U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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THURSDAY
APRIL 25, 2019

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

PRESENT:

SCIENTIFIC COMMUNITY

JOHN DEMENT
GEORGE FRIEDMAN-JIMENEZ
MAREK MIKULSKI
KENNETH SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
STEVEN MARKOWITZ, Chair
CARRIE REDLICH

CLAIMANT COMMUNITY

KIRK DOMINA
RON MAHS
DURONDA POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICIAL

DOUG FITZGERALD

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

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

8:42 a.m.

MR. FITZGERALD: Good morning, everyone. My name is Doug Fitzgerald, and I'd like to welcome you to the second day of this meeting of the Advisory Board on Toxic Substances and Worker Health. I'm the Board's designated federal officer, or DFO.

Before we convene, just wanted to go over some general housekeeping and remind people that should there be an emergency, the exits are to the back of the room. Please exit and find your way outside if there is an emergency.

Also, there are restrooms located out the back and to the left down the hall, and there are water fountains there by the restrooms as well.

Our agenda today will take us to around the noon hour. We'll do our best to try to adhere to that schedule. There will be no public comment period today.

And with that, Mr. Chairman, I will turn it over to you.

CHAIR MARKOWITZ: Thank you. Unless someone requested, I think we might skip the introductions today, because everybody in the room here at least was present yesterday. So unless there's an objection? Okay.

So I thought we'd continue the discussion about the claims review from yesterday. If there were any additional claims that people wanted to discuss? Dr. Silver?

MEMBER SILVER: An interesting Parkinson's claim was for a Y-12 machinist who hired on in the 1950s and spent 45 years mostly as a machinist. He had a couple of managerial positions towards the end of his career in 1995.

His primary care doctor diagnosed him with Parkinson's at age 82. The family had already interacted with the EEOICPA program for squamous cell carcinoma. Under Part B he did not get compensation because the probability of causation was never more than about 15 percent. But if I remember correctly, people keep coming back as they get additional skin cancers, and the IREP model

sometimes comes out in their favor, but it did not in his case.

His primary care doctor made the diagnosis of Parkinson's and said, I feel it's due to job exposures, citing welding fumes, carbon steel, and stainless steel. The primary care doctor didn't say that the worker was a welder, so it's ambiguous as to whether he had bystander exposure or direct exposure to welding fumes.

I don't know if this helped or hurt, but the primary care doctor also said that the worker's spouse could really use some help with in home care in that diagnostic letter.

So there were two industrial hygiene reviews, one out of Jacksonville. A deficiency there is that they ignored the two types of steel that are in the site exposure matrix.

The DC industrial hygiene group did a better review and pointed out that there was a direct disease link work process for Y-12 stainless steel, carbon steel, and Parkinson's. A deficiency of the DC review was that they didn't

seem too curious about the percent manganese in the metals that he was working with, and that baffles me.

When an agent has been associated with a specific outcome, why wouldn't they put it any brain power into estimating the percent manganese in the ore or the metal over that period of time?

When it came to levels of exposure, they characterized them as low, and when the CMC looked over the file in the IH report, the CMC concluded that none of the exposures could have resulted in this gentleman's Parkinson's disease.

The CMC report I referred to yesterday has appeared to have a lot of cut and pasted boilerplate; in particular, a sentence about Parkinson's under 50 being associated with genetic factors. Well, this man was 82 when he was diagnosed, so that's kind of irrelevant, but it was in there.

I learned a lot about Parkinson's and secondary Parkinsonism yesterday, but a chapter by Robert Feldman, the late, great neurologist from

Boston University who trained a lot of occupational, environmental, and neurotoxic specialists, asserted that PET, positron emission tomography, was helpful for the differential diagnosis of idiopathic Parkinson's disease versus toxic Parkinson's disease.

I know Dr. Berenji said there was mixed evidence on that, but I thought that was a missing piece of information from his file.

So the claim was denied -- oh, one other relevant fact is that the primary care doctor mentioned that L-DOPA was slowing the progression of disease, and although there's a lot of nuance to this, kind of heuristic, is that if L-DOPA works, it may not be a toxic agent that's causing it.

So despite my problems with the exposure assessment in the CMC report, I came down on agreeing with the determination, as the onset was 82 years old, L-DOPA was working, and in my gut, I felt it was probably idiopathic Parkinson's disease.

CHAIR MARKOWITZ: Questions or

comments?

MEMBER SILVER: And I'm not heartless. I also want you to know that he also developed D-cell lymphoma and they got Part B compensation and survivor's compensation.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: A couple of comments: first, rather than speculate about the percent of manganese in the various steels, which does vary quite a bit, is there any way to get actual information data from the SEM or -- some of this may actually be classified. Is there a way to find out what the percent manganese in the various steels that were used in the different plants, or is that just futile?

MEMBER SILVER: Well, if I had been asked to work on this case, I would have gone to a couple of reference sources. I'm at a school without a lot of library resources, so we inadvertently have a great historical collection of the Kirk-Othmer Encyclopedia of Chemical

Technology, 2nd Edition, from the era of the Cold War.

It often has chapters written by engineers and chemists who worked in the DOE complex. So that is one reference source that I would have checked on typical manganese concentrations.

I think it might be available in the open literature, but -- in curiosity, we've seen, on the part of the CMCs and the IHs tells that you never take that kind of deep dive into the literature.

MEMBER FRIEDMAN-JIMENEZ: Okay. It sounds kind of difficult to determine with any confidence for a particular job, not to mention a whole career, but I think manganese is a pretty common alloy in most of the stainless steels ever used. Is that right, John?

MEMBER DEMENT: Yes.

MEMBER FRIEDMAN-JIMENEZ: Yes. So the second question: I don't know that the test, for example, the globus pallidus versus the

substantion diagram finding are really accurate enough to distinguish with confidence idiopathic Parkinson's from manganism.

Typically, manganism shows findings in the globus pallidus, but they are not very sensitive, and they're not very specific either. So I don't know that we would expect that that would be used to distinguish.

I think a default presumption that Parkinson's and manganism are not clinically distinguishable with confidence would be reasonable. Marek, do you think that's accurate?

MEMBER MIKULSKI: I think that's a fair comparison. I was looking at this last night actually, and this is exactly what you have been saying. There's really -- those are not sensitive enough to use diagnostic testing in order to be able to use it as definite diagnosis.

CHAIR MARKOWITZ: This is Steve Markowitz. I think the Procedure Manual actually recognizes that -- I'll try to find the section -- but I think they aggregate the various relevant

ICD diagnoses and consider them to be subject to the issue, so -- Mr. Nelson, do you have a comment you want to make?

MR. NELSON: Just a point of clarification. In the Procedure Manual in Appendix 1, Chapter 15-4.16 of the Procedure Manual says tells CEs to develop claims for Parkinsonism, Parkinson's disease, and any reasonable alias in the same manner.

CHAIR MARKOWITZ: Okay. Thank you. That was the section I was referring to, yes. So that's a healthy approach. Dr. Redlich?

MEMBER REDLICH: I think that case also illustrates one other aspect of Parkinson's, which is the incidence does increase with age, and he was 82 years old, and age is considered a risk factor. It's also more common in men than women, especially in the older age group.

MEMBER MIKULSKI: Do we know at what age he was diagnosed?

MEMBER SILVER: Eighty-two.

MEMBER REDLICH: That's right.

MEMBER SILVER: Is it at all relevant that when he retired, he had no neuro symptoms at all? At age 64? If it had been the manganese, would you have expected some neurotoxicity before the later onset of full-blown Parkinson's? Or is that not a predictable case representation?

MEMBER MIKULSKI: I don't know.

MEMBER FRIEDMAN-JIMENEZ: I think that's a valid question. I don't think anyone here knows the answer, but what is the latency period for manganese-induced Parkinsonian-type symptoms? It's something that may be studied or may not have been studied.

But these kinds of facts or factors, I think, are useful in distinguishing, but even with that, with the age, with the response to L-DOPA, with the imaging findings, it's still quite difficult to distinguish -- and I don't know that it's a reasonable goal, and I think the Procedure Manual really has it as well as we can formulate it -- to consider them indistinguishable, clinically.

CHAIR MARKOWITZ: Steve Markowitz. I think, Marek, the issue of latency maybe is something that, when we move forward on providing some advice to the Department, we should -- if there are data on that issue.

Any other questions or comments on this claim? Is there another claim that people want to review? Dr. Dement.

MEMBER DEMENT: This is a fairly brief review. This is an interesting case. This is an individual who worked at Sandia as a metallurgist, a materials scientist from '78 through 2008.

He developed symptoms of Parkinson's at age about 60 and submitted a claim. The claim was originally denied, or the recommended decision was to deny it based on lack of finding exposure information on the SEM.

His authorized representative, who was his spouse, asked for an appeal at the time the recommended decision was made and stated it was difficult to get information on his exposure from the cause of classification. The case was

recommended for further development.

So the interesting thing about this is, this individual published a number of articles that specifically talked about his work with these metal alloys, and as they produced a whole list of publications that came along with it, peer-review publications that demonstrated it.

The claims examiner went back and made the direct disease link between manganese alloys and Parkinson's, and it was awarded. So that's a good story.

CHAIR MARKOWITZ: So it is useful to publish. Is that the lesson?

MEMBER DEMENT: Yes, sometimes people read them for different reasons. I looked at the publications. They were really complex publications, quite detailed.

MEMBER MIKULSKI: What was the site that he worked on?

MEMBER DEMENT: Sandia.

CHAIR MARKOWITZ: Questions or comments on this case? Are there additional cases?

Dr. Silver?

MEMBER SILVER: Are we ready for some more COPD?

CHAIR MARKOWITZ: Yes, we can move back to COPD, that's fine.

MEMBER SILVER: The claimant was a laborer --

CHAIR MARKOWITZ: Is this an accept or a denial? Just to --

MEMBER SILVER: This was a denial.

CHAIR MARKOWITZ: Okay.

MEMBER SILVER: Employed at the Nevada test site for eight years, from 1980 through 1987. There were several sources of exposure information. The SEM was the main one relied upon by the IH and the CMC.

But the employer also had hazard profiles for some of the work areas that were included in the file, and I was distressed that the DOL people did not rely very much on the information provided by the employer.

But the main exposures considered were

silica, asbestos, certain metals, lead, diesel exhaust as well, wood dust, welding fumes, and cement.

She was not diagnosed with COPD until age 73, after having left the Nevada test site for a couple of decades. Early in the assembling of facts for her, it was referenced to six years of heavy exposure to asbestos when she started at the Nevada test site, but that dropped out of the documentation as the claim progressed, and I'm not sure why.

Missing from her files were the actual pulmonary function test data. Her primary care doctor diagnosed her with COPD, referred to the six years of heavy asbestos exposure and the other vaporous gases, dust, and fumes that I've mentioned. He didn't use that phrase, but we all know diesel, cement, silica dioxide fall into that category.

She reported smoking only one to two cigarettes per day, and no one ever questioned that in the documentation that I saw. But when it

reached the CMC, the CMC saw fit to include a paragraph about how 80 to 90 percent of COPD cases are due to smoking, and it seemed like cut and pasted boilerplate with no reference to her actual smoking habits over the years.

She also developed Lewy body dementia while the claim was being processed and relied on her authorized representative, a family member, to advocate for her.

So the claim was denied, and then on the question of whether I agree with that, I just looked at the Board's presumption that it's not yet been accepted by DOL and saw that she had five years of exposure to asbestos, diesel, cement, other vapors, gases, dust, and fumes. With that as my guiding light, I felt it was an unfair denial.

She had not been through the former worker program; I think that would have helped her, since I know they do some fine grains, characterization of people's work histories for the Nevada test site program.

I think DOL ignored the fact that she

spent time at Area 51. I'm not the conspiracy theorist I used to be, but we do know that they had a lot of exotic materials being incinerated out there.

They also overlooked information about her work with molten asphalt rubber to fill cracks in the road. That information was provided by her employer, and other information provided by her employer said she spent time around a tank farm, which would have resulted in gas and vapor exposure.

So that's my take on it. Any insights on Claim Number 5427?

CHAIR MARKOWITZ: So I reviewed that claim also, and my take on this is that one doesn't need to resort to the approach of vapors, gas, dust, and fumes, but actually for a laborer in the SEM, the Nevada test site, if you look at how labor and COPD overlap, what the exposures are, which includes cement, diesel exhaust, and the like, she would appear to have had those exposures.

In fact, my puzzle on this case -- the CMC just followed what the IH said, so I ultimately

said there wasn't significant exposure, and the CMC followed.

But let me just read from the IH report briefly. Conclusion, quote, in the absence of compelling data to the contrary, it is highly likely that the Claimant, in her capacity as a laborer at the Nevada test site, was significantly exposed to cement, diesel exhaust, lead, mercury, crystalline silicon dioxide, welding fumes, and wood dust.

Any exposure to these agents that she might have received would have been incidental in nature, parentheses, occurring in passing only, end parentheses, and not significant.

So there's a direct contradiction within that statement, and I don't know that that was ever corrected or not, but it was puzzling. The other aspect is the references that the IH provides are the usual references; meaning, the site exposure matrix, facility database, and then a number of textbooks, which clearly don't have the detailed kind of information that would allow a person to

make these conclusions.

So clearly, they were relying on their expertise understanding of the site and industrial hygiene. So that's where I found this case to be puzzling.

CHAIR MARKOWITZ: Comments? Questions?

MEMBER POPE: I also see that -- I reviewed that case as well, and I concur with Ken, and as well with you, Dr. Markowitz. But it seemed like there was a trend or commonality with the IH starting out saying there is a connection, and then having that contradicting language following. It says there is a connection, and it says no, I think it's environmental related.

CHAIR MARKOWITZ: Yes, Mr. Domina.

MEMBER DOMINA: I guess a couple of questions. Some of these claims -- I apologize, I haven't had a lot of time to review, but some of them are still open, and we have questions about -- there's got to be a mechanism for us to talk to DOL about them, to get more information or see

where some it is going, in my opinion.

Then the other part where we always see below regulatory limits; who is that? Who is the regulatory limits that they're referring to? What agency is that, and are they all citing the same agency?

And then an observation from me: You look at all of these sites that have SECs for the Part B for radiation; if you don't have any radiation data, you don't have any data for anything else either, because that always came first.

We need to come up with a mechanism -- just me saying out loud -- if there's an SEC, they need to look at stuff different for the chemical exposure or any other exposures, because you know there is no monitoring, because a bunch of us lived it.

And to put the onus on the worker to come up with stuff when the claim is not properly adjudicated, just like the one John just talked about -- well, the guy's a metallurgist. Then you're taking somebody who is obviously at a lot

lower level, trying to tell them they weren't exposed. I mean, that's criminal.

CHAIR MARKOWITZ: Any other comments or questions?

MEMBER MAHS: Yes, I just had a look, and I think that four out of the six that I reviewed had that same contradictory statement. It says substantially exposed, but to low or very low or in-passing exposure.

CHAIR MARKOWITZ: By the way, just to follow up on Mr. Domina's question: Mr. Vance, are you on the -- if you're on the phone, the question is whether any of the claims we were provided for review are still open cases. I would have thought they would be closed.

MR. VANCE: Hi, good morning, Dr. Markowitz and the Board. Yes, John Vance. That was not a criteria we were looking for, so we were just looking for cases that met the requirements for the pool, which was Parkinson's denied, Parkinson's accept.

So there could very well be cases in

that sample size that have other ongoing issues or are currently in some sort of appeal.

CHAIR MARKOWITZ: Okay. Okay, thank you. Dr. Silver?

MEMBER SILVER: What a great idea, Kirk. If a site has an SEC, it's an admission by government that radiation, kind of the main act at the site, is not being adequately monitored. So it's not a great stretch to infer that chemicals were not being well monitored in that time frame.

I don't know how we get that recognized administratively and legally, but it's just exploding with common sense.

CHAIR MARKOWITZ: Steve Markowitz. In any of the claims that people looked at, in the pre-1995 period, was there any evidence that the industrial hygienist actually used monitoring data from the site in order to influence their decision?

I didn't see any reference to any monitoring data in the decision-making, and that's not a criticism, that's just an observation reinforcing what you're saying; that there is

minimal highly relevant monitoring information for decision-making on a claim.

MEMBER BERENJI: Hi, this is Mani Berenji. So to answer Dr. Markowitz' question, I actually did review a claim, COPD, that was approved. Case ID is 017, Date of Birth, (Redacted).

This was an individual who worked at multiple locations within the Rocky Flats Plant, so this individual worked as a radiation monitor, machinist, tool maker, construction millwright, as well as a supervisor. He was involved in construction and welding inspections, and he worked for multiple subcontractors over multiple periods of time.

So his work history, at least with DOE was fragmented. From what I was able to gather from the record it appears that he worked from 1962 to 1967, then there was a two-year lag, and then he worked from 1969 to 1973, and then from 1999 to 2003.

This is an issue I had with some of the

claims that I reviewed, especially with the folks who have had fragmented work histories. So I'm not really sure what he was doing between 1974 and 1998. I wasn't able to gather if he was still engaged in some sort of other type of activity that could have introduced him to additional exposures. That wasn't very clear to me.

But at least from that I was able to review, I thought that first and foremost, there were actually the occupational medicine reports, so this individual had multiple injuries at the Rocky Flats Plant, and there was actually good occupational medicine records with respect to the injuries that he had.

With respect to actual exposure data, again, I just did a brief review of this case, so I'd probably have to go back to get some more detail, but at least from what I was able to see, there were some sampling reports done by industrial hygiene at the Rocky Flats Plant.

This is addition to SEM, as well as the fact that this individual was in the Former Worker

Medical Screening Program.

I think it was just in this particular worker's interests that he was close to National Jewish, which is a very renowned health care system, and they actually have some of the best pulmonologists in the country. So he actually did have good surveillance screening program.

They actually did screen for beryllium, and he actually had some additional screening surveillance, monitoring for metals.

So I think this individual, by the fact he was at Rocky Flats, had good access to medical care, good access to screening protocols at National Jewish, and at least the industrial hygiene report that was issued on June 19th, 2018 did incorporate both the SEM as well as some of the sampling reports.

But again, I always run into this issue as well, with respect to the exposures that were listed in the industrial hygiene report, because I do find that there is still a discrepancy.

The exposures that were listed were

asbestos, cement, diesel engine exhaust, endotoxins, silicone dioxide, welding fumes, ammonia.

But I think we've all mentioned this at some point during this meeting, but the low to moderate, low to very low exposures in terms of the way they categorize the exposures, I feel like this is an underlying thing that we've come across day in and day out.

Despite the fact that this individual on the DOE Former Worker's Medical Screening Program actually had some sampling data -- I'd like to get John Dement's input on that at some point -- I feel like there's not a comprehensive way to incorporate all those data points. I feel that the industrial hygienists and DOL still resort to SEM at least 90 to 95 percent of the time.

CHAIR MARKOWITZ: I'm sorry, I didn't catch that last point. They still resort to 90, 95 percent what?

MEMBER BERENJI: The SEM. I feel that's their main go-to. Again, I feel that if

you get some industrial hygiene input from some of our colleagues here, but despite the fact that there was actual sampling data, I feel that the DOL still resorts to the SEM. I feel that that's an unfair protocol.

CHAIR MARKOWITZ: This is, oh yeah I'm sorry, Calin Tebay.

MEMBER TEBAY: Calin Tebay. Oftentimes we only see at the HWEC when folks come in with claims. The IH data that's in the file is submitted by the claimant.

MEMBER BERENJI: That wasn't made clear to me, because I wasn't there. But I'm not sure if DOL actually --

MEMBER TEBAY: That's what my question was going to be.

MEMBER BERENJI: Yes, that I don't know.

MEMBER TEBAY: I've personally never seen -- and to be honest with you, a year ago, almost to the day, we met with the DOL, the district office in Seattle with DOE and the HWEC. And this the

topic we discussed for two hours, this boilerplate language of not significant or significant but not above OELs and PELs, and where they're getting their information for this boilerplate language.

So this has been going on for quite some time, and the only time we've seen IH data that could potentially back up those kind of statements is when the claimant themselves had mined some kind of IH data from their own site and then submitted it themselves.

MEMBER BERENJI: Yes, I'm not sure about this particular case. It wasn't made exactly clear to me whether this was submitted by the claimant or DOL.

CHAIR MARKOWITZ: You know -- Steve Markowitz -- the other aspect of this is from the medical end. If you receive an IH report that lists some exposures and then ranks them frequent or occasional, low, very low, or frequent, I would expect there to be significant variation among the CMCs on how to interpret that information.

I could easily see that one CMC would

say that a frequent low exposure to X is not significant because its low; whereas, another one would say it's frequent even though it's low, and therefore it is relevant to the person's disease.

Consistency is very important, and I don't know that that's been looked at or how you develop a system that would be consistent so the claimants are treated equitably.

MEMBER MAHS: Kirk asked about any open cases. One of mine definitely is, 5227, a lady from Savannah River. They had asked for a review due to them not giving her the final recommendation, just the final decision, and they didn't use the testimony of two of her co-workers.

CHAIR MARKOWITZ: A question for Mr. Vance, just following up on Mr. Domina's suggestion. So if there are cases that are in some sense open, and Board members want to submit comments on those cases that might be useful in the review of those case, how should we handle that? Should we submit them to the Department?

Before you answer that question, I'm a little

uncomfortable with, in any sense, setting up an expectation that all the claims we look at and that all Board members would be obligated to do this, because that's not our role.

However, if we find issues that the Department would want that feedback on, then there should be an avenue to do that.

MR. VANCE: Yes, this is John Vance. Yes, I think that would have to be a conversation between the Board and the DFO and the program, as far as how that mechanism would want to work.

I'm just not sure how we want to do that. I mean, some of these cases were in some process of adjudication for a variety of things, so what their status is now or what it will be in the future is hard to tell. So I think that's a conversation between all three parties.

MR. FITZGERALD: This is Doug Fitzgerald, DFO. I wouldn't want to make a decision on the fly here without looking at this a little more closely, but I think the charge of the Board should be one that looks at more general

sort of application of the statute and the laws and how the program is conducting its business, rather than getting into individual cases.

I would hate to set up that expectation that the Board is going to weigh in and actually weigh in on individual cases. That's not to say that if things that are found in the normal course of business appear to be egregious, that the program should be made aware of, I don't want to cut off that opportunity either.

But to set up a sort of formalized process where the Board weighs in on individual cases I think might be problematic.

MEMBER SILVER: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: So, I understand your point, and I agree. I think, though, it's very useful for us to communicate in some formal way our opinions on various good and bad things that we've discovered in these reviews.

So maybe we should aggregate our findings in our reviews in a systematic way that

we can then transmit to the DOL that will hopefully be useful in changing some of the problematic things and reinforcing positively the good aspects of the reviews.

CHAIR MARKOWITZ: Steve Markowitz. You know, we do, this segues into the larger issue of, how do we move forward on claims review, and what do we do about it? We've been given 20 claims; we've had some time review them. I'm sure we haven't reviewed all of them. I'm sure we haven't been able to spend sufficient time on many of them to be able to weigh in properly.

Nonetheless, it's been a very useful exercise for us to understand the claims process and how the various pieces of information are used.

We do have an outstanding request to the Department for an additional 80 claims to review, including -- and this is from the December 10th request, just to remind you -- including 20 chronic beryllium disease claims, 20 sarcoidosis claims, 20 interstitial lung disease claims, and 20 asthma claims. So that's an outstanding request

already.

The second issue above and beyond that is, how do we want to move forward with getting to what I think Dr. Friedman-Jimenez was talking about, which was being able to do our Task number 4 of our charter, which is to evaluate the industrial hygienists and the physicians for objectivity, consistency, and quality of their input into the process. So if we could discuss that, how to move forward.

The floor is open for ideas. Dr. Dement?

MEMBER DEMENT: I think, as we walk on through these claims, and as we continue to go through the claims, I think there's some themes that recur in some of the claims across the board, and that's -- I really think that's the areas we ought to concentrate on.

Some of them have to do with the issues of consistency between IH assessments and CMC assessments. So I think, rather than concentrate on any particular IH or CMC or any particular claim,

I think it might be beneficial, as we sort of wind down, and we go through a set of claims, COPD, Parkinson's, asthma, or whatever, that each one of us sort of synopsize our observations.

After you've taken a look at all of these claims, what are the major points that you have seen with regard to the positive aspects of how the process works and perhaps those that need to be have some attention paid to.

And after we've had a chance to do that sort of by category, I think maybe if we reconvene and sort of compare notes, if you will, and we see some commonality in observations across the claims that might have some areas that could be addressed.

I don't know how else to bring this to a reasonable conclusion. I think the discussion that we've had in the last day or so has been helpful, and I think we have seen some emerging things, but I think we may see more as we dive more deeply into the process.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: What is the status of

the Board's request for an outside contractor to assist with claim reviews? I agree with Dr. Dement's approach, but the phrase, after we've reviewed all these claims, gives me pause, because most of us have day jobs.

I love doing this stuff, but it would be really helpful to have an outside contractor. The first version of this board thought our colleagues at the Association of Occupational and Environmental Clinics could help us get this done if resources were available.

CHAIR MARKOWITZ: Steve Markowitz. The short answer is, we have no outstanding request to the Department for resources to do any work. In other words, there was a request of the first board. That board's term has expired; this board has not made that request.

MEMBER SILVER: I think we should move to make that request again, and maybe we could add some more specificity to it as we sort of move forward.

CHAIR MARKOWITZ: So that's not a

formal motion, but we can discuss that and formulate a formal motion. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I agree with both Dr. Dement's proposal of synopsizing our findings and requesting additional resources.

And to make things maybe a little bit more difficult, I think it's also important to look at cancers: lung cancer, mesothelioma, some of the leukemias, bladder cancer, cancers that are likely to be caused by chemical carcinogens.

These are a different framework for the causal inference, and I think it's important for us to look at the cancer cases as well. I don't know how many there are, but I wouldn't want to completely ignore the cancers.

CHAIR MARKOWITZ: Well, it is true -- Steve Markowitz -- it is true that we only looked at claims -- this board -- for two conditions: COPD and Parkinson's disease, and it may well be that the approach that the industrial hygienists and physicians take is somewhat different by different condition because of availability of

information, their own working assumptions, or whatever.

So I would agree that, not just cancer, but we need to figure out, not necessarily today, but we need to figure out the portfolio of different types of claims that we think should be looked at so we end up with a credible set of conclusions, recommendations, that's based on a broad look at the program. Dr. Redlich?

MEMBER REDLICH: I think in that regard having a better sense of which are the most common claims, under which categories, and also what the trends have been, because I gather that there may be more of X disease and less of Y in terms of where to focus efforts.

CHAIR MARKOWITZ: Well --- Steve Markowitz -- in our December 10th data request we asked for that information for lung diseases, for the most common Part E conditions in general, for neurologic conditions, for cancers, and for kidney disorders. So that information has been requested.

MEMBER REDLICH: Yes, it would be very helpful to get that data to best focus efforts.

MEMBER BERENJI: This is Mani Berenji. I do agree with that. I think we should be able to compile all the statistics and then at least try to have some spreadsheet where we can actually kind of tease out these particular cases, approved and denied.

And then there are obviously some other extenuating circumstances with some of these claims, but I feel like we should have a systematic approach, and we should hopefully be able to at least get some quality data.

So at least from my experience on this board so far, I feel like we've never actually gotten an actual handout or spreadsheet just looking at how many claims they process per year, what percentage are denied, what percentage are approved. I feel like, at least for me, it's been a struggle.

CHAIR MARKOWITZ: Steve Markowitz. We did get some data on Parkinson's disorders, but

no data on the rest of the conditions, at least this board.

But I think the use of the word systematic is key, because so far what we have are claims for two conditions. We have, on a relatively short time for review, our impressions, our initial impressions about what these claims show, and we're not going to draw any conclusions from those initial impressions because it wouldn't be appropriate. What we need is a more systematic approach to examine the appropriate set of claims.

What we've done so far has been very useful because it does allow us to send out some preliminary categories of concern; issues that we would raise with industrial hygiene evaluation with the medical evaluation and the like, so it helps us design that kind of systematic evaluation.

But that's what's needed in order to understand the issues, because we have a taste of it, but we don't have a full understanding, and we couldn't credibly represent to the Department that we had any particular recommendations or, I

should say, not any particular recommendations, but a set of recommendations.

That wasn't meant to be a summary statement. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Two other potential issues that I want to ask whether we should raise them. One is injuries like chemical-induced injuries, chemical burns, dermatoses; the second is impairment, disability and impairment. In other words, time lost from work. Do we want to get involved in those two issues?

Because also those are involved in occupational medicine decision-making and would be related to chemical toxic substance exposure. So I'm raising it as a question; I'm not advocating for doing that.

CHAIR MARKOWITZ: Steve Markowitz. Well, the first question is, is it within our domain? Is it within our charter to address those issues?

And I would say to the extent that Task

4 is looking at the objectivity, consistency, and quality of the industrial hygiene and the medical input into the program, that impairment and chemical-induced injuries, which are just another outcome, would fall within what we're -- the advice that DOL has asked us to produce. I'm not asking for a bigger set of issues, by the way, but I don't see how they wouldn't be conceived as being within the domain. Dr. Dement?

MEMBER DEMENT: Sort of by definition of what our charter is on that part to look at issues of across claim in terms of objectivity, consistency; there's no other way to get at that without looking at claims in rather great detail. And that, by definition, is a time- and effort-intensive process.

So I think we're all interested in spending time on these claims, but each one of us has limitations; we have other jobs to do. And so I think we do need some other hands to take a look at this and help us with the process.

I don't know quite what that looks like

yet; where do we find that expertise, but I think it's appropriate that we request some assistance to get to the point that they've asked us to get to.

CHAIR MARKOWITZ: And that statement was in reference to claims review in general, perhaps including impairment, including chemical injuries and the like; is that right?

MEMBER DEMENT: Yes, broadly speaking.

CHAIR MARKOWITZ: Well, it seems the sense is, and correct me if I'm wrong -- Dr. Redlich, you wanted to say something?

MEMBER REDLICH: I mean, I think there's a Workers Comp system for acute events like a person is actively working. I don't think that it's part of our task. I think if there were a chronic, long-term sequellae of that acute exposure event that then resulted in a chronic condition, that that would be.

CHAIR MARKOWITZ: Steve Markowitz. It's hard to believe that we could rely on the excellent review by state workers' comp system of

chemical-induced injuries. It's possible, but it's not a default conclusion. And to me, it's just another outcome that could be within the ballpark of what's looked at.

MR. FITZGERALD: This is Doug Fitzgerald, DFO. I've been listening to your back-and-forth on this, and there's some unknowns right now in terms of whether or not there will more resources, or if we have the capability of doing that.

I think you could probably make all sorts of connections and linkages between what you're asking, as others have said, to look at. But is the link really a strong one? If you have limited resources, and you all have limited time and other jobs and that sort of thing, what is the work that this board should be focusing on and prioritizing? Is that going to spread us too thin in the absence of other resources?

CHAIR MARKOWITZ: So I think the sense of what I've heard so far is that the Board would request additional resources in order to conduct

an appropriate systematic evaluation of an appropriate number and variety of claims in order to weigh in our task of contributing to an assessment of the objectivity, consistency, and quality of the industrial hygiene and medical input into the program. Is that an appropriate summary?

MEMBER DEMENT: It's an excellent summary of where we are.

CHAIR MARKOWITZ: I think we should formulate that or some version of that as a recommendation. I'm looking to Kevin because I'm hoping we can get it on the board, hoping he's remembered exactly what I said.

(Laughter.)

MR. FITZGERALD: This is Doug Fitzgerald again, DFO. I just want to raise the issue that what the Board may not be familiar with is our procurement process. Even if we, as an agency, agreed with the request and thought it was a valid one, the procurement process within the federal government is lengthy, and it requires a lot of -- it will take time.

So like I said, in the absence of any additional resources coming in, this Board still has to pursue its mission. So I'm just cautioning you in trying to manage expectations that even if there was an agreement immediately that we should provide the Board more resources that you're asking, it would be some time before those resources were available.

CHAIR MARKOWITZ: Thank you for that advice. To me, what that translates into is that we move in parallel on this issue, meaning that we make our recommendation about a request for resources to do that systematic evaluation, even as we continue to review claims, aggregate our concerns as I think Dr. Friedman-Jimenez mentioned, Dr. Dement said, from the claims we have now, perhaps from a limited number of additional claims for different -- not necessarily 80, but a limited number of additional claims for different outcomes so that we're able to design that systematic evaluation with greater specificity within a reasonable period of time.

But a recommendation that asks for those resources, at least puts it on the table that frankly, to weigh in on the issues that we need to weigh in on Task 4, we can do so, but it's limited unless we have additional resources. But to move in parallel, because we know it will take time to get those resources. Ms. Pope?

MEMBER POPE: Yes. I think it's very important for us to -- it's great for us to acknowledge and identify the different concerns that we have about these claims that we're reviewing, but is there a way that we can, and especially for the benefit of the new members on the Board, to find out the recommendations that we did submit that have been approved and accepted by DOL?

CHAIR MARKOWITZ: What the status is?

MEMBER POPE: Yes.

MEMBER BERENJI: This is Mani Berenji. So yes, I think that would be great to have some sort of dashboard in terms of questions that we've brought up, the DOL's responses, what percentage

have been implemented, what percentage are still outstanding. I think that way we have some sense of what's happening, and we can hold ourselves accountable, but we can also hold DOL accountable for what's being done and what's still outstanding.

So honestly, I'm happy to put that together; that's not hard. We'll just have to get a spreadsheet and create a dashboard.

CHAIR MARKOWITZ: That would be great, and I think we'll make that as an action item. In fact, Ms. Leiton yesterday volunteered to bring us up to date on the status of the interview of the claimant by the industrial hygienist, which they agreed to, as long as the claims examiner was involved.

She didn't quite know the status, but volunteered to -- so that applied to the other recommendations, we will ask them for, and I'm sure they will accept Dr. Berenji's assistance in organizing that. So we will do that, thank you.

MEMBER DOMINA: This is Kirk Domina. You know, yesterday when Ms. Leiton was talking,

they just came out with Procedure Manual 3.0, and she said it's soon going to be 3.1. I'm just curious if something they're doing there affects anything that we could be doing, so that we're not doing something that we've got to redo.

MEMBER BERENJI: That's where the dashboard would come in. So like I said, at least we can have some sort of working document we can add on to it over time, but at least we have some way to kind of keep ourselves accountable.

Because at least from my perspective, I find this kind difficult to be able to track, so it would be good to have some systematic way of tracking what we're doing, what they've been able to accomplish, what's still outstanding, and then really trying to advocate for more concrete data.

I know we keep asking for specific numbers, but I would love to be able to see some bar graphs starting from the date of implementation of Part E from, I believe it would be, what, 2004, 2005 to the present.

I'm not sure why it's difficult to get that concrete data just in terms of how many claims come in on a yearly basis, what percentage are approved, what percentage are denied. I mean, at least we'll have a better sense of what's happening, because at this point, I still don't know.

I'm not sure if you folks have additional data that I don't have access to; I still don't know.

CHAIR MARKOWITZ: To follow up on your comment, Mr. Domina, we've raised this issue before about Board input into the policy-making process, and I think I recall that the Department's position is that it is not the Board's role to review policy changes that are under consideration, except for the initial Board's weigh-in on the that official rule. But it's not our role to weigh in on changes as they are under consideration.

And that's understandable. I must say, it gets awkward sometimes, because the new Procedure Manual 3.0 removed the section about asbestos exposure from 1986 to 1985, which is a

topic that the Board, in general, has spent a lot of time on, asbestos consumption.

That section was removed unbeknownst to us, and then we discussed it initially yesterday: what does that mean? And there will be some back-and-forth between the Board and the Department about that. Maybe the next version will have it restored, and maybe not.

So it's awkward, because that's a topic that we spent a fair amount of time on, and a section is gone that's obviously relevant. Now, after the fact, we're going to provide our opinion about that, but it's an awkward process, let me just say that.

So I think Kevin's put the agenda back on, thinking that we should probably move on. But I would like to go back to that recommendation.

So the recommendation is that the Board requests resources in order to conduct a systematic evaluation of an appropriate number and variety of claims in order to assess the objectivity, quality, and consistency of the industrial hygiene and medical evaluations that are part of the claims

process, parentheses, Task No. 4.

Okay. So how should that be modified, now that we see something in writing? To conduct a timely systematic evaluation? Okay. So take out the, and put in a timely.

MEMBER BERENJI: I think we need to specify what exactly we mean by resources. Are we talking about manpower? Are we talking about technological? I think we need to specify that.

CHAIR MARKOWITZ: Okay, so let's suggest some words.

MEMBER BERENJI: I would probably put in parentheses, personnel. I mean, do we have a specific number of folks -- I mean, we could probably put a range.

CHAIR MARKOWITZ: Well, we clearly have to flesh out some details, but I don't think we're capable of doing that right now. I think we should flesh it out over the next four to six weeks so that they have something real to go on.

But I don't think we need to do that today.

MEMBER BERENJI: Okay.

CHAIR MARKOWITZ: But the categories, I agree with.

MEMBER BERENJI: So personnel and IT support; I would probably at least put that in there. And then in terms of timely, I think we need to specify that too. Within what, a six-month time frame, a one-year time frame?

CHAIR MARKOWITZ: Well, there are two time frames: one is receiving resources, and the other time frame is actually conducting evaluations.

Of course receiving resources, we want to make that as short a time period as possible, and finishing the evaluations, we want to be realistic.

MEMBER BERENJI: I feel like we really need to be specific with these folks, because I feel like a lot of these recommendations are very vague, and these folks need to be told, like, we want this, this and this, and we need to be very specific. At least that's been my experience so far. I'm not sure if you folks agree, but --

CHAIR MARKOWITZ: I agree with the need for specificity; I don't think the recommendations have been all that vague, but that's another issue. Dr. Silver?

MEMBER SILVER: I'm concerned that the phrase, personnel and IT support could be misinterpreted to mean that DOL would reassign their personnel on an in-kind basis to assist us. I think what we really want is what the NIOSH radiation board has, which is an external contractor.

CHAIR MARKOWITZ: Now it says, in order to conduct -- that could be interpreted that we set out the general framework of that evaluation, but then don't necessarily oversee that evaluation. So the question is, do we need to be, in this request, more specific than simply to say, to conduct? For instance, we could say, to design.

MEMBER SILVER: Design and direct?

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Rather than

say design, I would -- I like the word conduct. I mean, there are several epidemiologists, industrial hygienists on this Board that can help with the design. That's not where the labor-intensive part of it is.

But actually doing the record organizing, selecting the records; we could design what kind of sampling we want, what diagnoses we want, but the actual work involved is beyond our capacity.

CHAIR MARKOWITZ: I see. So resources to support the Board to -- is that what you're getting at? So after, the resources would be to support the Board in order to conduct?

MEMBER BERENJI: I think this is getting too wordy already. I mean, I feel like this needs to be pretty concise and succinct.

CHAIR MARKOWITZ: So this is what we're looking at. Either, does it need any additional wording or, for that matter, should any wording be deleted to reflect what we're after?

MEMBER MIKULSKI: Take out the second

in order?

MEMBER BERENJI: Yes, I think that's a little too much wordiness.

CHAIR MARKOWITZ: I'm sorry; take out in order?

MEMBER BERENJI: In order --

MEMBER MIKULSKI: The second one. And then the variety of claims to assess the objectivity, quality, consistency --

CHAIR MARKOWITZ: Yes, that's fine. I don't know whether, Doug, as the designated federal official, whether you see any areas of that request that are so vague that it wouldn't transmit the intended request?

Obviously, there are going to be details about numbers of claims, types of claims, and all that. That, we will provide. But at this level, is there anything additional in specificity --

MR. FITZGERALD: If you're trying to kind of create a placeholder for a more refined request later, I don't know that you need to be more specific than this. But you were going to

have more discussions, I think, about the wording of this, so --

MEMBER REDLICH: Did we want to specify an external contractor?

CHAIR MARKOWITZ: Questions? Comments?

MEMBER SILVER: If this is just a placeholder, I don't think we're going to bring on the wrath of government procurement specialists if we mention the would-be contractor by name.

I mean, we're going to refine this, so if this is a statement of our sentiments, then I would propose we put in the Association of Occupational and Environmental Clinics as the first board discussed.

CHAIR MARKOWITZ: Mr. Mahs?

MEMBER MAHS: It may be just me, but you have the support to support, but would it be better to replace the support with, assist the Board, instead of two supports there?

CHAIR MARKOWITZ: All right. That's good. Speaking about -- I don't think we should

name a particular -- at this point, I don't think we should name a particular -- it could be limiting, actually, because what if that particular organization doesn't want to do it?

But my concern is that it's possible that a blend of internal and external resources might be able to make this happen.

For instance, the claims need to be organized, indexed, and it's possible that there's internal support that could do that in preparation for, ultimately some -- we need some physician time and industrial hygiene time to evaluate these claims, and we wouldn't want that from inside the Department, because of conflict of interest, essentially. So it could be some blend of internal and external.

MEMBER REDLICH: That was what I was asking, not knowing what resources are available internally, it seems that that request should just be as open as possible, the point being, request resources.

MR. FITZGERALD: I don't want to speak

officially for the energy program, but I think, in general, the availability of federal personnel is going to be very limited.

CHAIR MARKOWITZ: Is what?

MR. FITZGERALD: Very limited.

CHAIR MARKOWITZ: Very limited. Okay. So we could leave it, then, as external contractor, and if some limited internal resources are provided, as long as there's no conflict of interest or whatever, that would be fine with us.

MEMBER REDLICH: It could be such as --

CHAIR MARKOWITZ: Such as an external contractor? This is part of the reason why many chapters in medical industrial hygiene texts have single authors; otherwise, they'd never get done.

MEMBER BERENJI: This is Mani Berenji. So I'm thinking the way we should probably break this down is maybe have some bullet points, so that way it's a little easier to read.

So, the Board requests resources (such as external contractor to provide personnel and

IT support) to assist the Board with the following: and then just literally bullet points, so at least it's easier to read.

Then we can just list by bullet point what we want. In order to -- get the colon in there, and then we just bullet-point, just go for it. We just add whatever we want. At least it will be easier to read.

CHAIR MARKOWITZ: I wouldn't underestimate the ability of the Department of Labor to read these requests.

MEMBER BERENJI: I don't think so, at least from my --

CHAIR MARKOWITZ: I would read bullet points if they were multiple parallel tasks, right? So conduct this, to assess that, to provide that: three equivalent parallel paths. But this is just a single function, which is to allow us to conduct a systematic evaluation of X, Y, and Z.

Why don't we do this? Why don't we go with bullet points and see what they sense. But while we do that --

MEMBER REDLICH: It's a related concept, so -- I'm normally in favor or short bullets and short sentences, but I think in this case they're linked.

CHAIR MARKOWITZ: Right. Because the conduct and evaluate -- to assess is the function of the evaluation, right? So it's, they're linked.

So other comments, questions? This is now a motion, or someone needs to make a motion to accept this recommendation.

MEMBER BERENJI: I make a motion to accept this recommendation.

MEMBER REDLICH: Second.

CHAIR MARKOWITZ: So the floor is open. The motion is to accept the recommendation that the Board requests resources (such as an external contractor to provide personnel and IT support) to assist the Board in order to conduct a systematic evaluation of an appropriate number and variety of claims to assess the objectivity, quality, and consistency of the industrial hygiene and medical evaluations that are part of the claims process.

I would make a friendly amendment that the phrase, to provide personnel and IT support and additional resources as required, just to leave open that we may have forgotten something.

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay. It's open for comments. I'm just looking for the Board charter to make sure that this language is entirely consistent. So I would actually make another friendly amendment. Where it says in the third line, to assess, I would say, to assess and to ensure. I add that because that's what the charter says.

Okay. Are there additional comments on this, because the floor is open. Otherwise, we need to take a vote.

MEMBER BERENJI: So this is just a placeholder, correct? I mean, we're going to refine this over time.

CHAIR MARKOWITZ: Well, this is a request to transmit to DOL, and yes, we need, over a relatively short period of time, to start to fill

out exactly what that would look like.

So let's take a vote. How do we take a vote? I can't remember.

MR. FITZGERALD: We'll run down the list and get everyone's --

CHAIR MARKOWITZ: Okay. Okay.

MR. FITZGERALD: And then just go with the names as they're represented here. Dr. Dement?

MEMBER DEMENT: Yes.

MR. FITZGERALD: Dr. Dement is a yes. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. FITZGERALD: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. FITZGERALD: Dr. Silver?

MEMBER SILVER: Yes.

MR. FITZGERALD: Dr. Berenji?

MEMBER BERENJI: Yes.

MR. FITZGERALD: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. FITZGERALD: Dr. Redlich?

MEMBER REDLICH: Yes.

MR. FITZGERALD: Mr. Domina?

MEMBER DOMINA: Yes.

MR. FITZGERALD: Mr. Mahs?

MEMBER MAHS: Yes.

MR. FITZGERALD: Ms. Pope?

MEMBER POPE: Yes.

MR. FITZGERALD: Mr. Tebay?

MEMBER TEBAY: Yes.

MR. FITZGERALD: It's unanimous.

CHAIR MARKOWITZ: Then let's discuss two things: one is, the claims we already have, with additional time to review those claims, what are we going to do with our observations?

I think there's been a suggestion that we aggregate those, sort of categorize and aggregate those observations, looking at commonalities across claims. Not that that work will necessarily lead to specific recommendations to the Department, but at least it organizes our thoughts and prepares us to perform a more systematic evaluation.

So should we do that over the next period

of time, and then have a telephone Board meeting in two to three months in order to discuss the aggregated observations about the claims we have so far?

We just need a sense of the group; we don't need to actually vote on that, I think.

MEMBER BERENJI: Yes.

CHAIR MARKOWITZ: Okay. So what I think I'll do is, I'll propose, after the Board meeting, a way in which we do that so that, in terms of who's reviewing what and which claims are already reviewed, et cetera, so that we come up with a common output. I don't think we need to do that right now.

MEMBER BERENJI: I'm sorry, I just think it would be good to at least have a couple of general things we can already at least kind of put into respective buckets, at least with respect to the industrial hygiene, CMC.

At least we can kind of put some general categories, because I feel like those were where we found the issues, so at least we can kind of

set up some sort of form at least some sort of way to organize our though process with respect to the most common issues that we came across.

CHAIR MARKOWITZ: So what we could do with reference to that is, within the next week or two, send in our preliminary issues that we've found so far so that we can begin to develop some categories which we then can use to further look at these claims. So that's a good idea; we'll do that.

There is the issue of our request for 80 additional claims. I detect a lot of enthusiasm. But that is an outstanding request, and we need to -- if we're going to modify it, modify it. But right now, that's our outstanding request to the Board.

Those are in, as I said before, chronic beryllium disease claims, sarcoidosis, interstitial lung disease, and asthma. So do we want to take a look at that again? Do we -- internally, do we have the capacity to review 80 claims?

PARTICIPANT: Depends on the time frame --

MEMBER REDLICH: I think it would be helpful because we've already reviewed those claims, and I think to see if there's been any changes.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Why don't we write up what we have now, the ones we've already reviewed, and then when we see what we have, then we can decide what additional diagnoses or additional information we would want to request.

But I think we already know a lot of what we want to say, based on reviews we've already done. So why don't we just write them up now and then revisit this in our conference pool and design what we want to request?

Do we want a random sample of all claims? Do we want specific diagnoses? Do we want some information on the frequency of each diagnosis? What exactly do we want to ask for?

Because we're generating a lot of work for the DOL, and also, we want the most useful information that we can get. We've already reviewed a lot of these claims; we know a lot about what we're going to say in our synopses.

CHAIR MARKOWITZ: That's entirely sensible. Here's my problem with that: if we suspend our request and wait to reformulate that for two to three months, there's just a time delay. Obviously, it takes time to identify and prepare those claims.

MEMBER REDLICH: So you were on a different subcommittee. We have reviewed prior beryllium and sarcoid claims, and I think that was now two years ago. And I think what we'd like to see is, we have a sense of what has been done, and see of that process has changed at all over this period of time.

So I agree potentially for other categories, but there was a subcommittee that did review the respiratory claims.

CHAIR MARKOWITZ: So then the question

is, do we really want 20 claims of each of those four different categories? If we shrank the number of claims, then things might happen more expeditiously.

MEMBER BERENJI: We could to a random sampling of 20 of the CBD, sarcoid, ILD, and asthma, so five from each cohort.

MEMBER REDLICH: We had also seen the data on the numbers of new claims in those categories, and they were not that huge, is my recollection. You had looked at that, John, annually, so I think, at least for the -- I think we need more than five.

CHAIR MARKOWITZ: Okay. Well, there are some numbers between five and 20.

MEMBER FRIEDMAN-JIMENEZ: We are already over-sampling diagnoses of interest like beryllium, sarcoid, so I would propose that we request a random sample of, say, 100 claims that will give us rough, small numbers on the relative frequencies of different diagnoses; that we request the categories you listed; and also, I would like

to add cancers: lung cancer, mesothelioma, and leukemias; maybe bladder cancer.

MEMBER REDLICH: We do have a piece of it. We know from the prior look at the data that John -- that was focused on respiratory, so we do have that sense of -- as far as the respiratory claims. But I think that all the other conditions, I think we do want to see what the most common ones are in terms of where to focus our efforts.

So I think, in terms of the cancers and the like, I'd first like to see where the big buckets are; where the --

MEMBER FRIEDMAN-JIMENEZ: A random sample will answer that question, the most common. It won't answer the question of how many leukemias and the rare ones.

MEMBER REDLICH: I mean, John had nicely organized five respiratory diseases -- we can probably even pull that up -- asthma, COPD, the number of claims, the percentage accepted. And that did identify areas to target. I think if we had that for other conditions, then it would

help focus.

MEMBER FRIEDMAN-JIMENEZ: So you think random sample by strata of respiratory, neurological --

MEMBER REDLICH: No. I personally would stick with our current request of the 20 claims. For those of us who are familiar with looking at the respiratory ones, we could go through those rather quickly.

It would favor for other conditions that the request we've already put in, which is to get the sort of basic data on what those claims are: cancer, neurologic. And then when we see that, decide which claims outside of the respiratory arena --

MEMBER FRIEDMAN-JIMENEZ: Could we request a data run that would just give us the diagnoses of everybody, of all claims, so that we could see the relative frequencies of them, rather than giving us all the information on each case?

MEMBER REDLICH: That's what was requested, basically, already.

MEMBER FRIEDMAN-JIMENEZ: Okay, but that would be a separate request than the actual medical records.

MEMBER REDLICH: Can I -- I can quickly pull up John's --

CHAIR MARKOWITZ: But the question is, for outstanding requests, four pulmonary conditions, 20 claims each; do we really need 20 denied claims each?

MEMBER REDLICH: We probably don't need the 20 accepted for each.

CHAIR MARKOWITZ: No, our request was only denied claims, actually, for the five pulmonary conditions. So do we need 10 denied sarcoidosis?

I'm questioning the Board's ability to thoroughly evaluate a large number of claims, and I hesitate to ask the Department for products that represent considerable work if it's --

MEMBER REDLICH: So what if we just did 15?

MEMBER FRIEDMAN-JIMENEZ: I would

propose that we request, say, 10 denied, oversample the denied, and five accepted. I think we should look at some of the accepted. I think there's some useful information there. But we don't need as many, I don't think, and we could concentrate our efforts on the denied claims but still look at accepted, smaller numbers. We probably don't need 20.

CHAIR MARKOWITZ: For these conditions, given the fact that we've looked at some of these things before, is it really useful to look at accepted claims?

MEMBER BERENJI: I think it's good to look at accepted claims because you can look at what was done right, and I feel that it's good to provide -- at least inform the DOL that there are things that are working in the process. I think it's good to have that.

And then you can also look at the denied claims, and then you're able to kind of bring up the themes and the issues that were seen on a repeated basis. So I think it's good to have both.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I'd like to weigh in on that. If we're looking at consistency, there's no way to do that unless you look at accepted and denied claims. There's no way to assess that. I mean, we can concentrate on more denied than accepted, but I think you have to look at both.

CHAIR MARKOWITZ: So is it the sense that 15 claims of each of those conditions, 10 denied and five accepted, is a better formula?

MEMBER BERENJI: I think it should be five and five; at least a total of 10. I just feel that we don't have the manpower in the field to reveal those cases unless we create a separate working group to focus on those only. And I really like what Dr. Friedman-Jimenez was mentioning, doing a random sample. That way we're able to capture more cases and be able to identify more diagnoses.

I mean, at least we could create two working groups in parallel, and Dr. Redlich could kind of focus on the respiratory. I'm happy to

kind of focus on the general sampling, because I do feel that will capture a lot more information if we're able to cast a wider net as opposed to just homing in on respiratory, even though I do feel that it's important.

I feel there's already been work done. I think we really need to focus on capturing other diagnoses: cancers, other types of diseases that we don't even have a clue about.

MEMBER FRIEDMAN-JIMENEZ: Well, the reason I proposed the random sample was mainly to get the information on relative frequencies of different diagnoses, especially the common ones. But that's already been requested in a different form that's much less labor intensive.

So maybe we could go through that information and then make a second request on the ones we feel we want to oversample and look at in detail and actually go through claims.

But to go through 100 random-sample cases is a lot of work, and we'd probably be better spending our time on five and five or 10 and five,

of the specific diagnoses of interest.

So I would withdraw the random sample idea, give what Carrie's saying that we've already requested, the information that would answer that main question.

Is that true, John, that we can get that information from what we've already requested, for all diagnoses, including injuries? Including everything? Has that already been requested?

MEMBER DEMENT: I thought we had requested it.

CHAIR MARKOWITZ: Are you talking about the Power Point that --

MEMBER REDLICH: I have it here. I just couldn't --

CHAIR MARKOWITZ: I sent that Power Point to Carrie. Maybe in the briefing book. I think it might have Dement Power Point or something like that, slides.

MEMBER REDLICH: I'm sending it.

CHAIR MARKOWITZ: In any event, let me continue the conversation. Dr. Dement, you were

--

MEMBER DEMENT: I sort of lost my train of thought.

MEMBER FRIEDMAN-JIMENEZ: What has been requested in terms of the overall view of the database and the diagnoses? The frequency of diagnoses?

MEMBER DEMENT: I think we concentrated on the respiratory conditions in that one. We were given a -- I think it was in an Excel file, a data dump, and all I did with that was to pull it into some programs I can use to summarize the data. But I don't think we got everything, and that was old, anyway, and we're a couple of years out.

So we've got two issues: I think the program can provide that summary, similar to what we have; or alternatively, I guess we could do another overall data dump and do it ourselves maybe. That's part two.

Now, I'm willing to take it on if that's something the Board wants to do, but it's in and of itself, a little bit labor-intensive.

CHAIR MARKOWITZ: Steve Markowitz. I'm looking at that request from December 10th, and it included the 20 most common conditions in descending order for which claims had been filed since 2013. Then we provided a sample table of what we wanted it to look like, which reflected John's work previously.

We then requested 10 most common neurologic conditions, 10 most common cancers, and the 10 most common renal or kidney disorders. So that's the information that would be very useful, yes.

MEMBER FRIEDMAN-JIMENEZ: That sounds excellent, and what is the status of that? Are we going to receive that any time soon, that we can use it in our decision-making of what we want to look at in detail?

CHAIR MARKOWITZ: Mr. Vance, are you still on the phone?

MR. VANCE: Yes, I am.

CHAIR MARKOWITZ: Do you have any -- I don't know if this is within your area, but do

you have any sense on the progress on that part of the request?

MR. VANCE: Not at this time. I know that we've got a lot of different requests floating around.

CHAIR MARKOWITZ: Okay. So we need to make our decisions today without knowing when that information will come.

MEMBER REDLICH: I think -- this is what John had done before and, John, you're welcome to speak. I think part of our new request for data was based on this data, such as when we happened reviewed the sensitization claims, we thought those were very reasonably adjudicated, and we did not request more of them.

So we were -- and also taking into account their trends, and there were trends over the past 10 years in terms of more asthma, more COPD. So we had this in mind.

John might want to quickly run through, or I can, either one, but please speak up. I think -- let's see, the first slide -- is that the first

of the data slides? I think if you go to the first of that section.

So this, I believe, was the total number of claims over -- it was a 10-year period of time -- under each category. I think it will be more helpful to go through the next slide.

Also, this is not given individuals, because a given individual could have more than one claim. So an individual could have a claim of beryllium and COPD. But the next slide -- this one just gives you some idea of the trends.

It shows the third column down is the total number of claims under, let's say, CBD beryllium sensitization. CS is chronic silicosis, approved and denied under each of those.

And I believe this was the -- because a given condition could recirculate, so --

CHAIR MARKOWITZ: These are just counter-claims where people sent --

MEMBER REDLICH: That's right. We had highlighted certain trends so that there were more of the CBDs, and also as a percentage approved,

that the CBD claims, that percentage had gone down, that may have been because -- or reasonable claims had been approved, but we were just looking at the trends.

I think the next slide --

(Simultaneous speaking.)

MEMBER REDLICH: Yes, because it was the year, I believe, is referring to the year that the claim was processed. That could be processed for a pre. I think over time, more of them are in post 1996 simply because of the timing.

The next slide, this was additional -- it's the same organization. These were the additional conditions we had gotten, the data John had analyzed for: asthma, COPD, ILD, and sarcoid.

So I think you can see that from 2005 the number of asthma and COPD claims had gone up. The ILD was really a total of only 21 total claims. Most of those were denied, so that was the reason we had an interest in looking at more of those, and sarcoid was a relatively small number of claims, but they were denied. So we had targeted our recent

request with this in mind.

CHAIR MARKOWITZ: One thing that this shows -- Steve Markowitz -- is that we request five or 10 approved sarcoidosis claims, we're not going to get any. Similarly with ILD, we're going to get a large percentage of those that had been approved. So we might consider modifying that. But I didn't mean to interrupt you.

MEMBER REDLICH: I thought that that was the upper limit, that there might be not as many claims in the category that we requested.

I think the next slide -- please, John, speak up, because you did this. These were the denial reasons, and I believe this was not -- these were the reasons that John -- there was a reason given in the database.

And the reasons varied somewhat for the different conditions, so for CBD and BS, beryllium sensitization, the most common reason was medical information insufficient. For chronic silicosis, it was some additional reasons too, in terms of whether the employee was covered.

For some of these, we saw examples of them: where there was a claim for beryllium sensitization and there wasn't a result of the test, and the claim that someone submitted that, and there was a final adjudication, all of which was appropriate.

I think there's one more slide. These were for, then, the additional COPD, asthma, and these were a different negative-positive result for COPD, and I think we saw -- we've seen some examples of that. So it is a different reason than insufficient medical information, and same with asthma and interstitial lung disease. So we had an interesting focus on these conditions.

CHAIR MARKOWITZ: Is there anything else --

MEMBER REDLICH: I think some of these negative-positive results, based on the records that we had reviewed, relate to the interpretation of the exposure information, and the issues that we discussed yesterday at length.

And I think -- is there one more?

That's it, I think. So our feeling was that it would be useful to have this data updated for the past two years to see if there's been a change in these trends, since we have been working on this and meeting, and then to use that information to best target where we focus our efforts.

But, George, I totally agree, this is focused on the respiratory component.

CHAIR MARKOWITZ: Right.

MEMBER BERENJI: But I just want to comment; Dr. Dement and Dr. Redlich, you guys did a great job at least kind of developing the methodology. It would be great to able to kind of apply this basic methodology to other organ systems, perhaps Parkinsonism, manganism. We could definitely apply the same methodology, because it looks like we've already got it down to a science, pretty much.

MEMBER DEMENT: I wouldn't necessarily call it a science at this point. The data came in an Excel file, and it took a bit of going back and forth of the program staff to interpret some

of the fields.

I guess we got it down to a possibility. If it's the Board's desire that we expand that and look at it across the board for other conditions, then I guess I could take that on if needed.

MEMBER REDLICH: John did this; I simply took his tables and formatted them to put them into the Power Point.

CHAIR MARKOWITZ: Well, we're going to take a break, and I'll try to look at -- in our request, we did request data for a variety of conditions in a certain form which reflected what we've been looking at. So let me just take a look at that detail, and then we can discuss that further.

But I propose that we take a break and reconvene in 10 minutes, at 20 of 11, if that's all right.

(Whereupon, the above-entitled matter went off the record at 10:29 a.m. and resumed at 10:46 a.m.)

CHAIR MARKOWITZ: We have a very engaged public here. We're going to get started. Okay. So we have a pending data request on a number of important conditions, including pulmonary disease, neurologic, cancer, and kidney disease, and the most common conditions overall, organized in a way that should be similar for all the outcomes.

We're not sure when that data request will be fulfilled, but it's pending, and it will be useful.

I would just suggest that we, on the claims request, we modify our current request. Pending is four outcomes, 20 each, so that's a total of 80 claims. And so the question is, how many of those claims do we actually want, believe that we can review if it's less than 20? And then, what's the breakdown, accepted versus denied?

I would suggest that requesting claims for any other conditions such as cancer and the like, that we wait until we get the data so that we can make an intelligent choice about --

meanwhile, we get additional claims, we'll have our hands full taking a look at those claims. Dr. Redlich?

MEMBER REDLICH: I think the point about wanting to look at some accepted claims is appropriate.

MEMBER FRIEDMAN-JIMENEZ: Move closer.

MEMBER REDLICH: I'm sorry. So I think that the point made that we should need to look at both accepted and denied claims, so we could do something like five accepted and 15 denied for the different conditions.

I'm open to others. I found that the pulmonary ones, once you are familiar with them, can be reviewed rather quickly.

CHAIR MARKOWITZ: It is true. Dr. Redlich reminded me at the break that for these outcomes, as opposed to COPD, and as opposed to Parkinson's disease, the path for decision-making is much clearer because it's set out in part by the regulation in the statute, for instance, chronic beryllium disease, sarcoidosis and, to some

extent, asthma. So reviewing those claims is more straightforward, takes less time, than the claims that we've looked at to date.

But then you're proposing the same number, 20 divided by five accepted and 15 denied.

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: For the four conditions. And my question is, do we need that many?

MEMBER REDLICH: Based on our past experience, there were a number of claims that were very appropriately adjudicated. So we want to identify any issues, I think, that the team denied would be appropriate.

CHAIR MARKOWITZ: We need some consensus on this, because we're --

MEMBER REDLICH: John and Kirk also reviewed them. I'm open to other suggestions.

CHAIR MARKOWITZ: We need some consensus on this, because this is work that we're going to do ourselves. So this is synonymous with a commitment by the Board to get this claim review

done. Board is smaller this iteration than it was previously, so if we're going to stick with a request for 20, we should just be assured that we're going to be able to do that work.

MEMBER DEMENT: Would you remind us again of what we've asked for, because I'm a little lost. I know we have 80, but how do they distribute themselves?

CHAIR MARKOWITZ: Sure. So the original request was for a total of 120. Twenty of those were for Parkinson's disease, and we have those. The remaining 100 of those were for lung diseases, and it was each of five different conditions. So five times 20 is 100.

We have the ones for COPD, so there are four pending pulmonary disease requests, and those four conditions are chronic beryllium disease, sarcoidosis, interstitial lung disease, and asthma.

The request was that only denied claims should be included, and the most recent claims available should be selected. We should exclude

claims that were previously reviewed by the Board.

Let me just say, the Department of Labor has already done work. The pool claims, in compliance with this request. We should not reverse or modify our request. That, in any way, subverts any work they've done to-date on these claims. We're not sure where they are with this request, but just, the request is not to undo work that they've done so far.

MEMBER MAHS: Ron Mahs. Was there a chance you could continue with those 20 and just ask for an additional five accepted? Because those were all denied that you asked for correct? That you asked for?

CHAIR MARKOWITZ: You mean increase the number to 25?

MEMBER MAHS: Well, whatever we're allotted to do each, if we can get to them all, that's fantastic. If we can't get to them all, at least we've got the opportunity there.

CHAIR MARKOWITZ: Well, I mean, the problem is that it appears to be considerable work

on the part of the Department to secure and provide these claims, so I don't think we should make a request unless we believe we can do our work on those claims.

MEMBER REDLICH: So I had proposed that we reduce the number from 20 to 15 of the denied claims, but also include five accepted.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: It is still 20, but if people want to reduce that further, I -- other people's thoughts.

CHAIR MARKOWITZ: Right.

MEMBER REDLICH: My guess is also that in that number what happened last time was, there was overlap. So it would be like COPD, the same claim could end up in both buckets, because the person could have a claim for COPD and pneumoconiosis, so the total number of people was less than the number of requests.

CHAIR MARKOWITZ: Okay. So the proposal is that we stay with 20 claims request for each of the four conditions, but modify the

request to include 15 denied and five accepted. However, if DOL has already done the work to provide the 20 denied claims, that would be fine.

So does anybody want any departure from that? I don't think we need to formulate an official recommendation about that.

MR. FITZGERALD: No. In fact, that's one of the reasons we created the form that we discussed yesterday, to try to avert this sort of issue where there is maybe some uncertainty or changes going on in terms of the thinking.

We want the Board to able to really think about what the requests are, formulate the data requests, be very specific about what the use of that data is going to be so that we're not grappling with trying to address those issues. I think the form will actually help us, and that process will get better.

CHAIR MARKOWITZ: Okay. So let's move on. Let's get back to the agenda. Mr. Tebay?

MEMBER TEBAY: Calin Tebay. Before we leave today, I know we're running out of time, but

I'd like some help in this matter where the Board will make a formal recommendation regarding the IH response.

Basically, what they're saying is the lack of data is lack of risk, or the fact that an OEL or a PEL determines a diagnosis.

I think we should come up with some kind if recommendation here to modify that response or that language so it doesn't almost set the claim -- I mean, the IH is driving the diagnosis at this point. It seems to be; maybe I'm not communicating that correctly, but I'd like to -- maybe we can make a formal recommendation to change how that's being worded.

CHAIR MARKOWITZ: So just a point of clarification. You're talking about the boilerplate language about post-'95 exposures. That the lack of data means that it doesn't exceed --

MEMBER TEBAY: Not meeting regulatory limits is seeming to drive the direction of the claim.

CHAIR MARKOWITZ: Okay. Discussion? And I would say that this relates to Task 4 of the Board: in duty to assess the quality of the industrial hygiene evaluation.

So if we're going to elaborate a recommendation, then we need to actually put that text on the board and see if we can come to agreement. This relates to the recision of Circular 15-06. So how do we want to phrase this?

MEMBER DEMENT: This is John. I think it ought to be phrased first in stating what we've observed based on the case review.

So the observation is that the IH assessments continue to use the phrase and the determination that exposures in the past, the mid-1990s, would not exceed regulatory limits, but without supporting information, both with regard to levels and what regulations are actually being referred to. So that's an observation.

I think the second part of it is, the Board recommends that this language be omitted from the IH report, and the basis for determination

exposures in mid-1990s and be stated by the IH that is -- period. That's a first draft.

And basis for exposure determination be provided by the IH in the report. Be provided by the IH in the report.

CHAIR MARKOWITZ: Well, their statement that no monitoring data exist as evidence of exceeding regulatory limits, to play devil's advocate, would be their basis for their exposure determination. We don't have any data to suggest it's above the limits. That's the basis for our exposure determination.

MEMBER DEMENT: The alternative would be to the --- rescinding the circular, and the observation is it continues to use the language contained in the circular, basically.

I don't know how to phrase this perfectly, but just say get it out of there.

CHAIR MARKOWITZ: How about that the absence of monitoring data post-1995 should not be automatically interpreted as representing an absence of risk?

MEMBER DEMENT: I would say, in absence of exposure or risk.

CHAIR MARKOWITZ: Right.

MEMBER DEMENT: Because there's two things that are going to be addressed by that statement: one is the absence of exposure, and the second is, the assumption is, if you were within the regulatory limits, there is no risk. And we know that not to be the case for many materials.

CHAIR MARKOWITZ: Well, that observation will be in the rationale for this. It will be addressed, unless you want to put it here, right in the front.

MEMBER DEMENT: And I think we should modify this second part of the recommendation: the basis for a negative exposure determination be provided by the IH.

CHAIR MARKOWITZ: So to fill out this first line, The Board has observed that industrial hygiene assessments -- or rather, recent industrial hygiene assessments appear to frequently use stereotypic language, indicating that the absence

of monitoring data above the established regulatory levels.

So I think indicating has to be changed to citing. They use stereotypic language that cite the absence. After cite, you can just take out that.

So I wonder there on the last line where we talked about the basis for negative exposure determination be provided, whether we should add, if available?

MEMBER DEMENT: I guess, back to our discussion yesterday, just trying to get to the rationale behind that determination. Sometimes it's based on monitoring data; sometimes it may be based on professional judgment. If so, that's what it is; it's professional judgment based on IH. I'd just like to see that in there.

CHAIR MARKOWITZ: Right. And that can be perfectly acceptable.

MEMBER DEMENT: Sometimes it's just common sense.

CHAIR MARKOWITZ: Right. Dr.

Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: In the spirit of providing, not just an explanation of the problem but a proposed solution, I think that the data largely don't exist at all. What we're seeing is a paucity of monitoring data in general, not just monitoring data above some limit.

And the reality is that many of these jobs do have some information on exposure that's reflected the SEM and in the industrial hygienist's knowledge of those kinds of jobs. These are people that have specific knowledge of many of these jobs.

And so the exposure assessment will need to reflect the industrial hygienist's expertise and judgment. I think that word is useful: judgment, as to what level of exposure actually existed in the absence of individual or area monitoring data for that particular site and person.

It's going to have to be job-specific, not individual-specific, and that's the reality. So I think we should suggest that they use

industrial hygiene literature as well as their specific knowledge of these work sites to generate these exposure assessments.

Because exposure assessments have to be generated, and we don't have this Holy Grail of individual or area monitoring data. So we have to suggest something, I think.

CHAIR MARKOWITZ: Well, I disagree, actually. They could talk to the claimants. They could find out what actually happened post-'95 in the workplace.

They could find out what they did and whether that disruption likely produced results, because they're not going to find them in the text, and their professional judgment is great, but DOE is a very big complex, and they've been everywhere and assessed all those jobs.

So there are multiple sources, but frankly I think upgrading their interaction and understanding of what actually happened in the workplace to that claimant post-'95 would be a good place to start. So I don't want to be specific

here.

MEMBER FRIEDMAN-JIMENEZ: So this prohibition against subjective information, I think we have to address that. What people imagine is objective measurement really isn't objective at all; it reflects a lot of variables. So I agree with you completely, that starting with the occupational health questionnaire, the individual's perception of exposure, that's important information that has to be factored in by the industrial hygienist.

CHAIR MARKOWITZ: Well, and DOL recognizes that, because part of their assessment is the occupational health questionnaire and whatever affidavits are submitted and the like.

So they recognize the legitimacy of that information. We're talking about amplifying it; we're talking about emphasizing it for post-'95 where it's not clear what was going on.

MEMBER TEBAY: What -- Calin Tebay. But we have hundreds of IHs on these sites, and each working group has a -- what do they call them

-- they're a project IH for each individual working group.

If they're using professional judgment, the contracted IHs, why aren't they reaching out to these project IHs or these work groups, along with the workers and saying, What were the exposures that exist?

I can tell you from working at a couple of sites in different places, that I think a lot of professional judgment is used. I don't think there's a bunch of IH data that exists for each one of those work groups, but the professional judgment is there to say, These are the possible potentials. We don't know what levels, because we don't monitor for them, but there's definitely these potentials for these exposures.

But once again, the IHs are not being forced to reach out to the worker or the other resources at all. They're just making a boilerplate response and walking away. Why aren't they being forced to reach out to the people with the information?

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: George Friedman-Jimenez. One potential problem with that is that it puts the individual IHs in the workplace in an awkward position. They are responsible for the health and safety of the people on their site, and for them to say, Well, the exposures were really pretty substantial and could have led to health defects, would maybe be difficult for them.

So it puts them in a difficult position and almost a conflict of interest. I'm not sure that that's going to lead to objectively better estimates of the exposures. So we'd have to think about that. I don't know the specifics, but --

MEMBER TEBAY: Sure, I understand.

MEMBER POPE: It seems like the cases I've looked at, the IHs that were making these blanket statements, saying that the exposure was low, and I totally agree with Dr. Dement's comment about, if you don't know, then say no, the exposure did not exist.

But for you to blanket and say that the exposure was low just to forward that claim through, I think we've seen a lot of that, where the IHs are making that statement. So the CMC is concurring with that assessment from the IH.

CHAIR MARKOWITZ: Mr. Vance, are you still on?

MR. VANCE: Yes, I am.

CHAIR MARKOWITZ: So an interesting question has been raised about the industrial hygienists that you have that are working on these cases, claims whether any consideration of reaching out.

I know that there's a request for whatever records DOE has, but has it ever been discussed, any sort of communication with the currently-employed industrial hygienists at the sites?

MR. VANCE: Not that I'm aware of. We would always be getting information from the Department of Energy with regard to any individual monitoring data that we have on an employee, but

as the Board noted, oftentimes that information might not be very comprehensive or cover the entire working history of an employee.

The context of our discussions up to this point have been mostly focused on what information would be best obtained through the occupational health questionnaire and modifications to that process, but I don't recall discussing specifically or engaging in any kind of formal interaction between our industrial hygienists and site industrial hygienists.

CHAIR MARKOWITZ: Okay, thank you. So we're looking at -- we have language of -- we're looking at language of a recommendation. Before we receive an official motion to accept this recommendation, is there any change in the language that we're looking at that anybody proposes?

MEMBER MAHS: I would like to make a statement if I can, Ron Mahs.

CHAIR MARKOWITZ: Sure.

MEMBER MAHS: In the last 15 years before I retired, I was general foreman at Y-12

and the other two plants. We toured many buildings every day, because I had people working all over the place. And in all of those years, about the only thing I saw IH ever monitor was for asbestos or for radiation.

If you're on the job looking for toxin or something, the safety person assigned to that job did it. IH had no contact or no idea what the exposures would be.

CHAIR MARKOWITZ: Thank you.

MEMBER REDLICH: Carol Redlich. I'll just add that I think the cases that we've reviewed to date, the prior ones, the major reason we disagreed, in cases where we did disagree with the final adjudication was where the CMC interpreted the IH report differently, given our expertise in occupational lung disease, occupational medicine, industrial hygiene exposure, based on the information we had from the occupational health questionnaire, the type of work the person did, and the time period, that we felt that the SEM was not accurately representing the exposure, and that

the CMC, then, didn't have our expertise to also, let's say, look at the questionnaire and put a lot of weight on the SEM that we felt was not accurately reflecting the exposure.

One example, just being a miner of 15 years where the SEM said that the only relevant exposure as far as COPD was aluminum or -- and knowing the nature of what mining work is like, we felt that that was not correct. So we knew how to interpret the SEM. So I think that's why it's so important that that wording be modified.

CHAIR MARKOWITZ: When you say that wording, you're talking about what we're looking at now?

MEMBER REDLICH: Yes, exactly. Because I think that, given the nature of the physicians who are the CMCs, given that they're more limited expertise in pulmonary occupational medicine conditions are weighing the SEM very heavily.

CHAIR MARKOWITZ: So I have some suggestions for the language: the Board has

observed, comma, based on review of a limited number of recent claims, comma, that -- leave that second recent in, just to be duplicative, but you can take out that the before the recent -- appear frequently to use. So we don't have a split infinitive.

And then above the established regulatory levels in the mid-1990s, so we're clear what time frame we're talking about. Any other suggestions on the wording? Yes, Dr. Silver.

MEMBER SILVER: Should we put in a phrase that draws attention to Circular 15-06, rescinded by Circular 17-04? That is what we're talking about, despite the official rescinding of Circular 15-06, the Board has observed --

CHAIR MARKOWITZ: You know, we could put in something to the effect of it. I wouldn't write this, that this appears to contradict the rescision of -- but we actually raised this yesterday with Ms. Leiton, and she had a response to that, how this language did not contradict the rescision.

So I'm a little concerned that we --

it doesn't further our recommendation. Dr. Redlich?

MEMBER REDLICH: My reading, and I think others can correct me, was that it's not that they cite the absence of monitoring data; they don't state the basis of their conclusion that there is no low exposure or low risk.

Did you just check what the wording was? I think we should just check what the wording is.

MEMBER DEMENT: The actual phrase that consistently appears is that no available evidence, i.e., personal or area industrial hygiene monitoring data, paren close, to support after the mid-1990s, as exposure would have exceeded existing regulatory standards.

So you said, there's no available evidence. So they're sort of saying there's no sampling data. Then I look at what I got from a DAR, the request for information, and for the most part there's nothing there except for some radiological monitoring data; very little IH data that I've seen in what I've reviewed so far.

So the question is, so nobody sampled, so therefore you assume that because some programs were beginning to be implemented to have industrial hygiene at these sites, that exposure didn't exceed; that's not an appropriate conclusion to draw.

MEMBER REDLICH: Yes, okay. So I'm just wondering what the most clearest way to state what our concern is. It might be first that they should, number one, clarify the source of the data that their decision is based on; and number two, that lack of data should not be interpreted as low or no risk. We may have worded it that way.

MEMBER DEMENT: I think the source and basis -- support the negative exposure.

MEMBER REDLICH: Yes. But I think we just put in active of what we want.

MEMBER DEMENT: So down at the bottom of the recommendation, I guess.

MEMBER REDLICH: Okay. So I'm sorry.

MEMBER DEMENT: I support the data sources in basis for negative IH reporting.

MEMBER REDLICH: So why don't we just make it more general for whether it's negative or positive, we would like clarification on the source of the exposure data? And then that statement that lack of data should not be interpreted as --

MEMBER TEBAY: So real quick, because I've read the version that you read, what I've seen is the lack of data. But then there's the version that says that there's significant exposure, and there's a lack of data showing that you've been exposed over an OEL or a PEL; therefore, having or contracting some kind of disease or condition would be not -- so I want to make sure we're still covering that portion, right? Because that's what happens.

When they say that there's a lack of information, we know you've been exposed. But it's going to be below an OEL or a PEL, and then when that moves on to the CMC, the CMC then interprets that as, there's no way this person was exposed at enough of a level to create some kind of condition or disease.

So as long as this is covering that, I'm good, and I'll rely on you folks to determine that.

MEMBER DOMINA: This is Kirk Domina. One of the other issues I have when Mr. Vance was on the phone about the information he gets from DOE; well, DOE didn't have a moratorium on destroying records until way after '95. So you're always going to get that answer.

So even if there was data, they didn't have to keep it. And so to me in my thinking, we need to move that '95 date out because of their moratorium of not having records. It's biased against the claimant.

MEMBER REDLICH: I think we're all saying the same thing; it's just a matter of how we word this recommendation.

CHAIR MARKOWITZ: Well, and what we could do actually, in the last sentence: the absence of monitoring data post-1995, or evidence of data showing exposure levels of below regulatory limits. Does that capture --

MEMBER DOMINA: That's better.

MEMBER DEMENT: I would say, absence of -- You could say significant exposure. I mean, the issue is -- sometimes they'll say significant exposure, but they did say it's a low regulatory limit so therefore, de minimis. They don't say de minimis, but that's they really interpret it as.

CHAIR MARKOWITZ: So, Kevin, the third word from the last, exposure? If you could just put in in, significant, before that. Yes, that's it.

MEMBER REDLICH: And so omitting language; there's variations on the language, so I think what's most important is that we want clarification of the basis of the exposure data, because that's usually not stated, and the absence of monitoring.

We also are concerned about the language. I just don't think that that is the number one piece, because there's lots of variance of language.

CHAIR MARKOWITZ: Yes, but the question is whether what we're looking at now captures what we mean.

MEMBER REDLICH: So industrial hygiene folks, what do you think would be appropriate information to include as justification for the conclusions that the IH has come up with?

MEMBER DEMENT: There can be lots of things. There can actually be some experience with the industrial hygienist's experience with that particular job, that work site, that task, and that's all legitimate.

There can be published literature that supports in that time frame that exposures were significantly reduced. So we all come to this with our own experiences, knowledge, and determinations, if you will. I just think they need to put it there.

If it's in IH's -- based on my own personal experience and the published literature, exposure were likely not to have exceeded regulatory limits, then that's our basis.

It does three things: it gives you the basis for the decision; it also sets some parameters about your certainty about that decision.

MEMBER REDLICH: I understand. Are they providing the basis of their conclusions? What IH data do they use to determine?

MEMBER DEMENT: Yes, I mean --

MEMBER MAHS: No, is that partly happening?

MEMBER DEMENT: We saw yesterday, I think the standard reference list, most of which don't provide a basis for determination of exposures for that job. I mean, it's a standard IH set of references, some of which are actually on some medical texts.

CHAIR MARKOWITZ: Very good, very good medical texts, I would add.

MEMBER DEMENT: Yes, they're old. Some of them are quite old. They really don't provide a basis for that decision. Now, if you were to go on diesel exhaust, for example, you can go to the literature, and you can find exposure

determinations based on objective measurements that would actually support, in the mid-1990s and early 2000s, that exposures to diesel exhaust in a general way, were reduced.

MEMBER REDLICH: So all I'm -- is it appropriate for us to request as a recommendation that they provide a better basis for their assessment?

CHAIR MARKOWITZ: But no. The language currently in there on the second sentence says that we recommend that language be omitted from the industrial hygiene report and that the basis for a negative exposure determination be provided by the industrial hygienist.

MEMBER DEMENT: Yes, I don't know how to get more specific than that. For example, if the document request came back and there were some industrial hygiene monitoring data, not even for that person, but at least for a similar job or a similar location, that could be used. That's legitimate information, so I don't know think we want to box ourselves in to specify exactly what's

needed, because it can vary a lot.

MEMBER REDLICH: Okay. I agree. So I just think we want the wording to be broad enough so it's both a negative or a low. So I just think that we should start with the request that we want the basis for the determination of the exposure assessment.

And we want to get rid of certain language. But I think that the more active thing is, we need the basis for their determining low or no risk.

MEMBER DEMENT: Right. You know, if you went on the second sentence after IH report, put a period and then start a new sentence --

MEMBER REDLICH: Yes, that's fine.

MEMBER DEMENT: -- so now, one line up, IH report, period. Right, okay. Then start a new sentence: The basis -- is that?

MEMBER REDLICH: Yes. I think sometimes they are mentioned as being low, and I think that's --

MEMBER DEMENT: We're asking for the

basis of their determination. So if they determine that it's low, fine. What's the basis?

MEMBER REDLICH: Yes, but you have negatives. So I think whether it's low, whether it's negative, we want the basis for the exposure determination provided.

MEMBER DEMENT: Right.

MEMBER REDLICH: We want it broader.

MEMBER DEMENT: So what language do you want, where?

MEMBER REDLICH: The basis for the negative or low exposure determination. We want the basis for all exposure determinations. I defer to John and --

CHAIR MARKOWITZ: My concern -- I understand that, but it dilutes the impact, because we're really zeroing in on use of specific language.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: I'm afraid our main point may get a little lost or diluted.

MEMBER REDLICH: Okay.

MEMBER DEMENT: I think it will be,

because in some cases IH is making a determination that, prior to this time frame, in the mid-1990s. In some cases they are making a determination that exposures were significant and sometimes not higher than low anyway. So I that's -- they're using a time frame reference to make that determination. I think that's fine.

MEMBER TEBAY: Can I ask a quick question of Mr. Vance? Is he still on the phone?

MR. VANCE: Yes, I'm still here.

MEMBER TEBAY: This recommendation, how does that get distributed? Because really, there's part of this that apply to different people in the process, right? I mean, you've got the IH that's going to read it; the CMC is going to utilize it, and the CE. The last sentence of it is really important for the CE. How does this get distributed?

MR. VANCE: What specifically are we talking about?

MEMBER TEBAY: For instance, the last part of this recommendation says, the absence of

monitoring data post-1995 -- you follow me there? That piece?

MR. VANCE: Right. You have to keep in mind that what the Department of Labor is utilizing is the opinion of subject matter experts. So what the Board is always going to struggle with, what the Department of Labor is struggling with is the absence of information.

We do not have direct, personal information about many workers, so we leave it to the judgment of the industrial hygienist's team, toxicology team, the medical folks, and other experts to give us information.

So a lot of the information that you're discussing is directly attributable to an industrial hygienist looking at it and saying, This is my best understanding of the information that I have in case, in my knowledge, my education, and background in being able to respond to this.

So what we did was, we took away the ability of claims examiners who make those generalizations, and now it's the industrial

hygienist that's incorporating that information and their best understanding of the information that they're being asked to respond to from an extent and nature or duration of exposure.

So that's sort of where that information comes from. So that's what I think the Director was talking about the other day, is that what we did was, we said, Okay, but this is not a claims examiner generalization any longer. This is an industrial hygienist looking at it and applying their best understanding of exposure information.

I think Dr. Dement was talking a little bit about that. They operate in sort of these generalizations and their own understanding of their expertise as industrial hygienists. And there can always be a lot of discussion about that interpretation of whether that's accurate or not. But that's the general source of that information. Does that make sense?

MEMBER REDLICH: Yes.

MEMBER SILVER: A comment.

CHAIR MARKOWITZ: Go ahead, I'm sorry.

MEMBER SILVER: Yes. Mr. Vance, you said there can always be a lot of discussion, but it can't be an informed discussion unless we crack open the black box of their judgment.

An analogy to radiation for a long time, the health physics profession said, We're the experts; we've got it figured out. The NIOSH Advisory Board has cracked open that black box in various perspectives have been brought to bear on the large number of assumptions that are made in the absence of hard data very often, and we're looking to do the same thing here.

This dovetails nicely with our long-standing recommendation that the industrial hygienist be able to talk to the claimant.

When that additional data from the claimant is part of the determination, it can be laid out with various sources of information; documents and literature; there are models; there's a rational process that starts with a volume of material; the energy that's applied to it; the volume of the work space in which it's diluted;

the presence or absence of ventilation systems; the position of the worker in relation to the sources of contaminant.

You can get that from talking to the worker and spell out as much of that as is available in the hygienist's brain.

CHAIR MARKOWITZ: So we do need to move on, so I just want to make sure we don't -- and I'm not suggesting Dr. Silver did this, but we shouldn't repeat comments that have previously been made. But I'm not suggesting you did that. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: A quick point of information; question: Does this site exposure matrix have a time dimension? Does it differentiate between pre-1995 and post-1995?

CHAIR MARKOWITZ: The answer is --

MEMBER FRIEDMAN-JIMENEZ: That's an area in which individual workers can have perceived a change or no change. Assuming that they have a good memory, and they're not memory loss people with Parkinson's disease, but they may not know

exactly the identity of the dust that they're exposed to, but they would know if it's decreased a lot recently.

So I think, again, we should really push for the industrial hygienist having access to ask the claimants what their perceptions were and take that for what it is. I mean, it's a subjective piece of information, but it is a data point where we're really -- there's a real absence of hard data.

CHAIR MARKOWITZ: Right. So take a look at this language. We need a proposal, a motion on this.

MEMBER REDLICH: I just would suggest one or two minor modifications of the wording. That recent IH assessments -- it's based on review of a limited number, so I think we could take out the appear.

CHAIR MARKOWITZ: That's fine.

MEMBER REDLICH: And there was one other -- just to make it more -- and then the absence, the last sentence? Automatically -- I think the word automatically could be removed.

CHAIR MARKOWITZ: That's fine also. Friendly amendments accepted. We could also spell out IH; that would help. Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: The last sentence: The absence of monitoring data post-1995 or evidence of data showing exposure levels below -- that is ambiguous as to whether you mean the absence of evidence of data showing exposure levels or -- I think we should clarify that language.

CHAIR MARKOWITZ: I think we should have a comma after post-1995. And if you want to put either at the beginning of the sentence, would that help, George? Put either the absence or evidence, to make it clear that there are two distinct conditions.

MEMBER FRIEDMAN-JIMENEZ: Yes. I think that clarifies it well.

CHAIR MARKOWITZ: Aren't some of you glad you don't work for a university?

MEMBER REDLICH: One other friendly suggestion: the first sentence, they use language

that cites the absence of monitoring data above the regulatory levels as -- they're using that data as indication of no risk, or --

CHAIR MARKOWITZ: They don't say that, actually. They just make the statement; they don't actually draw that conclusion. You know what I mean?

MEMBER REDLICH: Corrected?

CHAIR MARKOWITZ: Yes. Okay. Is there a motion?

MEMBER TEBAY: Yes.

CHAIR MARKOWITZ: Okay. That's a motion to accept this recommendation. Is there as second?

MEMBER MAHS: Second.

MEMBER FRIEDMAN-JIMENEZ: Do you want to take out that and where the cursor is now? So it would be provided by the industrial hygienist in the report?

CHAIR MARKOWITZ: So right now it says, The Board has observed, based on a review of a limited number of recent claims, that recent

industrial hygienist assessments frequently use stereotypic language to cite the absence of monitoring data above the established regulatory levels in the mid-1990s.

The Board recommends that this language be omitted from the industrial hygienist's report. The basis for a negative exposure determination should be provided by the industrial hygienist in the report.

Either the absence of monitoring data, post-1995 or evidence of data showing exposure levels below regulatory limits should not be interpreted as representing an absence of significant exposure or risk.

MEMBER REDLICH: Evidence of data versus just data. Do we need the evidence of?

CHAIR MARKOWITZ: We can take that evidence off; that's fine, in the interest of shortening the recommendation. Okay. Open for discussion, final discussion.

MEMBER FRIEDMAN-JIMENEZ: Do we want to only ask for negative exposure determination

basis be provided, or also low or all exposure determination? The question that --

MEMBER REDLICH: I -- we --

CHAIR MARKOWITZ: No, no. That dilutes the impact of -- this is targeted to specific language, and I'm afraid if we expand the domain of this, the impact will be diluted.

MEMBER REDLICH: I already took back that suggestion.

CHAIR MARKOWITZ: He's reneging it.

MEMBER REDLICH: I agree with Steve.

CHAIR MARKOWITZ: Okay. Final comments; otherwise, we're going to take a vote. Okay.

MR. FITZGERALD: All right, I'll call the role here. Dr. Dement?

MEMBER DEMENT: Yes.

MR. FITZGERALD: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. FITZGERALD: Dr. Mikulski?

MEMBER MIKULSKI: Yes.

MR. FITZGERALD: Dr. Silver?

MEMBER SILVER: Yes.

MR. FITZGERALD: Dr. Berenji?

MEMBER BERENJI: Yes.

MR. FITZGERALD: Dr. Markowitz?

CHAIR MARKOWITZ: Yes.

MR. FITZGERALD: Dr. Redlich?

MEMBER REDLICH: Yes.

MR. FITZGERALD: Mr. Domina?

MEMBER DOMINA: Yes.

MR. FITZGERALD: Mr. Mahs?

MEMBER MAHS: Yes.

MR. FITZGERALD: Ms. Pope?

MEMBER POPE: Yes.

MR. FITZGERALD: Mr. Tebay?

MEMBER TEBAY: Yes.

MR. FITZGERALD: All right. Vote passes unanimously.

CHAIR MARKOWITZ: Okay. We're going to resume with the agenda. We will not finish by 11:45 today. Could you bring up the language on the non-cancer outcomes?

So this is a brief item. Dr. Silver,

just to remind you, fashioned some language trying to add some, I think, specificity or helpful language to DOL's request to us. They requested that we help them with looking at non-cancer outcomes of radiological materials.

So this is just a reformulation of that language, which actually I think we reviewed at the February 28th meeting and pretty much approved. I just want to put it out there.

We have no plan to actually work on this as of yet, but I want to make sure it remains on the radar.

And let me say that I don't think we necessarily need to engage in an extended discussion about the specific words of this. As long as it get the gist of what we think they might be after, we can submit it, because this is going to go to DOL. They're going to tell us whether this is what they had in mind. So, Dr. Silver.

MEMBER SILVER: That's the key point: we want DOL to give us feedback on whether this is what they were after.

CHAIR MARKOWITZ: You want to read this, Ken?

MEMBER SILVER: Some of this language was adopted in whole cloth from what DOL originally gave us, and then other language here was our reformulation.

In reviewing some of the radioactive substances found in DOE sites, the SEM only linked uranium with non-cancerous condition of acute tubular necrosis.

DEOIC asked the Board to conduct research, a peer review, human studies, to ascertain whether there are additional non-cancer diagnoses that literature link to exposure to radioactive substances such as uranium, plutonium, polonium, thorium, and americium.

While all are technically heavy metals, plutonium, polonium, and americium have no stable isotopes. Health effects may be based upon non-cancer effects of radiation, high LET alpha radiation in particular, chemical toxicity, or a combination thereof.

A related set of issues pertains to non-cancer effects, especially circulatory diseases observed in the life span study of atomic bomb survivors with an association with low LET radiation exposure.

Evidence of such non-cancer effects in nuclear worker cohorts or other occupational groups would be of interest. The Board could offer advice on the results of its analysis, including recommendations, additional links produced by the division as part of an update to the SEM or its policy guidance.

CHAIR MARKOWITZ: So were there any comments on this? It's a different matter as to the extent to which Board members are currently willing to volunteer to work on this issue, but in any event, this is the reformulation.

Anybody have any discussion on this? Okay, that's fine. Actually, I think I submitted it, but only within the past week to DOL, so obviously there wouldn't be a response.

Then we can postpone the issue of who

wants to work on this particular subject, so we needn't have that discussion. Thank you. Ken, yes.

MEMBER SILVER: Thinking one or two steps ahead, if DOL wants us to take this on, I would do a little outreach to the NIOSH Advisory Board, because they may have thought about this, and dose matters, whether you're talking about cancer or non-cancer effects, and they have some top-shelf expertise.

CHAIR MARKOWITZ: Okay. So let's wait until they get back to us, and then we can consider whether we have -- we're also one person short on the Board, whether we have time and resources to address this issue.

The next item on the agenda is review of public comments. I thought that we should -- we received a number of comments that were posted on our website, the written submissions, and there were a number of comments yesterday.

I thought we should just take a few minutes to mention some of those and also address,

I think, the status of some of the issues raised in those public comments.

I've done some of that. If others want to chime in, that's fine. There was one comment we received about raising the issue of the quality of an industrial hygiene assessment on a peripheral neuropathy case, that certain relevant exposures were not adequately considered.

The submitter also provided the example with personal information, identifiable information, deleted.

Frankly, I think this issue falls within our discussions about the claims and about assessing the adequacy of the industrial hygienist assessment. So it's an argument, actually -- in this case it was peripheral neuropathy, which is probably a fairly common claim, but I think we're going to address this in our recommended claims evaluation.

There was one comment citing the ombudsman 2017 report, that it contained items relevant to our mission, and thankfully, Mr. Nelson

and Ms. Felin have attended this meeting and yesterday gave us an update on the 2017 report, which we should review as a board.

There is a comment on -- a couple of comments actually, on this issue that we just made a recommendation about. So we've addressed that.

There's a comment on impairment. This came in a couple of months ago, actually, having to do with the question of what the policy of the program is. Let me just read this short section here, because it encapsulates what the issue is.

This a is January 28th, 2019 letter from ANWAG: It has come to our attentions that DOL's Division of Energy Employees, Occupational Illness and Compensation changed their policy regarding assigning impairment ratings for pulmonary disease.

This policy is not published on the DEOIC's website. It is our understanding that this policy was issued only to DOEIC's contract medical consultants and not to private practice impairment specialists. And then it gives an example of use

of impairment ratings.

So I think what we need to do is simply ask for clarification from DOL about what this involves so that we can understand the issue. Not right now, Mr. Vance, but we just should request some clarification.

And this pertains to our Task number 4. I'm already assimilating that data form that you used. This relates to Task number 4, which is our obligation to look at the consistency, objectivity, and quality of the medical input into the claims process.

A couple of comments that came up yesterday: I did ask the Department of Labor, Ms. Leiton if, as a standing request, if we could have their participation in all of the board meetings, which I had not asked prior to the February 28th meeting, and they have agreed.

They will either attend in person or attend by phone our meetings to be available for clarification. I want to thank you, Mr. Vance, for being available today.

A question arose yesterday about whether this board needed to re-approve or confirm the prior board's recommendations. So this is a question I've always -- I saw no need in that. I assume those recommendations still to have full weight or standing. Isn't that right, Doug?

MR. FITZGERALD: Yes, I mean, the Board's made determinations of which --- and the agency --- yes. I would say that is correct.

CHAIR MARKOWITZ: Okay. There's also a question raised, which we've talked about briefly before, that the industrial hygiene assessment seems to focus on a limit of seven toxins, despite the fact that the SEM frequently has a much larger number of toxins in association with any given job title.

I think that's something we should discuss in the future.

MEMBER DOMINA: Steve.

CHAIR MARKOWITZ: Yes.

MEMBER DOMINA: On the comment just before there that Doug was talking about, I saw

a letter from Ms. Hearthway where we had asked in a prior board about an advisory committee or someone to help us, and she said that this board, if I remember correctly, did not ask for it, and so it was null and void, something to that effect.

I think that letter was like, maybe last fall, early --

CHAIR MARKOWITZ: Well, yes. I think that refers to the previous board's request for resources, which we've taken care of today.

MEMBER DOMINA: All right. I just want to be clear.

MR. FITZGERALD: I think there was discussion within the past boards about resources, but I don't think there was any formal request that came forward from the Board.

CHAIR MARKOWITZ: There was a comment yesterday about a preponderance of evidence. The Board needs to look at that issue, a: whether it's relevant to our assigned tasks, and then b: if so, what it means. But we're not going to do that now. We actually need to read that comment, I

think, which will be in the transcript.

I think actually that same comment has been made before, so if it's relevant to our assigned tasks, then we need to look at that and discuss that.

Any else on the public comments that I didn't -- I didn't review all of them, but many of them.

Okay. I can give a brief update on the Presumption for Solvent-Induced Hearing Loss. We haven't forgotten about it, but we also have not prepared a response to DOL's response, pretty much a rejection of our recommendation regarding solvent-induced hearing loss.

I think they did, in the most recent version of the Procedure Manual, 3.0, I believe they've added a couple more solvents to the list. I believe that may have come out of our recommendation; I don't quite remember. If so, that's great. But we will continue to look at that issue and see whether there's evidence that we can assemble that would be persuasive to Department

of Labor.

Any comments on that? Okay. Maybe the new Board member will be an expert in solvent-induced hearing loss, with any luck.

I want to, in a few minutes, go over what we expect to do in the next couple of months, the things that we've assigned ourselves, but I think we should spend a couple of minutes. And I'm thinking we don't have that much more, so that we can just continue to work and then adjourn, instead of taking a lunch break.

But I'd like to put on our agenda some reflection, a little bit of time to reflect on the workings of the Board and whether there are some alternative structure, alternative means, or additional communication that would improve the functioning of the Board. So this is a moment when, if you have suggestions on how we work and how we can be more effective, then let's discuss them.

So while you're thinking, I would note that this Board has not developed committees per se. The previous board did, and those committees

had meetings, telephone meetings that were open to public.

We have a single working group with this board, which is on the Parkinson-related disorder, which we intend to continue. There's no particular reason why those discussions wouldn't be open to the public as a committee, except for the fact that it may just prolong the process. But we should discuss that, I guess. Dr. Dement?

MEMBER DEMENT: I guess we had a working group on the OHQ as well. I think the process of having that working group report back to the Board anything that's at least for the discussion development, I think that works reasonably well, other than having standing committees, per se.

CHAIR MARKOWITZ: In the past, working groups -- we have not scheduled them. The Federal Register had the six weeks' advanced notice. It gave us a lot of flexibility. On the downside, it meant that the public didn't have as much access to the discussions. What do we want to do about that?

MEMBER DEMENT: This is John again. I guess, unless there are some objections from the public, we could change where we are. I think it gives us more flexibility to have a meeting to exchange information and work on issues; no decisions are made, obviously. They're just working groups to assemble data and facts to present to the Board for discussion.

And those discussions, whatever the working groups bring forward, need to be open to the public. I think it works reasonably well unless there are some objections to it.

CHAIR MARKOWITZ: The committees had broader domains. Working groups are really very targeted, task-specific, and it frankly is helpful to be able to have the flexibility of having those discussions on a more frequent basis without scheduling them two months ahead of time.

I'm thinking about Parkinson's disease, for instance. That group could easily make excellent progress over the next period of time, and then have a discussion.

So unless there's a big objection, I would agree that for these two working groups, we continue them as they are, but be thinking, first of all, the logic -- the discussion that is had in those working groups be brought both to the full Board, which has the benefit of the full Board being involved, but also has the benefit of the public having access to the thinking that comes out of those working groups.

I think that would address the issue of public access adequately. But that's my opinion. Dr. Silver?

MEMBER SILVER: When a meeting is announced in the Federal Register, our DFO and assorted staff make sure that all relevant documents get posted on the web. I'm happy with the working group arrangement, but to strike a balance with public transparency, let's just try to be scrupulous about posting any and all documents that don't contain PII.

Our review sheet, for example, for the claims and any other things that the working groups

develop before the next full Board meeting.

CHAIR MARKOWITZ: That's reasonable. I mean, in the Parkinson's disease, some of those documents were published articles, and actually we discussed that. We published the names of the articles, but we couldn't publish the articles because there are restrictions on those.

But if we were, for instance, to come up with a draft of an OHQ, yes, we could put that online. As it stands now, it's not up to us to come up with a new draft; it's actually up to the Department to look at the advice that we've given them.

Okay. So we'll go, then, as we've been proceeding, and if we hear a lot of objections, or if we, in our self-monitoring, think that we're engaging in discussions that the public ought to have access to, then we'll change our way of working, if that's all right.

Any other aspects of the way the Board works that you think need attention, could be improved, aside from me getting the agenda out with

a little bit more notice? Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I want to make a request that I've made before, which is that the medical records that are provided in PDF files be provided as searchable PDFs, rather than bitmapped PDFs. It would save us a lot of time in reviewing; it would probably save the CEs and CMCs a lot of time too.

It's an extra step, running it through an optical character recognition program, but I think it would really add to the efficiency of the record review.

MEMBER DEMENT: This is John. Some of these documents are barely readable, and some of them are not readable at all.

MEMBER FRIEDMAN-JIMENEZ: Sure.

MEMBER DEMENT: And so there's going to be a lot of garbage that comes out of the optical character reading. The other thing that I've experienced in optical character reading is that sometimes you can't rely on the words that come out of that thing.

So indexing of where things are in this big file, what page number the OHQs or what page number the CMC report is on -- IH report -- you know, key pieces of information of where you can find them, that would probably be of much greater benefit to me. I can go in and read them and know I'm reading the exact words, rather than maybe something I have to verify.

MEMBER FRIEDMAN-JIMENEZ: So you're saying having someone actually go through the file and index where the different key sections are?

MEMBER DEMENT: Well, I --

MEMBER FRIEDMAN-JIMENEZ: That would work too, yes.

MEMBER DEMENT: Yes, maybe that's sort of this -- you know, we've asked for some help to do this. It would greatly cut down on our time if that were done. You know, we could review the cases much more quickly if that were done. That wouldn't be a great burden, I don't think. It would take some time on the individual's part.

But now, I would say that half the time

I spend on these cases was on my thumb, going through them, back and forth, back and forth, trying to find something. That's a waste of time.

CHAIR MARKOWITZ: Okay. Let me ask, actually, the Department: Communications from the public come addressed to me. I'm assuming that those are disseminated to the Board without my asking, assuming that the Department decides that it's relevant to the Board's mission. That's true?

MR. FITZGERALD: Yes, that is true.

CHAIR MARKOWITZ: Okay.

MR. FITZGERALD: I mean, what is relevant to the Board's work is posted unless it involves individuals and things that are more case-specific things. We make a determination and make sure the information with the Board is not public because it's not necessarily prudent to share some of the things.

But if it involves the Board's work or -- I will also say, we also get correspondence and communication from to the Board that is not in their area. It may go on to the program; those things

get referred to the program for a response.

MEMBER REDLICH: We can't hear you.

MR. FITZGERALD: I'm sorry; I don't know why this microphone is giving me so much trouble.

So basically, yes, we do post everything that's relevant to the Board's work on the website; however, sometimes we get information that's very case-specific, and it's not prudent to share that information with the public.

We may alert the Board to the issue. Whether or not it's in their scope, it could be contextual: here's some information that you should be aware of, but it doesn't necessarily reflect on what the Board's work is.

Other times information and questions and correspondence comes in to the Board and to the Chair that's really not in the Board's purview, and we refer that on to the program usually, where it's best responded to.

CHAIR MARKOWITZ: Okay. Dr. Redlich, you wanted to --

MEMBER REDLICH: Just a request. In terms of our requests of information, do we know when we will be getting the additional materials that we requested such as the data and the other cases? I think it would -- I understand if it takes time or if certain of our requests may not be reasonable in the form they were in, but it would just be very helpful, and I think enable us to plan our time better if we knew this will take us approximately this much time, or could we get part of the request, so we just know what the plan is?

MR. FITZGERALD: Yes, that was actually one of the reasons we created the form, the request process we created, so that there can be some limited back and forth between the Board and the program, refining the request to make sure that we're doing the most efficient --

MEMBER REDLICH: Okay.

MR. FITZGERALD: -- as possible. Or if the data you were asking for may not be available in the form you're requesting it in, but maybe there's proxy data that we could provide or

something of that nature, and then determine what the time frame would be for making that deliverable.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: Okay. So we expect we'll probably have a telephone meeting in a few months; probably three months, and then another in-person meeting in about six months. I'll talk about that in a moment.

I just want to talk about what we're going to do in the next three months, so there's some understanding. I have a list; I think maybe it's a full list, not quite sure.

But we're going to continue to look at the claims we have, and we're going to develop, each and every one of us, a list of concerns about the claims, and at the telephone meeting, we're going to try to identify a set of common concerns that appear across claims.

If, in the interim, we aggregate, we can discuss them as to what the most sensible organization of them is going to be.

So at the next telephone meeting, then,

we will probably not spend a lot of time reviewing claims, you'll be happy to know, but we will be shooting for a list of, however long it is, of issues that are of concern.

And that's going to help us when we have the opportunity to conduct a larger, systematic evaluation of the claims.

Two working groups: I think the occupational health questionnaire, I think it's a question of just waiting for DOL to respond to the recommendation that we made at the February 28th meeting. And there were two other recommendations we made, one on asthma, one on asbestos, and we're waiting on response to those as well.

On the Parkinson's disease working group, great work so far. Clearly, we can make additional progress on both -- there are four aspects to DOL's request, but they really focus on the diagnosis, advice on the diagnosis, and advice on causation. So I think we can continue to make progress.

Now, that working group right now is Dr. Mikulski, Ms. Pope, and Mr. Mahs, right? Okay. So I'll join that -- what's that? And I'll join that working group.

But if anyone else wants to participate, you're welcome. If you want to think about it, you can join next week too; it will remain open.

We're going to get, I think, an update on the status of the approved recommendations from the Department. I think this was a dashboard issue. Our hope is to get an update and then a periodic update automatically, not by request when we think about it.

And finally from this meeting, hopefully Carrie has developed a list of some action items which I will review and circulate to see if we've gotten it right, see if we've left anything off and the like.

Are there any other issues that we have promised to look at over the next period of time that have come out of this meeting? Yes.

MEMBER POPE: The replacement of Dr.

Cassano.

CHAIR MARKOWITZ: Yes. Well, we've been told that pretty soon, the announcement will come out in the Federal Register, and then we tell all our friends and get them to apply, those who are still talking to us.

And I think, Doug, you said yesterday that we expected appointment by someone during the summer. Hopefully, it will be by the time we have the telephone meeting so they can participate, but if not, hopefully several months before the next in-person meeting so they can get oriented.

Any additional comments, questions? Any you want to say?

MR. FITZGERALD: No. I just want to thank the Board for all their work. We've covered a lot of territory over the last day and a half, and I appreciate all your efforts.

I thank the public for participating and coming here to listen to deliberations, and I think the SIDEM; the contract staff here is really doing a great job with the logistics and

coordinating all the travel, meeting set-up and everything else, and Carrie Rhoads, my alternate DFO.

CHAIR MARKOWITZ: And I want to echo those thanks. Kevin becomes, next week, the most popular person, because that's the person we submit our reimbursement form to, and if you don't submit it, he'll remind you. So don't worry about that; he's very good about that.

The next in-person meeting: the way we select the location has generally been where -- who's next on the list in terms of the number of claims or claimants? We try to hit that geographic area.

I haven't looked at the list lately, so I don't know. NTS? All right. Okay. But we're going to base that decision on objective data, not lack of data.

And the telephone meeting at three months arrives towards the end of July. We may have a bit of a challenge, because of people's different schedules, scheduling that, so we'll

trying to schedule that sooner rather than later. But be responsive to the request to schedule that, because we may have to go back and forth a bit. We'll try to be as inclusive as we can. Mr. Tebay?

MEMBER TEBAY: Could we add to the agenda to revisit the borderline test results for beryllium sensitization or the diagnostic criteria? Before, when we did that, it was based on two borderline tests. They're utilizing three borderline tests. I think we could just add it to the agenda as a reminder to discuss, rather than -- but I would appreciate it if we could do that.

CHAIR MARKOWITZ: Yes, that's fine, particularly if DOL has anything new to add, because we've made that recommendation, and they haven't accepted it, based on the statute. But we should keep it on the agenda when we can.

MEMBER TEBAY: Thank you.

CHAIR MARKOWITZ: So I guess the meeting's adjourned. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:13 p.m.)