do it, when we do a site update that's, we, that's why we ask for the current site maps, current lists

of buildings, and all those buildings, those changes are added.

Now, buildings that have been repurposed and all that are still in SEM, because it all depends on what the situation was when a claimant actually worked at the facility. So that's why we don't take buildings out.

The building, and as I pointed out in our meeting in March, that the, you can see the whole life cycle of many of the buildings that you look at in SEM, you know, from when it was first utilized, as it was decommissioned, decontaminated, and repurposed. All that information is in and kept in SEM, you know, for use for claims.

MR. VANCE: Yes. This is John Vance. Let me give you an example of what Pete is talking about. So let's say you have a map that lays out the boundaries and the designations of buildings in 1950.

And they have a building called the A Building in 1950. Well, they're going to classify

that building as the A Building in the Site Exposure Matrices.

And then through whatever circumstance Paragon is able to get an updated map in 1970. And comparing that map to the old map, well now they're calling it the 1A building.

We're not going to go back and delete out the prior A building designation. We're just going to add a new alias for that same location as 1A.

So they're trying to keep as much information available about that individual building as new information becomes available. And they're not going to go back and just remove something simply because they've got something more current. It's going to be as comprehensive an inventory of the buildings.

Now that requires though that Paragon or someone in the public submit or present something that clearly identifies what would have been the facility's naming convention for that location. And it is very true that over time many of these

buildings change.

But I think the response that we provided in the most recent questions from the Board basically stipulates that that's how Paragon goes through their building inventories.

MEMBER SPLETT: I guess, go ahead, Gina.

MS. GRIEGO: I can add, this is Gina from DOE. Just to go back, we do not provide real time data regarding operations for DOE if a building is, you know, shuts down or decommissioning. We only provide it when Labor requests it, when they do an update.

So when Paragon comes in like they're doing now, you know, we'll provide them with that data. But we don't, we do not provide them real time updates as to changes in operations.

MEMBER SPLETT: I'll just go back to the PFP example. It's still showing as operational. I know DOD employees. And I don't know when the next upgrade or updated Hanford is. But that is one of the concerns that we had. Any

more comment on that section?

CHAIR MARKOWITZ: Steve Markowitz. So I understand how a building may change name over time. And you can use aliases to identify the building at different time periods.

But what I still don't understand is as that building is repurposed over time, and one decade might involve a certain set of potential exposures, and two decades later involves an entirely different set of potential exposures.

How do you denote, how do you indicate that evolving set of exposures? Is the entire universe of exposure, potential exposures from the entire history of that building included, and connected on the SEM? Or do you somehow indicate, in the 1960s there was X, Y, and Z, in the 1990s there was A, B, and C? I still don't understand that.

MR. TURCIC: All these potential exposures are in there. And the way a claims examiner would find it is depending on, separated out the labor category or the work practice.

So in each building you look in SEM and the building has a list of, you know, the work processes that apply to that, or that have been performed in that building. Those are going to change over time. But they're all there.

So you would go and you would look at the work process that was associated with the work process during the time, you know, during the function of when the claimant worked there.

John, do you want to explain some of that in more detail? Changes over time?

MR. HOVINGA: We can. The original comment is quite insightful in terms of how you would track an evolving mission and set of processes over perhaps a three or four, or even a five decade life cycle on a building.

And so the, it is often very difficult. It is often, quite frankly, very difficult to separate a specific date or year from one process moves to another.

What we try and do is have enough definition in the work process, so that you can

determine how a mission might evolve, and how the work process and the associated toxics evolved over the life cycle of that building.

You know, for example, I'm just picking one. A uranium process mill, for example. Depending on the ore they would originally get they would perhaps use the old acid leach process.

But then as the ore shifted from other parts of Colorado Plateau, for example, you might go to a resin and solvent leach process. And our work process, we would attempt to define enough information so that the individual processes and the toxics associated with those different processes would be identified in SEM.

So you can trace it mostly through the specific work processes. And then obviously potential labor categories or name changes and aliases.

But he's correct. We don't take anything out of SEM. Because SEM is meant to represent the entire life cycle of the buildings. And then one last comment on what I think you said

PFP, Gail.

MEMBER SPLETT: Yes.

MR. HOVINGA: Is we, when we do a major update, and we're trying to run these cycles through between five and I think maybe seven years.

But when we do a major update one of the things we do and have been doing for the last, I don't know, I'd say four years is go back to our POCs and get an indication of what D&D and perhaps, and demolitions and environmental restorations have occurred over that past five years, so that we can try and get a current snapshot of what operations are actually going on within that site, you know.

And in addition to that we try and get any ORRs or new safety analyses, or hazard analyses for new processes or new facilities, so that we can add that information in the SEM as it has been established and occurred.

So that's an ongoing process that we revisit every few years. Sometimes we get information back from the Department of Energy on

some of those old buildings where all we've got is a name and a number. And sometimes we don't.

But, you know, that's, it's lost in history or something. But we keep the information in SEM even if it's only as a placeholder, in case somebody comes up with something someday.

MEMBER SPLETT: So I think you're touching on one of the other things we'd asked earlier, which is, those entries that only have a building name and title, you are reaching to the Department of Energy and asking for that information?

MR. HOVINGA: When, yes. What we, when we do a major update one of the, one of our steps is to do what I'll call a gap analysis. And we look at what we have for current buildings.

Now, and then we make a value judgment as to whether we ask for it. If it's a storage pad and we don't have anything on it other than a storage pad, we're not going to reach out to the Department to try and flesh out that it was a storage pad.

But if it was a maintenance or a craft shop, and all I've got is this is a sheet metal shop, and I don't have anything else in there, well that leads us to ask the question, you know, if it's a sheet metal shop, what did they do in it? And who was in there? Obviously sheet metal workers.

All right. Was it a real fabrication shop? Or once in a while it will be a break room? Well, you know, a break room is a break room. You're not going to have much toxic exposure there.

But if it's a real building with a name that implies that it had potential toxic exposures we reach out and try and get some feedback if it can be provided or exists from the Department of Energy. And then when we get that we blend that back into SEM.

MEMBER SPLETT: I think that gets to some of the other questions we were asking later, which is, how many of those facilities are there where you have only a name and a building title? Or excuse me, a building number and a building

title?

MR. HOVINGA: Yes. There's less than we used to have. Because this has been an ongoing process. But on a major site like Hanford of Savannah River, Idaho is a perfect example as well, Los Alamos, Nevada Test Site, you know, those types of places have been around for 70 years or more.

Missions have evolved. Buildings have been erected and gone away, or been repurposed. And so it's, I'd hazard anywhere from ten to maybe 20 on a major site --

MEMBER SPLETT: Have you done any --

MR. HOVINGA: -- I think would be a typical -- You know, that's my impression. Without going through and really doing a detailed check I'd say that's probably about where we are.

MEMBER SPLETT: So are we ready to move on, Board, to the next one? Okay. On all the divisions of labor that are identified one of the things that we wanted to talk about is there's got to be a process for identification in the SEM.

If groundskeeper got moved out of Labor

there should be some notation. And that's one of the things we'll look at, I'm assuming in one of our recommendations. But that was really a big issue that we identified.

And the same thing with chemical, the chemicals that were removed without any traceability of that, or any visibility of that. And there's another one.

And I don't even want to bring it up in front of the Department of Labor, because we've discussed it several times, which was consistent labor categories among sites.

Because I think we all recognize that's very difficult between contractors and unions, and whatnot. Kirk, do you want to address that any more about all the security officials, or the patrol, or --

And I know that Dr. Markowitz has addressed this before with our frustration of not having that consistency among sites.

MEMBER DOMINA: Well, I think part of it is we had that discussion with Paragon about

moving or just changing a job title and they talked about going to DOE. Well, DOE doesn't have that information. They're not the ones that get to decide that you call it this or that because it changes between what the union has and whatever. It causes issues when a worker was this job title, now all of a sudden they can't find it in the SEM because it's changed some than what they're used to especially with a sick worker, the memory causes some issues and stuff too, but I just think they could do a better job of reaching out to the unions because it's been years, like 20 plus, since anybody's talked to them that I'm aware of to make sure they're in line and not just arbitrarily changing a name based on the information that they think it fits under. That labor category may or may not exist at that site under that job title and what they've put it under.

We've seen it with some of the claims that we've had to do where there may not be enough understanding of that with claims examiners from site to site that a union has several job titles

and it could be a subcategory because that works belongs to that job title and they don't understand that.

MS. GRIEGO: Gail, this is Gina. I just want to say when Paragon does their updates, they only have a scoping call with the site to discuss the update. We would be happy to facilitate contact with the unions, so when we start doing those updates, we could put Paragon in contact or at least get some information for them. That's not a problem.

MEMBER KEY: Not only in the job classification and how each union is different, the differences between building construction trades and industrial, but also on the work processes themselves. The original creation of the SEM for the three gaseous diffusion plants has a wide variety of exposure chemicals listed, that's unacceptable. The three facilities perform the same enrichment of uranium. Why someone would think that Portsmouth has got 32,000 and Paducah has 12 is ridiculous. Thank you.

MEMBER SPLETT: I think that was the majority of what the Board reported. We did come up with a list of questions that we did a response on Monday while we were traveling. Of course, we only gave you like three or four days. We intended just to ask them, but Dr. Markowitz wanted to provide them to you.

MR. VANCE: Yeah, this is John Vance. I'm going to give credit where credit is due. Pete and the Paragon team got that and really got us feedback very quickly so I commend them for doing that. Our internal clearance process somehow magically worked very effectively to get that done. We were very interested in making sure that the Board got those responses, so I think everyone has a printed copy of our written responses.

MEMBER SPLETT: Appreciate that.

CHAIR MARKOWITZ: This is Steve Markowitz. I want to thank the Department and Paragon for setting this dangerously timely precedent.

(Laughter.)

MR. VANCE: I warned them about that.

CHAIR MARKOWITZ: And resetting our expectations for the future. Thank you.

(Laughter.)

MEMBER SPLETT: I just want to address a couple because I -- Dianne, did you want to say something?

MEMBER WHITTEN: Only if you're done.

MEMBER SPLETT: I was going to go over some of the responses, but why don't you jump in.

MEMBER WHITTEN: Oh, okay. Let's go back to the deletion of the chemical constituents from say the name brand chemicals. The reason we were told was because of a document from the Institute of Medicine back in 2013. That just brings to mind the lack of transparency that Paragon communicates to the stakeholders. There could have been a communication on the SEM actually that would notify people that we're looking at their facilities, their job categories, work processes that there might be less chemicals than there were last year because of this particular reason. That

would have stopped a lot of confusion and anxiety among our claimants and claims examiners probably too, or authorized reps.

There are also other recommendations that came out of that document and those were not followed up on and we weren't explained as to why some of the other recommendations were not followed up on, such as transparency, well that's one of them. Another one was time periods that the chemicals were used. You would have to add another filter obviously to the SEM to make that searchable. Say they only used this chemical from 1956 to '66 or something like that, that would have been helpful too. Are there any questions on that?

CHAIR MARKOWITZ: Steve Markowitz. Yeah, I actually think providing timing details for potential exposures would be immensely challenging and probably not well supported by available information and, ultimately, may not work in the favor of the claimants.

Actually on the issue of these brand name products and the fact that the constituents

were removed in favor of the brand name product, which occurred 10 years ago or whenever, maybe an ongoing basis, but I don't really understand why there can't be some indicator in the SEM that that change happened. I don't understand why for relatively infrequent special events that one or other similar to it, I don't understand why there can't be some additional information built into the SEM that would be more informative about the process. I'm sorry, the question is why can't this be done? That's as much for Paragon.

MR. VANCE: I'm going to try an answer here because I think that this is just presently we structure the Site Exposure Matrices based on the best available facility information that we have. Your comment about the temporal data of chemicals is very true.

The IOM report is available and has been available for public consumption so there was an entire discussion with IOM about that. We agreed to remove those from the Site Exposure Matrices so we do have the agreement that the Department

of Labor made to remove them. I would not want to comment on behalf of the Department of Labor about any kind of commitment to better communicate what has occurred with regard to the removal of the constituents other than to say that we agreed to do that and we facilitated the removal of those materials. I think that's where I'll leave it.

If the Board has a specific recommendation with knowledge about what IOM recommended and the actions that the Department of Labor took in response to that about what they feel we should report about, the removal of constituents or if there is an alternative view point about how that should be considered by the Department of Labor, such as a change to how those constituents are handled, that would have to be a recommendation of the Board.

CHAIR MARKOWITZ: Thank you. My sense from the report back on the working group is that it wasn't necessarily a desire to kind of reverse that process as much as just to have some indicator in the SEM so that people can understand what went

on or what's going on. Is that right?

MEMBER WHITTEN: That's correct. Just some communication. This is Dianne Whitten. Communication to the claimants and the claims examiners as why there's a change. That also goes for work processes, labor categories, such as when they removed the groundskeeper work processes from the laborer labor category and it also removed chemicals from that labor category so that confused people as to why those were missing and there was no explanation as to where they were moved to. That's not the only one. That was one example. I'm sure there are many, many other examples of them moving job processes, work processes out of a labor category thus removing the chemical list from that labor category.

It all goes back to communication between all the stakeholders and if they would just put a note where they used to put references. If you look back in some of the really old copies of the SEMs, there was a section for references as to how they found those labor categories or work

processes or chemical lists, it was referenced. They took that out years ago and I'm not sure why, but I think they told us it was because of redactions and classification issues and what not, but I think just a simple explanation would be helpful.

MEMBER SPLETT: I think Dianne hit the nose right exactly correctly. It's a lack of transparency. I don't think we necessarily had issues with the separation of the labor categories, but the lack of documentation of what was moved and why and in this letter it appears that we ask how many times did that happen and it doesn't appear we're able to track that. Where they were and where they are now and why.

I'm not even sure it's as important why they were moved, but that they were moved. I mean once we have the answers from Paragon, it was like oh well that really explained it, but it's not documented for other than those of us who were in the room listening to them.

CHAIR MARKOWITZ: Is that correct? Here anything else on the SEM? We actually have the

recent letter that was sent to the Board with some responses. I mean we can show it if there's any --

MEMBER SPLETT: I think between Ms. Whitten and myself I think we already addressed most of the answers.

CHAIR MARKOWITZ: Okay.

MEMBER WHITTEN: This is Dianne Whitten again. Before we stop on this topic there was some information that came out of the meeting such as Paragon told us that they had just added the instrument techs to the TCE exposure. My question is were any of those claimants identified or notified that possibly they could have been exposed to this chemical, which may have caused their illness? Is there any follow up when they do add an illness to a job category to go back and look to see if maybe there was a claim that was denied based on that and then --

MR. TURCIC: That didn't add an illness, that added an exposure.

MEMBER WHITTEN: Right.

CHAIR MARKOWITZ: Well, if I understand that question correctly, as the SEM evolves, then how does the program use that information at all retroactively to look back at claims that the decision may be different. I mean that sounds immensely complicated, but how do you think about that?

MR. VANCE: This is John Vance. This question has come up in the past and what we use SEM for is a prospectus. We are moving forward with the information that we have. It is and would be immensely difficult to go back simply because of the lack of information that we would be able to utilize to identify impacted cases based on toxic substances or the labor categorizations, so we are constantly using SEM and it's evolving information on a prospective basis moving forward. If we have the ability to identify certain populations of cases that we are knowing are dramatically impacted by something, we can initiate a revisit of the cases. We've done that for the hearing loss cases. We've done that for chronic silicosis. We've done

that for the beryllium standard.

But we're talking about a multitude of changes that are occurring in the Site Exposure Matrices that may or may not have an impact on cases. It would be a huge workload for the program to identify what would constitute a substantive change that could impact cases. I am more than willing to acknowledge that's a challenge. If the Board has some viable recommendation that can be made to the Department about how that could be facilitated, we would do what we always do with a Board recommendation, we would evaluate it, consider it, figure out what the options are if any and provide a response to that.

CHAIR MARKOWITZ: Go ahead, Mr. Domina.

MEMBER DOMINA: My question is for Mr. Vance just for everybody's knowledge, when through a DAR or whatever that there's a building identified at sites what process you go through to get it added to the SEM when it's not currently there.

MR. VANCE: Well, the staff have been advised and I do it myself. If I'm looking through

a case file and I'm identifying relevant facility information about buildings, labor category, work processes, incidents that guidance to our staff is submit it to the contracting officer representative for Paragon, that then gets reviewed and transmitted to Paragon. So, staff are on the lookout for that.

I know I periodically will submit things that I think are relevant or important to Paragon and so we encourage staff to do that. We also have the public submission process so if people are obtaining information that they think identifies a building or provides a characterization of a building that isn't currently in the Site Exposure Matrices, they are free to submit that as well for consideration by Paragon. Gina just said they also submit information to us.

Whatever sources of information we get and Pete and his team, when they're looking at the updates for all of the site profiles, they're going to be looking for that information as well. If they see something of good quality that's

describing something about a building, it could be a new map. It could be anything that adds to their knowledge about a site. That information will be added into the Site Exposure Matrices, in particular, the building characterizations or designations. If it's being called something else that will be added in to the inventory of what the characterizations are for that particular building as an alias.

CHAIR MARKOWITZ: Mr. Key.

MEMBER KEY: Yeah, this question is for Gina. Since there is a lack of transparency and communication between the Department of Labor and the Department of Energy, and Labor does not have access to the DOE or its reporting system for an incident that occurred on site that they have no record of, it's not in the SEM, a CE has no knowledge of, the SEM contractor, be it the current one or future one, have no access to, can an individual who was involved in an incident request that information from the Department of Energy?

MEMBER SPLETT: I don't have an answer

for you right now, Jim. I'd have to ask. I don't know enough about the CARES system or ORPS system to really talk about it as to what information is in there, but I can definitely go back and ask that question.

I do know and maybe Pete can actually clarify this or his team, that when they work with the sites, they do give them access to like maybe CARES or ORPS and I could be wrong, Pete, but just correct me if I'm wrong, but with respect to a member of the public, I don't have the answer.

MEMBER KEY: Yeah, well let me follow up on that. If that communication between a SEM contractor and DOE is occurring, then certainly those instances are not being recorded and put in their database.

CHAIR MARKOWITZ: Ms. Rhoads, could you just make a note in the transcript or whatever that we need to -- thanks. Ms. Splett.

MEMBER SPLETT: I'm sorry, it's just not there.

MR. VANCE: Pete, did you want to add

anything? I thought I heard you chiming in on that.

MR. TURCIC: Yeah. There's a couple of ways of doing that. One, when we do an update one of the things we ask the sites for is any incidents that occurred during the time period that we're updating. In addition, there are often times we get information through the public SEM, through the IAS, about incidents that occurred and when we get those, if we don't have any information about it, we will go to the POC and ask about the specific incident and normally we get that information and then add that into the SEM.

CHAIR MARKOWITZ: Steve Markowitz. I think this direct contact between the Board and the Department and Paragon has been extremely useful and the Board ought to think about a request for continuing regular contact, maybe consider that tomorrow. I heard Mr. Vance issue a challenge to the Board to assist the Department in figuring out how to feasibly conduct look backs when things change. Examples you gave were recent examples, chronic silicosis particularly in Nevada, hearing

loss.

We're going to discuss the Group 2A carcinogens, a couple of carcinogens that Paragon reviewed that believes are sufficiently related to human cancers to be added to the SEM. One is trichloroethane and multiple myeloma. One way of doing that is to identify claims for multiple myeloma that have been made in the past and perhaps relooking at those that have been declined because of lack of causation and seeing whether, in fact, they did have exposure to 1, 1, 1-trichloroethane. You are able to search the claims by claimed condition, right?

MR. VANCE: This is John Vance. This is a much easier methodology to identify cases where we have denied a particular condition that there's now some changing parameter that requires us to go revisit it. But in response to Ms. Whitten, just random changes that are occurring in the Site Exposure Matrices based on work processes and those types of exposure categorizations that would be significantly more challenging.

CHAIR MARKOWITZ: All right, so going in by claimed condition is feasible. Going in by some aspects of exposure more challenging to be sure, okay. Thanks.

MR. VANCE: That is correct.

CHAIR MARKOWITZ: Okay, additional comments, questions on the issue of SEM? Yes?

MS. GRIEGO: I just want to clarify, Jim, your question. You're asking whether or not the public can have access to ORPS or CARES. Is that your question that you want me to --

MEMBER KEY: No, not the public in general.

MS. GRIEGO: Okay.

MEMBER KEY: But past workers.

MS. GRIEGO: Employees, okay.

MEMBER KEY: Employees who have filed claims and instances that occurred that create exposure back in the '70s, '80s and '90s, whenever the ORPS reporting system or the other DOE reporting system came online and forced the contractor to report these instances, where before they covered

them up and as far as the SEM having added information that's only, apparently by Mr. Turcic's response, recent instances. We're looking at claims adjudication and the documentation to support it from the '80s and '90s, which is not in the SEM.

MS. GRIEGO: Okay, I'll ask. I know that as a current employee, I can request permission, but I don't know about former employees so I'll have to ask that question.

CHAIR MARKOWITZ: Okay, thank you. We're going to move ahead on the next agenda item, which is Parkinson's disorders. We have a PowerPoint brought to us by the working group, which consists of Dr. Mikulski and Dr. Bowman. You'll need to explain, remind us of the background of this work. Actually, if the Paragon folks can hang on in this because there may be some questions in relation to Paragon. Thank you.

MEMBER MIKULSKI: Kevin, if you can move to the next slide. Thank you. This is Marek Mikulski and together with Dr. Bowman we wanted

to give you a brief update on our working group's review of SEM. We've looked at the overall information on Parkinson's disease and parkinsonism and also assessed in SEM and also assessed the consistency of that information with the Procedure Manual as well as Haz-Map which is the most referenced occupational disease database in SEM.

You may remember the Board recommended in the 2020 Parkinson's disease recommendation that the diagnosis of Parkinson's disease be treated the same as parkinsonism throughout the claim adjudication process. We provided the Department program with the listing of ICD codes and aliases for both terms. This terminology has been updated in the SEM with the exception of primary parkinsonism which is a term used in earlier literature to describe the diagnosis of Parkinson's disease. If you can move to the next side.

There is currently 109 toxic substances linked directly to parkinsonism in SEM under the health effects link. The substances would have

resulted in exposures to carbon monoxide, steel, manganese as well as solvents, carbon disulfide and trichloroethylene. This exposures are consistent with the Board's recommendation from 2020. The itemized listing of the toxic substances, the products, linked to parkinsonism is also consistent with the listing of hazardous substances linked to parkinsonism in Haz-Map; however, Haz-Map only links parkinsonism to carbon monoxide and manganese exposures so we could not really verify the other substances listed in SEM. Next slide.

The program has a Part E presumption of causation established for parkinsonism and exposures to carbon monoxide, manganese and steel products. All three exposures are referenced in the Procedure Manual, so presumably the claims examiner in developing these claims would look up these toxic substances in SEM to confirm their linkages to parkinsonism. There is no presumption of causation accepted by the program for carbon disulfide and trichloroethylene exposures despite

the Board's recommendation. Both are listed as associated or linked to parkinsonism, so the claims examiner in developing these claims is instructed to obtain additional IH review and medical opinion on causation. Next slide.

SEM currently lists four work processes as linked directly to parkinsonism under the health effect link. These processes would have resulted in exposures to manganese, those are three of those processes and one with exposure to carbon monoxide. This information is slightly different from the information in the Procedure Manual which lists an additional 10 work processes associated with these presumptive exposures. These processes in the Procedure Manual are listed in SEM; however, for the claims examiner to access them, they would need to go to detailed properties of each of the toxic substances in order to be able to confirm they are linked directly to the diagnosis.

CHAIR MARKOWITZ: I'm sorry, could you explain that again? I didn't understand it.

MEMBER MIKULSKI: Out of that list of

the toxic substances, when you access directly each of those toxic substances, it provides you with more detailed information on that toxic substance which lists some of the work processes that are included in the Procedure Manual, but they are not linked directly to parkinsonism as these four. Next slide.

SEM also does not link or list 12 other work processes that are linked to parkinsonism in Haz-Map. These work processes are associated with presumptive exposures to carbon monoxide and manganese. Of those 12, we only found gas welding and capping listed in SEM and that was linked to toxic pneumonitis, not parkinsonism, so they would warrant to be added in SEM. Next slide.

We've put together a set of recommendations to follow our review and open up the floor for discussions and questions.

CHAIR MARKOWITZ: Steve Markowitz. Why don't we take questions, comments about the report first and then discuss the recommendations if there are any comments. Dr. Bowman, do you have

anything to add, by the way?

MEMBER BOWMAN: No, I think Marek did an excellent job presenting the information that we found and which forms the basis of the recommendations that we'll discuss later, if there are any questions about the report itself.

CHAIR MARKOWITZ: Steve Markowitz. If I understand it correctly on a previous slide, the Haz-Map had connections between carbon monoxide and certain work processes?

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: That would relate to parkinsonism. So, this has nothing to do with adding trichloroethylene or carbon disulfide, which was relatively recent. This has to do with the old recognized Parkinson agents?

MEMBER MIKULSKI: Yes, with the presumptive exposures.

CHAIR MARKOWITZ: Right. Thank you. Comments or questions? Sure, let's discuss the recommendations.

MEMBER BOWMAN: Perhaps we should go

through them one at a time?

MEMBER MIKULSKI: Sure.

MEMBER BOWMAN: Would that help? We have divided them, you'll see four paragraphs on the screen, which I don't know how many people's eyes can actually read those from the screen. I will proceed to read them if that helps.

CHAIR MARKOWITZ: Oh, yes.

MEMBER BOWMAN: These are recommendations that we discussed within the working group and we are proposing them as potential recommendations for the Board to make to DOL.

The first of these is the Board requests that DOL ensure that all work processes associated with chemical exposures that have presumptions for parkinsonism in the Procedure Manual also have the associated linkages to parkinsonism in the SEM. In essence, much of what we have here it's just a way of bringing coherence between the SEM and the Procedure Manual. Marek, anything else you'd like to add on that?

MEMBER MIKULSKI: No, I think this

reflects actually our reviews.

MEMBER BOWMAN: Any questions or comments about that?

MR. TURCIC: I have a question. Are you for putting the process associated -- okay, so you're just saying that the process of the chemical exposures that have presumptions for parkinsonism in the Procedure Manual also have associated links to parkinsonism in SEM.

MEMBER BOWMAN: Yes, that's correct.

MEMBER MIKULSKI: That's correct, yes.

MR. TURCIC: Are you referring to the toxics or are you referring to in SEM the direct disease link work process?

MEMBER MIKULSKI: So, these would be the links to work processes under health effects. Parkinsonism as a health effect.

MR. TURCIC: Okay. So, you're saying that those work processes should have a direct disease link work process in SEM?

MEMBER MIKULSKI: Correct. For those presumptive exposures to carbon monoxide,

manganese --

MR. TURCIC: Okay.

MEMBER MIKULSKI: And steels, yes.

MR. TURCIC: Thank you.

MEMBER BOWMAN: I guess we could make these slides available. Are these slides available to all on the call or just when it's up on the screen? I just think those work processes that we're talking about are the ones that were on the slides that we just went through and for which there's screenshots of the Procedure Manual.

MEMBER MIKULSKI: And we do have those in the report.

CHAIR MARKOWITZ: Okay sure --

(Simultaneous speaking.)

CHAIR MARKOWITZ: -- along with the recommendation there would be rationale and it could include the report.

MEMBER MIKULSKI: Yes.

CHAIR MARKOWITZ: Definitely.

MEMBER BOWMAN: Thank you. If no further questions about this, the next paragraph,

the second part of the recommendation that we have as a working group for the Board is that the Board also requests that DOL add work processes to the SEM and Procedure Manual that are currently found in Haz-Map that link parkinsonism to exposures that are already on the current presumption list for parkinsonism. These would be manganese and carbon monoxide. I'll open that up for discussion or comment.

CHAIR MARKOWITZ: Steve Markowitz. Just clarification, didn't the first recommendation ask the SEM to associate work processes for the traditional Parkinson's agents within the SEM? Aren't you repeating -- the first line of the second, isn't that repeating the same request? I understand the Procedure Manual is new, but adding it to the Procedure Manual, but adding it to the SEM, isn't that what the first paragraph is about?

MEMBER MIKULSKI: These are two different sources of these work processes. There is a set of work processes in the Procedure Manual

as well as another set of work processes in Haz-Map, so all together they could be combined in a single recommendation, I agree, but at this point, we recommend that both sets be added to SEM.

CHAIR MARKOWITZ: No, sorry, I wasn't recommending you combine them. I was just trying to understand.

MEMBER BOWMAN: If we go back one slide from what's on the screen.

CHAIR MARKOWITZ: I understand now.

MEMBER BOWMAN: Oh, you've got it? Okay, never mind. We don't need to. Yeah, separate lists these are the ones from the Haz-Map. We thought there would be value into itemizing these so they could be considered individually. Any other comments or questions about this second part of the proposed recommendation? All right, I'm not seeing any. I will continue on.

In addition, the Board also recommends that all associated aliases for parkinsonism be updated in the SEM and Procedure Manual to include primary parkinsonism.

MR. VANCE: This is John Vance. I do know that right now the Site Exposure Matrices list parkinsonism as the condition. So, is primary parkinsonism just a clarifying diagnosis or just another terminology that a physician would utilize?

MEMBER MIKULSKI: That would be another terminology that physicians would utilize. This was not covered. This was covered in the initial recommendation, but in the response we've only discussed the idiopathic and secondary, but not the primary parkinsonism, which is the same ICD code as Parkinson's disease, so there is a chance that a physician may address it that way.

MEMBER BOWMAN: I think there's a synonym coming on here so it is meant just as a clarifying term. That's why I'm open for discussion if there's concern, but we viewed it as a rather simple request.

MR. VANCE: Yeah, my point was just I think most claims examiners if they would see primary parkinsonism, they would automatically assume that it means parkinsonism. I mean I don't

see it as a particularly challenging to add it for clarification, I would think most claims examiners would go down that route anyway, but that was my question, just to make sure I was understanding it correctly. Thank you.

MEMBER BOWMAN: Any other comments? Finally, the fourth proposed recommendation is that we recommend that a working group continue a review of the literature to evaluate whether associations between parkinsonism and solvents, or other chemical likely to be present at Department of Energy sites, warrant consideration for new exposure presumptions.

This derived from conversations that we had looking at new literature since the last time such chemicals were considered and there is certainly a growing literature on the role of chemical exposures that risk for increasing the incidence of parkinsonism.

This can be found in both epidemiological literature, some small fraction of this literature even includes cohorts that are

inclusive of Department of Energy sites as well as mechanistic and molecular-based literature, looking at roles of different agents in risk for parkinsonism at the level of the molecular underpinnings of what's thought to be a part of the etiology of the disease. So, while this particular Board is expiring, we thought it would be helpful to have a recommendation that these be considered. I'm not sure how that would fit exactly into this recommendation, but we propose it here.

CHAIR MARKOWITZ: Comments or questions about just this last four? One comment I had actually, we're going to discuss it very quickly. The working group that looked at the Group 2A carcinogens, IARC carcinogens and essentially endorse the Paragon analysis of adding 2A carcinogens to the SEM. I wonder whether there should be an ongoing working group, sort of a science working group, that would monitor the parkinsonism, but also handle the Group 2A carcinogens. I realize we're talking cancer

versus neurologic disease, but at least have an entity that carrying forward, which will have diverse members of this working group and where we could park these ongoing science monitoring issues. That doesn't mean we need to change this recommendation, I'm just saying whether we want to continue that as the structural way of continuing the Board. Yeah, Dr. Bowman?

MEMBER BOWMAN: I think that does make a lot of sense in terms of sort of the work product of the working group being consistent with that. We certainly don't have a composition of this Board to cover all areas of the science and so we're often obviously moving outside of our principal scientific expertise to be inclusive of our more broad scientific expertise in the context of this and so, yeah, I at one point was on the IARC group as a part of that.

CHAIR MARKOWITZ: Oh.

MEMBER BOWMAN: And that made sense at the time.

CHAIR MARKOWITZ: Yeah, you may still

be on that group actually.

(Laughter.)

CHAIR MARKOWITZ: Okay, we need to take a vote on these recommendations.

MR. VANCE: Can I add a quick comment?

CHAIR MARKOWITZ: Sure.

MR. VANCE: John Vance. I had sort of a question. Dr. Bowman or Dr. Mikulski, when you guys were evaluating this, one of the things that I thought I'd highlight is that I know that our presumption right now as it exists in chapter 15 speaks about carbon monoxide, I think, and the exposure that triggers that presumptive standard.

What we have done historically is looked at for presumptive causation, looking at duration of exposure that the program can accept presumptively that if an employee encountered a particular toxic substance that could be associated with Parkinson's disease, parkinsonism or one of the other aliases, and the science is pretty confident that if you have an individual that worked

with trichloroethylene, carbon disulfide or one of the other identified toxic substances, is there is science that would suggest we're pretty confident that if somebody was working with this material for a certain duration of time and develops the disease, there's probably a very high probability that there is a causal nexus. Because that's what we have done in a lot of our other standards.

I know right now we sort of have this unique presumptive standard that's in our Procedure Manual. I think that would be one area that I'd be curious to know, have you looked at that? Is there any kind of medical health science that you think exists for that?

That's what we would really be most interested in is that the epidemiology that would show that okay, working with manganese and having an exposure of a certain duration of time, the program could be told, yeah, if you were working with this material for 10 days, 50 days, 60 days, 250 days is the standard we generally look at for

most of these presumptions, that would be very useful because I don't think that we've ever really looked at that specifically, but I'm just making that comment.

I was curious if you had seen anything in your review of that sort of nature in looking at that.

MEMBER BOWMAN: I think -- actually if what you just said could be contained within a response to this recommendation, it would help to inform this working group.

MR. VANCE: Okay.

MEMBER BOWMAN: Of sort of a sense, I think that's important. We have not gone to the level of identifying something that would say X number of days, 250 days or so forth. That, I think, is the work that needs to be done to have confidence that that should be a presumption and the --

MR. VANCE: Do you think that exists?

MEMBER BOWMAN: It depends on the nature of the epidemiological data. There's

usually definitions of how that work defines exposure. Now, it's not going to be that there's going to be looking at 50 days, 100 days. There's not going to be that kind of a level of detail.

There's going to be some threshold set in any particular study and then you would look at those data for that study. So, it's not that, for example, if there was a study where they set the threshold coincidently at 250. If such a study existed, that does not mean that 249 would not be likely. That's sort of the nature of the science. It's just because of where they set that in the study, but that doesn't mean we can't set a presumption based upon that literature.

MR. VANCE: Right and that's what the program would look for is a recommendation of presumption because what you're basically saying is if this occurs, we're accepting causation programmatically. If it doesn't occur that means we're going to defer to the judgment of a physician looking at the unique features of the case. That's all I was trying --

(Simultaneous speaking.)

MEMBER BOWMAN: No, and I think that would be fine. I think a response like that to this recommendation would help the next working group to think about it.

MR. VANCE: Okay.

MEMBER MIKULSKI: There is some very limited epidemiologic evidence in support of that. I believe we actually suggested a minimum duration of exposure in our previous recommendation, but this was based on a very small sample of subjects and, as such, wasn't really accepted under the presumption.

CHAIR MARKOWITZ: Steve Markowitz. But the current Procedure Manual contains presumptions for parkinsonism with carbon monoxide, steel, manganese, etc. This is a question for Mr. Vance, I don't think they -- they don't contain durations, do they?

MR. VANCE: Well, this standard actually has been in the Procedure Manual for quite some time. I think that was one of our reasons

for bringing it up for Board consideration was that it's very unique in the way it's presented in that it's identifying a presumptive standard when you're dealing with acute exposure to carbon monoxide that causes unconsciousness and if that standard is met, we're accepting that that is a causal nexus. Then it goes on to sort of talk about now here's some things that we know about Parkinson's that are substances that can induce it, but it's not communicating a presumptive standard.

What's in the Site Exposure Matrices is based on the information that has been recommended by the Board as far as aliases are concerned and making sure that we have identified in SEM those toxic substances with a known parkinsonism health effect. So, keep in mind that the SEM and the presumption are a little bit distinct. I do know that we've made a lot of adjustments to the Site Exposure Matrices based on the work of the subcommittee.

I think that if we could get this recommendation -- but I know that we would probably

likely come back with something like that and just say if we could get something like that and I know, I remember the recommendation on -- that was a very small study. I think it was like only eight or 10 people and we were like that doesn't seem like it's enough for us. But that's what we'd be looking for, is something along those lines.

CHAIR MARKOWITZ: I take it this will be a new request to the Board for additional information regarding parkinsonism in order to perhaps help fill out, modify the presumptions in the Procedure Manual?

MR. VANCE: Yeah.

CHAIR MARKOWITZ: Okay. Anyway, any final comments, questions about this recommendation? Otherwise, we're going to vote on them. By the way, Dr. Cloeren, can you see the recommendation pretty well?

MEMBER CLOEREN: Yes, just fine.

CHAIR MARKOWITZ: Okay. Does anybody on the Board need another reading of these recommendations? Okay, good. Then we'll take a

vote. I can't remember how we do votes.

MR. JANSEN: I'll record the vote. Dr. Bowman?

MEMBER BOWMAN: Yes.

MR. JANSEN: Mr. Catlin?

MEMBER CATLIN: Yes.

MR. JANSEN: Dr. Cloeren?

MEMBER CLOEREN: Yes.

MR. JANSEN: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. JANSEN: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. JANSEN: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. JANSEN: Dr. Vlahovich?

MEMBER VLAHOVICH: Yes.

MR. JANSEN: Mr. Key?

MEMBER KEY: Yes.

MR. JANSEN: Ms. Splett?

MEMBER SPLETT: Yes.

MR. JANSEN: Ms. Whitten?

MEMBER WHITTEN: Yes.

MR. JANSEN: Mr. Domina?

MEMBER DOMINA: Yes.

MR. JANSEN: There are 11 yes votes and zero no votes.

CHAIR MARKOWITZ: Okay, thank you. We're going to take advantage of having Paragon online to review the IARC 2A carcinogens. Paragon produced a report at the request of Department of Labor, report issued August 3, 2023, in which they reviewed the last couple of years of changes in the International Agency for Research on Cancer's ranking or classification of carcinogens and identified two probable human carcinogens, that's IARC 2A. Probable human carcinogen means that the expert review group reviewed available scientific studies and concluded that there was sufficient evidence in either mechanistic or animal studies and at least limited human epidemiologic evidence of a relationship between the exposure and human cancer.

It would be considered a definite human carcinogen Group 1 if there were more definitive

human evidence in epidemiologic studies. Paragon identified two 2A carcinogens; 1, 1, 1-trichloroethane and trivalent antimony. The trichloroethane is related to multiple myeloma. It's a blood cancer in humans and trivalent antimony related to lung cancer.

They concluded that these two carcinogens -- I'm just sort of looking at the document now, and basically they reiterated the IARC findings making them 2A probable human carcinogens. The subgroup that took a look at this report, which included, I think, Dr. Friedman-Jimenez, Dr. Bowman, myself and I feel like there was one other, but I can't quite remember. Anyway, we agree with Paragon's assessment. We need to just recognize or vote on this as a Board and the recommendation would be that the Board endorses the findings of the Paragon August 3, 2023 report, which concludes that 1, 1, 1-trichloroethane is a probable human carcinogen in relation to multiple myeloma and trivalent antimony is a probable human carcinogen in relation

to lung cancer. That's the recommendation.

Any questions or comments? I have a comment. I want to thank Paragon for looking over the 2A carcinogens and summarizing these for us. I think when we first did this, the Board did this several years ago, taking on 2A carcinogens. We did the original review which was laborious and it was much nicer to have a summary. We went back to the original 2A IARC documents to confirm it, but it was nonetheless much better to have a summary, so thank you for that.

Any other comments or questions? In that case, we'll take a vote.

MR. JANSEN: I'll record the vote. Dr. Bowman?

MEMBER BOWMAN: Yes.

MR. JANSEN: Mr. Catlin?

MEMBER CATLIN: Yes.

MR. JANSEN: Dr. Cloeren?

MEMBER CLOEREN: Yes.

MR. JANSEN: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. JANSEN: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. JANSEN: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. JANSEN: Dr. Vlahovich?

MEMBER VLAHOVICH: Yes.

MR. JANSEN: Mr. Key?

MEMBER KEY: Yes.

MR. JANSEN: Ms. Splett?

MEMBER SPLETT: Yes.

MR. JANSEN: Ms. Whitten?

MEMBER WHITTEN: Yes.

MR. JANSEN: Mr. Domina?

MEMBER DOMINA: Yes.

MR. JANSEN: There are 11 yes votes and zero no votes.

CHAIR MARKOWITZ: Okay, we're going to take a breath until 10 of 3 and then we'll continue with our recommendation regarding terminally ill claimants and then carry on from there. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:33 p.m. and resumed at

2:54 p.m.)

CHAIR MARKOWITZ: Okay, we're going to move on to the recommendation that the Board made with respect to handling claims from terminally ill claimants. Kevin, if you could bring back my PowerPoint.

MR. BIRD: Give me one second, I'm sorry.

CHAIR MARKOWITZ: Yeah, that's okay. Basically, the recommendation was that the Department have either each district office or some unit a single point of contact or point person, who kind of shepherds through the claims for claimants who are terminally ill and also serves as a point of contact for the claimants or their families to get updates about the claim.

Unfortunately, I'm waiting for my PowerPoint because the Department's response was a little bit longer than the recommendation and I summarized that in the PowerPoint. After that, we'll review response to claims review information relating to silicosis claims, the hearing loss

claims and then at 4:15, we have the public comment period, but we're going to have some time before that.

I thought we'd start on thinking through kind of to the end of this term. We still have two more months, but this is the last meeting. The end of this term and what we want set in place that would be in place for the next term. We'll spend a few minutes discussing that, we may have some extra time this afternoon. We may take a little longer break.

If you go about seven or eight slides in, go back, back. Okay, this was our recommendation from before. Next slide.

So, let's just discuss -- just taking elements from the response from DOL that the current system of handling claimants who are terminally ill or become terminally ill, this system works. The claims examiner can identify, designate claims for priority handling. The claimant and the authorized representative, if they want, can request to speak with the supervisors, get beyond

the claims examiner to find out what's going on with their particular claim.

There's a 48-hour turn around on IH and CMC reports that can be arranged, expedited. They provided several relatively recent examples from last year of claimants who were terminally ill with details about how well their claims were processed.

The floor is open for comments. Mr. Key.

MEMBER KEY: Yeah, I do not accept the Department's response. The current system is not working. It is broken. Again, Mr. Vance shared with us one successful turnaround that occurred, but he did not highlight the three or four others that no movement could be obtained and as a result, the claimants passed away without their claims being adjudicated, approved and compensation being provided.

I stand by the Board's request for a designated person in order to expedite. If the Department wants to continue to stonewall and delay and not provide us this, then we as a Board need to seek alternative measures.

CHAIR MARKOWITZ: Steve Markowitz. I wonder whether we can make some progress on this. I can think of a couple of things. One is we could get together the details protecting confidential information if we could, about the claims, Mr. Key, that you're mentioning that were not handled in satisfactory fashion.

Another approach would be actually to collect data from the system to the extent that such claimants can be identified. I realize the Department provided three examples and another one today, but just look at a recent year, two years' worth, whatever, whether such claimants could be identified. Then if there's a total of 20 or 30, whatever the number is, just look at certain aspects of how those claims were handled so that the Board could be confident, beyond a few examples, that the DOL method of handling these things is appropriate or whether there are problems.

Personally having read the response and looking at the Procedure Manual, etc., it seems clear that they understand the problem and that

they found some mechanisms to attempt to deal with the problem, that's not to say that it works perfectly either always or often. I really don't know, but we have anecdotes, we have examples. The question is should we request real data on a larger number so that we can understand what's going on. Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: So, there seems to be a disagreement about whether the system works or not. I don't know what kind of data you would have available that could answer that question. I'm thinking maybe you could just do a poll. Do a random sample of everyone that was on hospice say a year ago, who presumably would have passed and contact their family and ask them some questions, what you want to know about how long it took, how well the DOL responded to the needs of the person.

Just do like a marketing study, if you do it quickly, it probably won't cost much and it would probably give you some pretty useful information to answer that question about whether

people are satisfied or not. I mean this is not a science question, this is a question of people's satisfaction with how the program is meeting their needs or not and I think a marketing survey like that could answer the question.

CHAIR MARKOWITZ: Steve Markowitz. I have a related question about that. Do you have identified in the system terminally ill claimants? Are these new claims that are filed and the person is identified as terminally ill or are these established claims and then the person has a greater health need because they're terminally ill? They get worse and now they present as terminally ill? Can you identify sort of systematically over the last couple of years who is terminally ill?

MR. VANCE: Yeah, well, what we can do and this is where it gets to be the challenge, and this is John Vance. The way it works in procedure is that when you have a case and you have someone that has made a Report of a Terminal Illness. A terminal illness can be whatever the claimant wants to characterize it as. It will come into the

Department of Labor. We will then have it screened by the claims examiner to assess what is the medical evidence that supports that classification.

It needs to be something from a physician describing that this person has some sort of life ending disease, which we encounter quite frequently within the Department of Labor and some semblance of characterization of that as being short-term life expectancy. That's the challenge. If you ask a physician, okay, what's the expected life expectancy of this person, you're going to get a variety of answers.

Depending on how compelling or convincing or persuasive the physician's argument is, that will then be presented to a supervisor, who is responsible for deciding is there sufficient information to classify this claim as terminal and there is a flag that has identified in ECS. The interesting thing about that flag is it doesn't have a corresponding date stamp associated with it, so we know that a case has been identified in the past as being related to a terminal claimant.

That should then initiate the expedited processing of the claim through as many steps of the process as possible.

Now, of course, the challenge here is that just because you have a person that's identified as terminal doesn't mean that we can solve every evidentiary hurdle that exists in getting through to a compensable claim.

Where we can get the information quickly from the claimant, where we can get through every single one of the requirements for adjudicating the case, we can make it happen very quickly, especially if we start getting reports that that individual is really entering a last stage of life and that could be someone has been moved to palliative care. They're in hospice. They're in a hospital situation where their life expectancy is days or shorter. We can move along quickly, but if we are unable to get the documentation we need in a timely fashion, you're going to potentially end up in a situation where we can't facilitate a decision or a payment to an individual

before they pass away.

It's an unfortunate circumstance, but that's the way our mechanism works. We need the medical documentation that affirms the status of the patient as terminal. We need to have a supervisor review that, identify and flag that case as a terminal. We then need to make sure that the claims examiner is moving that case forward through the process as quickly as possible, but we still would need those requirements for a compensable claim to be met. If we don't have that information, we can't necessarily just bypass those requirements. So, that's the challenge that we have.

I will say plainly that we do take it very seriously to try to move these cases along. The challenge, of course, is that it's difficult for physicians, for claims examiners and anybody else to predict what the life expectancy of any individual is.

The other aspect of this that I don't mean to sound callous, but the reality of a terminal

case is your taking a lot of people offline to move these cases through and we will do that, but, you know, for a lot of authorized representatives and other folks we work with they feel that simply using the word terminal status is going to get their clients preferential treatment. So, we're also dealing with that type of a scenario, where okay, you have now given us a physician's one sentence note just saying, this person has a prostate cancer and is terminal. Is that compelling and convincing and what do we know about that?

So, it's a really challenging situation that we're facing and that is something that we are hoping the Board can help us with, because that's what we're facing. It's a hard reality and while the program goes to great lengths to try to proceed through with development as quickly as possible, there are other situations where we get very poor information up-front. Maybe the patient is suffering from a much more debilitating disease than what the physician is writing in a letter. Because we're judging it based on what a doctor's

communicating to us. There are many challenges here. Trying to define what a terminal status client is or claimant is that's the challenge.

CHAIR MARKOWITZ: Mr. Domina.

MEMBER DOMINA: Kirk Domina. I just have a quick question. What triggers a claims examiner to really move it to a supervisor? Because some of the things we hear, it gets hung up at that stage.

MR. VANCE: Mr. Domina, it's going to get caught up at that stage if the claims examiner is struggling to understand the -- I'm trying to say it in a not offensive way. Like what is the truth behind what they're seeing in a medical report. I've seen some of these things and I know that physicians are told, you know, hey, I can get this claim moving along faster if you just write down on a piece of paper that my client's terminal.

So that comes in and the claims examiner is well, what does that mean? I don't see anything in the case file that would corroborate that kind

of a classification. So then what we end up in is this really unpleasant reality of a claims examiner reaching out to an authorized representative or a claimant or their physician and saying well, I need more information about your terminal status, which is also very unpleasant for our claims examiner to have to face.

We've had to counsel claims examiners about the appropriate interaction on those kinds of circumstances. It's fraught with emotion. It's very challenging. I understand what you were trying to suggest about doing some sort of survey, but remember this would be going to people that have lost someone, who has gone through a lot and you would have the federal government coming along asking you to complete a survey about how well it went. It's just fraught with a lot of problems and yes, things happen that are not the way we would prefer them to happen and it's a challenge.

If you create a specific standard for what we define as terminal, you're going to find that people will force it. They will try to do

that and it just becomes how well are they documenting it and then you get into a variety of things. So, we have standards in place to try to deal with it, but it's an imperfect solution to a very challenging situation.

CHAIR MARKOWITZ: Steve Markowitz. Does a claims examiner have access to a physician on short notice if they have a letter from the personal physician saying this person is terminally ill. They have some medical records and they really need help in the short term to get a physician's input into whether this really sounds like a terminally ill person or not.

MR. VANCE: Yeah, what we have is the availability of our DEEOIC nurse consultants. A claims examiner can make a referral to one of the nurse consultants who can reach out on a one on one basis to reach out to either a home healthcare company if that's the situation or the physician's office to try to get that information. Again, we have to be very delicate about our efforts to try to validate the status of someone in those kind

of circumstances.

CHAIR MARKOWITZ: There you go. Ms. Whitten.

MEMBER WHITTEN: Dianne Whitten. I'm just wondering how many terminal ill claims you get say a month.

MR. VANCE: I'd have to go back and get that information. I don't know how many are classified as terminal, but it's a fairly large number, but again, we would only be able to tell you that at some point in that case, the employee has been designated as terminal. We don't really have very good temporal data. We'd have to do some analytics to try to figure out how to do that --

(Simultaneous speaking.)

MR. VANCE: -- and to provide that information.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I'm not sure the exact number or percentage of people who have a terminal illness who go into hospice, but I think

it's pretty high. Dr. Cloeren may know roughly percentages, but I would say I agree it's a very delicate and difficult topic that is fraught the possibility of hurting people, alienating people, but if you just look at how many claims are made for -- there's a formal application for hospice. Look at your hospice patients, they're usually pretty well characterized.

The hospice patients would be a good base that you could sample after the fact and frame it in a way that we're looking to improve our services that we provide, would you mind answering a few questions. Ask some questions to start out that ask about what we could do better and, you know, are there any things that we could have done that we didn't do and what did we do well? What was good about it? Then ask how long it took and if they were satisfied with the process. I think it could be done without harming people.

MR. VANCE: What you're speaking about with regard to hospice, would be one of the factors that we would look at in evaluating the medical

evidence characterizing someone as terminal.

In other words, if I get a medical report that is from a physician stating that my client with prostate cancer, no further care is going to be improving this person's status. The prostate cancer is one problem of a multitude including cardiac failure. This person is now immobilized and bed bound. This person is moving to palliative care with hospice. They're on severe pain medication and I'm not expecting this person to live more than two to four weeks. That's pretty convincing evidence compared to another physician who writes well, this person's got prostate cancer and is terminal.

Okay, that's what you have to understand is that information that we get and all the claims examiner is getting is the information that's been written down, then they have to take that and decide okay, is this enough. If I take that to a supervisor, they're going to look at it and say what else is going on with this person with prostate cancer? Then they might look at recent objective

treatment notes and what happens when there's no active ongoing treatment, there's no indication that anything has been going on in that case. Nursing notes might be there, but there's no indication that the person's status has changed.

All of these things are things that have to be evaluated when you're looking at those kind of cases because it is a resource-intensive effort to prioritize and move these out of the routine process to bring new people on to try to move this through the process much quicker. You're talking about all right, we've got to put a rush on dose reconstruction if it's a Part B case. We've got to put a rush on a CMC referral. We've got to push an IH referral.

All of these things we have mechanisms to move them through, but that's an exception process, that's not routine. So that's just something that everybody has to understand exists in that process.

CHAIR MARKOWITZ: Steve Markowitz. There's a question I'm wondering about. Is there

a standard definition for admission for hospice care? Is it less than six months expected life remaining?

MEMBER FRIEDMAN-JIMENEZ: There are objective criteria and most people do meet those criteria. Some people outlive their six months or whatever prediction. It's not that inexact a science, you know, most of the physicians can give a roughly accurate prediction, but the people that don't apply for hospice and that say that their patient is terminal, there may be some other issue there that they're perceiving that there's a delay and they may be dissatisfied and that's a sign of it, but those people then wouldn't be included in the survey. You might have to find another way to get their opinions.

CHAIR MARKOWITZ: I mean, you think, let me just follow this up. Insurance companies, which cover hospice care have to pay money for additional special services for hospice and so you'd think they would have worked out some sort of standardized definition of who's eligible for

hospice care, which they may or may not be right all the time. They're probably not because it's inexact, but still there would be a standard that perhaps could be useable by the program. Mr. Key and then Mr. Catlin.

MEMBER KEY: Yeah, so I'm a little bit passionate about this because three of the cases that I'm aware of, I worked with these individuals. They all met the SEC criteria. There was no dose reconstruction that needed to be done.

In the one case, the doctor supplied additional medical information. The individual was in the hospital. Supplied that information. The CE was contacted, trying to push it through, three days later the gentleman passed away. The second case, same scenario. The doctor provided the information within a week that individual passed away.

As far as a survey, on the one case of the gentleman who only lived three more days in the hospital, we cannot even get his daughter now to talk to on the phone to file for survivor benefits

because of what she saw and what she went through. I think in that case if they received a survey, it'd go in File 13 immediately. They wouldn't waste their time with it. As I say, the current system does not work.

CHAIR MARKOWITZ: Mr. Catlin.

MEMBER CATLIN: Just to Mr. Vance, and I recognize how really delicate this whole question is. My wife has been a hospice volunteer for decades and this is really a tough issue. You mentioned that you all could flag the cases that have been in your system where people have gotten -- are you able to also identify cases where the claimant or the claimant's doctor made the request, but then it was denied for various reasons and you've described some?

MR. VANCE: No, the flag identifier would be that that's the identifier that signifies that a CE has identified medical evidence that the supervisor has reviewed it and agrees that that case should be designated as terminal. If they would not identify it as terminal because they don't

feel that the evidence satisfies that requirement, it's not going to have that flag. There wouldn't be -- it's not a decisional metric. It's just is the evidence sufficient to characterize is as terminal or not. Again, the temporal data just doesn't exist for like when does that flag turn on or not.

MEMBER CATLIN: Okay, so that set of cases we wouldn't be able to identify?

MR. VANCE: No.

MEMBER CATLIN: So, I'm just wondering because what I'm hearing is it sounds like the potential problem I'm hearing is that the more definition of what standard you'd want a physician to meet for that criteria of rapid end of life, then there may be people who misuse that standard to try to accelerate their own cases.

MR. VANCE: Yeah, this is John Vance. I don't want to suggest that there's anybody acting in an inappropriate way, but you have circumstances where maybe it's not clear what that means and we're not able to ascertain are you talking about that

person being terminal in years or months or days or hours and that's the challenge.

We have looked at trying to define terminal status much more explicitly and it has always been whatever we've come up with just isn't going to work. That's why it operates now based on sort of a discretionary authority and our guidance is you know it when you see it kind of thing.

When we have a CE that reviews it and has a supervisor that can certify that status, then we feel that that's an appropriate way to address it. It is a challenge simply because if you're looking at something and saying well, why isn't this person terminal? Well, then you've got to start asking these very challenging questions about give me more information about your terminal status, which is very difficult to get that kind of information.

That's why we do rely on nurses for very delicate interactions between claims examiners and usually my preference is to go to the authorized

representative to explain it, if one exists, because if you're going to the family to ask those questions, it gets really very challenging very quickly.

MEMBER CATLIN: Okay, thank you.

CHAIR MARKOWITZ: Ms. Splett.

MEMBER SPLETT: I'm struggling a little bit with this. I would think if you -- first off, I know it's a very sensitive subject, but if you get presented with somebody who's an SEC claimant, where you've got the diagnosis, that would be relatively easy to expedite, would it not?

MR. VANCE: Yes.

MEMBER SPLETT: But those that still require more evaluation whether a NIOSH dose reconstruction, those would be much more difficult and you'd need to follow the process regardless of their status, correct?

MR. VANCE: Right.

MEMBER SPLETT: So, I think from what I understand from the last meeting, the recommendation was there a person in each office

to look at each one of those to get them going down the right task? Not just saying everybody who's a terminal claimant gets paid because that's not correct.

MR. VANCE: If I recall correctly, the recommendation was that we would have claims examiners dedicated to facilitating, expedited processing of terminally classified cases. Yes, what you're saying is true regarding SEC cases, they're much easier to process, but we have routine processes for most of our cases. The routine processes for an SEC we process --

MEMBER SPLETT: They're pretty straight forward.

MR. VANCE: There is an incentive there for the claims examiner to process those out of the system because they're easy. I always do the easy stuff first then you move to the more challenging cases, like the dose reconstruction cases.

What ends up happening though is when you have a terminal designated case, a terminal

request come in, you've got to make a judgment, okay, is there enough evidence here to sort of supercharge that case through the process? To sort of create an exception because even if it's an SEC case, that means that okay, we've now got to move, if it's terminal status case that means I've got to move quickly to get that recommended decision written. That might mess up my case adjudication planning for whatever else I was doing because now I'm moving that to the head of my queue. I've got to do that, then I've got to coordinate with the Final Adjudication Branch to let the hearing rep know hey, this case is coming. I've also got to call the authorized representative and say you have to get this waiver in as quickly as possible and what happens when the authorized representative doesn't call you back? Well, that's causing time, more time.

The hearing rep has got to get that decision issued and verify that it's a payable case. They issue the payment documentation, they then have to go get the fiscal people and we have an

entire process set up separately for same day payments which requires, it's like launching nuclear weapons. You've got to have a person with the certification officer key. You've got to have somebody that is the data entry operator. Those people have to do a sequence. You've got to then transmit that information to the Department of Treasury and meet their expectations. The Department of Treasury says you've got to have those in by a certain time frame, so then they're rushing to have that.

There's so many steps involved. So you can imagine the time commitment to move those to an expedited status. So, yes an SEC case is simple once you start saying it's a terminal case that requires exception processing, you're taking extra steps to move that along and there's a lot more coordination.

When we get those kind of situations, I will get involved or Josh will get involved where we're reaching out to the resource centers because we have this EN-20, well where is the EN-20? It's

with the authorized representative. Well, we need the patient to sign the EN-20 and that means we've got to run over to the hospital. We've got to run to the hospice facility to try to get this signature in place. If that person is unconscious, we now need to get a power of attorney in place.

MEMBER SPLETT: Yeah.

MR. VANCE: So, I mean there's so much work involved with these and it's a challenge. When you're talking about those situations, it might take days and while you're talking about days of us trying to get all these pieces together, that person passes away, unfortunately, that's what we're dealing with, which is that person just missed out on the opportunity to get paid. Now we need to look and see okay, well, is there an eligible survivor and the hope is that there is, but if there's not that means that that family potentially lost out on compensation because of the way the statute is.

(Simultaneous speaking.)

MEMBER SPLETT: I picked your

recommendation, Mr. Key, I'm looking at you, was that there be one designated person in each district office to help coordinate that process. Is that correct?

MEMBER KEY: Yes, ma'am.

MEMBER SPLETT: Is that -- okay, I'm not going to say.

CHAIR MARKOWITZ: Yeah, Mr. Domina.

MEMBER DOMINA: I just have a comment because you helped me back in 2019 with a mesothelioma, which drug almost a year of which never should have happened and you know that as well as I do. So, let's just say that you get a couple of meso cases, then they should be paid, I would think, no later than 30 days, 60 days max, you know, because generally they live a year, but what if they don't? Because this one, I never should have had to go to you.

MR. VANCE: Yeah.

CHAIR MARKOWITZ: Other comments or questions? I propose that we kind of think on this overnight and then come back tomorrow and decide

whether we want to make some further recommendation on this topic and maybe people can talk among themselves. We can't talk as a Board unless we do it in public, but you can talk among yourselves and decide whether there's some formulation of a recommendation that we think would be helpful.

Okay, so the next topic is information we've gotten from the Department on claims that have been reviewed. I didn't prepare a slide, I just have some numbers to share with you. This relates to two things, one is hearing loss and the other is silicosis. I think mostly in Nevada.

On the hearing loss what happened was the Department liberalized, created an alternate pathway for employees who didn't have a job title in the qualifying list of job titles, but had a comparable job. They looked back on 1,000 cases with these updated requirements and ultimately identified 139 Part E claimants. We evaluated them and of the 139, 82 were accepted. I guess they'd been previously denied and 10 were denied and that leaves about 47 which are still in process. That's

a favorable outcome.

On chronic silicosis, there are some requirements that need to be met in terms of 180 work days of occupational exposure to silica or work in the tunnels and at least a 10-year latency. When they looked back, there were 15 claims that needed to be reopened. They've issued the final decision in 12 of those claims, I'm sorry, 12 were accepted, so 15 looked back, 12 accepted, one was still in process and the one didn't meet established criteria and one I don't know what happened to it, but in any case, the vast majority of them, 12 out of 15, were accepted and one is still pending.

Those are the experiences of looking back on these two categories of claims. Any questions, comments?

MEMBER CLOEREN: Dr. Markowitz? That was just for Part B silicosis, right? Because Part E --

(Simultaneous speaking.)

CHAIR MARKOWITZ: Yes, Part B.

MR. VANCE: No, it was Part E.

CHAIR MARKOWITZ: Part E.

MR. VANCE: Right, under Part B we --

(Simultaneous speaking.)

MR. VANCE: -- already have a statutory standard for developing chronic silicosis cases. What we did was added essentially an epidemiological presumption for silicosis under Part E.

MEMBER CLOEREN: Gotcha. Thank you.

CHAIR MARKOWITZ: But didn't this result as the change in particular at Nevada recognizing that working in the tunnels beyond 1992 --

MR. VANCE: There were two factors we looked at. The 1992 date, so for everybody in the room, we had originally had a policy that basically said that there was no underground experiments or testing relating to nuclear weapons that occurred after 1992, which was the test ban treaty.

Well, when the Board raised this, we went back and started looking at it and we actually interacted with Paragon on it and we actually went

back and looked at some resources that were available at the Nevada Test Site.

We found that they were still doing testing and experiments relating to nuclear weapons, just not detonations or criticality, so they were doing underground mining and other types of things. In fact, it's the nuclear stockpile -- there's a name for it. It's like basically they're making sure that the components of the weapons can still work and function and so they're testing those things and they're still doing mining of tunnels for those experiments.

We accepted that that standard would be met after 1992. When we were looking at the cases, we were looking at a change in our standard for presumption under Part E and looking at cases affected by that 1992 date change.

CHAIR MARKOWITZ: Okay. Any questions, comments on -- this is really just a report back on information requested.

We have a few minutes before the public comment period and we will take a break, but I wanted

to open the discussion about setting things up beyond July for the next Board. My question is, should we have a couple of standing working groups because we have issues that occur either continuously or recurrently. Some issues that still are going to require looking at over the next period of time.

As opposed to ad hoc groups, we could have two or more standing groups that deal with problems. One I can think of was related to the Site Exposure Matrices, since there are questions or issues that people express continued concerns.

I can think of a second one, what I mentioned before of a science working group, which immediately would deal with the issue of what we think is a coming request regarding parkinsonism from the Department, but also they would take on updates on IARC 2A carcinogens and any other science questions that come our way, which happens occasionally from the Department and possibly other working groups.

I don't know whether industrial hygiene, the CMC require a standing working group. Maybe combining the two, although they usually involve different people from the Board. What do people think? Are people thinking still?

(Laughter.)

MEMBER CLOEREN: I think that sounds like a good idea, Steve.

CHAIR MARKOWITZ: Okay, good idea. What's a good idea, Dr. Cloeren?

(Laughter.)

MEMBER CLOEREN: Having standing groups addressing recurring issues.

CHAIR MARKOWITZ: Would you have one for IH and CMC?

MEMBER CLOEREN: Yeah, I mean maybe consider it, I don't know, quality of causation analysis or something along those lines.

CHAIR MARKOWITZ: Other comments, questions. Yeah, Dr. Bowman.

MEMBER BOWMAN: I tend to support as well as this idea of the IH and CMC as a standing

many of the things we talked about, for example, on the IH, were relating to communications between IH and CMC and vice versa.

So it makes some sense and within that working group there could be sub-working groups, I would think, given that you noted that the composition of these two groups has been different. What title for the science board reviewing literature for considerations of presumptions and such? You had a title for that group?

CHAIR MARKOWITZ: No, that question is open for suggestions.

MEMBER BOWMAN: Yep.

MEMBER CLOEREN: Epidemiology.

CHAIR MARKOWITZ: What's that, Dr. Cloeren?

MEMBER CLOEREN: How about epidemiology? It's a fancy name, epidemiology, the Epidemiology Working Group.

CHAIR MARKOWITZ: No, I think it's broader than that actually. Because causation includes other concerns. We don't have to come

up with a title today, we can come back tomorrow refreshed and think of a new title.

MEMBER BOWMAN: Was there a third group you were suggesting? I don't know if I --

CHAIR MARKOWITZ: Well, the three that I had was the science, the SEM and the IH/CMC, so those are three separate groups. Are there other ongoing issues that would require that kind of structure?

MEMBER BOWMAN: So, there was the group that we're going to bring up tomorrow on the sensorineural hearing loss. I think that might easily fall under the science board, so that would be just one more under that overall board and not require its own potentially.

CHAIR MARKOWITZ: Right.

MEMBER BOWMAN: Because it's a similar sort of activity as the IARC NPD (phonetic).

CHAIR MARKOWITZ: Yep. Okay, well why don't we take a break. We have actually until 4:15 public comments. How many public commenters do we have? Three? Three, okay, good. So, 4:15

let's be prompt because it's public and we're online and then we'll take it from there. We'll reconvene tomorrow at what time? 8:30, okay and I'll adjust the agenda somewhat, but we do have a number of things to cover tomorrow, so we will be prompt and we conceivably might even be done a little early. Back at 4:15.

(Whereupon, the above-entitled matter went off the record at 3:35 p.m. and resumed at 4:15 p.m.)

CHAIR MARKOWITZ: Okay, it's 4:15, we open the public comment period. We have four commenters. Please hold you remarks to ten minutes so it gives us a little bit of wiggle room. And the first is Mr. Calin Tebay, who may not be here, actually. He=s in the hallway.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Yes, would you mind?

And the for those online, we=re going to have Faye Vlieger, who=s a former Board member, we=re going to have Deb Jerison, who=s here, and we=re going to have Tyler Bailey.

Welcome, Mr. Tebay. I was saying that you have ten minutes.

MR. TEBAY: I have ten minutes?

CHAIR MARKOWITZ: Yes.

MR. TEBAY: Really?

CHAIR MARKOWITZ: I know you only have three minutes of comments, but I=m saying if you want you have up to ten minutes.

MR. TEBAY: I could take, like 30 to 40 minutes --

CHAIR MARKOWITZ: You have ten minutes.

MR. TEBAY: Okay, I have ten minutes. Thank you for all your participation on the Board. I=ve been on the Board. It=s not easy. It=s hard work. I appreciate the opportunity to be able to provide comment today.

I am Calin Tebay. I work for the Hanford Workforce Engagement Center. I started as a sheet metal worker on and off site as a building trades sheet metal worker. So I=m pretty familiar with a lot of the conversations that happen here.

I also was a HAMTC sheet metal worker, and I worked safety and health under MSA and HMIS. So a lot of these conversations today are in an office I am now, the Hanford Workforce Engagement Center. We are a one-stop shop that provides education to workforce on short-term disability, long term disability, paid family medical leave, labor and industries, EEOICPA. Sometimes we even get into VA benefits.

A lot of times these programs obviously conflict, and some people don=t know that before they get into these programs. So we kind of provide an education on all their options. And from there they are allowed to choose. So EEOICPA is a major part of our office.

My first comment today is regarding the beryllium modification that was, I think -- January, I think, is when the -- is Mr. Vance still here? Is he -- I think it was January was when we --

(Simultaneous speaking.)

MR. TEBAY: Yes, January. So I did a

little homework, and it seems that I was pretty energized on that topic. But I did a little homework, and the three-year time limit was not a part of the original drafts.

But it seemed that somewhere in Congress and in our Senators that that three-year time limit was attached to be consistent with OSHA which was not really, at the time OSHA was not what I would say completely accurate.

So getting that changed, right, after all the time it took us to get it done to begin with, getting that change is going to be rough. I would say that we still have a gray area and a population of workers that will not be able to get a claim, even though they have a diagnosis that came with three borderlines outside that time period.

Some of those folks, depending on the algorithms, some of those tests become false positives or false negatives. And there never is a diagnosis. But for those folks that do get a diagnosis outside of the three-year time period,

we still have a population stuck without an avenue.

I would ask that maybe the former Worker Screening Program, which we=ve discussed, maybe extend testing to those folks that maybe justify the test after the primary test. Maybe that=s the fix. Maybe that=s the fix for people going forward. But we=re still always going to have a population that is not going to qualify because of the three-year time period.

And that discussion happened earlier today, and I appreciate that. I didn=t have to travel all the way from Washington State to have this conversation, but I=m here. I appreciate the conversation.

My second topic was expediting claims, which Mr. Key had some energy on. I want to clarify that any time that my office is involved, and we=re not authorized reps, right, we=re just workers from Hanford that you come in and see that help you navigate, we provide the ability to use the fax machines, printers, computers, we teach people how

to navigate the Energy Document Portal. We just help those folks that don=t want to utilize an authorized rep.

But anytime we=ve been asked or questioned about expediting a claim for purposes of terminal status, that terminal status, and originally I believe it was terminal, and then it was imminent terminal, or it was terminal at less than six months. And now it=s, I believe, what we=re asked is imminent with days to weeks.

So the interpretation has changed several times in the past. I=ve been doing this almost 14 years, I=ve been doing it six years at the HWEC. And so that interpretation has changed on what the doctors are asked to document.

Now, we can=t just call and ask anyone to provide this letter. When we ask for an expedited process, we=re asking a doctor to write this letter that documents that this person is in immanent status. They have days to weeks to live, based on their judgement, right, at that point.

Now, although we=ve had some really good luck with the Seattle office, I can=t speak outside the Seattle office, with these style of claims, and I understand that the DOL does have to have the right people in places to carry out the process.

The fact is, is most of the burden is on the worker, because although the steps are there when you request that expedited process, there=s forms, right. There=s a process, there=s certain forms that have to be filled out, and submitted, and returned.

And you have to provide those across the platforms that the DOL requires. You can=t just email those to your CE. You can=t just fax EN-20s. You cannot just, I mean, you can=t just pick up the phone, right. Sometimes these are after-hours. You know, imminent situations don=t always happen between 8:00 and 4:30.

So the burden, although the DOL does have a burden, and they=ve been responsive, we have to look at what the family is dealing with at this

point. And what I mean is, is we are the ones that have to run out and get those documents. We are the ones that have to access a computer and try to get it through the portal. We are the ones that go out and get the EN-20s, and the previous waivers, and whatever forms that are required.

And as Mr. Vance has said, sometimes if that person=s not conscious there=s a power of attorney, right. There=s a lot of pieces and puzzles. But there is not, that I know of, one individual that I can call and rely on to complete this process.

And a lot of people that we deal with don=t even have the resources to provide that kind of communication or exchange in their own homes. So to do that, it sure would be nice if we=ve seen some kind of step by step cheat sheet. What do we call them? I don=t know, management directive or office directives. At Hanford we=ve got a name for everything, right. But we have some sort of a cheat sheet that says, if you=re going to expedite the process, these are the people you contact, these

are the forms.

I mean, pretty much most of the people in these processes are winging it at that point. And if they don=t have somebody like us around, or an authorized rep that is really fluent in the process and has all those resources, it=s almost impossible to negotiate.

I do appreciate the ones that we have asked. I think the DOL has done a fairly good job in the Seattle office. Like I said, I don=t know about the other ones. We get some pretty good support. But we do have ones that we just can=t get done. And it is because of a lack of communication. There=s a breakdown somewhere in the process.

And we=ve run out of time. So I think that that conversation would almost fuel itself for some conversation, right, and then try to figure out a way to solve that, or drill down as far as we can and try to eliminate missing those pieces as much as possible. So that=s all I=ve got.

CHAIR MARKOWITZ: Thank you. I have

a clarifying question. So you described success on this issue in Seattle. And is it because of your unique, the presence of your unique organization?

MR. TEBAY: I think so.

CHAIR MARKOWITZ: Oh, that=s good. Because the assistance you can give the claimants who have to produce any number of things in the process to make it happen, but in addition, in combination with a Seattle office that is very responsive, is it the combination, really, that --

MR. TEBAY: I think it=s the combination. I think we are prepared to go through those processes when they happen. And I think our CEs there, once that happens, if the CE is responsive right off the bat, you=re only as fast as they are, right? You=re only as fast as the DOL.

So we are prepared, between 8:00 and 5:00, or from 5:00 until 8:00 the next morning, right, we have the ability to stay and complete

the process. But we=re only as good as the DOL at that point. Because when they start -- when we submit the document they ask for, and then they return that response saying, okay, now we need this, we immediately, you know, we keep that process going.

But I think, because the uniqueness of the HWEC and the relationships that we=ve built, I think that it works for us, but not everybody. In fact, the HWEC that I work at is the only office of its kind in the whole DOE complex. Not everybody has that resource.

CHAIR MARKOWITZ: Okay, thank you very much.

MR. TEBAY: Thank you.

CHAIR MARKOWITZ: Next we have, I think online, Ms. Faye Vlieger who, I might just say for Board members, was previously a Board member. So, Ms. Vlieger, are you there? You need to unmute yourself.

MS. VLIEGER: There we go, how=s that?

CHAIR MARKOWITZ: That's great.

MS. VLIEGER: Okay. As Dr. Markowitz said, I=m a former Board member. And I have been an authorized representative for claimants since 2004. It=s been my experience that the Board has the ability to do many things. And of the discussions held today, I hope that we can come up with a constructive solution to the industrial hygiene statements that are prejudicial in the claim files.

The ANWAG, the Alliance of Nuclear Worker Advocacy Groups, has submitted a letter. Al Frowiss submitted it to the Board. And I would like to read the letter, however, I don=t know how much time I=m allotted.

CHAIR MARKOWITZ: So you have ten minutes.

MS. VLIEGER: Oh, great. Let=s see if I -- up to ten minutes. All right, let=s see how far we can get.

Dr. Markowitz, the Alliance of Nuclear Worker Advocacy Groups has written to the Advisory Board in the past on matters of importance to

advocates and claimants. Most recently, policies and practices related to the management and utilization of the Site Exposure Matrix has garnered much attention.

AToday we write with concerns related to the industrial hygiene process which we believe should be revisited with an eye towards correction, improvement, and common understandings.

AWe focus on the following, use of the monitoring evidence language in IH reports which creates incomplete or false impressions to the reader/claimant, program communication processes, and understanding of respective rules and responsibilities between claims examiners and IH staff and, three, commonly understood rules of evidence from a program and legal standpoint. We raise these issues and ask questions, and certainly do not have the answers.

ASite monitoring language in IH reports, a stated objective for IH reports is to present a reasonably accurate assessment as to the potential chemical exposures based on a worker=s

job function for consideration of the claimant=s physician, or a contract medical consultant, for the purpose of developing a causation opinion.

AThis process is heavily reliant on a physician=s interpretation of an IH report and then their comfort and willingness to provide a causation opinion.

AANWAG and the Board have previously discussed references to adherence to regulatory standards found in the IH reports. And the language was removed by policy change at DEEOIC. The language=s concern we raised today follows.

"It is important to note that after the mid-1990s, environmental health and safety programs at DOE facilities were well developed and fully implemented. These programs include, but are not limited to, chemical/hazardous material management programs, strong administrative and engineering controls, the extensive use of personal protective equipment and, where appropriate, industrial hygiene monitoring.

AThis does not mean the employees would not have had potential for hazardous exposures. However, it does mean that the likelihood for significant exposures or toxic materials at DOE facilities was greatly reduced after the mid-1990s, and that any work processes, events, or circumstances leading to significant exposure would likely have been identified and documented in employment records."

The next paragraph, "However, there is no evidence in the case file, i.e., personal and/or area industrial hygiene monitoring data, claimant provided information or documentation, or other relevant site industrial hygiene records indicating that, as part of this position after the mid-1990s, exposures occurred that would have been considered a workplace exposure violation or incident. Any exposures he or she might have received, as part of this position after the mid-1990s, would have been incidental in nature, well-controlled and not significant."

The first paragraph is found in the

opening discussion paragraph of Case ID 50034644, and Case ID 50040561 IH reports. And the second paragraph is presented as the conclusion of each chemical assessment of all DOE employment occurring after 1995 when an IH opinion is that there have been either no exposures or insignificant exposures, most all cases.

There are many aspects of this boilerplate language to breakdown as to what is factual, presumptive, and practical, given the variations in operational and records management policies at all work sites.

However, our focus herein is on the intended reader of such reports, a claimant=s chosen physician. Our contention is that this language directs the reader, the physician, to the conclusion based on misleading assertions, that there was, A, no exposure of significance, and B, there were processes in place to monitor individual and site exposure levels for all chemicals in question.

The language has the potential to

discount incremental causation and/or contribution due to chemical exposures without supporting facts.

ANWAG requests a review of this language and its implications and potential actions including, one, a recommendation from the Board for removal of such language from all future IH reports.

Or two, a requirement for proof relative to the scope of the actual individual and/or site monitoring if, in fact, there was any, and the above language is used in an IH report.

Or three, moving the language to make it a footnote or a separate paragraph in the reports that makes it explicit that the language is based on non-public statements, assertions from DOE, without detailed or claim-specific support in the record, and that it fails to acknowledge that business practices varied from site to site, and there may be the potential for unaccounted exposures.

It is useful to note that the

conclusions reached and communicated by the DOE-contracted industrial hygienist are at odds with the EEOICPA legislation. Nowhere in the statute passed in 2000 is there a suggestion that, after 1995, the DOE had implemented and always adhered to applicable industrial hygiene regulations.

The amendments passed in 2004 that created Part E and repealed Part D, made no reference to DOE=s successful and effective implementation of industrial hygiene regulations.

The EEOICPA is a remedial statute designed to reverse decades of DOE efforts to prevent workers from receiving their compensation for their occupational illnesses.

DOE, the agency that exposed its workers to hazardous substances, sometimes without their knowledge or consent, should not be given the benefit of the doubt on this issue in the absence of evidence that occupational exposure was properly monitored.

While it is a worker=s burden to show

that their occupational illness was contributed to by exposures at a DOE facility, it is completely inappropriate to prevent the worker from making their claim when DOE cannot present relevant industrial hygiene evidence and did not collect and preserve industrial hygiene data.

This turns a program designed to attempt to give the worker the benefit of the doubt where evidence is sparse or absent upside down, such that the DOE is given the benefit of the doubt connected to its industrial hygiene practices in the absence of relevant industrial hygiene data.

This places the burden of industrial hygiene monitoring on the worker and not DOE. It is/was not the worker=s obligation to collect industrial hygiene data. Without evidence, the IH report is nothing more than conclusory speculation and conjecture, which is exactly what the IH process is designed to eliminate from physician medical opinions as to causation.

Recently the DOL agreed to lift arbitrary limit on Part B chronic silicosis claims

after October 1992, agreeing that the mining of tunnels was continued at the Nevada Test Site to the present day.

This means that current Nevada Test Site employees could potentially have a chronic silicosis claim accepted under Part B should they meet all the criteria. However, if the worker falls short on one criterion, such as the latency period, then they are subject to an IH referral.

So now, solely because a worker was diagnosed with chronic silicosis less than 10 years after their initial exposure, and their employment occurred after the arbitrary limit of December 31, 1995, IH reports reach the conclusion that, in the absence of evidence to the contrary, those workers were not exposed to a significant amount of silica dust.

This includes workers working underground in the tunnels at the Nevada Test Site. This conclusion is reached without any monitoring data from underground within the tunnels. See NIH rolls and responsibilities.

ANWAG has growing concerns about poorly drafted questions that are provided to the industrial hygienist by claims examiners who are not conducting adequate or comprehensive searches of DAR records, or who are not familiar with worksite and labor category specifics that may have bearing on exposure.

Additionally, there is an indication that the Final Adjudication Branch is assigning more probative weight to an incomplete IH report than the physician=s opinion.

The EEOICPA Procedure Manual specifies that the CE=s questions to IH=s should identify a specific set of chemicals or biological toxins to which the Employee was most likely exposed. The PM indicates that no more than seven toxins should be identified and that only those from SEM results that provide affirmative results should be submitted along with other DAR records that reference that reference relevant exposures.

PM Version 8.0, Exhibit 15-5.3, Questions for the IH, this guideline implies that

a CE will be knowledgeable and discerning through the course of DAR records review and capable of recognizing significant or at least relevant information. However, there are growing indications of a CE=s lack of time to conduct a meaningful review of DAR records.

Additionally, a CE is likely to lack knowledge about occupational exposures that are related to specific labor categories at any number of unique worksites across the nuclear complex.

This is particularly problematic since the National Office 2018 decision to divert EEOICPA claims away from experienced and knowledgeable adjudicators who had the benefit of institutional knowledge at district offices that had maintained regional jurisdictions since EEOICPA=s onset in 2000.

As EEOICPA claims are now randomly assigned to CEs who lack familiarity with the most basic characteristics of worksite operations, CEs are routinely falling short of recognizing information in DAR records that it relevant or

significant.

As a result, there are now growing indications that the CEs are posing poorly drafted questions to the IHs, and that toxic substances may be randomly selected from SEM search results. As we have already identified, SEM search results may no longer be providing comprehensive information.

Moreover, there are indications that, even when the District Office recognizes a physician=s narrative as sufficient, the Final Adjudication Branch can override the information in favor of an incomplete and inadequate IH report that was based on limited information.

(Simultaneous speaking.)

CHAIR MARKOWITZ: Ms. Vlieger?

MS. VLIEGER: Yes?

CHAIR MARKOWITZ: Yes. So that=s been about 12 minutes. Actually, all of us have written copies of your comments.

MS. VLIEGER: Exactly.

CHAIR MARKOWITZ: So we=ll complete the

reading of those letters by ourselves, and we=re going to discuss public comments tomorrow. So if you want to make one or two closing comments, otherwise, we need to move on. Thank you.

MS. VLIEGER: Yes. And then I have a separate public comment from myself, not from ANWAG that is very brief.

So I would just like to point out the last page about creating evidence and making sure that it=s actually evidence and not supposition or speculation. And that is on Page 7 of the ANWAG letter, and that concludes the ANWAG submission.

CHAIR MARKOWITZ: Okay. Thank you very much.

MS. VLIEGER: Thank you. Briefly, for myself, in addition to the letter submitted on behalf of ANWAG, I will be submitting a letter with U.S. Department of Energy reports which show inadequate and non-existent worker monitoring at the Hanford site after the mid-1990s.

As the Hanford site had and has

processes and procedures similar to other DOE sites, it is not unreasonable to conclude that worker toxic exposures occurred beyond 1995 at other DOE sites.

The U.S. Department of Energy reports are readily available on the OSTI site to anyone, including the U.S. Department of Labor.

For EEOICPA to continue to cite post mid-1990s as a factual reference date, when toxic exposures at DOE sites were concluded, is pure fallacy. DOE report after report from Hanford inspections, accident reports, process evaluations, and industrial hygiene reviews cite poor, inadequate, or non-existent employee monitoring.

In addition, I found a DOE report detailing a review and testing of commonly used respirator masks that were not performing to standards and failing in use.

How can EEOICPA continue to ignore evidence from DOE=s own reports that refutes both the DOE and EEOICPA=s assertions that toxic

exposures do not occur at EEOICPA sites post the mid-1990s?

I will provide these comments, my letter, and the OSTI site citations for the DOE reports to the Advisory Board administrator for posting. I request the Advisory Board search for these reports, and accept submissions of the same from other interested parties, for review towards repealing the mid-1990s citation and replace it with claimant-favorable language.

I also request the Advisory Board draft language to stop the use of the mid-1990s language immediately in claims adjudication until factual evidence can be provided be EEOICPA to support its use. And that ends my comments.

CHAIR MARKOWITZ: Okay, thank you. I have one request, briefly. On Page 2 of the ANWAG comments, there are two cases that are cited. If you could just provide, at another time, the month and year of those cases, that would be useful. Thank you.

Next we have Ms. Deb Jerison. Welcome.

I think I may have mispronounced your name. I think it=s Jerison.

MS. JERISON: First, thanks to the Board for all the great work you do. It=s really appreciated. And thanks for this opportunity to address the Board.

The job of this Board is a large one. I=m concerned that DOL is not providing the Board with the resources they need. What are the plans -- I=m sorry, thank you -- what are the plans for the Board to be provided with a contractor or contractors so assist with their tasks?

I am very concerned about the site exposure matrix and some of the changes. It=s very distressing to hear that buildings are missing from the SEM. While the number of chemicals used at the sites is huge, it should be possible to verify all the buildings listed. Most of the buildings are well documented and should be easy to keep track of in the SEM.

With this in mind, I took a quick look at Mound SEM. One of the first things I noticed

is that both the numbered buildings and the lettered buildings are not in numerical or alphabetical order in the SEM. This makes it difficult to locate the building you=re looking for, and it would be easy to fix by reordering the code behind the page.

The SEM lists 209 buildings for Mound which sounds impressive until you examine what=s missing. I checked against the 1972 Mound documents, MLMMU-72710401, Security Classification, list of Mound laboratory buildings and their contents.

This document lists 27 buildings listed by alphabet or words, yet three of these buildings were missing from the SEM. Of the numbered buildings, the document contains 54 numbered buildings.

Eight are missing from the SEM. Some of them may be lumped together under magazines, but the individual magazines are not named. While the historical document lists 44 trailers by name, the SEM only lists two.

What happens to claimants who tell DOL

they worked in buildings that don=t exist in the SEM? I suspect their claims are denied.

I took a look at a couple other categories in the SEM to see how useful the information would be to a claims examiner or a claimant.

The A Building, Administration Building, has only two job categories listed, nurse and doctor. However, there are ten non-medical processes listed for this building. I doubt that the nurse and doctor were running the print shop, for one example.

Building 38 was known in 1972 as the PP Building. PP stands for Plutonium Processing. The SEM does show that Building 38 was known as the plutonium processing building. However, plutonium processing is not listed as a process done in the building.

Job categories also seem to be lacking as well. I looked at the SM Building, Special Metals, I think. SM Building had a very troubled history at Mound. According to workers, it quickly

became so cracked up from work with plutonium-238 that it had to be torn down.

The SEM lists one incident in 1962 and two incidents in 1966. I was able to locate 34 documents relating to incidents in 1966 alone. Again, some key job titles seem to be missing.

This is just a quick review of a few points in the SEM. It seems obvious to me that, at the very least, each site needs to be checked against historical records to verify that all the buildings are included in the site. This in itself is a large enough job to justify providing the Board with a contractor.

In the early days of the SEM, each addition was footnoted in the document providing -- with the document providing the information added. I realize the SEM has grown exponentially since then, but changes made to the SEM need to be documented. The SEM is a living tool and always changing. However, both claims examiners and claimants need to trust the information is correct.

To this end, it=s very important to show

how the changes are being made, why the changes were necessary, and the documentation for these changes, as well as a sensible organization of the information.

Without these guardrails, the SEM will become useless over time, especially as people age out of the process and institutional knowledge is lost. Thank you.

CHAIR MARKOWITZ: Thank you. I have just a quick clarifying question. So initially you laid out some errors or things missing from the SEM. Have you submitted those to the public, the mechanism for public submission.

MS. JERISON: I just found them last night.

CHAIR MARKOWITZ: Oh, okay. Okay, thanks.

MS. JERISON: So I will.

CHAIR MARKOWITZ: Okay, very good. Thank you.

Next is Mr. Tyler Bailey, who I think is probably online.

MR. BAILEY: Yes, sir. Can you hear me?

CHAIR MARKOWITZ: Yes.

MR. BAILEY: All right. Thank you for the opportunity to speak here.

I won't echo in the exact same language with Ms. Faye Vlieger=s comments of the ANWAG letter. But I would like to echo a couple of things. I=d like to take a moment to address the trend that we=ve seen as authorized representatives in the last few months following the industrial hygiene re-writes and re-wording.

And I=d like to see if there=s a way that we, more of a discussion than just my comments, that we as representatives, as claimant=s, the Advisory Board, program directors can get intimately involved in the process and help the claimants by fostering an environment of mutual understanding.

I would really like to see the leadership of the Department of Labor and the EEOICPA program talk to us as representatives who

represent claimants and tell us what we need to do better and/or what we=re doing wrong.

Because right now, in recent months, there=s been a significant change. Not in the program manual itself, because it hasn=t been updated for a while, but the program direction.

And I=ve had the opportunity to speak with multiple claimants, multiple claims examiners. And collectively they=ve given me, and several other colleagues that I=ve spoken with, the impression that there=s behind the scenes guidance that we are going to create bottlenecks. I=m not directly quoting any particular claims examiner, but we=re going to create bottlenecks and really rework the program to make it more difficult.

I would like to give one example, if I will. And I will try to be brief. Because I would like to have a little bit of back and forth discussion.

But let=s take Nevada Test Site, for example. In Nevada Test Site, chronic silicosis

exposure is presumed. So they presume that silica is in the Nevada Test Site and permeating throughout the area.

And that takes roughly one year of exposure to get a chronic silicosis claim if you do have the medical evidence that supports that claim. So we look at one year of exposure.

But if you look at a disease process like pulmonary fibrosis, or a similar disease process in the lungs, opacities in the lungs where you may be able to diagnose that with a 0/1 B read versus a 1/0 B read, the Industrial Hygiene Reports are now making it very, very difficult, if not impossible, to get acknowledged for pulmonary fibrosis.

Because they=re saying that you can=t have had enough exposure, because maybe the claimant only worked there two or three years. But if a silicosis claimant worked there one year, then their exposure is presumed and accepted.

I just don=t think that there=s a lot of clear guidance. I would love to know, as a

representative who tries to make this a favorable environment for claimants, what we could do better, what I could do better, what all of us can do better who represent these claimants.

There are a lot of claimants who need the help and who have disease processes that are getting kicked back by the FAB. And I=d just like to -- is there opportunity for discussion back and forth in this environment? Or is it just me making a statement and then going off stage, if you will?

CHAIR MARKOWITZ: It=s really just making a statement. I mean, we=re permitted to ask clarifying questions, but there=s no real back and forth. I=m sorry.

MR. BAILEY: No, that=s completely okay, and I understand it. Then my message to the audience and the advisory board is there are program blockages that are being administered by the program that are creating an unfavorable environment to clients.

I would love to be able to discuss, as claims go forward, what we can do better and why

these are happening. I know that, as authorized reps, you know, we may be looked at in either favorable or unfavorable light sometimes. Because we really are advocates for the claimant.

But that=s just one example, you know, pulmonary fibrosis claims at the Nevada Test Site. But we=re seeing a lot of things go to CMCs. And I don=t believe that CMCs are treating the claimant=s fairly. I truly don=t.

And when they get kicked into the process, and the Program Manual very specifically states that treating physicians will be given the first opportunity to provide any medical opinion, and then they=re skipped, or the FAB remands something and sends it direct to a CMC. It can really muddy the waters.

And, you know, we as reps, we can help if we=re talked to and not around. So thank you for your time. I really have enjoyed the meetings today, and I=ve gotten a lot of good information out of it. And thanks for everything everyone=s doing.

CHAIR MARKOWITZ: Okay. Thank you. And you=re welcome to submit written comments. And, you know, if you do, and provide further details, that would be useful. Thank you.

MR. BAILEY: Thank you, sir, I appreciate it. We will do that.

CHAIR MARKOWITZ: Okay. I think that ends our public comment session which means we=ll resume tomorrow morning at 8:30. Anything, Mr. Jansen to --

MR. JANSEN: No, that's it. The meeting is adjourned.

CHAIR MARKOWITZ: Okay, thank you.

(Whereupon, the above-entitled matter went off the record at 4:56 p.m.)