UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

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MONDAY,
JUNE 19, 2017

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The Advisory Board met telephonically at 1:00 p.m. Eastern Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

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

MEDICAL COMMUNITY:

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

CLAIMANT COMMUNITY:

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

DESIGNATED FEDERAL OFFICIAL:

DOUG FITZGERALD

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

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

1:08 p.m.

MR. FITZGERALD: Thank you. Good afternoon, everyone. My name is Doug Fitzgerald. I'd like to welcome you to today's teleconference meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

I'm the board's designated federal officer or DFO for today's meeting.

First, I want to take a moment just to say we appreciate the time and diligent work of our board members in preparing for this meeting and for their forthcoming deliberations.

I'll introduce the board members and at the same time take an official roll of those in attendance.

Let's begin with our board chair Dr. Steven Markowitz.

CHAIR MARKOWITZ: I'm here.

MR. FITZGERALD: Okay. Dr. John Dement.

MEMBER DEMENT: Yes, I'm here.

MR. FITZGERALD: Mr. Mark Griffon.
MEMBER GRIFFON: Yes, I'm here.
MR. FITZGERALD: Dr. Ken Silver.
MEMBER SILVER: Here.
MR. FITZGERALD: Dr. Leslie Boden.
MEMBER BODEN: Here.
MR. FITZGERALD: Dr. Rosemary Sokas.
MEMBER SOKAS: Here.
MR. FITZGERALD: Dr. Carrie Redlich.
MEMBER REDLICH: Here.
MR. FITZGERALD: Dr. Victoria Cassano.
MEMBER CASSANO: Here.
MR. FITZGERALD: Mr. Kirk Domina.
MEMBER DOMINA: Here.
MR. FITZGERALD: Mr. Garry Whitley.
MEMBER WHITLEY: Here.
MR. FITZGERALD: Mr. James Turner.
MEMBER TURNER: Here.
MR. FITZGERALD: Ms. Faye Vlieger.
MEMBER VLIEGER: Here.
MR. FITZGERALD: And I believe we have two members who may be joining us in a little bit,

Dr. Laura Welch as well as Ms. Duronda Pope. If they call in -- oh, and Dr. Friedman-Jimenez as well.

All right, just a few words about folks who are in the room today with me. I have Carrie Rhoads who's the deputy DFO as well as Kevin Bird from SIDEM, our contractor.

Just a few pieces of information to note regarding meeting operations.

All copies of meeting materials and any public comments are or will be available on the board's website under the heading Meetings and a listing there for this full board meeting.

Documents will also be up on the WebEx screen so everyone can follow along with the discussion.

The board's website can be found at dol.gov/owcp/energy/regs/compliance/advisoryboard.htm or you can use your browser and put in the board's name and it will probably come up as one of the first URLs.

If you haven't already visited the

board's website I strongly encourage you to do so. After clicking on today's meeting date you'll see a page dedicated entirely to today's meeting.

The webpage contains publicly available materials submitted to us in advance of the meeting.

We will publish any materials that are provided to the board where you should also find today's agenda as well as instructions for participating remotely.

If you are participating remotely and you have a problem please email us at energyadvisoryboard@dol.gov.

By WebEx, please note that the session is for viewing only and will not be interactive.

Phones will also be muted for non-advisory board members.

At this time I'd like to ask the participants to put their phones on mute unless they are speaking because we're getting a lot of background noise.

Please note that we do not have a

scheduled public comment session today. The call-in information has been posted on the advisory board website so that the public may listen in but not participate in the board's discussion.

A transcript and minutes will be prepared from today's meeting and during board discussions today. As we are a teleconference line please speak clearly enough for the transcriber to understand.

When you begin speaking especially at the start of the meeting please state your name so we can get an accurate record of discussions.

And at each time when you speak during the discussions please announce yourself so that we will know who's actually speaking.

Also, I'd like to ask our transcriber to please let us know if you are having any issue with hearing anyone or with the recording.

As DFO I see that the minutes are prepared and ensure they're certified by the chair. The minutes of today's meeting will be available on the board's website no later than 90 calendar

days from today per FACA regulations.

But if it's available sooner they'll be published before the 90th day.

Also, although formal minutes will be prepared we will also be publishing verbatim transcripts which are obviously more detailed in nature.

Those transcripts should be available on the board's website within 30 days.

I'd like to remind the board members that there are some materials that have been provided to you in your capacity as special government employees and members of the board which are not for public disclosure and cannot be shared or discussed publicly including this meeting.

Please be aware of this as we continue with the meeting today. These materials can be discussed in a general way which does not include using any personally identifiable information such as names, addresses, specific facilities, cases being discussed, or doctors' names.

And with that I convene this meeting of

the Advisory Board on Toxic Substances and Worker Health and turn it over to Dr. Markowitz. Thank you.

CHAIR MARKOWITZ: Thank you. So I join in the welcome to this meeting. This is our first meeting by telephone.

I hope it's a useful mechanism so that we can address the issues and make recommendations on a --

MEMBER SOKAS: Steve, can you speak up, please?

CHAIR MARKOWITZ: Sure, is that any better?

MEMBER SOKAS: Yes, much better.

CHAIR MARKOWITZ: That's much better? Okay.

So, welcome. This is our first meeting by telephone. I'm hoping it's a useful mechanism so that we can use it in the future and not have to wait six months between our face to face meetings in order to have useful discussions and perhaps make recommendations but we'll see.

Because the telephone meeting is relatively short we decided, meaning basically I decided that we would skip the public comment section. I apologize if anyone is offended by that.

We do welcome public comments and we have some written comments since our last meeting and I welcome other written comments now or in the future to allow a mechanism for people to provide some comments between our meetings.

We will adjust our future in-face meeting in October and November, the amount of time of that meeting to ensure that we allow for adequate public comments as we have in the past.

I think that we should do just -- we know each other on the board but we should probably for the benefit of any public participants who may be new to board activities we should probably just go around and introduce ourselves quickly.

I am Steven Markowitz and I'm an occupational medicine physician and epidemiologist at the City University of New York.

Actually, maybe Kevin or Doug or Carrie, if you could call people's names out that would be the most orderly way of doing it.

MR. FITZGERALD: Okay, I will be happy to do that. Dr. Dement.

MEMBER DEMENT: My name is John Dement. I'm an industrial hygienist and epidemiologist at Duke University Medical Center.

MR. FITZGERALD: Mr. Mark Griffon.

MEMBER GRIFFON: Mark Griffon. I'm a consultant health physicist.

MR. FITZGERALD: Dr. Kenneth Silver.

MEMBER SILVER: Associate professor of environmental health at East Tennessee State University calling in from the great State of New Mexico where I still keep up with some Los Alamos families and former workers.

MR. FITZGERALD: Dr. Leslie Boden.

MEMBER BODEN: Hi, I'm a professor at the Boston University School of Public Health.

MR. FITZGERALD: Dr. Rosemary Sokas.

MEMBER SOKAS: I'm an occupational

MEMBER WHITLEY: I'm a former worker of 40 years at the Y-12 National Security Complex in Oak Ridge and work with the worker health protection program at Oak Ridge.

MR. FITZGERALD: Mr. James Turner.

MEMBER TURNER: I worked at Rocky Flats Nuclear Plant for 26 years. I was diagnosed with chronic beryllium disease in 1993.

MR. FITZGERALD: Ms. Faye Vlieger.

MEMBER VLIEGER: Faye Vlieger, former worker, Hanford Nuclear Plant and worker advocate.

MR. FITZGERALD: Okay, thank you very much. Mr. Markowitz.

CHAIR MARKOWITZ: Sure. So, something on the public comments I forgot to mention. Some of the comments that have been posted in the last couple of months, please make sure, board members, that you read them.

They raise some new issues that we haven't addressed in the past entirely. And in particular I think the committee chairs take a look and see whether these questions fall within the

area of their particular committees that correspond to the tasks of the charter for the board.

So do take a look at those. We should figure out whether (a) they're within the scope of what we as a board should address, and (b) if so, who should address them, how should we address them. So please do take a look.

We only have two important topics at today's meeting and then we'll get a little bit into administrative issues.

So I think we can -- unless a board member has something to add to the agenda, or a comment at this point we can get into actually what we're going to start with, item number 2 which is the beryllium questions.

I should say that I got an email just now from Duronda Pope who has had a family emergency and won't be on the call. So she sends her regrets.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I was just able to call in so that I could speak. It was on listen-only

mode. But I'm on the call. Thank you.

CHAIR MARKOWITZ: Okay, great. Welcome, George.

So, let's start with Dr. Redlich's draft recommendations, but more really responses to the issues that DLL asked us to look at with respect to beryllium.

MEMBER REDLICH: Okay. I had circulated this to our subcommittee and to some others to get their input.

I was planning to get the revised version back to everyone before I have a two-week block of inpatient attending. But I did not do that so I apologize for you're not getting it - a refresher because I think it can be hard for us to keep track of what the other subcommittees are doing and who has jurisdiction over which piece of this activity.

So this is the refresher. The committee was asked to address issues almost entirely related to beryllium, chronic beryllium disease, beryllium sensitization, and also a few

issues related to chronic silicosis.

To date we have looked at some of the data on these claims. We've reviewed about 80 Part B cases, not the complete files, but the recommended decisions.

And we have reviewed the various sort of guidelines or training materials related to the Part B cases.

And at our last meeting we had made just one recommendation which we voted on which was the recommendation regarding borderline BeLPTs.

So I believe that we don't need to readdress that.

So at this meeting what I thought would be helpful was we had come up with a couple of other draft recommendations.

And also there was a pretty complete response to the original questions that the DOL had put forward to our committee.

Most of these questions overlap with concerns that have been raised by either at our meetings or had been submitted to our committee

related predominantly to the activation of Part B claims.

So, and I thought -- let me just stop there if there are any questions.

If not, I thought we could discuss the additional recommendations that we made. And I will -- I think we'll go in order of the draft document.

If everyone has that, it's on page 2. I'm looking at the WebEx. Oh good, okay, so you have it up.

And the highlighted was just the actual recommendation.

So the second recommendation if anyone cannot see it I will read it. The following criteria are proposed to define a clinical course consistent with a chronic respiratory disorder for use in evaluating pre-1993 CBD claims.

And so the criteria are respiratory symptoms that are chronic. And the asterisk clarifies the word "chronic." Plus one of the following four other conditions - abnormal

pulmonary function test, abnormal chest imaging, hypoxemia, or chronic use of respiratory medications such as Adin or COPD inhalers.

And again, the asterisk explains both chronic and also the tests.

I should just preface this that this was one of the questions that we were asked to address, and also one of the areas where the current training manual and -- I forget the name of that procedure manual had sort of multiple definitions for chronic respiratory disorder that was not entirely consistent in different places. So that was the reason for addressing this question.

And I would say that the area that has generated the most feedback in comments from other members of the subcommittee and others was how one defined chronic respiratory symptoms.

And so between being totally vague and not defining it, or picking a specific number of months.

So I tried to find a compromise and I defined chronic as indicates symptoms or

medication usage that are present for more than several months to differentiate from symptoms or medication usage wherever the term is being used related to an acute infection or other problem that resolves.

And also as far as the testing, generally one does not perform pulmonary function tests in the setting in acute illness, but one could -- a chest X-ray.

So the point being that those studies should be done not in the setting of an acute transient illness such as pneumonia.

So I think it would be good to get people's input, thoughts as far as this definition.

MEMBER SOKAS: Carrie, it's Rosie. I like the definition.

My only suggestion might be to use three months rather than several months. Present for three months or more. Because that is what we used for other things.

MEMBER REDLICH: Okay. The other reason that -- I think that is reasonable.

The concern I have in general with greater specificity is -- I mean, I think all of us have a sense of what chronic is. As with other aspects of this task when one goes from a clinical concept that we all understand to writing down the specific criteria that a non-physician might then use while looking through records, then there can be some arbitrary decisions that may not make that much sense.

And decisions that may be in part limited by the available records.

And so these are cases, although the request sort of referred to the term chronic respiratory disorder for both pre and post 1993 claims, the original EEOICPA Act and there's really only reference to this term chronic respiratory disorder for pre-1993.

So those claims which someone would be reviewing older records. And I actually went through some older records just to see how this definition might hold.

The problem that one gets into is that

you may have more limited records, and they comment on so-and-so's short of breath. It sort of might be apparent to one of us that it's clearly a chronic problem, but the physicians don't necessarily comment.

The limitation is the notes that physicians frequently write.

CHAIR MARKOWITZ: This is Steve Markowitz. Also, looking back at old records it also depends on how frequently the person saw the doctor as to the documentation.

In the back and forth I had proposed six months. But I think that Carrie has the right approach of saying several months given this particular purpose here which is for pre-'93 CBD claims. So we're talking about really old records.

This kind of ambiguity I think better reflects kind of the quality of the information that we're likely to have.

MEMBER CASSANO: This is Tori Cassano.

I understand not wanting to set six

months. My concern with using several is the variability between one claims examiner and another.

One claims examiner may think several means five. One claims examiner may think several means three.

And so I think rather than setting a six month limit, you want to set the lowest limit that you can so that people don't arbitrarily say, well, it was only four months, that's not several.

And I think that's where Rosie was going.

MEMBER BODEN: This is Les Boden. I have this same general concern about using several which is whether that would end up being really helpful for the claims examiner.

And perhaps a compromise -- and I don't know what the right number is -- is to use a specific number of months, but then add a sentence at the end saying in many cases that level of specificity isn't available, and a claims examiner will have to use their best judgment about whether the claim

fits.

Not those words, but that's the idea.

I think it's useful to indicate to the claims examiner what the number is that if you had it you could use, but give them flexibility if it's indeterminate in the claim file.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez.

This is difficult because it's essentially a clinical decision. And I think maybe saying something like for more than several months, or can clearly be differentiated from symptoms related to an acute infection.

Something that will trigger if it's really ambiguous the case being referred to a clinician to make a clinical judgment. Because I don't know that the claims examiners are going to be able to make a clinical judgment.

If someone is consistently improving over six months or seven months they may have an infection-related respiratory presentation. Or it could be related to something else.

It's subtle, and I think it is not really something that a claims examiner would be able to determine if it's outside the bounds of a clear-cut case.

MEMBER REDLICH: I appreciate all these comments which is why an earlier version didn't have a period of time.

And I think this is one of the -- Les and others clearly stated what the problem is, that you want to give some idea of what -- that we're referring to chronic versus just an acute transient problem.

But one also wants to leave an out for the scenario where I think it's clearly chronic but because of limited records the record might not have the specificity where it spells out exactly how many months.

CHAIR MARKOWITZ: This is Steve Markowitz. Let me make a suggestion.

If Les's approach makes sense which is to add a number but then also add a clause or a sentence saying that if an exact number isn't

available the CE needs to figure it out.

If that approach makes sense then, Les, if you want to propose either at this moment or in the course of this discussion some language which we can get down then we can send it to Carrie, put it up, we can look at it and which will allow us to vote on the recommendation.

So I don't know, Les, do you want to just dictate that language now? I'm ready to type. Or whether you want to do it yourself at your computer and send it in.

MEMBER BODEN: I think it would probably be better if I could think about the wording.

The wording would be for the alternative if records weren't -- obviously I'm not in a position to judge what the number of months should be if the records were good. So that should be a position left to the occupational physicians and the --

CHAIR MARKOWITZ: Well, yes, don't worry about the number of months, just it's that

sentence that we need added to this that gives the CE leeway in case the records don't really.

If you could construct that sentence then we could look at it.

MEMBER BODEN: I'll do that.

CHAIR MARKOWITZ: Okay, great, thanks. And Carrie Rhoads, are you able to receive emails so we can put it up and look at?

MS. RHOADS: Yes, I can I receive emails. Also, you can read it and Kevin can type it in live if you want to do it that way.

CHAIR MARKOWITZ: Okay. So let's continue.

MEMBER REDLICH: Okay, thank you. I think I would go with the three months and then the wording that Les is going to come up with.

Then I think we should just see what people feel about the double asterisk in terms of not obtained during an acute illness.

An earlier version did not have that caveat.

CHAIR MARKOWITZ: This is Steve

Markowitz. It makes perfect sense to me. I'm not sure whether the claims examiner will be able to time things correctly, but this looks right to me.

MEMBER REDLICH: Yes. And so my concern with this, and it is enforced by my past two weeks attending on a very busy inpatient pulmonary consult service, that patients can have remarkably advanced disease before they come to medical attention.

And then the one event that brings them to medical attention, the infection that when they're admitted is clearly on top of a chronic process may also be their fatal event.

And so the only imaging, and I have several patients that fell into this category in the past two weeks despite living in a part of the country that is well populated with physicians, is that the only imaging available is imaging during an acute setting.

And there was no prior pulmonary function testing, and no prior imaging to sort of -- and so someone might say, oh, but this is an acute

illness because the initial diagnosis on the chart is for pneumonia. But it's really chronic interstitial lung disease, or COPD that was not recognized. So that is the concern.

MEMBER CASSANO: Carrie, I think that what you say --

CHAIR MARKOWITZ: Sorry, please identify yourself.

MEMBER CASSANO: Hi, it's Dr. Cassano.

I agree with your last statement and I think that in addition to what Les is doing instead of having this here to add something that says in cases of ambiguity when it is either records were unavailable, or if the condition comes to light during an acute illness it should be referred to a CMC.

Because you're right, from our visit to the Seattle office claims examiners are very procedurally bound. And they don't usually -- if they're given any wiggle room they usually don't use it.

So if it's not written as it needs to

be, or give them something like this they'll say oh, they had pneumonia and deny the claim. Just like calcified granuloma which with beryllium disease because it's in the manual then, or the policy, it just -- there's no thought process.

So I think we need to not make this statement.

MEMBER SOKAS: I agree with Tori. I think the double -- this is Rosie Sokas -- I think the double asterisk part probably might not need to be there.

MEMBER REDLICH: This is Carrie. I am fine to remove it. It was not there originally, but was suggested.

The other thing, I would just remind people that this whole phrase is in context with the period for pre-1993. And I included that on the last page of this document because I found it helpful.

I would say sort of not constrained, but that is the context that this wording will be used. So if someone could scroll on the WebEx to the final

page.

But it does include the exact wording from the EEOICPA statute. And it's the C part there for diagnoses before the presence of. And so it was number 4, clinical course consistent with a chronic respiratory disorder.

I am, again, it's one of these situations where a clinician might I think understand the context of when the imaging was done, but that a non-medical person, that might be challenging to do.

So, does anyone object to removing the double asterisk? Maybe we're going to come up with a revised written text that we could look at. Let's comment. If no one objects then we remove the double asterisk.

MEMBER BODEN: So, this is Les. I've been trying to do two things at once and sort of draft a sentence.

And I just wanted to raise a question which is so there are two possibilities if there isn't adequate evidence on the record that three

months or whatever the number of months is going to be.

One is to have the claims examiner use their best judgment. And the other is to refer to a CMC.

So I'll read you what I have at the moment and then ask the question about referral. If that's okay? Is that okay?

CHAIR MARKOWITZ: Sure, yes.

MEMBER BODEN: Okay. So if there is not sufficient information in available records claims examiners should use their best judgment based on those records about whether the condition more likely than not was present for more than let's say three months.

The alternative is to say that claims examiners should defer. And of course I'm open to changes in wordings. But the first question is do we want this to be a matter of judgment for the claims examiner. Because I've sort of heard two different versions on that.

CHAIR MARKOWITZ: This is Steve

Markowitz.

Given how many claims examiners there are and the likely variation in a whole set of factors relating to their performance I think we're -- and given how important this is to the claimant that they may rest on this interpretation of chronic respiratory disorder that I think we're probably better off with your second option which is that it be referred to the CMC.

MEMBER BODEN: Okay, with that specific question. Okay. I'll reword this and get back to you once I've done that.

CHAIR MARKOWITZ: But let me ask -- this is Steve again. Are there other comments besides mine on what Les just proposed?

MEMBER TURNER: This is James Turner. I would think that some claims examiners probably have become disgruntled. They might say well hey, just pass it on rather than taking a look at the claim.

CHAIR MARKOWITZ: Other comments?

MEMBER REDLICH: This is Carrie

Redlich.

The only other possibility to this which I think others haven't felt is specific enough is to define chronic as symptoms that persist, differentiate from symptoms related to an acute infection that resolves without actually defining.

And there was also a version that simply had persistence at -- basically defining the issues of chronic respiratory disorder you have to have respiratory symptoms without defining the chronicity because -- and the argument in favor of not defining the chronicity is since the respiratory symptoms alone you need some other item that's on this list.

And if you've got abnormalities it's likely.

The only thing that we would possibly be over-calling would be a transient infection.

CHAIR MARKOWITZ: This is Steven. The fact that the program has asked for help in defining this term that they found to be ambiguous and

certainly public commenters have focused on this as well.

I think we're probably better off erring on the side of being more specific rather than less. In that sense I think the number of months is probably better than reverting to language like persistence or whatever.

MEMBER REDLICH: Yes, I think you're probably right in that then somebody else will try and define that more specifically if we don't. So I agree with your point.

Okay, so I would prefer the three months to the six months.

CHAIR MARKOWITZ: That's good.

MEMBER REDLICH: And then I think I would defer to someone who knows more about the process like Tori as far as whether all or a use your judgment.

MEMBER CASSANO: I think if they cannot make that determination based on the record they need to refer.

Because what we're trying to do by

standardizing is make it as close as we can the same outcome for people with the same -- relatively the same history.

And if you leave that kind of wiggle room you're going to get some people, you know, somebody maybe as you said the fibrosis was discovered when the person became treated because they had a pneumonia.

And they say oh, well they had a pneumonia and it's only been four months since their pneumonia, blah blah blah, I'm going to deny this.

I think if it's not there with a low and hard number and they can't make that decision then they need to refer it to somebody with clinical judgment or someone that can use clinical judgment.

MEMBER BODEN: Okay. Well, I just rewrote it on that basis and I'll give you a read and a question.

So the current rewritten version is if there's not sufficient information in available records to determine whether a condition is

chronic, claims examiners should refer the case to a CMC requesting an opinion about whether the condition more likely than not was present for more than three months.

Alternative more likely than not is chronic because now you're talking to a CMC and maybe you don't want to limit the CMC to three months.

MEMBER REDLICH: Could we end it with just refer to a CMC period?

MEMBER BODEN: I thought it would be good to say why you're referring it. Because they have to make specific requests to the CMC, right?

MEMBER CASSANO: I think you can do both. I think you just need to switch it around, Les, and say if the examiner cannot determine based on the record whether the condition has been present for at least three months then they should refer to the CMC to determine if there is -- if this represents a chronic respiratory condition.

And that way you are giving the CMC the freedom to go beyond the three months. But you're

not giving the CE the freedom to arbitrate chronicity.

Does everybody understand that?

MEMBER BODEN: Just say it again, I'll try.

MEMBER CASSANO: All right. If the claims examiner cannot determine based on the record if the respiratory symptoms were persistent for three months or more then they should refer the case to the CMC to determine if the condition is a chronic respiratory -- is considered a chronic respiratory condition.

So what you're doing is you're setting the limit on the CE but not on the CMC.

MEMBER REDLICH: This is Carrie Redlich. I agree because the question is not whether the symptoms -- but the question goes back whether the chronic respiratory disorder. That's the bottom line question.

MEMBER CASSANO: Exactly.

MEMBER REDLICH: Yes or no, does this represent a chronic respiratory disorder. And

this was giving ways that one would -- so related question.

How many cases approximately that there was a question -- so this is only in the context of the question does the person have CBD for pre 1993.

Do most of those get referred to a CMC anyway?

MEMBER CASSANO: We didn't see that many of them. Unless because we were looking primarily at Part E.

The one that got denied that I know was a beryllium case, and we talked about this already, the only one that I saw that was denied for beryllium that we thought was a CE problem was the one with the calcified granuloma.

So, I can't really answer your question.

MEMBER REDLICH: Okay. So let's see. Should we reread the current wording?

MEMBER BODEN: If the claims examiner cannot determine based on the record whether the

condition was present for more than three months then the case should be referred to a CMC to determine if the condition was a chronic respiratory illness.

MEMBER REDLICH: Disorder. It's just the wording.

MEMBER BODEN: You heard the question in my voice.

And I have one little question about that. Should it say whether the condition was present for more than three months, or whether the condition was likely to be -- no, I don't like that. Never mind. I retract my question.

Okay, shall I just send this wording on and somebody can go from there? Rather than -- would you like me to read it and have Kevin input it?

CHAIR MARKOWITZ: Carrie, can Les send it to you and you give it to Kevin?

MS. RHOADS: Yes, go ahead and send it to my email at the energy inbox and we'll just cut and paste it into the document that's on the screen.

MEMBER BODEN: Okay. Will do.

MEMBER CASSANO: I have one more comment about the definition.

Under chronic use of respiratory medication such as asthma or COPD inhalers I'm wondering if we should put the word "prescribed" in there.

I don't know whether you can still get Primatene Mist over the counter, but I'm sure there are some naturopathic inhalers that are available or some other un-FDA approved inhalers or remedies or medications that could be used.

And I think we need to be a little bit more specific.

MEMBER REDLICH: So you're referring to let's say chronic use of --

MEMBER CASSANO: Medication. Prescription medication. Prescribed medication.

MEMBER SILVER: Well, this is Ken Silver.

Going back to Dr. Redlich's scenario a little while ago in a part of the country heavily

populated by physicians it seems to me there are a lot of people who delay and delay and delay and try naturopathic things and then come into the clinic setting the bar at using prescribed medications.

I mean, we don't want to open this to sweat lodges in Santa Fe, but.

MEMBER REDLICH: This is all in the setting of or and or. So it was trying to give people multiple ways to qualify as a chronic respiratory disorder rather than to eliminate ways.

MEMBER CASSANO: Well, I'm wondering, since we are defining out chronic symptoms, chronic respiratory symptoms, do we need the use of the word "chronic" to medications?

And then you can just say use of prescribed medications.

Because they have to have the chronic respiratory symptoms for over three months.

And then okay, they tried all this other stuff. And boom, now they've gone to an urgent

care center or whatever, or wherever they're getting their healthcare, and they get prescribed medication.

MEMBER REDLICH: I'm fine with taking out the word chronic. Are others?

CHAIR MARKOWITZ: Yes, that's fine.

MEMBER REDLICH: So, Carrie, that would be another edit to what's up on the screen under D.

MS. RHOADS: I haven't gotten anything in my email yet, so I'm not sure. Picking up from chronic on part D?

MEMBER REDLICH: Yes.

MEMBER CASSANO: That's and prescribed. Use of prescribed respiratory medications.

MEMBER SILVER: Do you see the change?

MEMBER REDLICH: Yes. The word "prescribed" you could -- well, prescription. People borrow inhalers from people.

MEMBER SILVER: At one time Primatene was available over the counter. These are pre-'93

cases.

MEMBER REDLICH: I think that might just confuse somebody.

MEMBER SILVER: The word prescribed.

MEMBER REDLICH: Yes, I think I would just not have it.

CHAIR MARKOWITZ: So, what's the suggestion, that simply say D would be use of respiratory medication? Such as asthma or COPD inhalers.

MEMBER SILVER: That would satisfy me. Ken here.

MEMBER REDLICH: Any objection?

MEMBER CASSANO: No.

MEMBER BODEN: Are antihistamines respiratory medications? And is that okay with people?

MEMBER REDLICH: Sorry.

MEMBER BODEN: I'm just asking. I don't know. I'm not making a suggestion.

MEMBER CASSANO: I would think like Flonase, you know, guaifenesin, is that considered

a respiratory medication. Then it would have been Benylin that people took for cough.

MEMBER REDLICH: This is Carrie Redlich. The fire alarm in my building has gone off.

MEMBER BODEN: Oh great.

CHAIR MARKOWITZ: Okay, Carrie.

MEMBER REDLICH: Given the field that we're in to not follow appropriate safety code we are being instructed to leave.

CHAIR MARKOWITZ: Take care. Exhale on your way out.

MEMBER REDLICH: We all have to leave. I will call from my cell phone once I am out of the building.

MEMBER BODEN: Carrie, did you get my email? Les.

MS. RHOADS: I didn't see it yet. Let me look again.

MEMBER VLIEGER: This is Faye Vlieger. A number of times during the course of my treatment I've been told to purchase over the counter

medication.

And so I don't know about the trail of those other than the doctor mentioning it to me many times. They never appeared in the document notes or the chart notes from the visit.

MS. RHOADS: Hey, Dr. Boden, I don't have an email yet from you. Could you possibly read it and we could type it right into the document?

MEMBER BODEN: Sure. So, if the claims examiner cannot determine comma based on the record comma whether the condition was present for more than three months comma -- and tell me to slow down -- then the case should be referred to a CMC to determine if the condition was a chronic respiratory disorder.

MS. RHOADS: Does it look correct on the screen? Can you see it?

MEMBER BODEN: I'm just going over it now. Yes, that is what I said.

MS. RHOADS: Okay.

MEMBER BODEN: That should probably

just follow -- be part of the paragraph with the first asterisk.

Notice I said that's what I said. I didn't say it was correct. So people should look at it and see if it needs to be changed.

CHAIR MARKOWITZ: This is Steven. It looks good. I think this is what we agreed on.

MEMBER CASSANO: But I think that do we need then three months on the first line? Are we going to leave several and then three?

CHAIR MARKOWITZ: No, no, the idea was to change the several to three.

MEMBER CASSANO: Yes.

CHAIR MARKOWITZ: All right. Okay. Were there any other comments on this section that we're looking at right here? Just that one paragraph that begins quote unquote chronic with a single asterisk.

MEMBER CASSANO: I do have a general question based on this discussion. I don't know if it's possible, but is there any way that we could have either a claims examiner or a supervisory

claims examiner sort of standing by at these meetings for us to be able -- for them to be able to say yes, this would work, this is good for us.

Rather than having it go as a recommendation and then not getting approved, or adopted because it's too cumbersome, or whatever for the claims examiners.

It would be nice to have some input from the examiner to see if this kind of language actually helps them.

CHAIR MARKOWITZ: Yes, this is Steven. That's a good idea. You know, in the previous meetings we've always had somebody from DOL who -- and not necessarily a supervisor claims examiner or the like, but someone who obviously is experienced and knowledgeable who's been able to give us that kind of immediate feedback.

In this instance I think whatever recommendation we make may not be accepted whole cloth, and they may modify it slightly, hopefully not too much.

But it's to conform with the realities

of running the program. So for this instance I wouldn't worry too much. But I think the point is well taken.

So if there are no other comments on this particular issue about three months I just want to return and settle the issue of the 2d, the issue of prescription medications because that section in green is what we're looking at.

This is all about pre-1993 CBD claims because the act only mentions chronic respiratory disorder in relation to CBD in relation to the pre-'93.

As a reminder, the pre '93 criteria includes the claimant has to have a history of beryllium exposure, but on the medical side they have to have any three of chronic criteria. And one of those criteria is chronic respiratory disorder or clinical course.

But the other ones are actually if you just go down to the end of this whole document the other ones are abnormality on imaging, abnormality on CT or chest X-ray, abnormality on PFT, pathology

which frankly should be the whole story right there, four is a chronic respiratory disorder, and then five is skin patch test or beryllium blood test.

And so the person in order to get a successful claim will have had to interact with a physician to get either 1 or 2 in addition to item number 4.

Meaning that they've come to medical attention and they haven't appeared to remain sort of symptomatic and completely unattended for any number of months or years until they become really ill.

And so I think the fact that items number 1 or 2 or 3 or 5 are required does raise the standard in terms of the level of evidence that's needed to have a chronic respiratory disorder.

In that sense I don't really think that we necessarily need to say prescribed medication because having a positive 1, 2, 3, or 5 means that there is harder evidence of disease.

And so I think -- my own feeling is we

can probably go without having to say it's a prescribed medication, just that it was chronic or usage. If we could scroll back up.

MEMBER CASSANO: Yes, can we scroll back up? Because I can't see.

But it's only one of those. So it would either be they don't ever -- I mean, respiratory symptoms that are chronic.

But I guess you're looking at the records so in order for it to be in the record they would have to have seen a doctor. Okay. Because it's any one of those.

So you could not have a PFT or a chest X-ray or be determined to have hypoxemia. You would be chronic respiratory symptoms plus use of medication.

CHAIR MARKOWITZ: Right, right. So item number 1, the symptoms, and item 2d, medication use would get you according to our suggestion a chronic respiratory disorder.

But you still, under the act you still have to satisfy two out of the other four

requirements.

MEMBER CASSANO: Okay, I see.

CHAIR MARKOWITZ: The bar is pretty high in terms of objective documentation.

So I think that that then has sort of colored my thinking about this. So Tori or those who have spoken in favor of use of the word prescribed here, or for that matter people who think that we should not use prescribed, are there other comments or general feeling about this?

MEMBER VLIEGER: This is Faye. I don't know if you saw the note from Dr. Welch. For some reason she can't speak anymore.

MEMBER WELCH: I think I'm on now. Can you hear me?

MEMBER VLIEGER: I can hear you.

MEMBER WELCH: Okay, good. Carrie sent me the instructions how to get on I think because I logged on late the operator wasn't there anymore. But I'm here.

CHAIR MARKOWITZ: Welcome. Do you have a time constraint today?

MEMBER WELCH: No.

CHAIR MARKOWITZ: I just want to make sure. Okay.

MEMBER WELCH: And actually I've been on the call for half an hour but I guess emails aren't going through to Carrie. So I finally emailed the whole group and a couple of you responded to tell me what to do so thank you.

CHAIR MARKOWITZ: So anyway, are there other comments on this issue of using the word prescribed or not? Faye, I think maybe you were -- or someone.

MEMBER VLIEGER: Just that during the course of coming up with a diagnosis for me I was seeing the doctor and being told to purchase over the counter medication.

Those recommendations I didn't ever see any certainly.

CHAIR MARKOWITZ: All right. Okay, any other comments on this issue about saying prescribed or not prescribed?

Okay, so I think we'll just hold off on

that for the moment. We'll come back to that issue when we actually come closer to voting on this recommendation. But I don't want to do that without Carrie Redlich on the phone.

So I suggest if there are no other comments on recommendation number two let's move on and when Carrie Redlich rejoins us.

I can lead the discussion I think. So draft recommendation three is recommending substantial revision in the sections of the procedure manual and related to appeals relevance of Part B conditions, taking into account the comments in this document and other feedback from the advisory board.

So we're going to go through this language. So unless you've already seen it you won't know what we might be voting on. But so that's what this recommendation is about.

And the rationale is that frankly sections of the procedure manual and other materials are inconsistent and confusing, and even sometimes medically inaccurate. So they need

correction.

And then the next piece is an endorsement. We already discussed this issue at length. And I can't remember whether it was at length in the committee or at length at the full board meeting or not.

So, I'm sorry, I'm getting an email from Carrie Redlich. She's back online. Carrie, can you hear us? Can you speak?

Okay. She can hear us but can't speak apparently yet.

MS. RHOADS: Can you push *0 and get the moderator's attention?

CHAIR MARKOWITZ: Okay, so while that's happening just so you know. So we -- this endorsement is our realization that in fact we endorse the presumption of CBD in situations where the diagnosis of sarcoidosis in an individual meets the definition of a covered beryllium employee under Part E or Part B. So that is the current policy of DOL and we're simply endorsing it.

But in the rationale for our

examination and endorsement the presumption already exists and is stated in both circular and in the procedure manual.

However, implementation of this presumption has been problematic and revising the relevant sections to the procedure manual and training materials within the statutory limitations of EEOICPA should help alleviate this problem.

So, I think we get into discussing a little bit of that language in subsequent pages. But there's nothing to vote on because this is not a new recommendation because this policy currently exists for DOL. Let's go to page 3.

MEMBER REDLICH: This is Carrie. I think I'm back on the phone now.

CHAIR MARKOWITZ: Okay, good. And you're in front of a computer, Carrie, as well?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay, so take it away.

MEMBER REDLICH: So, I think -- that's

the last of the either recommendations for different wording for this one.

Do we want to as a board vote on the recommendations, Steve?

CHAIR MARKOWITZ: This is Steven. Let's go through the comments and then come back to the recommendations because there may be a little bit of discussion in the comments.

The comments, we're not going to vote on accepting or not accepting I think. I would propose we simply endorse them with any possible modifications that people have on the phone.

Because these are questions that DOL asked us and not necessarily changes in the policy. But this language we're going to look at in these responses to comments do relate to the recommendation number 3 I think which is that we suggest they change some language.

Does that sound okay?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay, so let's just start with item 1, beryllium sensitivity. And

Carrie, are you?

MEMBER REDLICH: Sorry, when I moved offices my computer's frozen so I'm just going to need a minute.

CHAIR MARKOWITZ: Okay, that's fine. Let me start with the first one because that's easy. The first question has to do with consistency of testing results among different diagnostic facilities.

And the response is that National Jewish Medical Center, ORAU and the Cleveland Clinic are the only labs that we know of that currently perform BeLPT on a regular basis.

These labs have extensive experience with performing the tests, consistency among these labs has improved, and does not appear to be an ongoing issue.

Additional laboratories would likely increase problems with accuracy and reproducibility of performing BeLPT testing.

So anybody have any comment on that? Okay. We'll go on to item number 2 here. And

Carrie, just jump in when you're all set.

So, this question posed to us has to do with the reinterpretation of quote unquote normal test outcomes as abnormal by a consulting physician.

Our response is that a patient's BeLPT report from the lab performing the test should not be reinterpreted by a consulting physician.

However, the quality of the interpretation of standard clinical tests used to evaluate patients with pulmonary disorders, chest X-rays and CT scans, pulmonary function testing, lung pathology can be quite variable and significant inter-observer variability can occur.

These tests involve interpretation of multiple images, patterns and/or data points, and treating or consulting physicians routinely re-review the studies themselves or with the appropriate specialist such as a chest radiologist, a pulmonary pathologist.

Proper interpretation also can require comparison to prior testing results if available.

So, this response is merely that if it was BeLPT report you would take the report as is from the laboratory, but for other clinical tests that physicians routinely look at the data themselves and can reinterpret their results.

MEMBER CASSANO: Steve, I have one question.

CHAIR MARKOWITZ: Sure.

MEMBER CASSANO: When we're talking about a consulting physician we're not talking about their -- we're talking about a consulting treating physician.

We're not talking about the consulting medical -- contracted medical consultant, correct?

MEMBER REDLICH: This is Carrie. Yes.

MEMBER CASSANO: Okay.

MEMBER REDLICH: My guess is that the question was asked in reference to the BeLPT. And its answer could have ended after the one sentence first paragraph.

I added the second one because some of the cases that we reviewed it is not uncommon for

the written report to not accurately reflect the actual study.

And so to understand that it was okay in various other settings to re-interpret the written report.

MEMBER CASSANO: Okay, thanks.

CHAIR MARKOWITZ: Moving onto 3. So Carrie Redlich, you have this in front of you now?

MEMBER REDLICH: Yes.

CHAIR MARKOWITZ: Okay. I don't think we -- I think actually do you want to just paraphrase some of these responses. That would probably be sufficient.

MEMBER REDLICH: Okay. So I think what's in 3 was are there new and better tools out there and the answer is no.

And it was suggested that throughout the procedure manual that's referenced to patch testing was to -- could be confusing and that it should be removed because it is no longer recommended or done.

Anyone has questions or suggested

alternate responses please speak up.

The next one is definition of beryllium medical monitoring. The wording was taking the italicized bolded was the wording of the comments that we were given.

And so the question was what sort of medical monitoring.

And the answer was we proposed using what the American Thoracic Society recommends in the recent evidence-based document that they published which was every two or three years, or sooner if there is a concern about progression of disease.

And then it just mentions what that should entail.

And I think what would be assistance in examination of pulmonary function testing. And then it left further testing such as bronchoscopy or lung biopsy open for a case-by-case basis.

I don't think we want to prescribe more on basis testing. That involves the judgment of the physician.

Are there any questions about any of those? We could go on to number 2.

So the next couple of questions were sort of just technically requesting clarification of what characteristic imaging findings were.

They already have an existing list that was reasonable. And I sort of tweaked it with a few more suggested terms to use.

I don't think we need to go through that in detail unless anyone has questions. But I said that they were generally prescribed appropriately in exactly what sections, and then suggested some edits.

Number 2, the pulmonary function testing. So does anyone have questions about the imaging?

CHAIR MARKOWITZ: This is Steven. I just want you to point out that one of your suggested changes in CBD granulomas can become calcified because I know there was a public comment I think that addressed this. So I just wanted to point out that that's a suggested edit.

MEMBER REDLICH: That is. So the -- exactly. There was a whole discussion around granulomas. And I suggest that getting into whether it caseates and calcifies, removing that text from the chest X-ray section and a calcified granuloma is not characteristic of CBD was an incorrect statement and should be removed.

Okay. And then number 2, the pulmonary function testing.

So again, I think that your request was to try and come up with a specific -- this is PFT finding of is this CBD, no it's not.

And I think that the fact is that you can have all different physiologic changes. It can be restrictive, obstructive, or actually involved in normal ranges.

So the wording they actually currently have was adequate and it really cannot be specified to a greater degree.

And I just mention also that it's important to compare to prior testing. Because someone can fall what looks like in the normal range

but has actually had a substantial decline. They may have started at 120 percent and gone down to 85 percent and that might still quote fall within the normal range, but really would be an abnormality.

A number of cases we have reviewed included a situation such as that where if you only looked at the last most recent breathing test it would appear to be quote normal, but if you looked over five different tests over a period of eight years there was a clear decline. So that was added as just a note.

And I think what some people would like would be to say if it's this exact range or the like it is or is not CBD and one cannot say that. So that was the pulmonary function testing section.

Any questions? So the lung pathology. So, they wanted guidance on the lung pathology findings consistent with CBD.

And so the response basically, the typical lung pathology of a non-CBD granuloma was mentioned, but that there are other findings that

can be consistent including just a lymphocytic infiltrate.

And the other point that was made is that in more advanced disease the process becomes more diffuse and fibrotic, and you may not actually have distinct granulomas.

And then I did make a note about there were some inaccuracies stated in the section related to pathology. And the main one related to mediastinal lymph nodes.

So I think this is a situation where there was additional detail that was added probably to try and provide guidance but which actually added I think inaccuracy and confusion.

So I think the simple thing is the pathology can be in the lung or the lymph nodes that drain the lung. And in fact when you take a biopsy sometimes you preferentially biopsy nodes rather than lung tissue because it can be a safer procedure.

So there was wording in the manual that if it was present in the node but not in lung tissue

that was not the equivalent.

It's much simpler than that. If it's in the chest -- well, that's the policy. You don't need to discredit it because it's in the lymph node.

CHAIR MARKOWITZ: This is Steve Markowitz.

Just looking at the language of the act, both the pre- and post-1993, and it describes -- this is the post-'93 quote.

Lung pathology consistent with chronic beryllium disease including, one, a lung biopsy showing granulomas or a lymphocytic process consistent with chronic beryllium disease, end of quote.

And in the pre-'93 of the advanced criteria quote lung pathology consistent with chronic beryllium disease end of quote.

So that's I think probably why the application of this language stuck literally to the issue of lung pathology.

I'm not defending it, I'm just I think pointing out the obstacle that we need to overcome

in arguing that lymph nodes that drain the lungs is equivalent to lung pathology.

I think you've done it actually.

MEMBER REDLICH: Thank you for pointing that out and I will make sure that I in the comments have a note about that the lymph nodes drain the lung and are part of the lung. I will make sure that that's clarified.

CHAIR MARKOWITZ: And I also think that -- and maybe you state this, but if you can say that a positive mediastinal lymph node biopsy or other lymph node in the chest, if that in practice translates to 95 plus percent of the cases having actual lung pathology, that that would also be persuasive.

MEMBER REDLICH: Okay. You're correct, it does say pathology -- it does say the actual lung.

So I will -- because the node was considered part of the lung. Okay.

So the next set of questions that the DOL case pertained to the post 1993 criteria.

I felt in the order that they had originally given us the comments and that's why there may be some overlap in the responses.

So the issue 1 was again related to the criteria used for post 1993 and defining the wording characteristic of CBD. And that really had been addressed in the earlier comments.

And then the issue 2 was addressing the question of a chronic respiratory disorder.

The one question I had, they sort of put this under the B part and referred to pre or post 1993 in terms of the issue they wanted raised. Pre- or post-1993 as evidence of a chronic respiratory disorder, issue 2, judging medical evidence for pre or post.

I read over the manual and the original act multiple times to see if there was reference to chronic respiratory disorder in this section so it really is only pre.

But I think that the comment part 3 or post should just be pre.

This is one that we have discussed so

I think we'll -- this section once we have a final decision I would edit to be consistent.

What's in here is the same wording that was in the recommendation that we started with.

And the other comment on here was just pointing out some of the inconsistencies in the wording that exist in the manual and also in the guidelines for CMCs. That was basically page 6.

Then if anyone -- I think we discussed the -- and this was just some of the existing wording that had been in there for describing chronic respiratory conditions.

So I think our recommendation would simplify that.

Any questions? Issue number 3 was necessitating lung lavages or lung biopsy on critically ill or elderly patients.

And that is a risky procedure and it is generally contraindicated in those situations. I don't think there's much to discuss about that.

I think then someone has to make -- do decision-making based on the available

information. But it shouldn't be sort of a penalty against someone that they didn't have the procedure.

So, issue 4, this had to do with specific diagnostic markers required for CBD. And again there is no one single diagnostic test or marker as that was stated previously.

And then issue 5 was guidance on the relationship between sarcoid and CBD.

So, this response that goes on for two pages basically gives the rationale for what had already been in place, namely a presumption that someone who has a pulmonary sarcoidosis and is a quote covered beryllium worker, has beryllium exposure, that CBD was the appropriate diagnosis in the setting and not sarcoid.

And the reason -- this went on for two pages and this is one sentence. I tried to address the different issues that had come up in different cases that had created confusion.

One of the most common was that we just -- sarcoid, just for background, for people who are

not familiar is a multi-organ disease and over 90 percent of the time it involves the chest and the lungs.

However, it does involve other organs. And sometimes the other organ may be where the biopsy is taken because it's more accessible than the lungs.

So that someone could have evidence, let's say based on a CT scan with involvement of their chest and what looked like sarcoid. But the biopsy that documented granulomas was taken from the skin.

So it clarifies why that would still be pulmonary sarcoid even though the biopsy had been taken from the skin.

And it also made the point that yes, there are certain features that are more common, let's say sarcoidosis in blacks and Caucasians, and yet extra pulmonary involvement is more common overall in sarcoid and CBD.

But both diseases occur in all racial groups and people with CBD can have extra pulmonary

involvement. So they shouldn't use those features to start teasing apart which sarcoid and sarcoid versus CBD.

So that is -- there was sarcoid that involved the lung, and the person had beryllium exposure, was a covered beryllium worker, but that was -- basically CBD would be the appropriate diagnosis in this setting.

And also if someone really does have biopsy proven sarcoid that they don't also need a BeLPT.

So, and also part of the section also described why you could have a false negative BeLPT test.

And this was already in the current procedure manual noting that you could have a false negative, and also that sometimes for various reasons a BeLPT may not have been done.

So it was basically restating the rationale and the argument for the presumption of CBD when there is a diagnosis of sarcoid and a history of beryllium exposure.

Does anyone have any questions? Because clearly this is an area that has created confusion. And with the cases we reviewed I think most of the ones that we would have considered not properly adjudicated have to do with sarcoid that was considered not beryllium.

Anyone? Hello?

CHAIR MARKOWITZ: We're here. I think it looks good. If no one has a comment then maybe we should move on.

MEMBER REDLICH: So, and someone had asked why don't we just make a recommendation about the presumption.

And I think the reason we didn't want to make a new recommendation was that this wasn't really something new. It had been previously decided and there was good reason for that. And it was really more understanding some of the issues of the implementation that was the problem.

But I think the rationale for having the presumption is very solid.

And so I tried to address any of the

problems or the reasons that cases had been denied in those that we reviewed and that others have told me about.

Okay. Also, I will say -- to see where this was -- that related to this is what qualifies as a covered beryllium worker. And that may be more the other group. But I just wanted to make sure that that is clear.

Because there were some cases that we reviewed that seemed like the person should have been considered having had beryllium exposure. But that was not.

MEMBER WELCH: Carrie, could you clarify, was that a question that DOL asked us? Or is that something --

MEMBER REDLICH: It was not asked about. It just appeared that there were some workers that to me seemed like they were covered beryllium employees but the CMC or somebody did not recognize beryllium.

MEMBER WELCH: This is Laurie Welch. Are you finished with your list? Because that's

probably something else we have to address later if they didn't ask us the question.

MEMBER REDLICH: We just finished the --

MEMBER WELCH: I think we should finish the list and keep it on the to-do list.

MEMBER REDLICH: That's right. Exactly. That's why I wanted to mention it.

And then the final -- so that would actually be pages 6. We're almost done here. Okay. And the next area they wanted comment on is on the bottom of page 9, recommendations regarding -- relating to conditions that are normal and unusual consequential illness CBC.

And there was a 2016 update that listed these sort of secondary conditions. And I thought that was an appropriate list. It included the pulmonary hypertension, heart failure, bone density, osteoporosis. And I thought that was a reasonable list and did not have anything to add to it.

And then number 7, input or suggestion

regarding assessment of BeLPT either false negative or borderline due to drug interference.

And this was addressed in the borderline BeLPT that was the first recommendation we voted on last time. And so we've discussed number 7.

So moving onto 3, chronic silicosis, there was really one comment or question and that was clear guidance on the certification requirements for the B readers and how that is documented.

And there actually is on the internet NIOSH provides a list of all certified B readers.

Also, my understanding is that a B reading is not required by the act. So I just mention that. I don't know if there was another -- I sort of feel that maybe I didn't fully understand the question that we were being asked, but I think that this should not be a problem.

And then finally, other comments. I basically just mentioned that the current procedure manual has some areas that were confusing

and inaccurate. Pretty much highlighted in my comments.

And then also the final comment was that concern just that the issue wasn't only the procedure manual, but also the quality and the oversight of the CMCs which is part of other committees.

CHAIR MARKOWITZ: Okay, so thank you. I think we should go back now and vote on the recommendations.

If we could bring up. So, recommendation 1 we already voted on. It's not showing on the screen, but it's done. We voted on it last time so we don't have to vote on that. Just recommendation number 2.

And the only -- we have the new language. The only outstanding issue is on 2d the issue of whether we should add prescribed medications as opposed to leaving it the way it is.

There's some variation of opinion. I generally want to make a further comment before we vote on various versions of this with or without

the prescription.

MEMBER DEMENT: Weren't we going to take off the double asterisk and the statement that goes with the double asterisk?

MEMBER REDLICH: Correct.

MEMBER CASSANO: This was the old one.

MEMBER REDLICH: Yes, I don't think this is --

MEMBER CASSANO: Oh, it is. Oh, that's good now.

MEMBER REDLICH: The chronic I think is the correct wording. I just wanted.

MEMBER CASSANO: Right.

CHAIR MARKOWITZ: Right.

MEMBER WELCH: This is Laurie Welch. I had a comment about the prescribed.

I would leave it off because if people are using over the counter medications it's hard to document it anyway because it won't be necessarily in the physician's record.

So I think it may be unnecessary and as we talked about before some inhalers were over the

counter so if the claimant can document they were using Primatene Mist, that's fine.

I would leave it out.

MEMBER REDLICH: I agree.

CHAIR MARKOWITZ: Any other comments?

MEMBER REDLICH: We've agreed on that the wording now if it's chronic, if the claims examiner cannot determine if it's chronic then it would be referred to a CMC to determine if the condition was a chronic respiratory disorder.

CHAIR MARKOWITZ: I should just facilitate things that we vote on just the issue of this using the word prescribed and not prescribed in item 2d.

And once we resolve that then we can insert the approved line into the overall recommendation and vote on that. Does that make sense?

MEMBER CASSANO: Steve, since I was the one that brought it up and I don't think there's anybody else that agrees with me we can just forget about it.

CHAIR MARKOWITZ: Okay. Well, if there's anyone else who -- maybe Rosie, I can't remember.

Does anyone else feel strongly in favor of using the word prescribed in D?

MEMBER CASSANO: No.

CHAIR MARKOWITZ: Okay. So let's just go with the recommendation.

Anybody think we need to read this out loud? Everybody's looking at it hopefully.

MEMBER REDLICH: Just to avoid confusion I would get one of the following. I would remove the double asterisk there.

CHAIR MARKOWITZ: Right.

MEMBER CASSANO: They're not there. Oh, it's under one of the following.

MEMBER REDLICH: Yes, thank you.

CHAIR MARKOWITZ: Okay. Final comments?

Okay. So draft recommendation number 2, all those -- well, we're going to have to do roll call here. Carrie or Doug, if you want to just read

people's names and they can vote in favor.

MR. FITZGERALD: Dr. Dement.

MEMBER DEMENT: Yes.

MR. FITZGERALD: Mr. Griffon.

MEMBER GRIFFON: Yes.

MR. FITZGERALD: Dr. Silver.

MEMBER SILVER: Yes.

MR. FITZGERALD: -- Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. FITZGERALD: Dr. Boden.

MEMBER BODEN: Yes.

MR. FITZGERALD: All right. Dr. Welch.

MEMBER WELCH: Yes.

MR. FITZGERALD: Dr. Sokas.

MEMBER SOKAS: Yes.

MR. FITZGERALD: Dr. Redlich.

MEMBER REDLICH: Yes.

MR. FITZGERALD: Dr. Cassano. Dr. Cassano?

MEMBER CASSANO: Get off mute. Yes.

MR. FITZGERALD: Okay. Mr. Domina.

MEMBER DOMINA: Yes.

MR. FITZGERALD: Mr. Whitley.

MEMBER WHITLEY: Yes.

MR. FITZGERALD: Mr. Turner.

MEMBER TURNER: Yes.

MR. FITZGERALD: Ms. Vlieger.

MEMBER VLIEGER: Yes.

MR. FITZGERALD: And Chairman Markowitz.

CHAIR MARKOWITZ: Yes.

MR. FITZGERALD: I believe that's unanimous.

CHAIR MARKOWITZ: Okay, 14 in favor. No no's and no abstentions. Okay, recommendation number 3 if you could just scroll down there.

The advisory board recommends substantial revision of sections of the procedure manual and related materials related to Part B conditions taking into account consideration of comments in this document and other feedback from the advisory board.

So this refers to the language we've

just gone over. And I would propose particularly for people who have maybe just seen this relatively recently that if you have minor suggestions that you send this to Dr. Redlich and those will be -- we'll figure those out even as we vote on this recommendation now.

The issue is I think if you have a significant difference with the language -- if we vote in favor of this recommendation now we probably can't amend a substantial difference. So I think that's the way we should look at this.

Any comments on this recommendation?

MEMBER REDLICH: I would just say that for those involved in some of the other subcommittees if there are other parts that you have come across such as the training materials that you find inconsistent or have questions about could you let me know.

So I have highlighted the substantial areas in the document, but I'm not sure I had all the training materials.

MEMBER CASSANO: Yes, I looked at the

training materials. They're very confusing and they are inconsistent.

CHAIR MARKOWITZ: Okay. So we're going to think about. If you could do the roll call.

MR. FITZGERALD: Okay. Dr. Dement.

MEMBER DEMENT: Yes.

MR. FITZGERALD: Mr. Griffon.

MEMBER GRIFFON: Yes.

MR. FITZGERALD: Dr. Silver.

MEMBER SILVER: Yes.

MR. FITZGERALD: Dr. Friedman-Jimenez.

MEMBER MARKOWITZ: George, you're on mute.

MEMBER FRIEDMAN-JIMENEZ: Yes. Can you hear me?

MR. FITZGERALD: Yes, we got it. Dr. Boden.

MEMBER BODEN: Yes.

MR. FITZGERALD: Dr. Welch.

MEMBER WELCH: Yes.

MR. FITZGERALD: Dr. Sokas.

MEMBER SOKAS: Yes.

MR. FITZGERALD: Dr. Redlich.

MEMBER REDLICH: Yes.

MR. FITZGERALD: Dr. Cassano.

MEMBER CASSANO: Yes.

MR. FITZGERALD: Mr. Domina.

MEMBER DOMINA: Yes.

MR. FITZGERALD: Mr. Whitley.

MEMBER WHITLEY: Yes.

MR. FITZGERALD: Mr. Turner.

MEMBER TURNER: Yes.

MR. FITZGERALD: Ms. Vlieger.

MEMBER VLIEGER: Yes.

MR. FITZGERALD: And Chairman Markowitz.

CHAIR MARKOWITZ: Yes.

MR. FITZGERALD: That's unanimous as well, 14.

CHAIR MARKOWITZ: Okay, 14 yes, no no's, and no abstentions.

We're going to take just a five-minute

break and then come back. We've got a really important discussion about solvents and hearing loss.

So, I have 2:58 so let's reconvene in five minutes. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:58 p.m. and resumed at 3:04 p.m.)

CHAIR MARKOWITZ: So we should get started. If someone could do a roll call that would be good.

MR. FITZGERALD: Certainly. Dr. Dement.

MEMBER DEMENT: Yes.

MR. FITZGERALD: Mr. Griffon.

MEMBER GRIFFON: Yes, here.

MR. FITZGERALD: Dr. Silver. I think Dr. Silver had some --

CHAIR MARKOWITZ: Yes, let's come back to him.

MR. FITZGERALD: He was going to disconnect because of his battery on his phone.

Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Present.

MR. FITZGERALD: Dr. Boden.

MEMBER BODEN: Yes, I'm here.

MR. FITZGERALD: Dr. Welch.

MEMBER WELCH: I'm here.

MR. FITZGERALD: Dr. Sokas. All right, not back yet. Dr. Redlich.

MEMBER REDLICH: I'm here.

MR. FITZGERALD: Dr. Cassano.

MEMBER CASSANO: Here.

MR. FITZGERALD: Mr. Domina.

MEMBER DOMINA: Here.

MR. FITZGERALD: Mr. Whitley.

MEMBER WHITLEY: Here.

MR. FITZGERALD: Mr. Turner.

MEMBER TURNER: Here.

MR. FITZGERALD: Ms. Vlieger.

MEMBER VLIEGER: Here.

MR. FITZGERALD: And Chairman Markowitz.

CHAIR MARKOWITZ: Here. Okay. So we

have 12 and the others will come back I'm sure.

So, Laurie, do you want to get started?

MEMBER WELCH: Yes, sure. So, at the end of our meeting in April we had a really short sort of an introduction to this concept of developing a presumption for hearing loss caused by solvents.

And we -- that showed then. And since the supporting documentation, or Carrie loaded up the supporting documentation on the recommendations and if people have questions we can go to those although I have to say I don't have every page in my head.

So as you know the current -- there is a presumption for hearing loss related to solvents. And up on the screen in front of you now is the current presumption.

So, someone has to have a diagnosis of sensorineural hearing loss in both ears. And they have to be exposed to one of the listed chemical solvents which I have on subsequent slides, and worked in one of the listed labor categories for

a concurrent and unbroken 10-year period.

So this is the list of solvents. This list is not unreasonable. This is based on the ones that have been studied in animals and humans.

So these are ones that have definitely been associated with solvent-related hearing loss and for which you have -- because of animal experts and biological basis that it's not complete.

And can we go to the next slide which is the list of occupations.

And same with this. Well, this is based on someone's understanding of occupations that would have had however you define significant solvent exposure or an opportunity for significant solvent exposure.

But again it has some of the major ones. If we sat down over a beer we'd probably come up with these, but there are as you know hundreds of job titles in the complex.

And so someone who worked as a chemical operator might not have that job description as a chemical operator. So that is a prescribed list

that is so specific it is also too specific.

And I don't think anybody would agree with me that these two lists are -- I mean they're fine, and they'll be helpful, but they can't be the final list. There has to be lots of people whose job is not on this list who get compensated. Okay, next slide.

So in terms of what data is out there on solvents and hearing loss there are -- I think that in the second bullet I mentioned the Nordic Expert Group and the EU OSHA. Those are the two documents that I sent to the group.

And they do a good review. I think one of them is 2010 and the other is 2009 so they're not really up to date but they're good.

And they have a pretty strong conclusion that solvents cause hearing loss.

There's good data that it causes more than the classic sensorineural hearing loss because it probably affects acoustic threshold, but those require quite sophisticated tests to document something that's not present audiometry.

So my recommendation is going to be we're going to stick with the sensorineural hearing loss because that's predominantly what people are presenting with and we can build a presumption around it.

So, to be really, really brief on what the literature shows that the animal experiments that are done with single chemicals and that list that you looked at before is the list of chemicals that have been tested in animals and show injury to the auditory system.

Most workers are exposed to multiple solvents and exposed to solvents that aren't on that list. And there are some human studies that suggest that a mixed solvent exposure or a mixed organic solvent exposure with the exception of a couple of ones that wouldn't be classified as organic solvents causes hearing loss.

It's not something you find in animal experiments because they generally aren't exposed to mixtures in that way.

But again I think there's good data that

mixed exposures will cause as well.

Where we come down to sort of a not really great data that begs the presumption is dose response. So how many years or what intensity of exposure causes disease in humans.

There is some information in the Nordic Expert Group and the EU OSHA summary of the literature.

I would say looking at that the literature suggests that you don't need to have a very high exposure to cause hearing loss, or to be a contributory cause in any case.

But that the human studies in populations that have been exposed for a working lifetime, many of them.

So even though there may be an area of signal effect that we might be able to see 5 years, more at 7, more at 10. Most of the population have more than 10 years of exposure, the human population.

So we have a little bit of trouble picking what that number of years of exposure would

be. Can I have the next slide?

So a little bit more from those. And this is kind of what I was talking about. But for some of these solvents we see hearing loss at or below the current OEL. And then either in humans or in animal experiments.

And then people are looking at mixed solvents among humans. The mixtures are often MEK, MIBK, of which I think that most of those are on that other list. Next slide, please.

And then the other interesting thing is there is good data that noise exposure is synergistic in causing hearing loss.

But we can't really assess noise exposure in the population here because it's not a habit that's considered unduly hurtful. So it doesn't include any information.

I think that -- let me pause. Anybody got any questions? Now because I'm going to go into what I think are recommendations.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez.

To say that noise is not considered a hazard under EEOICPA but hearing loss is an outcome that we're considered about really doesn't make sense.

So what is the process by which EEOICPA can consider noise a hazard? Because we're looking at only part of the picture and we know that there's an interaction between solvents and noise. And it's really confusing and misleading to only look at one part of the picture.

So is there a way to rectify this logical inconsistency?

MEMBER VLIEGER: This is Faye. Noise is considered a mechanical injury like a broken leg. It's not considered chemical. While it is toxic it's not considered under Part E.

CHAIR MARKOWITZ: This is Steve Markowitz. Yes, it's not in the act. Physical hazards aren't in the act. So we couldn't consider it.

But there is a way of thinking about this which I'm sure, George, you're familiar with.

So someone exposed to noise and to solvents is going to have some impact on hearing. And a piece of that is going to be had they only been exposed to noise there would be hearing loss from that. Had they only been exposed to solvents there would be some from that.

But when you put the two together there is an added loss due to the fact that they have -- and then added loss you can ascribe to the toxin, to solvents. Because if it weren't for the solvents they wouldn't have that added risk for hearing loss.

So the solvents are responsible not just for the noise, but they're in part contributing to -- from the act to the added risk that comes from simultaneous noise exposure, if that makes sense.

MEMBER FRIEDMAN-JIMENEZ: It makes sense, but what that implies is that the threshold dose of solvents for a combined noise and solvent induced hearing loss would have to be lower than the single solvent induced dose.

So we have to take that into account when we're considering the threshold dose at which we're going to call it solvent induced.

MEMBER WELCH: Right, and that's actually what -- before I put these presumptions out to the committee several members who are on the phone looked at them and made that point.

I think for the occupations that are on the list a great number of them we know they have significant noise exposure.

So if you go to the next slide I think I may have my recommendations.

Okay, so here's the recommendations, what I would put forth. So people -- a claim that meets the presumption for solvent related hearing loss if there's a diagnosis of sensorineural hearing loss.

And as I said before that could be ignoring other impacts of solvent or noise, but the presumption I think we want to say is diagnosis.

And significant solvent exposure defined as worked for at least seven cumulative

years in any of the job titles on the list in the current presumption, or in any construction or maintenance job.

Or, reported exposure to the specific agents on the occupational health questionnaire or evidence of exposure to organic solvents for at least seven years.

Or, reported exposure to solvent mixtures or evidence for those in the FEM for at least seven years.

Or, exposure for seven years cumulative established to work process.

And remember we talked about the last, the DDWRP and COPD because there is a way that DOL can develop more presumptions for tasks. They can say someone who did this task has significant solvent exposure. So it doesn't require -- the problem getting into the SEM is that it -- specific exposures. But one could set up a presumption for a particular task that it represents the following task, not a varying sort of task.

There aren't many of those, but the

DDWLP says there's a way now that DOL is set up to provide a little more help in the second tasks where it's complex exposures.

So, I think that the literature clearly supports a 10-year exposure period in human populations.

And I thought, well, let's set it at seven to take into account that many of the workers who have solvent exposure are going to also have significant noise exposure.

I don't think we can individually assess noise exposure for the reasons we just talked about. We don't have that information.

One could say well, if you have sensorineural hearing loss they probably did have solvent exposure already. We're getting noise exposure already. So if they've got an abnormal audiogram and they meet the definition of sensorineural hearing loss they probably had noise exposure. So that once they have that we can push the level for presumption, the number of years for presumption more than what we would need for

solvents alone.

And if seven is the right number I think that's the thing that we should make sure we agree on.

And then there's one more slide, the next one that says so then one more. This says the claims examiner should not routinely deny claims for solvents in hearing loss if the worker has had fewer than six or seven years of exposure, does not have a DDWL or is not in another category on the list.

Claims that do not meet the requirements set forth here but do have reported exposure to solvents for at least five years should be sent for review.

So that if you have seven you rate automatically, if you have five you get NIH or CMC review. The provision here is if you have fewer than five your claim wouldn't be accepted. Although that's not necessarily true. You could still make a case.

So I think if people would weigh in if

they think those numbers are reasonable. At seven years of exposure your claim is accepted, between five and seven you have to have a claim review, and IH review.

MEMBER REDLICH: This is Carrie. Laurie, before we get to just the number of years your use of the word cumulative.

MEMBER WELCH: Yes.

MEMBER REDLICH: Maybe it's a stupid question, but you clearly added that word. Could you just clarify what you mean by it?

MEMBER WELCH: Well, the way that the current presumption was to be continuous and unbroken, and I wanted that to be in the correct module. If someone had two years here and two years there and were on different tasks it would add up to seven.

MEMBER REDLICH: So just a total of seven years.

MEMBER WELCH: Cumulative seven years.

MEMBER REDLICH: Yes.

MEMBER WELCH: So maybe it makes sense

to take out the cumulative. I think that's a reasonable edit.

MEMBER WHITLEY: Garry Whitley here. I think the cumulative needs to be in there because NIOSH say consecutive or continuous and they really hold you to that.

Like if you had two or three jobs over 10 years, and then they were all listed in the list they'll still say you have a break, or they weren't consecutive in one job category and it's a fight. So I think that needs to stay in there.

MEMBER REDLICH: That's fine. I just wanted to -- that's what I assumed that you meant and I just wanted to be clear about that. Maybe a total of or something. But that's a minor point.

CHAIR MARKOWITZ: This is Steven. Can you back up one slide? Laurie, I don't think this was in the write-up that you sent around.

MEMBER WELCH: You're correct. And I didn't have a rationale for that either.

CHAIR MARKOWITZ: Well, the rationale you can get to later.

MEMBER WELCH: Okay. So the idea would be that caps with exposure to the list of solvents in the range of occupational exposure level, that DOL would develop one of the DDWL, or direct, which would make it much easier for the claims examiners to accept the claims.

MEMBER FRIEDMAN-JIMENEZ: Is OEL observed effects level or occupational exposure level?

MEMBER WELCH: Occupational exposure level.

MEMBER FRIEDMAN-JIMENEZ: Okay.

MEMBER REDLICH: Is that setting too high a bar?

MEMBER WELCH: I don't think that that's what we were thinking. Those are the solvent exposures that we want to be sure people can get compensated for.

We don't want to make it too hard because all the -- a lot of the jobs have stem solvent exposures.

MEMBER BODEN: Could you just go up one

more slide? I have a sort of trivial non-substantive suggestion which is the last line on that slide. It should say solvent exposure.

MEMBER WELCH: Oh, yes.

MEMBER BODEN: Like I said, not very substantive.

MEMBER WELCH: No, that's important. Yes. Because solvent exposure for seven years cumulative.

MEMBER FRIEDMAN-JIMENEZ: Looking at this language -- this is George -- I think replacing cumulative by saying a total of at least seven years, I think that would be clearer and I think it addresses Garry's concern that they're still enforcing the consecutive.

MEMBER WELCH: I like that.

MEMBER REDLICH: I know that the rest of the word is different but cumulative and consecutive both start with a C.

MEMBER WELCH: And people would say what does cumulative mean and might interpret --

MEMBER REDLICH: Yes, I agree.

MEMBER WELCH: That means everywhere we have cumulative we would replace it with -- a total of seven years. So that it has to be in the other book do the same thing where it says cumulative. It has to change too.

CHAIR MARKOWITZ: So, it's Steven. While you are doing that apparently Rosie Sokas can hear us but we can't hear her.

MEMBER SOKAS: Hi Steve, I'm back on. It's Rosie.

I just wanted to agree with what you're doing with the total. I think that's important.

CHAIR MARKOWITZ: What do you think?

MEMBER SOKAS: I think the cumulative is really important because of the whole issue with continuous in the past and then changing it to total works well.

MEMBER WELCH: So on the very bottom line can you add at least a total of.

CHAIR MARKOWITZ: So while they're doing that -- Steve Markowitz -- I had a question.

In your rationale when you reviewed the

long European agency report you listed a couple of -- you listed N-hexane as showing an effect, good evidence for an N-hexane effect.

But I don't see N-hexane in your list of exposures here. On this slide.

MEMBER WELCH: Yes, we should add that.

CHAIR MARKOWITZ: And my other question was in the current EEOICPA policy they list a couple of solvents which I don't think you have here. Methyl ethyl ketone and methyl isobutyl ketone. So we probably should add those as well.

MEMBER WELCH: We should add those too. Those would go in the second line there. They can go anywhere in there. MIBK and MIK.

CHAIR MARKOWITZ: MEK, yes.

MEMBER WELCH: MEK and MIBK.

MEMBER FRIEDMAN-JIMENEZ: Was there any methyl butyl ketone exposure?

MEMBER WELCH: There may have been but there isn't specific animal or human data on that one. The ones that we're putting in here are

specific exposures are the ones that are in the evidence-based review.

And then the ones that aren't are in -- sort of covered by the next one down, solvent mixtures.

MEMBER DEMENT: This is John. I have a question about that specific point, Laura.

We say reported mixtures to solvents on the occupational history questionnaire or evidence of sustained solvent exposures.

When we say solvent exposures here we are not restricting that to the list of specific solvents above, is that correct?

MEMBER WELCH: That's correct. Yes. So can we make that more clear?

MEMBER DEMENT: Well, the word "those" in there confuses me. To those solvent mixtures.

I would just make it very general because when I read it I'm almost forced to look above and look at those particular lines.

I think my point is that these are very mixed solvents and so they need to include them in

here and make sure we don't restrict them in this particular recommendation.

MEMBER BODEN: Maybe you should add the word "any" to solvent exposures.

MEMBER DEMENT: Yes. Well, I think we have to be careful to call them organic solvents too.

MEMBER BODEN: Organic, right. Because water is a solvent. Right.

MEMBER DEMENT: You have to say organic solvents.

(Simultaneous speaking.)

MEMBER WELCH: Because the line that's being highlighted, we should take out those which you have highlighted right now.

(Simultaneous speaking.)

MEMBER WELCH: Exactly. And above reported so we can do organic solvent mixtures on OHQ. That should be in that same line.

MEMBER DEMENT: I guess my other comment, I really like the expansion to construction and maintenance jobs based on what

we've seen in the DTMN data of reported solvent exposures across category.

MEMBER WELCH: Yes, actually John did a little sub-analysis of one of our studies and we found a strong relationship between solvent exposure and hearing loss.

However, it's not -- it was using the data that we had which had not chosen to answer that question. So we had some drawbacks but I think it convinced most of us that there's a strong relationship there.

So, can you go up? I don't know who's doing the typing. Kevin. Could you go up and the second bullet is reported. Add in there in capitals MEK, MIBK, N-hexane comma. Yes, so we got it.

CHAIR MARKOWITZ: And just an editorial comment. For exposure to organic solvents on the line below.

MEMBER WELCH: Okay, that's a big improvement. Thank you all for reading the document in so much detail. I think I've looked

at this so many times that I kind of get glazed over.

CHAIR MARKOWITZ: Laurie, next to the last bottom you use the word "sustained." And it doesn't appear anywhere else. So I'm wondering if there's any particular meaning.

MEMBER WELCH: And actually we need to take that out because the SEM doesn't ever have evidence of exposure. So we should take that out.

I think the claims examiner will be able to use this. SEM only tells you that this job at this location has this exposure and doesn't give you any idea about intent of years.

So if the claims examiner is using the SEM to identify that someone with seven years of exposure, it's really combining the SEM with their accepted employment.

But I think that would be pretty clear. I don't know if Garry or Kirk or Carrie have any thoughts on that particular thing.

You know, I think we can't use that because SEM doesn't tell us about years. You think that particular button is good enough for a claims

examiner to say, okay, they worked as a pipe fitter and that sort of job has solvent exposure and they worked for seven years. That's what we're trying to get at.

MEMBER VLIEGER: This is Faye. That will work. We have gotten claims approved under the ten-year rule where we proved that they had in excess of a normal work day that is overtime.

And our documentation proved that they had the equivalent of ten years exposure.

So I just want to make sure that if we could put something in there or equivalent to seven years.

Because, for example, a painter can work double shifts, weekends, evenings, and when we showed that overtime then they actually met the ten-year requirement.

MEMBER WELCH: Oh, good point. One way to do that would be to put an "or" and an hour which if we assume people work 2,000 hours a year to say 7 years or 14,000 hours.

MEMBER BODEN: Or you could say

full-time equivalent which is common.

MEMBER WELCH: Okay. Does full-time equivalent make sense to the people who know the claims better? If we say seven full-time equivalent years would that work?

MEMBER VLIEGER: This is Faye. An eight-hour day is considered the norm. And so they call it just a workday.

MEMBER CASSANO: So actually a year's worth of an eight-hour workday for usually computing salaries is 1,280 hours makes up a work year. And so you just multiply 7 by 1,280.

MEMBER BODEN: Sorry but that actually sounds way too low.

MEMBER VLIEGER: Yes. I'd say 2,000 hours.

MEMBER BODEN: Two thousand, yes.

MEMBER REDLICH: One could add an asterisk here and then basically explain what's meant by the seven years.

MEMBER WELCH: Maybe it's 2,080.

CHAIR MARKOWITZ: Kirk, did you have

something to say?

MEMBER DOMINA: Yes. I don't know if I like putting hours in there because non-bargaining people a lot of times don't have their hours listed because they're salaried, not hourly. So I think you've got to be careful or you're going to cut some people out that have -- that should be in there.

MEMBER VLIEGER: I think if we use equivalent seven years or equivalent work days that that would work. And the eight hours presumed are already in the program.

MEMBER WELCH: I'm sorry, I did miscalculate. It's 2,080, not 1,280. I don't know what I was thinking.

CHAIR MARKOWITZ: Can't we just say seven years or its equivalent?

MEMBER REDLICH: Yes, and then you could have -- Carrie -- you could have just an asterisk that explains what that meant.

MEMBER WELCH: I don't even know if you'd need the asterisk if you said seven years or

its equivalent. Because the only way to get an equivalent of seven years is adding up things. So let's just use equivalent.

MEMBER VLIEGER: And the way they get around the continuous wording on your SECs is they use the word aggregate.

MEMBER WELCH: Aggregate. That's sort of funny.

MEMBER REDLICH: I think total.

MEMBER WELCH: So two places and not the other two. I don't know if that was -- serious grammatical decisions.

CHAIR MARKOWITZ: Any more comments on this slide? Otherwise if we can go to the next slide for a moment.

MEMBER CASSANO: I do have one comment and it's just a question. And that's in the bullet about reported exposure to the list of when we talk about cumulative or total exposure.

Is it painfully obvious that we mean over the years any combination of those. And it's not we're just saying that it's seven years for

styrene, or seven years for toluene, but reported exposure to any of the following.

I mean, I think it's obvious but some people may not. You know, at year 1 you're exposed to styrene and you're not exposed for two years, and then two years later you're exposed to toluene is somebody going to say well that's not seven years total exposure to one particular solvent.

I mean, I'm trying to think on the lowest level of comprehension that you can get.

CHAIR MARKOWITZ: Well, before carbon disulfide you'd put "or." I think that might address that.

MEMBER CASSANO: Okay.

MEMBER WELCH: Yes, I think so, because the next bullet is really combined exposures.

MEMBER CASSANO: Right, but I'm talking about sequential exposures to different solvents.

CHAIR MARKOWITZ: Right, and the next bullet is mixtures actually.

MEMBER WELCH: Right. So I think the

mixtures would cover sequential exposures.

Really, if someone was denied it because -- the intent is pretty clear.

MEMBER CASSANO: I just work with claims examiner stuff all the time, not these claims examiners but others. And I'm amazed at how concrete people can be.

You know, what actually we could do. Reported exposure -- I don't know. Never mind.

It is what it is. I'm not wedded to any changes. I just saw it as a possible problem.

MEMBER BODEN: Well, if you really were worried about it you could say reported exposure to any combination of and then list.

MEMBER FRIEDMAN-JIMENEZ: For one or more.

MEMBER BODEN: One or more.

MEMBER FRIEDMAN-JIMENEZ: I think that would solve it.

MEMBER REDLICH: There's a word missing I think in the next part as it is for exposure organic solvents.

MEMBER WELCH: Two organic solvents.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: Yes.

MEMBER BODEN: So one or more of the following I think is what you need to say.

MEMBER FRIEDMAN-JIMENEZ: One or more organic solvents in the SEM. I think that's the exposure that we were talking about.

MEMBER WELCH: Well, we were talking about a combination of say two or three of those other ones.

CHAIR MARKOWITZ: It's not an SEM but it could be in the OHQ.

MEMBER BODEN: Yes, that's the next one.

CHAIR MARKOWITZ: Can we go to the next slide for a moment? I just want to understand as part of the recommendation.

So the OEL --

(Simultaneous speaking.)

MEMBER WELCH: We could if we want to. We could say PEL. And maybe that's what we're

talking about. Do we want it to be the OSHA PEL, do we want it to be the ACGIH. I mean, those are all the OEL.

It could be the DOE stats. But if it --

CHAIR MARKOWITZ: Well, part of the problem is DOE, there weren't a lot of exposure measurements done at DOE.

So if they go to apply this, if they accept it and look at these directives, these work links, they're not going to be able to decide which tasks actually were associated with any occupational exposure, whether it's ACGIH or OSHA or what have you.

MEMBER WELCH: And if the idea were to use other sources. Like for example, you know the exposed OEL. For tasks with likely exposure, where exposure was likely to have been about --

MEMBER REDLICH: I'm a little confused about this.

MEMBER WELCH: We could leave it out too. I mean, we could just leave it out.

MEMBER REDLICH: The individual solvent OELs are quite high. So is this restricting? Because I could imagine lots of scenarios where you look at -- I mean, many workplaces we actually look at the solvent measured data and it's usually quite low even though it's a lot of solvent. Because it's on each individual.

MEMBER WELCH: Well, what I was thinking really was that setup has directed this work process which would allow the claims examiner to accept a claim for exposure to solvents if they've done this task, whatever the task is.

So DOL decides in advance that this task has enough exposure.

But then the claims examiner doesn't have to figure out if there were solvents in the SEM. Because there's going to be jobs where all of us would say of course they're solvent exposed. But there's nothing in the SEM that says it's solvent exposed. So this is another way to assure that tasks that are clearly associated with a solvent, degreasing for example, that that's a task

where they certainly did that in industrial settings.

How you develop it and how you agree that that's a solvent exposure task really can't rely on the DOE internal industrial hygiene data because that would be insufficient. It would really have to be this IH data, epi data on the tasks. So it's not a small job to develop one of these things.

CHAIR MARKOWITZ: The other thing is that if they accept an expanded list of jobs, particularly if they include maintenance instruction, most of these tasks that are obviously exposed to solvents are going to be included in those jobs.

So this would become most relevant to jobs where we don't quite know whether they were exposed or not. And I don't think there's going to be the either specific or general knowledge to permit this exercise. So I'm not sure.

MEMBER REDLICH: There may be data that would show the levels were below, like past the OEL

or something, and that would then sort of be counterproductive potentially.

MEMBER WELCH: Let's just take this line out because it's really -- if we can get Department of Labor to accept the rest of it that would be very valuable and if it's going to be confusing and difficult we don't want to do that. I want to make it part of a presumption. Is that okay with everyone?

CHAIR MARKOWITZ: Yes.

MEMBER REDLICH: Well, I think it's more internally consistent also because the previous ones mentioned that there's not a good dose response.

MEMBER WELCH: Yes. Okay. Good. On the very last slide, Kevin if you're editing I can turn.

CHAIR MARKOWITZ: Okay, so we have now two slides which represent the recommendation. And I feel like we're getting pretty close to a vote here. We're also getting pretty close to 4 p.m.

So, are there additional comments?

MEMBER WHITLEY: Garry Whitley here. I want to make sure we all understand that prior to 1990 is not in this. It was in the old one. It's gone.

MEMBER WELCH: Absolutely it's not. And in the rationale I do say that the exposure should be counted up to the last day they worked because we're looking at health effects that occur below their exposure.

MEMBER WHITLEY: I agree. I just wanted to make sure we got that on the record.

MEMBER TURNER: This is James. I was wondering, has a study been done on these chemical solvents causing a sense of smell, taste, feel, and sight? Your eyesight.

MEMBER WELCH: There is some data, some studies, I think the last time I looked at it about a sense of smell. And they are neurotoxins generally so they can cause problems with memory and concentration.

There's been quite a bit of research on that topic which is usable. I don't think it

matters here though.

CHAIR MARKOWITZ: Maybe we can discuss that more fully either in the subcommittee or future, the larger range of solvents effects beyond hearing.

MEMBER WELCH: Yes.

MEMBER FRIEDMAN-JIMENEZ: This is George. I have a question about the seven year choice.

I'm looking at the Nordic Expert Group on page 76 and they quote a study of petrochemical workers where 26 percent of the workers in a department with solvent exposure and low noise exposure had significant worsened hearing thresholds in a five-year period.

So I'm wondering how much uncertainty is there around that seven years. And maybe it should be five years.

I haven't reviewed the data in detail but seven years sounds kind of long to me to have a significant hearing loss.

Is there enough evidence you think to

make it seven rather than five as the cutoff that we put in our document?

MEMBER WELCH: This is Laurie. I don't think there's a lot of evidence one way or another.

I mean, there may be one or two studies, probably human studies, 15 or 20. Many of them don't even tell you when you go and read the study how many years of exposure the workers had.

Most of them didn't look at a dose response related to years of work. Most of them don't have useful information.

And so it's partly just the way I approach a presumption. So I'm putting in my -- prejudice is not the right word, but you know.

So seven is really solid. I mean you couldn't argue that seven years is not long enough. And I think people could argue about five. So I wanted to pick one that was like the literature makes it incontrovertible.

And then if people have had solvent exposure but don't quite make that seven years,

well then they get an IH review.

MEMBER BODEN: Laura, I think that's a completely justifiable way of doing it.

Might we want to add a sentence that says there is evidence that less than five years of exposure can induce hearing loss? So it is important not to take seven years as the cutoff. To make it a little stronger.

MEMBER CASSANO: Well, I think then we need to change the at least five years to IH or CMC because we could make that a lower number. Make the seven years what the presumption is, then use a lower number down here for five. So, whatever you think would be appropriate.

MEMBER WELCH: I think that's fine. In the rationale for the presumption I do have at least one study of human exposure to toluene with hearing loss at levels of 50 for seven years with one other study showing effects after five years of exposure. So it's in there.

MEMBER BODEN: Right, but I would start to kind of put it in the body of the presumption

as a way of making sure that people don't miss it. To say something about either less than seven years or five years.

CHAIR MARKOWITZ: This is Steven. I don't understand the suggestion. Les, you want to cite the basis for the numbers in the recommendation?

MEMBER BODEN: No. What I thought -- so I think we have something in the recommendation, I don't have that particular part in front of me that says that --

CHAIR MARKOWITZ: Right, that's in the rationale.

MEMBER BODEN: Either the rationale or the recommendation. So, what if somebody has six years of exposure. Is there anything there that says, well, if it's less than seven but more than some other number then it should be referred?

MEMBER WELCH: Yes. It says at least five years. The very last slide.

MEMBER BODEN: Okay, so it is in there. Yes, okay, that's what I wanted. I just couldn't

remember if that was.

MEMBER SOKAS: And I think -- this is Rosie -- I think Tori's suggestion was to lower that a little. Because the study showed that at five years 26 percent had some evidence of hearing loss. You might want to go a little bit below that to encourage people to send it to an IH or CMC.

CHAIR MARKOWITZ: Well, to play maybe the devil's advocate here the CMC and the IH aren't going to be able to perform a whole lot of magic on the number of years. And they don't necessarily have good access to intensity data. So I'm not sure what they're going to do.

I think one of the strong suits of our recommendations in general is we really try to make it as much science-based as we can and not depart too much from the studies which I think is a real gain for DOL. I think it's a real contribution of the board.

So, what I've heard and what I see in Laurie's rationale is citing one study about five years. There's not much of a data base for these

lower numbers.

I personally would prefer to leave it at five just because of the argument that this is based on the best science.

I do understand the alternative.

MEMBER SOKAS: So just to mention, I mean there are a couple of case reports of people who were bathed in solvents and wound up with temporary hearing loss based on an acute exposure.

MEMBER WELCH: This is Laurie. I guess what I was hoping would happen with claims that were sent to the IH is that the IH would say well, we've set seven years as kind of the average solvent kind of job, but this is pretty intense so we should award at a lower number of years.

So they wouldn't be looking at the nature of the work they did based on their OHQ. Now that's asking, you know, we've asked for a big change in procedure by revamping the OHQ and then making sure that the industrial hygienist has it and the hygienist can go back and interview the worker.

So if they do all that.

MEMBER REDLICH: This is Carrie. What is something we said for consistency. And this opens the door for a lot of individual judgment.

MEMBER BODEN: That's true. On the other hand we don't want to create a situation in which we take the best scientific evidence and say we can really support seven years and have people assume that if somebody is 6.9 years that they don't qualify.

MEMBER REDLICH: I like having some other, like it's not an absolute. But if we're going to then we should maybe get some idea of what we are expecting the IH or the CMC review to do.

It doesn't have to be in this slide, but if we're saying we have a lower threshold set for IH or CMC review does it do something.

MEMBER CASSANO: Well, to determine if there was an event, or there is either an event or another reason that hearing loss would be manifested with less exposure. With less cumulative exposure would be how you would say it.

What this thing says here to the claims examiner is if they have anything less than five years of exposure the claim is denied. That's what this says.

If you're a claims examiner reading this seven years I can approve it. Five years, I have to send it to the IH or CMC. If it's less than five years I will deny it. That's how a claims examiner thinks.

CHAIR MARKOWITZ: This is Steven. I've got a procedural question actually for Doug or Carrie. Can we go past 4 p.m.?

MR. FITZGERALD: Yes.

CHAIR MARKOWITZ: Okay. Keep going.

MEMBER CASSANO: So, a claims examiner is going to use that term of at least five years to say well, it's 4 years and 11 months, I'm going to deny the claim.

So, if we're -- I'm not saying it should be anything different, but if everybody is okay with that, that's fine.

But if you're not okay with that then

we should say claims that do not meet the requirements set forth here but do have exposure to organic solvents and have a profound hearing loss should be sent to the IH.

I'd hate to send everything, but I don't know how to allow the claims examiner to defer without a hard number like this what should be sent and what shouldn't.

So basically anything that's been exposed less than five years will be denied.

CHAIR MARKOWITZ: This is Steven. I have an idea. We could use the word several.

MEMBER REDLICH: I would defer to Laurie. How strong is the literature for less than five years? Because hearing loss is very common. And on the other side this could potentially increase the number of claims substantially.

MEMBER WELCH: This is Laurie. I guess that's kind of what I was trying to do. I was thinking about that.

Because we don't have -- you can have different ways that you assure that it was people

who had kind of industrial strength solvent exposure because that's what the studies are about. They were people who were in jobs where there's ongoing daily exposure to solvents.

Or you could have even -- it doesn't really matter so much what your particular job and tasks were. We're setting a limit on the number of years.

But if you have a kind of end job that reported exposure to solvents needs a review that's going to be just about everybody who working in the complex.

Well, I mean there probably are some people who didn't, but most people did a lot of solvent use. The people working in labs, organic solvents used to clean up.

So it's really a question of balance. And it --

(Simultaneous speaking.)

MEMBER WELCH: -- that number of five, making it three.

MEMBER BODEN: I completely agree with

Laura. I think that really five. We are going to miss some people who maybe should have been compensated, but I think that this proposal will both streamline the process in general and get more people compensated than were before.

And the issue was the fact that older people often have sensory hearing loss. I think five is fine.

MEMBER WELCH: I can add more to the rationale about what the IH or CMC should do with this to basically say you want to look at the claim and see if they have the equivalent of either they were in a high exposure task or the high exposure labor category that you could end up with fewer than seven years. I can add that to the rationale.

I think I need to do that because I looked back at the rationale and there's nothing there that says what the IH or CMC would do with the case. So I can put that in the rationale.

Hello? I think everybody's still here.

CHAIR MARKOWITZ: We're here.

MEMBER BODEN: We're not in disagreement so we haven't said anything.

MEMBER DEMENT: This is John. I think in reality, I think five years is a reasonable threshold.

Sending to IH, all they're going to be able to do is try to discern whether or not there was some really abnormal solvent use.

For example, we have workers who report cleaning various facilities and structures using solvents from a bucket and rag. So as an IH if you see that then that's something to be concerned about. And certainly I think five years is a reasonable threshold.

And if that occurs between five and seven you'd probably recommend compensation.

MEMBER BODEN: Is there somebody who's not okay with that?

MEMBER CASSANO: I am sort of agnostic. I just wanted everybody to understand what that number meant to a claims examiner. And if everybody's okay with that then that's fine.

I think it's a reasonable number.

CHAIR MARKOWITZ: No, I think that was a good reminder actually of how this will actually operate if adopted so that was useful.

So if we can then -- I think we're getting close to being able to vote here. Any other comments on this slide? And actually for at least five years cumulative, I guess we have to change the language there for at least a total of five years.

MEMBER REDLICH: And I'm about to lose my phone.

CHAIR MARKOWITZ: Okay, then we should definitely take a vote. Any other comments on this? Okay, can we go back to the previous slide.

Any comments here? Okay. So if there are no comments then I think we can take a vote.

Is there any need to read this out loud? I don't think so. I think we've gone through this. So if we could do a roll call.

MR. FITZGERALD: Certainly. Dr. Dement.

MEMBER DEMENT: Yes.

MR. FITZGERALD: Mr. Griffon.

MEMBER GRIFFON: Yes.

MR. FITZGERALD: Dr. Silver.

CHAIR MARKOWITZ: Let's come back to him.

MR. FITZGERALD: Okay. Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Yes.

MR. FITZGERALD: Dr. Boden.

MEMBER BODEN: Yes.

MR. FITZGERALD: Dr. Welch.

MEMBER WELCH: Yes.

MR. FITZGERALD: Dr. Sokas.

MEMBER SOKAS: Yes.

MR. FITZGERALD: Dr. Redlich.

MEMBER REDLICH: Yes.

MR. FITZGERALD: Dr. Cassano.

MEMBER CASSANO: Yes.

MR. FITZGERALD: Mr. Domina.

MEMBER DOMINA: Yes.

MR. FITZGERALD: Mr. Whitley.

MEMBER WHITLEY: Yes.

MR. FITZGERALD: Mr. Turner.

MEMBER TURNER: Yes.

MR. FITZGERALD: Ms. Vlieger.

MEMBER VLIEGER: Yes.

MR. FITZGERALD: Okay. Dr. Silver?

CHAIR MARKOWITZ: Steve Markowitz votes yes too.

MR. FITZGERALD: Okay.

CHAIR MARKOWITZ: Ken? That's thirteen yeses I think.

MR. FITZGERALD: Yes.

CHAIR MARKOWITZ: Thirteen yeses, no no's and no abstentions. So that passed.

And I just want to thank Laurie for a lot of hard work on this particular issue, and a lot of clear thinking too so thanks.

MEMBER WELCH: Well, thanks. I appreciate that.

CHAIR MARKOWITZ: Okay, so just to -- I forgot to do this at the beginning of the meeting so let me just turn it over to Doug for a couple

of minutes just to get a short report on the status of our previous recommendations.

MR. FITZGERALD: It won't take a couple of minutes, but before the meeting I did have an opportunity to go check in with Gary Steinberg, deputy director of OWCP to find out what the status of the recommendations were.

And there's two sets and they're kind of at different stages in the process. But he's had some discussions with the second floor and things are moving through the clearance process on the first set of recommendations and that's about the only thing he could really offer at this point in time.

The Secretary is starting his seventh week here and he's still getting his leadership team in place.

So we're hopeful things are moving forward. And on a hopeful note most of you are aware that the charter renewal was signed by the Secretary so that's in place. And there will be a Federal Register notice hopefully published this

week. We hope to get it over to the Federal Register this week and then it may be published next week. But in any event that will be out.

And on the second set of recommendations as you know there was a lot of complexity with those recommendations and they're sitting with the department being reviewed and they're developing their responses to those questions.

CHAIR MARKOWITZ: Thank you, Doug. We're happy to provide some leadership on these issues and we hope that the program will be improved as a result.

I forgot to actually thank Carrie Redlich for all the work she did on the beryllium issue which was difficult in part because the language that's been worked on so far in the program has been complicated and sometimes a little convoluted frankly.

I think Carrie, you presented a lot of clarity on these issues so thank you very much.

MEMBER REDLICH: This is Carrie. I

had one quick question. It sounded like there might be a new procedure manual that was in the works. Did I understand that?

CHAIR MARKOWITZ: If you go on the website there is a reconfigured procedure manual if that's what you're talking about.

There's a little preamble and it states that the content hasn't been changed, but it's -- we don't have a way to make it much more readable which I think it is.

If you're referring to some draft changes they were thinking about making prior to our April meeting I don't know the status of that. But those are substantive issues.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: And so we've voted on the recommendations. When we submit them we submit the rationales. And so if you have some minor comments on the rationales please send them to Carrie and Laurie directly.

And what's a reasonable time frame, by this Friday while it's still fresh? And then next

week we'll be able to submit the recommendations if that works for Carrie and Laurie.

MEMBER WELCH: Yes, that's great. And I have a request that whoever was editing the PowerPoint could you send it to me because I want to then paste that back into the Word document.

MR. BIRD: We can do that.

MEMBER REDLICH: And could you also do the same for the Part B recommendations? Thank you.

MR. BIRD: Absolutely.

CHAIR MARKOWITZ: Okay. The next meeting, face to face meeting will be in the fall.

And Carrie Rhoads is going to circulate some time windows. It has to be after October 1 because that's the new fiscal year. And it can't be soon after October 1 because who knows what happens, if they'll actually get the budget done on time, October 1.

So, we're going to look at the weeks of October 16, November 6 and November 13. Some of us have a conflict towards the end of October so

we're avoiding those dates, but trying to get it in before Thanksgiving.

So Carrie will circulate these three one-week windows. If you give all possible good times then we'll try to resolve this as quickly as possible.

And then finally as to location. So this is my thinking. I revisited the DEEOICP website and looked at by state the number of claims and the number of cases for the nine most common states. You know all those states.

And we've been to Washington State, we've been to Tennessee. Those are really the leading in terms of the number of claims and the number of cases.

But by a lot the next location is New Mexico. Almost 14,000 claims from New Mexico and the next highest after Tennessee and Kentucky is Ohio with about 10,000 claims.

And if you look at the number of cases, the number of people the discrepancy is also that.

So if we're going to continue with the

spirit of going to places where people are and where there's some open facilities so that we can learn more about the complex then that argues for us to go to New Mexico.

But the floor is open for comments. James Turner, because I know James you would like us to go to Colorado, but in any case let me just open it up for comments.

MEMBER WELCH: Well, this is Laurie. I was just on vacation in New Mexico and I visited Los Alamos. And it was so interesting and I learned a ton without having a special board tour. So I think it's a great place for us to meet just for the continuing education of the board. Just my two cents.

MEMBER DOMINA: This is Kirk. If we're going to go to New Mexico, and I think I talked to Dr. Markowitz about it, about having time to both go to Los Alamos and Sandia because they are, I don't know, 90 minutes apart or something.

But I think it would be best if we're going to one state to hit both of those locations.

Plus there is a bunch of uranium miners there also.

CHAIR MARKOWITZ: Kirk, just for clarity, do you mean having the opportunity to meet in one place, right, but to have the opportunity if DOE can arrange it for us to tour both sites.

MEMBER DOMINA: That's correct. Because I know logistically it might be tougher for some people. But if we're going to travel that far I believe the people deserve and the workers deserve for us to visit both of those sites. Because I don't want to leave anybody out.

And then like I said the third part is all the uranium miners. So that's my two cents.

CHAIR MARKOWITZ: We can arrange a couple of days of tours, but all tours are optional anyway. But people could attend one or the other if they lack the time to do both.

Other comments.

MEMBER REDLICH: I agree that sounds like a good idea. I would just take for down the road in the future a lot of the beryllium claims

that were denied that seemed concerning were from the Savannah River Site. So I would just put that down the list for the future.

CHAIR MARKOWITZ: And South Carolina is high up actually in number of claims and cases.

MEMBER REDLICH: I agree with New Mexico.

CHAIR MARKOWITZ: Okay. So, any other -- before we close the meeting any final comments? We have a couple of subcommittee meetings, one this week on presumptions, one next week combined IH and CMC subcommittee with the weighing medical evidence subcommittee.

Chairs should give some thought as to whether they want to meet by phone prior to the next full board meeting.

We do have to come up with an agenda for the next full board meeting since we've covered an awful lot already. So give some thought to that as well.

Comments? Okay. So thank you all and we'll be in touch.

(Whereupon, the above-entitled matter went off the record at 4:14 p.m.)