

UNITED STATES DEPARTMENT OF LABOR

+ + + + +

ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

+ + + + +

SUMMARY MINUTES

+ + + + +

MAY 10-11, 2022

+ + + + +

The Advisory Board met via videoconference, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

AARON BOWMAN
MARK CATLIN
KENNETH SILVER
MIKE VAN DYKE

MEDICAL COMMUNITY

GEORGE FRIEDMAN-JIMENEZ
ROSE GOLDMAN
STEVEN MARKOWITZ, Chair
MAREK MIKULSKI

CLAIMANT COMMUNITY

JIM KEY
DURONDA POPE
CALIN TEBAY
DIANNE WHITTEN

DESIGNATED FEDERAL OFFICIAL

MICHAEL CHANCE

MONDAY, MAY 10, 2022

Welcome/Introductions

Michael Chance called the meeting to order at 1:05 p.m. The meeting was conducted via videoconference in light of the COVID-19 pandemic. Mr. Chance reminded Board members that certain materials they received in their capacity as special government employees should not be disseminated or discussed publicly. The Advisory Board is currently seeking nominees for its next round. DFO Chance encouraged current board members and others interested in serving to submit their nominations. The Board is interested in promoting a diverse pool of applicants. Chair Steven Markowitz welcomed Advisory Board members, Department of Labor (DOL) staff, and members of the public. He noted that the Board's term ends in approximately two months and suggested that if there is any outstanding work that the Board wants to get to before the end of the term, an additional short Board Meeting may be considered to address those issues. Chair Markowitz called for introductions and briefly reviewed the meeting agenda.

DEEOIC Updates: Program Highlights, Information Items since last meeting

Rachel Pond, Director, Division of Energy Employees Occupational Illness Compensation (DEEOIC), discussed recent changes geared toward making DEEOIC's quality review process more rigorous. Supervisory claims examiners are now reviewing more cases each month, and there is a quality review unit in the national office comprised of analysts who review cases on an ongoing basis in real time. This is a departure from the prior practice of holding an annual accountability review conducted by district office staff across the country. The ongoing reviews inform DEEOIC on how it can move forward in improving its processes and the quality of written decisions. In Q1 and Q2 of FY22, the Energy program's timeliness and quality results have been outstanding overall, exceeding in almost every category. Currently DEEOIC is working to develop a mechanism for digital signatures on EE-1 and EE-2 forms, which would allow applicants to complete their applications for benefits online, in hopes of easing the burden for claimants in obtaining benefits. DEEOIC has also developed a robust customer experience program over the last year. Surveys are now sent up at various stages of the claims adjudication process.

Beginning in June, DEEOIC will return to its in-person outreach model, with visits scheduled to Aiken, North Carolina, and the Navajo regions of New Mexico and Arizona. At those meetings, DEEOIC will reach out to tribal governments and groups to share information in partnership with other government agencies such as the VA, Department of Energy and Department of Justice. DEEOIC is also looking to translate its brochures and items on its website into Spanish to be as inclusive as possible in its communications. Recently DEEOIC created an employee engagement team. Since the pandemic, DEEOIC is 100 percent remote, so all of the employees are spread across the country. They are working on new ways to interact with each other with open lines of communications, with frequent virtual meetings and correspondence on Microsoft Teams. Overall, the biggest focus has been customer experience outreach.

John Vance, Chief, Branch of Policy, Regulations and Procedures, DEEOIC, discussed recent policy updates. The procedures are designed for providing staff guidance and how employees are to do their day-to-day job in administering established legal and regulatory guidance. Many procedures are updated based on staff experiences and operational updates. DEEOIC has recently published several bulletins and circulars regarding allowances for telemedicine. They continue to extend guidance relating to telemedicine opportunities for home and residential healthcare, which was covered in Bulletin 2201.

Mr. Vance highlighted a major update to the Procedure Manual since the last meeting in November. Version 6.0 of the Procedure Manual was released on April 4, 2022, and it is available on their website, along with a transmittal outlining all of the changes that were incorporated into the new edition. Historic language has been removed relating to the function of handling paper case files, as DEEOIC now works with a completely imaged case file system virtually. There have also been some updates primarily centered on the new functionality of the Medical Benefits Adjudication Unit and their role in administering medical benefits. Staff guidance was clarified with regard to handling and assessing Authorized Representative appointments. A new operational instruction was instituted with regard to the conflict of interest policy. While the underlying conflict of interest policy was not changed, the process for administering it was clarified in greater detail. There was also input regarding the site exposure matrices (SEM). The language has been changed to make sure that some searches are only necessary to be documented in the case file in situations where it is relevant as opposed to mandating it for every claim scenario. A

new organizational process was mapped out for how to handle scenarios pertaining to withdrawn impairment claims. There was also an update relating to coordination on state worker comp situations. There is a new resource that ensures individuals that are eligible to receive benefits are paid. The system checks payees against a Do Not Pay Portal, a tool operated by the Department of Treasury to ensure that payments are only disbursed to living individuals who are not prohibited from receiving payment. Other language was updated to remove references to paper checks, as DEEOIC has moved to a completely electronic funds transfer process. Paper checks are only allowed in very limited circumstances.

Mr. Vance also highlighted that the current edition of the program's forms expired on March 31, 2022. The new public forms have to undergo an intensive clearance process. OMB is responsible for conducting those approvals. If new forms are not released on time, the prior forms are extended indefinitely on a monthly basis. The currently listed forms are being extended until the new information collection is cleared by the OMB.

Chair Markowitz asked for an explanation on the 2021 Quality Summary Report that was included in the briefing book. Ms. Pond explained that it was part of an ongoing sampling review of quality. The report summarizes the QA team reports as well as the sampling conducted by the district offices. It is a way to track the results of quality reviews over the course of the year.

Chair Markowitz also asked whether there was discussion about making trichloroethylene (TCE) into a presumption for Parkinson's disorders. Mr. Vance recalled that Marek Mikulski gave a very descriptive analysis of that issue, and the context was making sure that the SEM was properly identifying toxins with Parkinsonism or Parkinson's disease.

Discussion of Written Follow-up to November 2021 meeting

Chair Markowitz reviewed prior Board questions and the Department's responses. The first question was whether the program gets any feedback in terms of use of electronic claim files by claimants. The response from the Department was that there has not been much feedback. Chair Markowitz asked if there is a feedback mechanism that might be useful as a way of improving file access for people. Mr. Vance said that there are efforts to expand functionality. With regard to feedback, the Department would have to figure out a mechanism for determining

its utility. Ms. Pond added that DEEOIC has been doing some research to determine how many people have been accessing their case files on the system. She said that once it is made available to Authorized Representatives, there will be more use because they are probably accustomed to using electronic methods for gathering information. These questions will also be asked during the upcoming in-person outreach sessions.

Duronda Pope asked when the customer experience meetings are taking place and how interactive they are. Ms. Pond confirmed that the outreach meetings will be happening throughout June, and the specific details are published on their website. There will be a general presentation about the program, and then the other various agencies will talk about their involvement. After that, there will be group sessions with the customer experience individuals that participants can sign up for.

The next item related to the IARC Group 2A carcinogens. The Board had previously recommended that the limited list of carcinogens for which there was some evidence of human epidemiologic causation, or association with exposure, should be included. The Board asked for clarification on multiple items, specifically on the pesticides Aldrin and Dieldrin. There is evidence that one of them causes human breast cancer. The Department accepted the Board's recommendation that the link in the SEM should include breast cancer in both males and females for both Aldrin and Dieldrin.

Another item had to do with evidence that styrene can cause lymphoma. The question was which lymphomas to add to the SEM and linking it to styrene. The Board's recommendation was to include all of the lymphomas, of which there are now 70 subtypes. The Department has added all lymphomas to the list relating to styrene exposure, and the category is lymphomahematopoietic malignancies.

Rose Goldman said that for some of the carcinogens that were Group 1 and other categories in the Procedure Manual, there were specifications for how many months or years you had to be exposed and how long ago. She asked if there is some guidance about the next steps in terms of seeing if it was an adequate exposure or fit into some criteria that was not put forth. Mr. Vance clarified that what the change to the SEM is doing is providing claims examiners with information that can be assessed as they are going through the adjudication steps. When a claims examiner gets a claim where covered employment has been established and the individual has been diagnosed with one of

the lymphoma types, they will then begin doing an industrial hygiene profiling effort. They try to identify work that brought them into contact with one of the toxic substances. If they can affirmatively conclude that exposure occurred based on a comparative analysis, the next stage would be to have an industrial hygienist (IH) provide a more detailed profile of that exposure. That information is then provided to the claimant's physician or a contract medical specialist. They then weigh in on whether the exposure was a significant factor in causing, contributing to or aggravating an illness. That is different from the presumptive standard, which allows the Department to say they are accepting the case if these conditions are satisfied.

The next question that the Board raised was regarding the current status of the SEM contractor, Paragon, on three categories of job titles that they wanted to see added to the presumptive list for asbestos exposure, to include chemical engineers, mechanical engineers, and industrial health and safety engineers. In response, Paragon recommended a research project on mesothelioma death certificates from the National Occupational Mortality Survey to link specific job titles to asbestos exposure to determine relevance for the Department of Energy. The Board responded that it was unnecessary to look at death certificates. On certain job titles, the Board agreed with Paragon that there were too few deaths in the system to include them on the list. For example, with jobs where there were 10 or fewer mesothelioma deaths in the National Occupational Mortality System, there is not enough information to proceed. On the other hand, for chemical engineers, mechanical engineers, and industrial safety engineers, there were 30 or more deaths and they had a relative risk of over 2.5-fold of mesothelioma compared to the general population.

The Board said that perhaps these engineers' titles are not being included appropriately because they had bystander exposure rather than direct exposure. The question was raised whether bystander exposure was actually recognized by the compensation system. Paragon responded that the SEM "does recognize bystander exposure when documentation such as industrial hygiene sampling demonstrates that potential asbestos exposure exists." The Board thought there was sufficient evidence that chemical engineers, mechanical engineers, and industrial health and safety engineers had asbestos exposure as a presumption that they should be included under the Asbestos Presumption List in the Procedure Manual. As of yet, the Department has not responded to the Board recommendation on this issue. Mr. Vance indicated that he spoke

with the Paragon contract manager about this topic. It is not a determination that Paragon is going to make; Paragon is being asked to look at information and provide some sort of rationale or justification for adding those to the program's procedural specifications for the presumption. Mr. Vance suggested the Board should take a look at Paragon's response and provide more input as to what the generalization should be and on what rationale it applies.

The Board requested the program's written guidelines or instructions on how claims examiners or IHs can perform detailed telephone interviews on the occupational health of claimants. The Board made this recommendation several years ago, and it was adopted by the program as a way of gathering data on frequency, intensity and nature of claimants' exposures. The IHs can request that an interview be done. That request goes to the program office, and the federal IH weighs that request. If it is decided that an interview would be useful, it is coordinated with the claims examiner. The claims examiner summarizes the interview in writing and sends it off to the contract industrial hygienist who then uses it in their evaluation. Mr. Vance added that he periodically asks the industrial hygiene team about this issue. They collect much more robust industrial hygiene information now as a result of the updated Occupational History Questionnaire process that the Board recommended. A lot of IHs feel that the amount of detailed information that is now coming in up front is mitigating the need to conduct these interviews.

Chair Markowitz asked why the interviews are not being conducted by the contractor IH who is actually going to be writing up the report and making the most important determinations about the significance of the exposure. Ms. Pond responded that there are strict contracting rules that require the federal IH to conduct the interview. Chair Markowitz suggested changing the contract next time it comes around in order to enable this option.

The Board also asked for clarification on the role of the medical director in the program. The Procedure Manual mostly refers to the medical director in relation to weighing in on experimental medication issues or on transplants, and not on the issue of impairments.

The Board also inquired about whether or not they could communicate with public commenters in instances when they do not understand the comments being provided. Mr. Chance checked the FACA rules and determined that during the public comment period, the Board would not get into frank discussions back and forth

with public commenters, but if the commenter makes a particular point that the Board does not understand, the Board can ask for clarification on that point.

The last issue relates to the history of the program. At one point the National Cancer Institute assisted the program in interpreting certain cancer types and the extent to which they were included in certain generic categories of cancer. Subsequently that was reversed by the EEOICP program, where the NCI assistance was not solicited. Mr. Vance said there was a legal issue that came up about reliance on NCI to determine certain anatomical definitions. Now the program relies more on the physician interpretation of the anatomical designation of cancers.

Review of Claims

Claim -6199 (last 4 digits of claim ID number)

The claim was a cancer/leukemia case reviewed by Aaron Bowman and Ms. Pope. The case was denied under Parts B and E. The denial was in part based on an inability to verify employment. Dr. Bowman focused mostly on the Part E element. Some parts of employment were able to be verified, while others were not -- specifically truck driver and pipefitter. There was discussion of insufficient IH evidence for exposure to benzene. For the jobs that were verified, the SEM search did not give a link to exposures relevant to any of the jobs listed, including those that were not able to be verified. When employment was not able to be verified, they used Social Security records of employment, and from there they were not able to make certain matches that were part of the claim. Based on the totality of the evidence, Dr. Bowman concluded that the final decision was justified. Ms. Pope opined that in some of the cases, claimants were not adequately represented. Ms. Pope said that the claimant needed an attorney or an advocate to help him build, navigate, and defend the claim. Chair Markowitz added that the claimant reported multiple job titles at Savannah River -- construction worker, truck driver, pipefitter, and electrician. The claims examiner filled out an exposure worksheet citing the pipefitting and electrician work. However, the claims examiner only asked the IH about the truck driver position, and the IH did not find much exposure to anything that would cause leukemia.

The claim was a chronic lung disease and COPD/asthma case reviewed by Mark Catlin and Dianne Whitten. It was filed by a worker who was listed as a laborer working for a contractor at both Hanford and Pacific Northwest Medical Lab. The claim was denied. It was initially for COPD, asthma and bronchitis as the diagnosed illnesses. Mr. Catlin said the employment history provided by the claimant was not very detailed. The Department put together some of the employment history using radiation badge records. There was a lack of records from the contractor. Mr. Catlin said it seemed like the claimant could have found better information with some assistance to document their history. The claimant also did not provide much supporting medical documentation or evidence. Mr. Catlin was interested in the SEM and the exposure history. The claim was referred to an IH; however, there was no evidence the hygienist talked to the claimant. Mr. Catlin said he would have focused on the silica dust exposure. He said he would rather see more transparency about the IH interpretation. Ms. Whitten indicated that the claimant was unresponsive when more information was requested about their exposures and job classifications. Chair Markowitz said that he agreed with the negative causation conclusion.

-0219

The claim was a cancer/myelocytic leukemia case reviewed by George Friedman-Jimenez and Calin Tebay. According to the IH, the claimant worked as a field engineer and project field engineer. The exposures of concern were benzene and 1,3-butadiene, both of which have been definitively implicated in leukemia carcinogenesis. Dr. Friedman-Jimenez looked at a number of problems in this case. The job titles that were listed, field engineer and project field engineer, were only some of the jobs that the claimant did. In different parts of the record, it mentions general manager, surveillance maintenance utility manager, project or program manager, and technical operations manager. The claimant also worked in deactivation and decommissioning, which involves a variety of different exposures. In the SEM, deactivation and decommissioning lists both benzene and 1,3-butadiene as potential exposures in the Hanford site where he was working. The question that the claims examiner posed to the IH did mention most of the employment information, but the IH report said that there is "no evidence of significant exposure to benzene, formaldehyde or 1,3-butadiene." However, they did not consider four out of the six job titles. According to Dr. Friedman-Jimenez, the IH ignored the titles that had more potential hands-on exposure to at least two of the three toxic substances. The IH mentioned that there were odors associated with benzene and butadiene, but it did not

account for the masking of odors that often occurs when there is a highly complex mixture of vapors. Dr. Friedman-Jimenez concluded that oversights in the IH report substantially reduced the credibility of the exposure assessment. Additionally, Dr. Friedman-Jimenez recommended having clerical staff organize and index the medical records in such a way that the physicians, IH, CMC and claims examiners have an easier time finding what they need from thousands of pages of documents. Mr. Tebay added that there were no IH records located in the DAR, which set the pace for the whole claim adjudication. The claimant does have multiple job categories for roles and responsibilities that were not applied in the SEM. Mr. Tebay said that the look in the SEM based only on job category did not provide much feedback in his favor, which ultimately weakened the claim. Chair Markowitz said that he would like it if the IH stated what records the IH examined to ensure that all of the relevant items were reviewed.

-4418

The claim was a three-part emphysema case, reviewed by Dr. Mikulski and Mike Van Dyke. There was a subsequent impairment rating and a claim for home health care. All three were accepted. The claimant was a 77-year-old former worker from Los Alamos. He worked as a mechanical technician for almost five and a half years, with exposures of concern to asbestos cement, diesel exhaust, silicon dioxide crystalline, welding fumes, wood dust, and endotoxin. The primary claim was accepted in March 2020. The treating physician's opinion said it was at least as likely as not that the exposure to asbestos during claimant's employment contributed to their emphysema. According to Dr. Mikulski, this is a well-based impairment with proper application of AMA guidance for impairment rating. The claimant will be eligible for another impairment re-evaluation and, based on their results -- which were submitted together with the home healthcare claim -- there may be another impairment finding. Dr. Van Dyke said that this case is a good example of where the SEM worked. The SEM listed the substances that he was exposed to and the report indicated that he was subject to moderate levels of exposure.

-7255

The claim was a cancer case, reviewed by Ms. Whitten and Rose Goldman. The claimant had kidney cancer. They were exposed to radiation and trichloroethylene (TCE). There was an IH report that says there was "mild exposure for a year and a half." The CMC referred back to a German article that said you had to have many years of exposure at high dose. In light of that, the CMC dismissed the claim. The recent IARC update on TCE broadened

mechanistic and other factors. TCE is a Group 1 known carcinogen. According to Dr. Goldman, since there is no specific reconstruction process, it becomes a judgment call. Ms. Whitten added that if the IH would have dug deeper in the file, they would have seen that this company has used over 2,000 gallons of TCE annually with no PPE. Char Markowitz pointed out that there is a presumption in the Procedure Manual for kidney cancer and TCE, but the claimant would need five or more consecutive years of exposure prior to 1990 at one of a large number of listed DOE sites. This claimant was not qualified for a presumption because they did not have five years of exposure.

Public Comment

Bob Rothe voiced his personal objection to the endless denial of his bilateral sensorineural hearing loss claim. Dr. Rothe worked as an experimental nuclear physicist at Rocky Flats from 1964 to 1994 and during that time was exposed to toxic chemicals. According to Dr. Rothe, two doctors have concluded that it is as likely as not that this exposure has caused or contributed to his hearing loss. Dr. Rothe contends that compensation should be provided under the provisions of EEOICPA. Dr. Rothe claims that he was denied because of his job title that he held at retirement, associate research scientist. Denver District Office recommended denial, and DOL in Washington also denied Dr. Rothe's claim. In all cases, the denial was because the job title did not fit DOL's list of Hearing loss-associated job titles. Dr. Rothe argues that the list is incomplete. The job title that was used for denial is not the job title Dr. Rothe held when he was exposed. Dr. Rothe contends that this is obviously true because of the FBI raid of Rocky Flats in 1989, which terminated all operations until the closure of the plant several years later.

Sandra Thornton pointed out several problems in her brother-in-law's case. She cited three doctor's letters and 3,400 pages worth of evidence. 25 claims have been filed; all have either been denied or never processed. Some have been sitting for over 23 months. One is currently in reconsideration. Ms. Thornton argued that DEEOIC is not giving a higher precedent to doctors who are familiar with the employee and the evidence. Ms. Thornton's brother-in-law has had over 120 toxic exposures, with over 16 links to occupational illnesses due to exposures at the Paducah Gaseous Diffusion Plant. The DEEOIC computer system does not allow claimants to check the status of claims, nor does it allow for communication with case managers to establish a trail of information for continuity.

Terrie Barrie, Alliance of Nuclear Worker Advocacy Groups, said that she was made aware in March by an Authorized Representative that new language has been added to IH reports. She raised concerns about the new language, contending that it is misleading and inaccurate. Ms. Barrie researched DOE's acceptance of the ACGIH threshold limits and found two references. The first is a survey that DOE provided to the Savannah River site, dated April 15, 2015. The second DOE document is titled Adopting the 2016 ACGIH TLV - Respirable Crystalline Silica (orau.org). Ms. Barrie expressed that she has serious doubts about DEEOIC's sincerity when they say how much they appreciate the Board's work, as they did not notify the Board about the changes until after they were complete.

Jason Jones, an attorney who represents a number of clients under the DEEOIC program, addressed similar concerns that Ms. Barrie raised regarding the wording of the IH reports. Mr. Jones said that his concern is twofold. The wording steps outside of the bounds of what the DEEOIC policy manual directs IHs to provide in their opinion. "The IH's role is to provide expert opinion regarding an employee's exposure as it relates to nature, frequency and duration based on assessment of the evidence presented." The IH report should not be providing a medical opinion on causation. Secondly, it does not provide any of the information that an IH is supposed to supply to physicians. It provides no estimate of duration, frequency, or the duration of exposure. The second take on the wording is that it is either a causation opinion, or the IH wording is requiring a physician to accept that (1) ACGIH standards were in place at the facility in question for that claimant, and (2) that these standards were inherently safe. Mr. Jones suggested that if ACGIH is referenced, the wording should be taken out that it's inherently safe and that there are no adverse health effects. The IH report should provide some evidence that the ACGIH standards were actually in place at the time, along with a statement of what the actual TLB/TWA values are, since they are more difficult to look up than OSHA standards.

Tyler Bailey, an Authorized Representative, said that the DEEOIC does a great job in general, although there are some things to improve on. Mr. Bailey said that the misuse of Contract Medical Consultants (CMCs) by claims examiners creates significant problems in the adjudication of cases. When a primary illness is adjudicated by the program, the Procedure Manual states that claims examiners should view the treating physician as a primary source of medical evidence before consideration of a CMC

referral. Mr. Bailey said that sometimes claims examiners will use a CMC inappropriately and without justification. This occurs regularly with Mr. Bailey's clients, and once it happens, the case is corrupted as a whole. Some claims examiners, supervisors, and district offices exhibit a pattern of sending claims to the CMC in direct violation of the Procedure Manual. Once the CMC's opinion is issued, it is viewed as being of equal or more probative value than the original treating physician's input regardless of content or rationale. Written objections generally result in the case being sent to a referee specialist; however, the referees are simply another CMC that tends to side with the original CMC.

Faye Vlieger, a former Board Member, saluted the dedication of those who submitted a request to continue their positions on the Board. Ms. Vlieger focused her comments on continued false statements and assumptions regarding toxic exposures at DOE sites, and the "post mid-1990s" toxic exposure policy guidance. Ms. Vlieger contends that since the issuance of EEOICP Circular 15-06 in 2014, a fallacy of safety and absence of toxic exposures has pervaded the EEOICP leadership and claims processing guidance. DOL rescinded Circular 15-06, but its language still appeared in the Procedure Manual, referral documents to CMCs, IHs, and claims decision documents. She added that it is apparent that EEOICP is still clinging to the erroneous idea that workers have been safe at DOE sites after September 30, 1995 just because DOE said so. To date EEOICP has not provided the basis documents which informed their opinion concerning "post mid-1990s" exposure criteria. Ms. Vlieger suggested that EEOICP should remove the "post mid-1990s" language and create a toxic exposure presumption that states: "Records of adequate toxic exposure monitoring are unavailable for EEOICP workers."

Elizabeth Brooks, an Authorized Representative, addressed the topic of chronic silicosis claims under Part B of the EEOICPA and the need for revision of the Procedure Manual. Many of Ms. Brooks' clients have been diagnosed with chronic silicosis due to the prevalence of silicon dioxide (crystalline) at DOE facilities located in Nevada. Ms. Brooks requested that the Advisory Board undertake discussions to review information on the atomic tests and experiments that have persisted at the Nevada Test Site in Yucca Mountain and recommend to DEEOIC that the Procedure Manual be reverted back to what it was prior to Version 3.1, so that claims for chronic silicosis under Part B may be adjudicated in a manner consistent with the criteria originally established by congressional law under the EEOICPA.

Josh Artzer, an NCO of 23 years at the Hanford Site, talked about the evolving diagnosis criteria for beryllium-related diseases and conditions. The BeLPT for years was based on an abnormal or negative test result. For quite some time now, the term "borderline" is being used to diagnose beryllium sensitization. The EEOICPA Procedure Manual does not include the term "borderline," and it seems CEs will not accept borderlines as an acceptable diagnosis for beryllium sensitization. Currently DOE, OSHA, National Jewish Hospital and Washington State Labor and Industries all recognize the borderline BeLPT in diagnosing beryllium sensitization. To date, most if not all EEOICPA claims Mr. Artzer is familiar with involving borderline BeLPTs are denied. Mr. Artzer hopes that the Board will consider and provide the DOL with a recommendation to modify the current diagnosis criteria to accept borderline BeLPTs. Many workers at Hanford are stuck in this gray area. These individuals will not receive the medical surveillance options they deserve until this issue has been resolved.

Melissa Herron, an electrician employed at the Hanford Site, identified herself as one of these gray area employees. She has five borderline tests. She has been diagnosed as sensitized by both the Cleveland Clinic and local medical providers. Ms. Herron said she is being treated just like her co-workers who have their positive BeLPT. She is no longer able to work in a beryllium area and is thus deprived of overtime hours based on her positive borderline BeLPT tests. Ms. Herron asked the Board to make a recommendation to the DOL that borderline criteria can be accepted.

Marieca Sharp, a 38-year employee at Hanford and co-chair of the Beryllium Awareness Group, was diagnosed as beryllium sensitized. She worked in a beryllium zone daily for two years. Ms. Sharp sees a lot of people in the group with borderlines, and they are having the same issues that everyone else has. It has a lot to do with the person's immunity and how their body is going to react to these substances. Ms. Sharp noted that the Board is focusing a lot on workers' job titles, and she recommended focusing more on an employee's job tasks. Ms. Sharp also suggested including the borderlines in the criteria.

Dale Fish, a teamster at the Hanford site since 2009, is also beryllium sensitized. He said that everybody knows there is no beryllium out at Hanford, but they still get cases every month. This is a real problem at Hanford, and Mr. Fish said he wishes that the DOL would take care of the people who have three

borderlines.

Aaron Burt, a Hanford worker for 13 years, said that he wants to see a change in the diagnosis criteria. A lot of people are falling through the cracks, and Mr. Burt is one of them. Mr. Burt had three borderlines, and he was diagnosed with chronic beryllium disease by the leading hospital in the nation for respiratory. He fought for two years with DOL to get a claim, which was ultimately denied.

Roger Torrie, a heavy equipment mechanic at Hanford for the last 16 years, said he hopes the three borderlines would get a positive BeLPT so that they can create an accurate program for the workers at Hanford.

Aaron Keck, a Hanford worker of 10 years, is an affected beryllium worker diagnosed with three borderline BeLPT's. His diagnosis is recognized by Washington State, Department of Energy, and leading medical facilities. Mr. Keck said it only seems reasonable for the diagnosis criteria to change to follow along with the others.

Toni Winborg, a lab technician who worked at the Hanford Site for 38 years, said that most of the time she was working, there was no industrial hygiene program in place. She documented exposure to beryllium in 2007, and has worked in many buildings and areas that are now or were listed as beryllium facilities. In 2012, Ms. Winborg received three borderline BeLPT results. She went to National Jewish Hospital in 2015 and was officially diagnosed as being beryllium sensitized with three borderlines, even though DOL does not acknowledge that in an EEOICP claim. Ms. Winborg recommended that DOE diagnosis criteria for beryllium sensitization needs to be updated to include the following: two abnormal BeLPT results, an abnormal or a borderline result, or three borderline BeLPT results.

Stephanie Carroll, an Authorized Representative who specializes in chronic beryllium disease, said that 90 percent of her claims are approved with negative beryllium tests for chronic beryllium disease under Part B. Ms. Carroll said that borderlines are evidence of a lymphocytic response to beryllium. When a BeLPT is billed to the DOL, it is actually billed as six tests. Each result the worker gets is the result of six tests that were done on different days. The University of Pennsylvania has noted that the BeLPTs have a virtually impossible chance of showing positive unless the patient has been exposed to beryllium. Ms. Carroll also said that she has documentation of a DOL library

that supports allof the SEMs that she plans to provide.

TUESDAY, MAY 11, 2022

Call to Order:

Mr. Chance called the second day of the meeting to order at 1:05 p.m. Chair Markowitz called the roll.

Board Request for Resources:

Mr. Chance gave the update. The Department did some market research and gathered information from vendors who are interested in doing the work. Chair Markowitz and Board Members have been working to flesh out the proper expertise and to cost it out on an hourly basis for the respective job types. Chair Markowitz confirmed that he has finished his review of the Statement of Work. Multiple comments were submitted and accepted, and there is a final performance work statement. The next step is departmental clearance. Chair Markowitz asked for a time table. Mr. Chance said they cannot commit to anything at the moment.

Continue Review of Claims:

Chair Markowitz briefly reviewed the Board's charter and reminded Board Members what they need to pay attention to as a Board. He pointed to item number two of the Medical Guidance for claims examiners for claims under Subtitles B and E of the Act, with respect to the weighing of the medical evidence of claimants. Chair Markowitz also highlighted the fourth task, the work of the IHs, staff physicians and consulting physicians of the Department, and the reports of such hygienists and physicians to ensure quality, objectivity, and consistency. Finally, he pointed to the next task, which is that it is within the Board's scope to examine and weigh in on the claims adjudication generally, including review of Procedure Manual changes.

-2157

This case was a beryllium claim reviewed by Dr. Van Dyke and Kenneth Silver. It was based on two claims, one from 2018 for beryllium sensitization, and the other from 2019 for CBD. The claimant worked for 45 years at a beryllium contracting facility that was covered by DOE. Dr. Van Dyke said that from an exposure standpoint, this was a fairly easy case because his exposure was substantiated by a letter from the facility saying that he was

exposed to airborne beryllium during the course of his work. According to the Procedure Manual, if an individual works for more than one day in one of these covered facilities, they are thereby covered for their beryllium claim. The claimant was referred to a physician in 1990 for an abnormal chest x-ray. He was worked up for the potential of beryllium disease in 1990, including a CT, biopsy, a beryllium blood LPT and a BAL LPT. In 1991, he was diagnosed with sarcoidosis on the basis of a negative blood LPT and BAL LPT. He did have evidence of granulomas on biopsy, which is a hallmark of sarcoidosis and chronic beryllium disease. The case went cold until 2018 when this claim was filed subsequent to an abnormal blood LPT. In 2018, the claimant filed for beryllium sensitization on the basis of the abnormal LPT. The claimant was awarded beryllium sensitization, and subsequently he filed for CBD benefits under Part B. This was substantiated based on the medical information from 1990. Dr. Van Dyke said that the only thing standing in the claimant's way of a CBD diagnosis was evidence of beryllium sensitivity, which was found in 2018. Dr. Silver noted that the claimant's Authorized Representative was from the human resources department of the company that had the contract to do beryllium for the Government. While there is no evidence that the Authorized Representative took any money, it goes to show how thoroughly institutionalized the benefit program has become throughout the DOE and its subcontractor complex. Regarding sarcoidosis, Chair Markowitz highlighted a quote on page 178 of the Procedure Manual: "Under Part B, the DEEOIC recognizes that a diagnosis of pulmonary sarcoidosis, especially in cases with pre-1993 diagnosis dates, could represent a misdiagnosis for CBD. As such, a diagnosis of pulmonary sarcoidosis is not medically appropriate under Part B if there is a documented history of beryllium exposure."

-9787

This case was a Parkinson's claim reviewed by Dr. Van Dyke and Dr. Goldman. The claimant had exposure to potassium permanganate, and was referred for both IH and the expert medical examiner. The patient initially presented with a resting tremor, which put him more in the category of idiopathic Parkinson's disease rather than manganese. There was a gap of 18 years from the last significant exposure and symptom onset, which made it less likely. There was an IH review which indicated that his only exposure was potassium permanganate, and in the SEM that is listed as associated with Parkinson's because of the manganese. Dr. Goldman tried to look up whether potassium permanganate could cause Parkinson's, but she was not able to find a definite answer. She concluded that this was a reasonable

review, including the IH and the qualified CMC who gave a very cogent analysis and reasoning why this claim was denied. Dr. Van Dyke agreed that it was a well thought out case. He concluded that the main reason the claim was denied was based on the CMC review saying that they did not believe that this particular Parkinson's was related to chemical exposure. In terms of the IH, the individual was employed for more than 30 years and was exposed to many different chemicals in their line of work. There was not a lot of documentation, but Dr. Van Dyke felt that they zeroed in on potassium permanganate because it appears on the SEM list of things that could be associated with Parkinson's. Dr. Van Dyke pointed to imprecision of the language in the IH reviews, specifically with regard to the use of words like "significant," "regulatory level," or "high, medium, and low." These terms often mean different things to different people. He suggested there is definitely work that could be done to make the language more precise by clearly defining the words that are used.

-0014

This case was a cancer claim reviewed by Chair Markowitz and Jim Key. Chair Markowitz said it is a straightforward case of a person in their 60s who worked at a Southern DOE facility. She developed lung cancer and thyroid cancer. Her job title for five years was administrative assistant, along with another closely related title. Her work was all clearly administrative. The claim was denied on both lung cancer and thyroid cancer. It was judged that the claimant did not have sufficient exposure to produce a cancer. They zeroed in on possible asbestos exposure. Chair Markowitz agreed with the conclusion that there was not sufficient evidence to demonstrate that she had enough exposure. In the Occupational Health Questionnaire (OHQ), the claimant identified that she used to handle contaminated records. Chair Markowitz opined that this is why she submitted the claim, but he did not see that issue addressed in the IH report. He also said he did not see any listing of what the IH reviewed. Nevertheless, both Chair Markowitz and Mr. Key agreed with the findings.

-7016

This case was a chronic lung disease claim reviewed by Dr. Van Dyke and Chair Markowitz. Dr. Van Dyke said that this was a harder case with respect to exposure than some of the other cases under review. The claimant submitted a pulmonary fibrosis claim that was denied. The individual was a lab tech for many years at a facility. When they talk about their exposure, they talk about exposure to lots of different things -- metals,

plastics, epoxies, urethanes, silicone, solvents, and silica. The focus of the IH report was on asbestos, aluminum, carbon graphite, kaolin, silica, and titanium dioxide. Throughout the assessment, the IH confirmed exposure to these chemicals at low or very low levels. With a confirmed exposure to toxin that is associated with this outcome, most of the case hinges on the denial by the CMC. The physician said it does not look like asbestosis. The CT scan is not consistent with heart metal disease. Exposures are not high enough for any kind of pulmonary fibrosis due to carbon exposure. In the end, the CMC says that it does not look like silicosis either. Dr. Van Dyke said that he thinks the claim hinges on the opinion of the physician that it does not look like any of the diseases that would be associated with the particular exposures that they delved into. Dr. Van Dyke also noted that there were a lot of exposures that were not explored much, such as epoxy resins; however, they are not on the list of positive agents for pulmonary fibrosis. Chair Markowitz said that on the medical end, the CMC decided it was not asbestosis. Chair Markowitz agreed that it's unlikely to be asbestosis, but he disagreed with the physician's logic. The CMC read the findings on the CT scan as representing pneumonitis, but those findings overlap with asbestos of the lung tissue itself. Chair Markowitz also said that the likelihood of a lab technician having sufficient asbestos exposure to cause asbestosis is low.

-7716 and -2560

Case -7716 was a chronic lung disease claim reviewed by Dr. Goldman and Dr. Silver. Dr. Goldman contrasted this case with another similar claim, -2560, which she reviewed with Dr. Catlin. In -7716, the claimant already had a claim accepted for pneumoconiosis. It was up to the CMC to give an impairment rating. In both cases, they used the AMA guide's definitions of lower limit of abnormality. In the report, the CMC pays attention to the claimant's report of breathlessness. The CMC looked at the whole picture, and did not limit himself to restrictive lung disease. In -2560, the individual has pleural plaques. Again, the CMC is asked to assess pulmonary impairment due to pleural plaques. The CMC uses the same process, but for -2560 the CMC organized the approach to whether or not only the abnormalities suggestive of restrictive lung disease are present. Because there was no evidence of restrictive lung disease at all, the CMC ignored the findings of restrictive lung disease and gave the person zero level of impairment. Dr. Silver added that the claimant in -7716 also had squamous cell carcinoma of the lip. The SEM found arsenic at the uranium mills because it was a component of the ore. On Case -2560, Dr. Catlin

added that the claimant -- a long-term roofer and sheet metal worker -- was also denied a claim for basal cell carcinoma. Dr. Catlin said it stuck out that a decision was made regarding the carcinoma on his nose. It was determined that because it was on his nose, it could not have been work related or else it would have had to be on his hands. Dr. Catlin said that in his experience, roofers can have exposures in all uncovered spots of the body.

Common Language in IH Reports:

Jeff Kotsch, manager of the medical health sciences unit at DEEOIC, led the discussion. The Board recently submitted questions to the program, and there was a rapid turnaround on responses. The first question regarded the fact that many IH reports indicate that existing regulatory standards have not been exceeded in particular claims. Chair Markowitz asked which regulatory limits are being cited in these reports. Mr. Kotsch responded that the Department of Energy has not historically adhered to OSHA PELs but has followed the lower ACGIH threshold limit in almost all cases. There is a discussion in the indices document about what defines the TLV/TWA. In essence, the DOL applied the most restrictive standard using the best information available on DOE's worker occupations. Each was looked at on a case-by-case basis since there are different sites around the complex. Mr. Vance said that OSHA standards are still relevant and referenced from time to time, but from a safety and health perspective most of the sites are striving to adhere to the stricter standards outlined by the ACGIH.

Chair Markowitz said that in 1995, DOE promulgated Rule 440.1. He asked which DOE rule determined what standards were followed prior to 1995. Mr. Vance said he would check and get back to the Board on that question. Mr. Kotsch added that one of the concerns is that around 1995, there was a much more stringent effort to improve the occupational safety and health monitoring of employees. There will always be arguments about whether DOE complied with or enforced those standards. There are instances where someone can be exposed to a toxin within the ACGIH threshold, which a physician could look at and still opine that the exposure was a significant contributing factor to a disease. It is left to the judgment of the physician and the working knowledge they have in reaching that type of conclusion.

Chair Markowitz asked how IHS deal with changing TLVs in the interim periods as they look at claims that go back a long time. Mr. Kotsch said that they are basically applying their knowledge

of what the current limits are, which are more restrictive than they were in the past.

Mr. Catlin said that while it is necessary to choose some system of comparison for the exposure limits, the ACGIH has consistently talked about the TLVs as levels that will protect nearly all workers. Back in the '90s, there was a lot of controversy within the profession and the medical community when OSHA tried to update their PELs using ACGIH. The "protecting nearly all workers" language was not well defined; it could mean 75 percent or it could mean 95 percent.

Dr. Goldman highlighted that when OSHA first came in, their standards were stricter than ACGIH. There was a lot of concern that the professionals in ACGIH were consulting with industry. Over time, OSHA, because of all of the contention surrounding their standards, has lagged behind tremendously -- a glaring example being lead. As a result, other professional organizations including ACGIH have proceeded to update their standards.

Chair Markowitz moved on to the next question: what constitutes the various types of evidence that demonstrate that regulatory limits have been exceeded. In general, there are two types of standards. There is a short term ceiling limit that might be exceeded for 15 or 30 minutes, and then there's the standard that applies to a full eight hour day. In occupational medicine, the focus is mostly on chronic exposure as opposed to the short-term limit. Mr. Vance said that generally there will be some incident or event that occurs that brings the employer into the work environment to do some sort of sampling or monitoring. That information would drive the IH's understanding as to whether or not there was a viable exposure beyond what was allowable in the particular scenario.

Chair Markowitz asked if no evidence concerning workplace exposure is available in either direction above or below regulatory limits for a given claim, whether the conclusion usually drawn that regulatory limits have not been exceeded. Chair Markowitz's question was whether it is factually more accurate to conclude that we do not have available data to determine whether levels were above or below regulatory limits.

Chair Markowitz thanked Mr. Vance and Mr. Kotsch for their straightforward answers to the questions. The Board took a short break at 2:57 p.m. and returned at 3:14 p.m.

Continue Review of Claims:

-2282

This case was a chronic lung disease claim reviewed by Mr. Key and Dr. Friedman-Jimenez. Dr. Friedman-Jimenez said he agreed with the decision overall. The claimant worked for six months, got COPD, and is a smoker. The exposure considered was asbestos exposure. He likely had some. He was an electrician who was tearing out some ventilation ducts for part of those six months. The asbestos standard is reasonably protective for COPD and asbestosis. The claimant's brief exposure period and the very likely lack of violation of the OSHA or ACGIH standard for asbestos made the likelihood of his being exposed at a sufficient level to cause COPD very low. Dr. Friedman-Jimenez had no criticism of the case, other than that the IH report should have discussed the work activity of disassembling HVAC ducts. However, the exposure was likely to be so brief and fairly low, and unlikely to have been the cause of claimant's COPD.

-2347

This case was a chronic lung disease claim reviewed by Ms. Pope and Mr. Tebay. Mr. Tebay said that although he probably agrees with the outcome of this case, there was a lack of diagnosis. For the claimed condition, although there was a second condition for chronic lung disease, the individual had identified specific exposures that may have occurred during their employment. The SEM search did not agree with all of the exposures listed, but it did identify some additional exposures. Mr. Tebay indicated that there was confusing communication from the IH on certain language such as "incidental," "significant" and "low." Mr. Tebay said that he does agree that the CMC's report is very detailed, and that both the CMC and the IH did their jobs. Ms. Pope agreed with Mr. Tebay. She said there is some conflicting information. There was not enough evidence to support or develop the claim. Mr. Tebay and Ms. Pope agreed that the IH got it wrong.

-6463

This case was a chronic lung disease claim reviewed by Ms. Whitten and Dr. Bowman. The claimant was in her 70s. She went in for a physical and it was determined that she had chronic lung disease, and she was steered toward the program and filed a

claim. The IH, because of her smoking and exposure to asbestos, decided that she was accepted under COPD. Ms. Whitten found it remarkable that the IH took into consideration the claimant's smoking and low level asbestos exposure as causes of her COPD. Ms. Whitten has seen other claims with the same circumstances that were denied. Dr. Bowman added that the criteria were given in the decision letter. There was one criterion that was not met, which relates to latency, in which the diagnosis should be made at least 20 years after the initial exposure during the covered employment. Because it did not meet this criterion, additional development was undertaken to determine if there was scientific merit to a link between the accepted diagnosis of COPD and potential exposure to toxic substances.

-7539

This case was a breast cancer claim reviewed by Mr. Catlin and Dr. Mikulski. The claimant was a 68 year old female who worked on the Savannah River site. She worked for a total of approximately 13 years as a painter, photographer, and janitor. The claim was processed under Subtitle B, with a probability of causation of 17.95 percent, and it was subsequently denied. The claimant then submitted another claim due to the morphological picture of the breast cancer being very similar to salivary gland cancer, which was also denied. The breast cancer claim was eventually reopened, given the new special exposure cohort designation for the Savannah River site that included the years and jobs that were applicable to this claimant. Upon the search for exposures related to breast cancer in the SEM, no input was found. It was a reopened claim that should be processed soon. Mr. Catlin added that the SEM review found no link to breast cancer in any chemical exposures. Additionally, Mr. Catlin suggested the Board discuss how to handle certain cases where the SEM is not up to date.

-8472

This case was a Parkinson's disease claim reviewed by Dr. Friedman-Jimenez and Dr. Silver. The claimant was a 78 year old man who worked as a maintenance machinist, mechanical technician, plant maintenance technician, assembly machinist from 1974 to '78, and as a tech liaison specialist and mechanical technician from 1978 to 1993 at Los Alamos and Lawrence Berkeley National Labs. The claimant was diagnosed with Parkinson's disease in 2017, although he may have had symptoms several years prior to the diagnosis. The claim was denied based on judgment by the CMC of too long a latency period for stainless steel and carbon steel, and the judgment by the toxicologist that the literature in 2018 did not support a

causal relationship between TCE exposure and Parkinson's disease. The IH report and the CMC report, perhaps as a result of the toxicology report, did not discuss TCE exposure. Dr. Friedman-Jimenez indicated that he disagreed with the denial and that it needs to be reconsidered. He said that it seems to illustrate a problem in the way the system is set up. Somehow the IH, CMC, toxicologist and the DOL all focused incorrectly on carbon steel and stainless steel, without investigating the manganese content of the steel. They failed to identify TCE as a likely causal agent. Dr. Friedman-Jimenez said there was more discussion needed on why certain studies pertaining to TCE were dismissed by the toxicologist. He also added that the claims examiner's initial question was framed too narrowly. Dr. Silver added that there was muddiness about the claimant's job title and tasks from the time that he walked into the resource center and filled out the OHQ. The claimant said he worked at the Meson facility. Someone knowledgeable at the site would have known that meant the Los Alamos Meson Physics Facility; however, it was misspelled "Mason," and as such there was a mix-up regarding his duties and exposures.

-7904

This case was a Parkinson's disease claim reviewed by Ms. Pope. The claim was accepted. The claimant was a security guard. There is language identifying that it is highly likely that the occupational lead exposure was at a high level. Ms. Pope said she did not have a problem with this case. Security guards tend to go everywhere on the plant, and as such are potentially exposed to a lot of things. This claim did have a significant amount of supporting documents that helped develop the case. Ms. Pope reiterated the importance of having the presumption from the IHS, CMCs and the claims examiners that a job category as a RCT or security guard has a very high potential for exposure.

-7855

This case was a cancer claim reviewed by Dr. Silver and Mr. Tebay. The claimant worked at Oak Ridge National Laboratory mostly as a clerk. He had prostate cancer, asthma, and squamous cell carcinoma of the ear. He got a very low probability of causation for the prostate cancer from NIOSH, less than 2 percent. The asthma was not the main focus. The claimant had job tasks described on the Atomic Trades Labor Council Worker Screening Program Questionnaire that were significantly dirtier than the normal duties of a records clerk. He was an assembly auditor, and describes being in a particular building, 9212, with highly enriched uranium operations when components were being taken apart and maintained. His cancer claim was denied,

but when Mr. Silver looked at the latest SEM for Building 9212, mineral oil is one of the potential exposures. Mr. Silver said that on appeal, the claimant would need to argue that he was not just a records clerk, that he was also involved in quality assurance, and that job title at that location produces an exposure to mineral oil that was missed. Mr. Tebay concurred with Dr. Silver's conclusions. Mr. Tebay added that there seemed to be several places where the CMC, claims examiner and the diagnosing physician did not agree that there was a clear diagnosis for the asthma.

Consistency in Beryllium Sensitivity:

Chair Markowitz led the discussion. The Board recommended in 2017 that the finding of two borderline BeLPT tests should be considered the equivalent of one positive BeLPT for the purpose of claims adjudication under Subpart E and EEOICPA. As proposed, the program should recognize the sensitivity and eligibility for compensation and treatment. The response from the program was that they do not support this change. They claimed that the recommendation was inconsistent with the explicit statutory requirement that beryllium sensitivity is "established by an abnormal BeLPT performed on either blood or lung lavage cells." They also contended that the program is bound by "specific, clear and unambiguous language of the governing statute." Chair Markowitz said that the program was not unsympathetic to the issue and the Board's recommendation; however, the plain text of the statute tied their hands into saying that an abnormal BeLPT test is required.

Mr. Tebay asked for an explanation on why the definition cannot change. Mr. Vance pointed out that the language cited is legislative in nature. The program has no sway in changing legal standards that were passed by Congress. The program is thus administratively bound to ensure that claims satisfy the standard. Because the language exists in the statute, the program is legally responsible for applying it in case adjudication. The only other option would be to have the U.S. Congress pass an alternative law that provides for a different standard.

Dr. Friedman-Jimenez said this is not the first time that legislation has equated test results with a diagnosis. This is a problem because it amounts to legislators practicing medicine without a license. In medicine, test results are not absolute. All diagnoses are probabilistic in medicine. It requires a clinician to make a decision, a judgment usually, on whether the

diagnosis holds based on all available evidence, which includes a physical exam, diagnostic test results, imaging, and other things. In this case, a positive test result is equated with berylliosis, chronic beryllium disease or beryllium sensitization, which is really a clinical judgment. Dr. Friedman-Jimenez feels strongly that it is out of place for the legislators to make a diagnosis based on a test result without the necessary clinical considerations.

Chair Markowitz suggested that the Board recommend to the Department that they consider asking Congress to make a technical amendment to the Act, recognizing that individuals have beryllium sensitivity if they have or have had exposure to beryllium while working at the DOE and have multiple borderline BeLPT tests.

Dr. Friedman-Jimenez also suggested putting together a peer-reviewed paper reviewing the diagnostic test and making a recommendation to the test company that they modify their interpretation of the test so that two borderline tests are equivalent to a positive test. That way it would not require an act of Congress, but it would require a redefinition of an abnormal test by the company that handles the tests.

Mr. Vance confirmed that the Department would respond to whatever recommendation the Board makes. Chair Markowitz said that even if their recommendation is not actionable by the Department, at least it provides some visibility to the issue that interested individuals could then raise to Congress.

After some additional back and forth, Dr. Friedman-Jimenez and Ms. Whitten ultimately volunteered to be on a subcommittee to work on the language of the recommendation. Going forward, the issue will be explored further in a working group.

Nominations for Next Term; Active Issues for Board's Next Term:

Members are able to self-nominate to continue to serve on the Board. There are some current Board Members who are not going to reapply. Chair Markowitz thanked those individuals for their contributions to the Board over the six years since its inception. The Board has contributed to improving the program and raising important issues over its own lifetime and prior boards.

Chair Markowitz presented a list of issues that are still active and should thus be on the agenda for the future Board. He

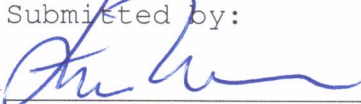
invited other Board Members to contribute to that list over the coming days. Chair Markowitz also prepared a document detailing areas of concern that have come out of the Board's claims reviews. He suggested that the incoming Board benefit from the current Board's work. Chair Markowitz indicated that he will draft a written description of the areas of concern and distribute it to the Board for input and modifications.

Chair Markowitz also proposed squeezing in a short July Board Meeting in order to refine some of the observations from the review of claims, in addition to doing some planning for the future Board's claims review arrangement with the contractor. Dr. Bowman concurred with this suggestion, and he added that it would be great to finalize the language on the beryllium sensitivity issue before closing out. Dr. Friedman-Jimenez concurred that it would be useful to have a final sign-out meeting in order to identify and hand off the most important priorities to the next Board. Chair Markowitz indicated that he will circulate dates in order to schedule the proposed wrap-up meeting in July.

Close of Meeting:

Mr. Chance adjourned the meeting at 4:57 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are an accurate summary of the meeting.
Submitted by:



Steven Markowitz, MD, DrPh
Chair, Advisory Board on Toxic Substances and Worker Health
Date: 6/27/2022