

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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THURSDAY,
APRIL 20, 2017

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The Advisory Board met at 8:00 a.m.
Pacific Time, at the Red Lion Hanford House, 802
George Washington Way, Richland, Washington,
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
ROSEMARY K. SOKAS**

CLAIMANT COMMUNITY:

DURONDA M. POPE

KIRK D. DOMINA

GARRY M. WHITLEY

JAMES H. TURNER

FAYE VLIENER

DESIGNATED FEDERAL OFFICIAL:

DOUG FITZGERALD

*Participating via telephone

** Not Participating

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P R O C E E D I N G S

8:05 a.m.

1
2
3 CHAIR MARKOWITZ: On the phone do we
4 have Mr. Griffon? But we do not have Dr. Sokas,
5 correct? Okay. She's --

6 MEMBER GRIFFON: Yes, Steve, I'm here.

7 CHAIR MARKOWITZ: Okay. Great. Okay.

8 MR. FITZGERALD: Good morning
9 everyone. My name is Doug Fitzgerald. And I'd
10 like to welcome you to this meeting of the
11 Department of Labor's Advisory Board on Toxic
12 Substances and Worker Health.

13 I'm the Board's Designated Officer or
14 the DFO. I want to, on behalf of the Department,
15 thank the Board and the Chairman for all their
16 hard work yesterday. And for their forthcoming
17 deliberations.

18 As the DFO, I serve as the liaison
19 between the Board and the Department. I'm also
20 responsible for ensuring all provisions of the
21 Federal Advisory Committee Act are met regarding
22 the operations of the Board.

1 I work closely with the Board's Chair,
2 Dr. Markowitz. And I'm responsible for approving
3 the meeting agenda and for opening and adjourning
4 these meetings.

5 I also work with the appropriate
6 agency officials to ensure that all relevant --
7 or excuse me, to ensure that all ethics
8 regulations are satisfied.

9 You will note that the agenda times
10 are approximate. So we'll try as hard as we can
11 to stay with the agenda.

12 But, because we had some leftover
13 business from yesterday, we'll be jumping around
14 a little bit, I think, in addition to that. But
15 we'll be mindful of the break times as well.

16 Copies of all meeting materials are or
17 will be available on the Board's website under
18 the heading meetings. The Board's website can be
19 found at [dol.gov/owcp/energy/regs/compliance/
20 advisoryboard.htm](http://dol.gov/owcp/energy/regs/compliance/advisoryboard.htm).

21 Or you can simply Google Advisory
22 Board on Topic Substances and Worker Health, and

1 it will likely be the first url that comes up.
2 If you haven't already visited the Board's
3 website, I strongly encourage you to do so.

4 After clicking on today's meeting
5 date, you'll see a page dedicated entirely to the
6 week's meeting. That page contains all material
7 submitted to us in advance of the meeting.

8 If you're joining by WebEx, please
9 note that this session is for viewing only, and
10 will not be interactive.

11 And I just wanted to point out, in
12 case there's an emergency, there are two exits at
13 the back, on the left and the right. So, if
14 there is an emergency of some kind, hopefully
15 that won't occur, just exit through those doors.

16 If you need to use the restrooms, they
17 are immediately to the right on the way out.

18 I also want to note that the FACA
19 requires that the minutes for this meeting be
20 prepared to include a description of all matters
21 discussed over the course of the meeting. And
22 any conclusions reached by the Board.

1 As DFO I prepare the meeting minutes
2 and ensure that they're certified by the Board's
3 Chair. The minutes of today's meeting will be
4 available on the Board's website no later than 90
5 calendar days from today per FACA regulations.
6 But if available sooner, we'll have them
7 published before the 90th day.

8 Also, although formal minutes will be
9 prepared, because they're required by the FACA
10 regulations, we'll also be publishing verbatim
11 transcripts. And those will be available by May
12 20.

13 And with that Mr. Chairman, I convene
14 the meeting, and turn this over to you.

15 CHAIR MARKOWITZ: Thank you. I echo
16 Mr. Fitzgerald's welcome to the public for
17 participating, those of you who are on the phone
18 and those of you who are present as well. And I
19 welcome back the Board members.

20 Let's redo the introductions today in
21 the event that we have some new public
22 participants.

1 I'm Steven Markowitz. I'm an
2 occupational medicine physician and
3 epidemiologist at the City University of New
4 York. Ms. Pope?

5 MEMBER POPE: Duronda Pope, United
6 Steel Workers Emergency Response Team. I was a
7 former worker at Rocky Flats 25 years.

8 MEMBER CASSANO: Tori Cassano,
9 occupational medicine physician, retired
10 military. And Department of Veterans Affairs.

11 MEMBER WELCH: Laurie Welch. I'm also
12 an occupational medicine physician. I work for
13 the Center for Construction Research and
14 Training.

15 MEMBER WHITLEY: Gary Whitley, former
16 worker developer of National Security Complex.
17 And work with the Worker Health Protection
18 Program.

19 MEMBER DOMINA: I'm Kirk Domina. I'm
20 here representing the Hanford Atomic Metal Trades
21 Council here in Richland, Washington. I am a
22 current worker. I've been onsite for 34 years.

1 MEMBER DEMENT: John Dement,
2 industrial hygienist and epidemiologist at Duke
3 University in Durham, North Carolina.

4 MEMBER FRIEDMAN-JIMENEZ: I'm George
5 Friedman-Jimenez. I'm an occupational medicine
6 physician and epidemiologist at New York
7 University School of Medicine and Bellevue
8 Hospital, New York City.

9 MEMBER SILVER: Ken Silver. I'm an
10 Associate Professor of environmental health in
11 the College of Public Health at East Tennessee
12 State University.

13 MEMBER REDLICH: Carrie Redlich, I'm
14 a Professor of Medicine at Yale and Director of
15 the Yale Occupational Environmental Medicine
16 program. And I'm also an epidemiologist.

17 MEMBER VLIEGER: Good morning. Faye
18 Vlieger, former Hanford worker, injured Hanford
19 worker from a chemical exposure in 2002. And
20 advocate for the injured workers.

21 MEMBER TURNER: James Turner. I
22 worked at Rocky Flats plant for like probably 26

1 years. Was diagnosed with chronic beryllium
2 disease in 1990.

3 MEMBER BODEN: Hi, I'm Les Boden. I'm
4 a Professor of occupational environmental health
5 at Boston University School of Public Health.

6 CHAIR MARKOWITZ: Mr. Griffon?

7 MEMBER GRIFFON: And I'm Mark Griffon,
8 a health physics and occupational and safety and
9 health consultant.

10 CHAIR MARKOWITZ: And yesterday we all
11 had the Board member, Dr. Rosemary Sokas, who's
12 an occupational medicine physician. And she
13 couldn't be with us today as scheduled actually.

14 So, we're going to change the agenda
15 a little bit. We're going to finish some of our
16 business from yesterday. And then move onto the
17 Part B lung conditions subcommittee report.

18 And the -- we're going to first
19 address an issue that was left over from a
20 discussion around chronic obstructive pulmonary
21 disease, COPD. I'm going to turn it over to Dr.
22 Welch to lead this discussion.

1 MEMBER WELCH: As you all remember, we
2 had tabled the question of work outside DOE. I
3 had originally included it as part of the
4 exposure criteria.

5 I talked some to the Department of
6 Labor representatives. And we had some
7 discussion among our SEM subcommittee.

8 I looked up the legislative language
9 and we figured that it's too -- it's -- would be
10 like giving the legislative history of the
11 program, which has focused solely on DOE work
12 that it's really not appropriate for us to change
13 it.

14 I mean, it's kind of like the -- it's
15 not specifically written that way in the
16 legislation. But, you can see how the intent
17 would be that. That's always been the focus of
18 the program.

19 And so my amendment, although we did
20 vote on the slide for the criteria, absent
21 consideration of outside exposures. So, what I'm
22 proposing as the final COPD presumption would be

1 everything we had, but no mention of outside
2 exposures in the presumption.

3 So, it would be five years exposure in
4 the specific job titles. Or exposure -- yes,
5 this is the legislative language, but I decided I
6 wasn't even going to renew them and they need to
7 cover it.

8 For reported history to vapors, gas,
9 dust, and fumes on the occupational history
10 questionnaire as revised. And that that's the
11 exposure assumption for COPD without direct
12 discussion or required consideration of outside
13 work.

14 So that's the proposal. So, in some
15 ways -- we've already voted on it. Except we
16 voted on it understanding that we would revisit
17 the outside work.

18 So, if we -- I'd leave it up to you
19 whether we want to bring up that slide again and
20 vote on it.

21 CHAIR MARKOWITZ: Well, why don't we
22 bring up the -- what we voted on yesterday.

1 MEMBER WELCH: Okay.

2 CHAIR MARKOWITZ: If we could.

3 MEMBER WELCH: So Kevin, could you
4 open the COPD one? Yes. There we go. So, go
5 down another slide. There. This is it.

6 So, what we -- we voted on this, but
7 we -- in speaking of it, we're excluding when we
8 voted the parenthetical. So that including non-
9 DOE work. With the idea we'd come back to it.

10 CHAIR MARKOWITZ: Right.

11 MEMBER WELCH: So what I'm suggesting
12 as an amendment now, is we would delete the
13 including non-DOE work. And have it otherwise
14 stay as the same.

15 CHAIR MARKOWITZ: But, that's what we
16 voted on yesterday. In other words, we voted on
17 this recommendation, removing the two phrases
18 where -- in parenthesis where it said, including
19 non-DOE work.

20 MEMBER WELCH: That's correct.

21 CHAIR MARKOWITZ: Okay. So, we -- I
22 think we can just let it -- yesterday's

1 recommendation stand. And the live issue for
2 today was whether we wanted to come add non-DOE
3 work.

4 And I think you're saying, let's not
5 add non-DOE work.

6 MEMBER WELCH: Right. That's my
7 recommendation. Let's not add it. But I think
8 we should in some ways get at least an informal
9 consensus of the board on that question, because
10 we did say we were going to come back and revisit
11 it.

12 Yes, could you -- Kevin, could you
13 take out the parenthetical that says, including
14 non-DOE work in the -- those two bullets?

15 CHAIR MARKOWITZ: So, while he's doing
16 that, is it open for discussion now?

17 MEMBER WELCH: Yes.

18 CHAIR MARKOWITZ: Dr. Friedman-
19 Jimenez?

20 MEMBER FRIEDMAN-JIMENEZ: I agree that
21 for perceptual reasons it's probably better to
22 take out non-DOE work. However, the five years

1 seemed reasonable, including non-DOE work.

2 So my question, and I'd like Dr.
3 Redlich to comment on this also. My question is,
4 what does the science say about how much exposure
5 you need to get COPD from the exposures involved?

6 Could we reduce the five years to say
7 three years or two years? What is the suspicion
8 amount of exposure if we're not including DOE
9 work in the formal definition?

10 We should probably shorten the DOE
11 time. Because on average, most people will have
12 additional exposures that contribute in the way -
13 - in an additive way at least.

14 MEMBER WELCH: The -- let me just
15 comment on that. That there isn't a lot of
16 population-based studies that look at the overall
17 metric, not specific exposures, don't have --
18 they're looking at long term populations
19 generally. So the only study I could find that
20 looked at VGDF overall that was -- well, it
21 wasn't even in the publication.

22 But John was able to look at it in our

1 construction workers. And it looked like five
2 years was the -- five years cumulative exposure
3 was where you start to see an increase in COPD.

4 You're correct that we could decide to
5 go four or three with the understanding that it's
6 most probable that people had other exposures.
7 Or we could go with five and then the people who
8 have four or three can come in with an individual
9 evaluation.

10 And that -- so their treating
11 physician or the industrial hygienist could, in
12 an individual evaluation, look at their total
13 exposure without it being written in our
14 presumption.

15 And that's a -- I was kind of
16 approaching it that way in my mind. But I would
17 still continue to -- for individual people, look
18 at their total exposures.

19 But to recommend it as a specific
20 presumption seems out of keeping with a
21 legislative history.

22 CHAIR MARKOWITZ: Dr. Redlich?

1 MEMBER REDLICH: I agree with Dr.
2 Welch. I think the reason it gets a little more
3 complicated is just that there's so much overlap
4 between asthma and COPD.

5 And you know, shorter term exposures
6 can cause asthma. The Germans actually lump as -
7 - when they look at work-related obstructive lung
8 disease, they actually treat asthma and COPD as
9 one entity that they term OLD. You know,
10 occupational obstructive lung disease.

11 And so I think that's where one could
12 potentially argue for a shorter time period.
13 It's not a, you know, a crazy thought.

14 But I think given the literature and
15 these circumstances, it's reasonable to use the
16 five years.

17 CHAIR MARKOWITZ: Dr. Boden, did you
18 want to say something? No.

19 You know, I think it's hard to make a
20 decision based on an assumption that a person
21 otherwise had some years of exposure to VGDF
22 outside of non-DOE work. We're saying that we

1 can't really justify looking -- in this program,
2 in looking at non-DOE work.

3 And then the suggestion is well, we
4 can assume that blue collar workers generally do
5 blue collar work in their careers. And therefore
6 it's likely that they have outside.

7 But that's an assumption. And it's
8 hard -- I think it's hard to build a compensation
9 program on that kind of assumption. Even though
10 there's some scientific validity to it.

11 So, I guess I would favor the five --
12 staying with the five years. And then in the
13 non-presumption at root, then on an individual
14 basis, it goes through the normal process of
15 looking at the exposures and judging whether
16 there's a contribution from two or three or four
17 years of exposure to the disease.

18 Mr. Domina?

19 MEMBER DOMINA: I just want to make
20 sure, because I don't have 16-02 in front of me
21 that we're not excluding AWE. Because say a guy
22 worked at an AWE site for a couple of years and

1 then he went to work for DOE, that that's
2 included in the five-year total.

3 CHAIR MARKOWITZ: Yes. You know, Ms.
4 Leiton, could you address that issue? Because
5 that's a coverage issue.

6 MS. LEITON: Okay. So if it's covered
7 employment, and it's an AWE or DOE facility,
8 whatever, actually, I'm sorry, AWEs are only
9 covered for cancer.

10 So the cancer conditions would be the
11 only ones that would be included in that.
12 Because we don't cover anything other. And Part
13 E is not covered. So never mind.

14 We don't do AWEs because they're not
15 covered under Part E. So, it wouldn't -- the
16 other part, it would only be Part B coverage.

17 So, let me just be clear about that
18 again. AWE coverage does not extend to Part E.
19 Since this is a Part E presumption, it would not
20 cover for AWE employees.

21 CHAIR MARKOWITZ: Further discussion?
22 Dr. Redlich? Dr. Silver?

1 MEMBER SILVER: A rationale statement
2 will accompany this recommended set of
3 presumptions. Maybe that's the place to
4 elaborate on non-DOE exposures around that last
5 point of the presumption.

6 Non-binding guidance, but at least put
7 it on the record for the program to remember when
8 they evaluate individual claims.

9 CHAIR MARKOWITZ: That's a good point.
10 Other comments?

11 (No audible response.)

12 CHAIR MARKOWITZ: So Dr. Welch, is
13 there a -- do you think there's a need at all for
14 something to vote on? Or are we okay? Okay.

15 Okay, so if we could move to my
16 slides. We're going to discuss occupational
17 asthma.

18 MEMBER GRIFFON: Hey Steve, this is
19 Mark Griffon.

20 CHAIR MARKOWITZ: Yes. Yes?

21 MEMBER GRIFFON: Just before you leave
22 the issue, just one thing. I mean, this might be

1 a little tricky, my mind was just on it.

2 But, the way it's written right now,
3 it's a five-year aggregate as reported on the
4 OHQ. I think it supposed to be five year
5 aggregate as verified by the Department of Labor,
6 right? At any code facility?

7 I'm not sure if that's not important.
8 I mean, I think we've got the nature of the
9 recommendation across. But, --

10 MEMBER WELCH: You know, I kind of
11 think that it's kind of assumed that --

12 MEMBER GRIFFON: Okay.

13 MEMBER WELCH: But, I mean, I wish we
14 could just use the OHQ. But I know that the
15 process doesn't work that way.

16 MEMBER GRIFFON: Yes.

17 MEMBER WELCH: So we could say five
18 years cumulative covered employment. If you
19 think that's important.

20 MEMBER GRIFFON: Right. I don't know
21 that we have to revote or anything. I'm just --

22 CHAIR MARKOWITZ: No, but looking at

1 the language, the only place where OHQ is
2 mentioned is with reference to vapors, gas, dust
3 and fumes. And that's the only place where it's
4 asked.

5 In other words, the OHQ is -- if it's
6 changed, that's going to be the only location
7 where that specific question is asked and
8 documented.

9 MEMBER WELCH: But for example, let's
10 say women in -- yes, we see this in construction.
11 They say they worked for, you know, seven years
12 at Savannah River.

13 But what can be considered covered
14 employment is like a three-month period in the
15 middle of that. And two years, and you know,
16 it's broken down and maybe not all of it is
17 verified. And so not all of it is covered.

18 So they report something that would
19 get them in under the presumption. But then the
20 amount of years that are accepted by the
21 Department of Labor as covered employees -- or
22 covered employment would put them under the five

1 years.

2 And that's likely to happen. But I
3 assume that that is going to happen. Because
4 that's, you know, exposures -- if there's no
5 covered -- if the employment isn't verified as
6 covered employment, then it's just not considered
7 under the way the regulation works.

8 So, I was assuming we didn't have to
9 put that in there. In this presumption.

10 CHAIR MARKOWITZ: Okay. Ms. Leiton?

11 MS. LEITON: I just would say, I look
12 at this like my lawyers are going to look at it
13 when they see it. And if they see with reported
14 exposure to VGDF on the OHQ, that's what that
15 says.

16 I mean, it doesn't say verified or
17 anything like that. So, you know, and other
18 people will think well, if I just put it on the
19 OHQ, I'm good.

20 And that might be a problem for us
21 when we're trying to administer. I'm just
22 putting that out there.

1 And when I know that other people
2 looking at these recommendations might say to me
3 -- well, you know, I don't know for sure, I just
4 want to put that out there.

5 I think it's a good point. Because it
6 does say reported exposure on the OHQ. We verify
7 these in other ways. We get this information
8 from DAR records. We might get it from other
9 sources.

10 It might not be on the O -- you know,
11 there's just a lot of different variations of
12 saying, on the OHQ. So it's, you know, I'm not
13 trying to tell you either way to do it, but
14 that's just probably what they're going to look
15 at and say to me.

16 MEMBER WELCH: And so what we were
17 talking about was something slightly different.

18 MS. LEITON: Okay.

19 MEMBER WELCH: Whether or not
20 verification of the exposure itself, but should
21 we say covered employment? Because this is
22 implying if they were --

1 MS. LEITON: It does. I mean that
2 would help.

3 MEMBER WELCH: Would help to put that
4 in there? Okay.

5 MS. LEITON: It would probably help.

6 MEMBER WELCH: Okay.

7 CHAIR MARKOWITZ: Dr. Boden?

8 MEMBER BODEN: So, I thought that our
9 discussion yesterday actually kind of
10 contradicted what you just said. That is, our
11 discussion yesterday was a suggestion that the
12 revised occupational health questionnaire, with
13 what detailed information from the worker, could
14 actually be used without external verification.

15 MEMBER WELCH: Absolutely.

16 MEMBER BODEN: Is that correct? Yes.
17 Okay.

18 MEMBER WELCH: That was the -- and I
19 specifically pointed out that the direct disease
20 work process link bulletin says that the workers
21 report can be considered probative.

22 So, I think -- yes, what I'm thinking

1 is that the -- it's not just reported exposure to
2 VGDF, it includes all the task information.
3 Which helps to validate the exposure.

4 So it's not the answer to that simple
5 question that allows them to accept the claim.
6 So, I mean, there's the option of -- and I don't
7 know, Steven, do you want to spend any more time
8 on this?

9 We've got to -- we kind of have to
10 move on.

11 CHAIR MARKOWITZ: No.

12 MS. LEITON: Can I make one more
13 comment on that?

14 MEMBER WELCH: Yes.

15 MS. LEITON: If you're talking about
16 coverage, you do say at the first sentence,
17 covered facility. So, it would have to have been
18 at a covered facility.

19 So if that's the issue, I think you've
20 got that in the language.

21 MEMBER WELCH: Okay. Great. Thanks.
22 Good.

1 CHAIR MARKOWITZ: Okay. Good. Great.
2 We can move on. So, if we can bring up the
3 PowerPoint on occupational asthma. So, it should
4 be after that.

5 What slide is -- are we on? Because
6 we covered this yesterday.

7 MEMBER WELCH: Yes. This is not the
8 right slide.

9 CHAIR MARKOWITZ: Okay. So just go to
10 the end and then go back about six slides.

11 MEMBER WELCH: Oh, it's in this slide
12 presentation?

13 CHAIR MARKOWITZ: It's all in the same
14 presentation. So, I'm going to talk about the
15 current policies on occupational asthma, written
16 policies.

17 And if you go up one slide, let me
18 just -- yes. Yes, that would be great. Okay.
19 So, just a quick review on the current written
20 policy on asthma.

21 Which is that if there is medical
22 evidence of occupational asthma, there's no need

1 for an exposure assessment or consultation with
 2 the SEM. Because the exposure's assumed to occur
 3 if the medical evidence is presented by in
 4 general, the treating physician.

5 For occupational asthma claims that
 6 are filed after the Department of Energy work
 7 ends, so this is for retired workers, it requires
 8 a well-supported report by a physician, meaning
 9 the treating or evaluating physician. And if
 10 that isn't present, then the CE collects exposure
 11 information and refers it to the CMC for
 12 evaluation.

13 For asthma claims that are not -- that
 14 do not have presented with them a well-supported
 15 rationale for work-relatedness, the CE develops
 16 the claim and just refers it to the CMC. And
 17 then there is a retroactive look with the
 18 institution of this policy in 2015, to look at
 19 previous asthma cases and make sure they complied
 20 with this guidance.

21 Now, the draft document that was sent
 22 to us a week ago, on exposure and disease

1 presumptions, significantly changes and tightens
2 up the requirements for occupational asthma. And
3 in particular, it requires objective verification
4 of or -- of the asthma by pulmonary function
5 testing.

6 And so why don't I discuss just a few
7 things in general about asthma, about work-
8 related asthma, and then get into a
9 recommendation. So, work-related asthma is
10 considered to be quite common. And causing up to
11 25 percent of adult onset asthma.

12 Dr. Friedman-Jimenez wrote a review a
13 year and a half ago on occupational asthma. And
14 cited that there are over four hundred workplace
15 agents that are known to cause asthma.

16 In clinical practice, the basis for
17 diagnosing asthma varies considerably among
18 healthcare providers. Often based on the history
19 and a trial of bronchodilators. Sometimes based
20 on pulmonary function testing.

21 But it's a lot of variation, which
22 some of the physicians here can speak to. And

1 that work-related asthma is frequently diagnosed
2 without the pulmonary function confirmation in
3 practice.

4 So, I'm going to -- I have a
5 recommendation that involves two or three slides.
6 And then a little bit of rationale mixed in.

7 So, the recommendation is that DOL
8 should use the generally accepted unifying term,
9 work-related asthma for claims evaluation and
10 decision-making. Work-related asthma includes
11 two forms of asthma.

12 One is occupational asthma, which is
13 new onset asthma that has initiated by an
14 occupational agent. The worker didn't have
15 asthma before. They develop asthma. The
16 physician identifies it in relation to a specific
17 exposure in the workplace.

18 There's also a second type of work-
19 related asthma, which is work-exacerbated asthma.
20 Which is established asthma, the person already
21 has asthma, or otherwise developed asthma, and
22 it's worsened by workplace exposures.

1 The recognition of both forms of work-
2 related asthma should be communicated to
3 claimants, the physicians, and consulting
4 industrial hygienists and CMCs. And this is
5 important because physicians vary in their
6 thinking about work-related asthma.

7 Some physicians maybe sticking with A,
8 only occupational asthma, whereas it's recognized
9 that work-related asthma encompasses a much
10 broader spectrum, not just occupational asthma,
11 but also work-exacerbated asthma.

12 And the background behind this is that
13 this definition exactly coincides with the
14 recommended usage of the terms by the American
15 Thoracic Society from the 2011 statement, and the
16 American College of Chest Physicians in 2008.

17 And Dr. Redlich served on both of those
18 committees and is a coauthor on these
19 recommendations that were published.

20 This inclusive and well delineated
21 definition is also very conveniently consistent
22 with the standard of causation in EEOICPA. Which

1 is to say, at least as likely as not, exposure to
2 toxic substance was a significant factor in
3 aggravating, contributing, or causing.

4 So, both the occupational asthma form
5 and the work-exacerbated form of asthma meet the
6 standard of aggravated, contributed or causing.

7 So the second part of the
8 recommendation that is, met the criteria for the
9 diagnosis of asthma. The diagnosis of asthma by
10 a treating or evaluating physician should be
11 sufficient for the recognition that the claimant
12 has asthma.

13 Bronchodilator reversibility of FEV1,
14 which is a pulmonary function test, and/or a
15 positive methacholine challenge test, which is
16 another form of breathing test, maybe helpful,
17 but should not be required to accept a diagnosis
18 of asthma, which is made by a healthcare
19 provider.

20 And then I think this is the third,
21 the last part of the recommendation. So what I
22 just reviewed was how the diagnosis of asthma

1 should be looked at in the claim. Now we move
2 onto how the diagnosis of work-related asthma
3 should be looked at.

4 Work-related asthma, whether
5 occupational asthma or work-exacerbated asthma is
6 defined as the presence of medically diagnosed
7 asthma that is associated with the worsening of
8 any of one or more, or is key here. One or more
9 of the following in relation to work: asthma
10 related symptoms, meaning shortness of breath or
11 wheezing, asthma medication usage, which is
12 temporarily related to work, or pulmonary
13 function indices, and then I list the various
14 recognized means, meaning change in FEV1 or the
15 peak expiratory flow rate, bronchial hyper
16 responsiveness or a positive inhalation challenge
17 test.

18 Such a history should be documented by
19 the treating or evaluating healthcare provider,
20 or addressed by a CMC if consulted in a claim
21 evaluation.

22 The same criteria for work-related

1 asthma should be used in evaluating asthma claims
2 whether the claim is made contemporaneous with
3 the period of DOE employment, or after the end of
4 that period of employment.

5 And a specific triggering event
6 causing the onset of work-related asthma may
7 occur, but is not typical or necessary. Inciting
8 exposures, such as dusts, fumes, heat or cold or
9 others, should be specifically identified when
10 possible, but should not be required for the
11 diagnosis of work-related asthma.

12 And so, -- and then just I just
13 provide the American Thoracic Society criteria
14 for work-related asthma from their 2011
15 statement.

16 This is the work-related -- the work
17 you actually -- this is the work-exacerbated
18 asthma, which is the person -- criteria one, the
19 person has asthma already. And criteria two,
20 which is that there's a clear temporal
21 relationship between symptoms or medication use,
22 or objective indicators, and the asthma symptoms.

1 So, let's open for discussion. Dr.
2 Welch?

3 MEMBER WELCH: I strongly support the
4 use of, you know, well developed, peer reviewed
5 criteria for the diagnosis. So, I think that's a
6 good improvement.

7 CHAIR MARKOWITZ: Dr. Redlich, you're
8 a Pulmonologist.

9 MEMBER REDLICH: Yes. You know, and
10 I am -- I am actually -- I apologize, the
11 internet wasn't working last night. I had
12 emailed back some minor edits to this.

13 I agree with this approach. I think
14 it's also just important to understand that the
15 evidence-based guidelines that are out there, you
16 know, some of which encourage things like trying,
17 you know, confirming asthma with a
18 bronchodilator, or doing peak flows, were really
19 developed for a pulmonologist who is, you know,
20 evaluating a patient real time with work-related
21 asthma. Or with potential work-related asthma.

22 And also must of the literature that

1 that is based on is sensitizer agents. And
2 predominantly European and Canadian literature.

3 And so I think it's just important not
4 to extrapolate that to U.S. workers. And the
5 situations where someone is using these
6 guidelines based on medical records that they are
7 reviewing.

8 And as an example, it's very commonly
9 stated in these guidelines, which I tried to
10 actually modify this. That, you know, you should
11 do peak flows at and away from work to confirm
12 the association with asthma.

13 And so that then implies that if you
14 haven't shown that association with peak flows,
15 maybe it is not work-related. That literature is
16 based on the relatively rare cases of work-
17 related asthma where there is a single
18 sensitizing agent.

19 And also studies from the 1960s,
20 1970s, largely in Europe where a worker would be
21 removed from work for three weeks, during which
22 three weeks away from work, their lung function

1 would improve enough that their peak flows would
2 be better. Then they would be put back at work
3 for three -- two to three weeks.

4 And so we in the United States don't
5 have the ability to do a diagnostic test that
6 involves removing someone from work for two to
7 three weeks. And then, you know, sending them
8 back to work.

9 So unfortunately some of the pieces of
10 the guidelines get extrapolated in a way that
11 because that documentation is not available. And
12 the other one that is unfortunately used
13 inappropriately is, confirming asthma with a
14 bronchodilator response.

15 The great overwhelming majority of
16 asthmatics in the United States and beyond, have
17 a clinical diagnosis of asthma. But have not had
18 spirometry at all, let alone spirometry that
19 shows a 12 to 15 percent improvement following an
20 inhaled bronchodilator.

21 And there are multiple reasons why
22 even if you had the test done, it can be falsely

1 negative. So I just mention that, because
2 there's some sort of common misconceptions in
3 some of these guidelines when they get applied to
4 current day workers.

5 CHAIR MARKOWITZ: Ms. Vlieger?

6 MEMBER VLIEGER: Having gone through
7 my asthma claim prior to this type of rationale,
8 I can tell you that this will help the workers to
9 no end. Because it is so difficult for them to
10 know first of all, what's wrong with me?

11 To get into a pulmonologist is
12 difficult. I had it reported to me today by a
13 claimant that he's trying to get into see one of
14 the local Pulmonologists here, and we have a
15 pretty robust community of doctors, and it's two
16 to three months out, you know, to be able to get
17 in to see them.

18 So, in the past, the Department of
19 Labor has really wanted them to see a specialty
20 doctor. So if this can be brought back to an
21 initial diagnosis that's accepted from the family
22 practice or general practice doctor, that would

1 be very helpful in getting them an initial
2 diagnosis accepted by the Department of Labor.

3 CHAIR MARKOWITZ: Dr. Boden?

4 MEMBER BODEN: So, I was very
5 interested to hear Dr. Redlich's description of
6 the problems with the pulmonary function tests
7 when they're using the bronchodilators. In
8 looking at a few claim files, I did see those
9 tests being used.

10 And it occurs to me that since, as you
11 put it, there can be a lot of false negatives on
12 that test that perhaps there should be guidance
13 to claims evaluators about not putting too much
14 weight on a false -- on a bronchodilator PFT. Is
15 that correct?

16 Am I saying that correctly?

17 MEMBER REDLICH: Yes. I think that's
18 correct. I think the current document needs
19 major revisions.

20 And that would be one of them. I
21 mean, asthma's a clinical diagnosis made by a
22 treating clinician or, you know, physician.

1 Another way to word that is, we have
2 a very extensive asthma clinic at Yale, and if
3 you actually look through -- well we're -- you
4 can't get in to be seen unless you have asthma.
5 And the physicians, the asthma specialists
6 believe all those patients have asthma.

7 And the great majority of them do not
8 have a positive bronchodilator. And I could go
9 into various issues with the testing and the
10 like.

11 But, that should not be a requirement
12 for a diagnosis of either asthma or work-related
13 asthma.

14 MEMBER BODEN: I'm sorry. I was just
15 wanting to make the point that also that the
16 existence of a negative test should not deny the
17 claim.

18 MEMBER REDLICH: Oh, absolutely. I --
19 that's correct. And unfortunately, that is --
20 and in fact, when this has been looked at, the
21 great majority of cases that have been diagnosed
22 with work-related asthma in the United States and

1 also in Canada, do not have a positive
2 bronchodilator.

3 CHAIR MARKOWITZ: Dr. Cassano?

4 MEMBER CASSANO: Two questions. Could
5 we just go to the second slide with the criteria
6 that you -- that you had -- no. Or yes. Okay.

7 I guess what I'm concern -- I agree
8 with this fully. But from a practical
9 standpoint, most primary care doctors that I
10 know, or that I've worked with, yes, you've got
11 asthma. Here's your bronchodilator, go away.

12 Most people are not going to get
13 diagnosed with work-related asthma unless they go
14 to somebody that understands work-related asthma.
15 And what I'm afraid of, I mean, how will the
16 depart -- how would the agency deal with this?

17 Somebody has a diagnosis of asthma.
18 They believe it's related to work, but all
19 they've got is their doctor's statement that says
20 you've got asthma.

21 They then have to go to a specialist
22 or get referred to a specialist. Which may or

1 may not be paid for.

2 So that's -- I'm trying to figure out
3 from this very good established criteria, how
4 practically that's going to get executed. Not
5 that we shouldn't do this.

6 But, you've got to get to the next
7 point.

8 CHAIR MARKOWITZ: Yes. The physician
9 has to confirm that the symptoms are work-
10 related. And that physician can be the primary
11 care provider. It can be the pulmonary
12 specialist or any treating or evaluating
13 physician.

14 And absent that it would be the CMC.
15 And I don't really see any alternatives, any
16 other choices.

17 It would be a little challenging for
18 the CMC to do that. Because they don't have
19 direct communication with the patient.

20 And so if it's still an open question,
21 they could involve a second COP or whatever it
22 is, the second, you know, opinion evaluation.

1 But, there are only so many choices here.

2 Ms. Vlieger?

3 MEMBER VLIEGER: In saying that it
4 needs to be work-related. In some cases there's
5 actually a traumatic chemical exposure that you
6 can cite.

7 For many of the workers, it's an
8 accumulation of long term, low dose. Or a
9 combination of chemicals that you -- they don't
10 even know what it was.

11 So, when you say work-relatedness,
12 that's really relying on the worker realizing
13 what's happening. And knowing, you know, that it
14 was work-related.

15 So, what I find an issue within the
16 Department is that the veracity of the claimant's
17 report of work-relatedness when they really don't
18 know what they were exposed to comes up quite a
19 bit.

20 CHAIR MARKOWITZ: Well, this
21 recommendation doesn't require identification of
22 any specific trigger or any specific set of

1 dusts, vapors, gases, or whatever in order for it
2 to be work-related asthma.

3 It's that the symptoms have to be
4 identified. Symptoms or medication usage. Or
5 the objective testing have to be identified as
6 being work-related.

7 MEMBER VLIEGER: So is it more of a
8 temporal relationship to the disease then?

9 CHAIR MARKOWITZ: Correct.

10 MEMBER VLIEGER: Okay.

11 CHAIR MARKOWITZ: And even that can be
12 challenging. I understand. But, there's going
13 to be something.

14 MEMBER VLIEGER: Right.

15 CHAIR MARKOWITZ: All right. Dr.
16 Friedman-Jimenez?

17 MEMBER FRIEDMAN-JIMENEZ: Since the
18 definition relies fairly heavily on symptoms, I
19 think when you mentioned symptoms in the
20 definition, you should include the four classic
21 symptoms that are described for asthma, wheezing,
22 which is not actually really a symptom. It's

1 often not perceived by the person. It's heard by
2 the doctor in the stethoscope.

3 But I would include it. Cough,
4 shortness of breath, and chest tightness are the
5 four symptoms that are typically associated with
6 asthma.

7 And each person has their different
8 symptoms that they perceive when they have an
9 asthma attack. And I would either include all
10 four, or not include any -- not mention them by
11 specifically.

12 Because if you just limit it to
13 wheezing or shortness of breath, many people
14 don't know that they're wheezing, and their
15 doctor tells them they're wheezing because they
16 hear it in the stethoscope.

17 And many people don't experience
18 shortness of breath even though they have
19 significant bronchial objection. So, I would
20 either take out the specific symptoms, or list
21 all four.

22 CHAIR MARKOWITZ: Well, I would

1 actually favor taking out the symptoms. Because
2 if it -- if we include cough, which can be a
3 manifestation of asthma, but can also be an
4 irritant, bronchitis without real bronco spasm,
5 then it opens the door.

6 So, I would favor just eliminating
7 wheezing or shortness of breath for the line four
8 here. Dr. Redlich?

9 MEMBER REDLICH: Yes. From reviewing
10 a lot of work-related asthma claims in various
11 settings over many years, physicians
12 unfortunately when you review their notes, rarely
13 got -- their visit is usually focused on the
14 patient's current symptoms. And managing those
15 symptoms.

16 And so in the most clear cut cases,
17 you can -- there can be remarkably little. But I
18 think there are other things that can be.

19 And one doesn't want to accept, you
20 know, asthma is a common condition in every
21 single case. But the type of things, and this is
22 what could be included in guidance is, you know,

1 in the period of time, was there a much greater
2 frequency of visits for asthma treatment?

3 So if you go to a job with a lot of
4 irritants or agents that could cause or
5 exacerbate asthma, and over that three-year
6 period of time, were you seeing a doctor for
7 asthma weekly? Instead of prior it had been only
8 once every two years. So, things like that.

9 Frequency of the medication usage, the
10 visits to physicians can be very helpful. And
11 relationship of that to the period of time that -
12 - of work time that's in question. And that's
13 something that one can get from medical records.

14 But those are the types of guidelines
15 that could be included. You know, A, B, or C in
16 terms of showing this association with work.

17 CHAIR MARKOWITZ: Dr. Friedman-
18 Jimenez?

19 MEMBER FRIEDMAN-JIMENEZ: One
20 different issue is the diagnosis of work-
21 exacerbated asthma. This is a relatively
22 recently described and accepted entity.

1 And most doctors, I think, are not
2 aware of this, the existence of work-exacerbated
3 asthma. And they think of -- you know, if they
4 know about occupational medicine at all, they'll
5 think of occupational asthma in the classic
6 sensitizer-induced situation.

7 So I think the document should
8 emphasize a little bit more the work-exacerbated
9 asthma. It's actually more common than
10 occupational asthma.

11 And it maybe in many cases, as
12 disabling as occupational asthma. And it's an
13 important disease.

14 And I think that this document should
15 really put it on the map of the CMCs and the
16 treating physicians, anyone that consults the
17 document. And patients aren't likely to think of
18 it either. Because they probably have never
19 heard of it either.

20 So, I think work-exacerbated asthma
21 should be highlighted a little bit more in your
22 recommendations.

1 CHAIR MARKOWITZ: So, it's, you know,
2 -- so, you know, I can do that in the rationale.
3 But I point out in the recommendation the last
4 three lines.

5 Which is that the recognition of both
6 forms of work-related asthma should be
7 communicated to claimants, physicians, and
8 consulting IHS and CMCs.

9 Dr. Boden?

10 MEMBER BODEN: I have a question.
11 Which just raises, but just slightly off topic.
12 So, pull me in if I'm --

13 CHAIR MARKOWITZ: I will.

14 MEMBER BODEN: If I'm out of line on
15 this. So, my question is, for cases where a
16 presumption would apply, we already have
17 presumptions in the program, is -- are claimants
18 and physicians provided with a link to the
19 presumption in the process of going -- by this
20 CEs?

21 So in other words I'm saying, is there
22 some way of communicating to people who might

1 otherwise not know that the physician should have
2 this presumption in mind when writing a letter to
3 the -- to the program?

4 CHAIR MARKOWITZ: Ms. Leiton, do you
5 want to address that?

6 MS. LEITON: Yes. When we have really
7 specific criteria such as this, and I think this
8 recommendation actually specifically says that
9 we'd have to do some education, something --
10 language along those lines.

11 But, we would be -- even without a
12 letter to the doctor, we would have to say, this
13 is what we consider to be work-related asthma.
14 You know, please provide us with X, Y, and Z
15 information.

16 So, that would be in the case of a
17 treating physician or a physician that the
18 claimant has already gone to. We would have to
19 tailor it about the letter to include the
20 language that said that.

21 And we do do that in certain
22 circumstances. If it were a CMC obviously we

1 would have to include that in our CMC training
2 package or whatever, so.

3 CHAIR MARKOWITZ: Okay. Dr. Redlich?

4 MEMBER REDLICH: I agree with the
5 importance of work-exacerbated asthma. I would
6 just say that -- and the great majority of
7 patients that I clinically see are referred to me
8 for work-related asthma. That's the entire bulk
9 of my clinical practice.

10 In the textbooks there's a very clear
11 delineation of new onset occupational asthma,
12 work-exacerbated asthma. In actual practice, it
13 can be very difficult to tell what is
14 exacerbation of pre-existing.

15 So, I think the term work-related
16 asthma is a very good term. Because for this
17 situation, and really for all of the now in the
18 United States compensation systems, the question
19 is, is the asthma either caused or exacerbated by
20 work or work factors contributing?

21 And so this differentiation, because
22 in reality is, did the person have very mild,

1 minimal pre-existing asthma that then got worse?
2 Or was this really new asthma?

3 And that is very challenging. And the
4 other factor is, anybody who has asthma, it's a
5 chronic condition, by the time they're seeing a
6 physician, they could already have had symptoms
7 for several years.

8 And whatever the original cause of
9 asthma, even if it was to a very specific agent,
10 becomes more defuse over time. And the triggers
11 become more defuse over time.

12 And so I just mention that. I think
13 in the terminology it would really be better and
14 easier to explain to the, you know, physicians
15 doing this work if one just used the term work-
16 related asthma. And that included work
17 exacerbation.

18 The other point that I think is
19 important to realize that every published study
20 on work-related asthma in the United States, when
21 you look -- and these are, you know, some of
22 these are publications where pretty extensive

1 evaluations have been done, you know, by
2 occupational lung specialists.

3 The causative agents that have been
4 found in those, you know, series and studies have
5 almost, you know, over 50 or 80 percent of them
6 are non-specific agents. Not one single
7 substance.

8 So, the literature talks about, you
9 know, a lot of very specific, there are over four
10 hundred different chemicals or things that can
11 cause asthma. In practice, what tends to be
12 identified, you know, is dust irritants, cleaning
13 products, and those sorts of exposures.

14 And then I think the other important
15 sort of factors that do substantially exacerbate
16 asthma and would be relevant at at least of the
17 sites that we've seen are extremes of temperature
18 and extremes of humidity can really seriously
19 exacerbate people's asthma. And limit their
20 ability to work in that environment.

21 I mean, we were told yester -- two
22 days ago that it could either be one hundred

1 degrees at that site, or you know, below -- you
2 know, very cold.

3 So, I just mention that because I
4 think the discussion should include not just
5 inhalational exposures. But, factors that
6 physical as well.

7 CHAIR MARKOWITZ: Thank you. Yes, I
8 think actually in this room they're trying to
9 recreate some of the experience of working at
10 Hanford.

11 (Laughter.)

12 CHAIR MARKOWITZ: The alternating
13 trips to the Arctic and Aruba, in this room here.

14 (Laughter.)

15 MEMBER REDLICH: No, no. And you
16 know, that is important. And it's also an area
17 where a small modification could keep that person
18 at work too.

19 CHAIR MARKOWITZ: Ms. Vlieger?

20 MEMBER VLIEGER: Slightly off topic.

21 But I don't know if we're going to address it.

22 But the wording in bulletin 16-01

1 right now specifically in paragraph 2B that
2 instructs that the position of specific
3 information on the mechanism for causing,
4 contributing, or aggravating the condition, the
5 strongest justification for acceptance in this
6 type of claim is the treating physician can
7 identify the specific asthmatic incidents that
8 occurred while working at a covered work site,
9 and the likely trigger.

10 So --

11 CHAIR MARKOWITZ Right. Well, so let
12 me just point on this reg -- the third part of
13 the recommendation. At the bottom it says a
14 specific triggered event causing work-related
15 asthma may occur but is not typical or necessary.

16 And it also says in citing exposures
17 should be identified when possible, but not
18 required. It tries to address the --

19 MEMBER VLIEGER: So, are we going to
20 recommend that this bulletin be rescinded? Are
21 we moving towards that later in the -- in a later
22 discussion?

1 CHAIR MARKOWITZ: Well this -- there's
2 a draft document that redoes the whole asthma
3 policy. Where the -- but this recommendation
4 we're trying to --

5 MEMBER CASSANO: Affect.

6 CHAIR MARKOWITZ: Affect. Thank you,
7 affect. Thank you. Right. We're trying to
8 inject some thinking that would affect what the
9 revised draft document would look like -- looks
10 like.

11 MEMBER CASSANO: So, getting back to
12 what they said, I don't think you want to put --
13 I'm sorry. I don't think you want to have a
14 document out there that contradicts what you're
15 trying to do here.

16 So something about modifying 16-02 or
17 16-01 -- 16-01 to include this information or to
18 remove the more stringent information needs to be
19 said. Otherwise you're going to have
20 contradictory documents out there, I think.

21 CHAIR MARKOWITZ: Yes. I don't -- to
22 me if this recommendation is accepted, it

1 necessarily drastically revises 16-02. And
2 drastically revises the draft presumptions that
3 DOL is looking at.

4 So, to me it would be a formality to
5 say that it should -- that they should rescind
6 that specific guidance. Because if they accept
7 this recommendation, they have to alter very
8 substantially that bulletin.

9 MEMBER VLIEGER: This is Faye.
10 Rachel, would that normally fall in once -- if we
11 recommend this and they're accepted into that
12 draft procedure manual that we've got?

13 MS. LEITON: Yes. And any changes
14 that we would -- if there are recommendations
15 that change any of the presumptions, anything
16 that's out there that says something else, is
17 going to have to ultimately be changed.

18 I mean, this -- especially right now
19 given that we're going to have a change to the
20 way we do our procedure manual, it will be a lot
21 easier to just make the change in the procedure
22 manual.

1 Any other documents obviously, like if
2 we were to go forward with the exposure chapter,
3 excepts of which you've received, then we're
4 already -- that says until incorporated into the
5 procedure manual.

6 So that's changing whatever's been out
7 there. We would -- those circulars or bulletins
8 that have that information would no longer be
9 valid. Because we have the most recent guidance
10 out there.

11 CHAIR MARKOWITZ: Okay. Thank you.
12 So, if we could just stick with comments that
13 aren't necessarily repetitive of previous
14 comments, that would be great.

15 Dr. Silver? Whomever?

16 MEMBER FRIEDMAN-JIMENEZ: Work-
17 aggravated -- work-related asthma I think is a
18 great example of a disease that illustrates the
19 worsening, contribution to, or cause concept that
20 we're trying to promote with the CMCs.

21 And I think that all this -- in the
22 CMC training it would be worthwhile including the

1 ATS statements on work-related asthma and work-
2 exacerbated asthma.

3 And ask them to actually read them.
4 I think they're quite illustrative of the concept
5 that we're trying to promulgate.

6 CHAIR MARKOWITZ: Dr. Silver?

7 MEMBER SILVER: Asbestos fit neatly in
8 columns and rows yesterday. But here we're
9 talking about hundreds of different agents.

10 And I wonder if those ATS statements
11 maybe say it better. But what I'm hearing is
12 that the CMCs with their old school habits of the
13 mind that we saw on our medical evidence
14 subcommittee need an explicit statement that
15 there's a high degree of inter-individual
16 variability in response to workplace exposures,
17 clinical presentation, time course, response to
18 diagnostic tests, and treatments.

19 They can't use a cookie cutter
20 approach. And the claims examiners need to take
21 that to heart as well.

22 CHAIR MARKOWITZ: Sure. Dr. Redlich?

1 Okay. Any other -- Mr. Griffon, do you have any
2 comments?

3 MEMBER GRIFFON: No. Not at this
4 time. I do not.

5 CHAIR MARKOWITZ: Okay. So are we
6 ready for a vote? Or are there other comments?

7 (No response.)

8 CHAIR MARKOWITZ: Should we read this
9 again so we know what we're voting on? Okay.

10 Work-related asthma recommendation
11 one, the Department of labor could use a
12 generally accepted unifying term, work-related
13 asthma, for claims evaluation and decision-
14 making.

15 Work-related asthma includes A,
16 occupational asthma, or new onset asthma that is
17 initiated by an occupational agent. And B, work-
18 exacerbated asthma. Which is established asthma
19 that is worsened by workplace exposures.

20 The recognition of both forms of work-
21 related asthma should be communicated to
22 claimants, their physicians, and consulting

1 industrial hygienists and CMCs.

2 Two, medical criteria for the
3 diagnosis of asthma. The diagnosis of asthma by
4 a treating or evaluating physician should be
5 sufficient for the recognition that the claimant
6 has asthma.

7 Bronchodilator, reversibility of FEV1,
8 and/or a positive methacholine challenge test
9 maybe helpful, but should not be required to
10 accept the diagnosis of asthma which is made by a
11 healthcare provider.

12 Three, and I will read this, but I
13 will also, in line four there's some language we
14 might want to revise. But let me read it as it
15 is. And then we can get to the revision.

16 Work-related asthma, whether
17 occupational asthma or work-exacerbated asthma is
18 defined as the presence of medically diagnosed
19 asthma that is associated with worsening of any
20 one or more of the following in relation to work.
21 Asthma related symptoms, wheeze or shortness of
22 breath, asthma medication usage temporally

1 related to work, or pulmonary function indices
2 change in FEV1 or peak expiratory flow rate,
3 bronchial hyper-responsiveness or a positive
4 inhalation challenge test.

5 Such a history should be documented by
6 a treating or evaluating healthcare provider, or
7 addressed by a CMC if consulted in a claim
8 evaluation.

9 The same criteria for work-related
10 asthma should be used in evaluating asthma claims
11 whether the claim is made contemporaneous with
12 the period of DOE employment, or after the end of
13 that period of employment.

14 A specific triggering event causing
15 onset of work-related asthma may occur, but is
16 not typical or necessary. In citing exposure
17 such as dust, fumes, heat or cold, or others,
18 should be specifically identified when possible,
19 but should not be required for the diagnosis of
20 work-related asthma.

21 So Kevin, if you could bring up the
22 version we can modify. So the question on line

1 four on this is whether -- and when the symptoms
2 are cited, there are only two symptoms cited,
3 wheezing and shortness of breath.

4 And the idea came, we should have had
5 cough and chest tightness. If you just throw
6 that up. Yes. That's it.

7 So, I think we should just take out
8 wheezing and shortness of breath. Okay. And
9 then on -- so line four, Kevin, in the
10 parenthesis, wheeze or shortness of breath. You
11 can take out the whole thing.

12 And the other issue is what Dr.
13 Redlich raised. Which is healthcare utilization
14 as evidence of asthma.

15 And it says asthma medication usage.
16 We could amend that to say asthma medication or
17 healthcare-related -- or healthcare utilization
18 temporarily related to work.

19 So, is that -- should we add that? If
20 anybody's following what I'm saying.

21 PARTICIPANT: So it would be more
22 specific in the health evaluation?

1 CHAIR MARKOWITZ: Or it would be
2 asthma related.

3 MEMBER REDLICH: Well I think the
4 recommendation for the, you know the rationale
5 detail should be added to that.

6 CHAIR MARKOWITZ: Oh right, the other
7 rationale or the guidelines. Okay. Okay. So we
8 could -- you want -- so should we leave it as it
9 is? Asthma medication usage? Or add the asthma
10 related healthcare utilization?

11 MEMBER REDLICH: No. That's fine.
12 That's fine. I can live with that. That's fine.

13 CHAIR MARKOWITZ: Okay.

14 MEMBER REDLICH: I'm just saying the
15 specifics of that.

16 CHAIR MARKOWITZ: Okay. So before
17 health, if you can put asthma related.

18 MEMBER REDLICH: But I would be
19 interested in getting rid of the change in FEV1
20 peak flow. I think in hundreds of asthma
21 patients where I have tried to document this, I
22 have maybe in 25 years been able to document

1 physiologic changes, either peak flows or FEV1s
2 in less than five patients in over 25 years.

3 And that's with very intensive trying.

4 CHAIR MARKOWITZ: So you want to take
5 out change in FEV1 and PEFr and leave bronchial
6 hyper-response to this?

7 MEMBER REDLICH: No. Take them all
8 out.

9 CHAIR MARKOWITZ: You want to take out
10 the pulmonary function indices entirely?

11 MEMBER REDLICH: Yes. Those are way
12 too -- in that setting. It is appropriate if one
13 wants to discuss just asthma generally doing
14 spirometry.

15 But in terms of association with work,
16 better at work/away from work, those really
17 should go.

18 CHAIR MARKOWITZ: Okay.

19 MEMBER REDLICH: If you look at the
20 literature, it's just not supported.

21 CHAIR MARKOWITZ: Is anybody disagree
22 with what --

1 MEMBER CASSANO: I sort of disagree.
2 Only because if you take that out, if somebody
3 actually has that documentation, then it's not
4 usable.

5 And as being a person that's in a
6 clinic that's, you know, in an industrial
7 setting, I have many times used cross shift of
8 peak flows. And have been able to document it
9 very well.

10 So, if it's here, I think you don't
11 want to lose it.

12 MEMBER REDLICH: No, no. It's a good
13 point. Because it -- including it one wants to
14 encourage doing it. Because it's helpful to
15 encourage.

16 So one wouldn't want to discourage
17 someone from trying to better document. That's
18 correct. It's just -- and that -- I -- if
19 available, that's -- or --

20 CHAIR MARKOWITZ: Well maybe -- yes,
21 Dr. Dement?

22 MEMBER DEMENT: Oh, I was just

1 pointing out, it's an or. It's not a
2 requirement. And I think this just provides
3 guidance.

4 So, I'm in favor of leaving it in.

5 CHAIR MARKOWITZ: Well --

6 MEMBER REDLICH: I thought as long as
7 people recognize that. Because what tends to
8 morph is once it's there, it tends to be
9 expected.

10 And I don't want to start getting
11 into, it's available, but once you actually have
12 it, well, how much of an improvement is actually
13 needed? Is it 20 percent? Is it 10 percent? Is
14 it -- so it's --

15 MEMBER CASSANO: Maybe you can just
16 modify that a little bit. That it says pulmonary
17 function indices, you know, related to work may
18 be helpful. But are not, you know, are not --

19 MEMBER REDLICH: Yes. And the
20 positive inhalation challenge test that's not
21 done anywhere in the United States. So I think
22 that should be removed.

1 CHAIR MARKOWITZ: Okay. So let's take
2 out positive inhalation challenge test.

3 MEMBER REDLICH: Yes. That should go.

4 CHAIR MARKOWITZ: And in the rationale
5 --

6 MEMBER REDLICH: Yes.

7 CHAIR MARKOWITZ: In the rationale we
8 can emphasize it.

9 MEMBER REDLICH: And a change in
10 bronchial hyper-responsiveness --

11 MEMBER CASSANO: Yes.

12 MEMBER REDLICH: Should go. Because
13 that means that you're doing --

14 MEMBER CASSANO: A challenge.

15 MEMBER REDLICH: A bronchodilator at
16 work and away from work. And comparing the
17 change in them.

18 CHAIR MARKOWITZ: Okay. So change in
19 FEV1, then take out the or. So --

20 MEMBER CASSANO: No. Keep the PEFR.
21 Because that's --

22 MEMBER REDLICH: Yes. The peak --

1 CHAIR MARKOWITZ: No, no. Let me
2 finish. Change the FEV1, PEFr, or bronchial
3 hyper-responsiveness.

4 MEMBER CASSANO: Take out the
5 bronchial hyper-responsiveness

6 MEMBER REDLICH: No, bronchial hyper-
7 responsiveness.

8 CHAIR MARKOWITZ: Take that out?

9 MEMBER CASSANO: Take that out.

10 MEMBER REDLICH: Yes. Because that --

11 CHAIR MARKOWITZ: Okay. Changing --
12 and I think that you want or PEFr.

13 MEMBER REDLICH: And in fact the
14 current guidelines, the data, it's really for
15 peak flows and not for FEV1. It's not actually -
16 - so it would just be the peak flows is what the
17 -- because to be able to show any change, you
18 have to do repeated tests.

19 And you can do that with a peak flow
20 meter, which is a portable device. You can't do
21 that with spirometry. And also spirometry, you
22 can only do let's say at work if they have it

1 onsite. And someone might improve the next day
2 in the light, so.

3 CHAIR MARKOWITZ: Okay. That's good.

4 MEMBER REDLICH: The guidelines
5 actually are peak flows.

6 CHAIR MARKOWITZ: Mr. Turner?

7 MEMBER TURNER: I was just wondering
8 about wheezing and shortness of breath. Why
9 would you take that out?

10 CHAIR MARKOWITZ: So, we'll put that
11 in the rationale. But we didn't want it -- the
12 problem is, if we put only two symptoms in, it
13 ignores say, chest tightness.

14 So if we include -- if we list too
15 many symptoms, then it can address conditions
16 that aren't asthma. So, we're going to put that
17 in the rationale.

18 But, the feeling is that we don't need
19 to specify which particular symptoms represent
20 asthma in this recommendation. If that makes
21 sense.

22 MEMBER REDLICH: Just to simplify that

1 wording. I think the pulmonary function indices,
2 I think if you simply said change in peak flows.

3 CHAIR MARKOWITZ: Okay. So you can
4 take out pulmonary function indices.

5 MEMBER REDLICH: And just leave it as
6 peak flows and get rid of FEV1 also. And that's
7 actually consistent.

8 (Laughter.)

9 MEMBER REDLICH: Yes. Which is only
10 one index. And that's peak flow.

11 CHAIR MARKOWITZ: Okay.

12 MEMBER REDLICH: Does that make sense?

13 CHAIR MARKOWITZ: That makes sense.

14 Yes.

15 MEMBER CASSANO: So the change in peak
16 flow only.

17 MEMBER REDLICH: Yes. That's correct.
18 That's right. That's good. Thank you. Perfect.

19 CHAIR MARKOWITZ: Okay. Again, and
20 once you -- okay. So just to -- if you back up a
21 line, where it says asthma medication usage, or
22 asthma related healthcare utilization.

1 Okay. So, any other -- any final
2 comments on this? George or Dr. Friedman-
3 Jimenez?

4 MEMBER FRIEDMAN-JIMENEZ: Yes. I
5 agree with these changes. There -- in the
6 literature several studies have tired -- many
7 studies have tried to do peak flows on
8 asthmatics.

9 And the best case scenarios with
10 people who are continuing to work, have gotten
11 maybe 10 or 20 percent of their group to do the
12 peak flows successfully to two to four weeks.

13 So I think it's as Dr. Redlich was
14 saying, it's doable in some cases, it's the
15 minority of cases. And when it's present, it
16 should be used.

17 But I think there should be a
18 statement in the rationale saying that in the
19 great majority of cases, it's not feasible. And
20 it's not to be expected.

21 CHAIR MARKOWITZ: Right. Okay.
22 That's fine. So is there a motion to approve

1 this? This recommendation that I've just read
2 and we've modified?

3 MEMBER BODEN: Can I ask a question?

4 CHAIR MARKOWITZ: Sure, sure.

5 MEMBER BODEN: So, one other thing
6 that I'm hearing, and I'm wondering if it should
7 be explicit in the recommendation, or if I'm
8 hearing it wrong, is that really IH input is
9 irrelevant to the diagnosis.

10 Because we don't really need an
11 exposure. We just need to have somebody have
12 been at work.

13 And I'm wondering if -- I'm wondering
14 a, if that's a misrepresentation. But b, if it
15 isn't, whether it should be explicit in the
16 recommendation?

17 CHAIR MARKOWITZ: Right. So the
18 current policy, it excludes pretty much exposure
19 of the little consultation with the SEM. Because
20 it depends on the diagnosis of occupational
21 asthma.

22 But I can certainly add that to the

1 rationale. Dr. Cassano?

2 MEMBER CASSANO: The only thing I see
3 missing is, is it possible that somebody could
4 misconstrue this to that one episode of
5 bronchospasm that occurred at work for an unknown
6 reason would be considered -- doesn't it have to
7 be somewhat chronic? Or recurrent episodes?

8 CHAIR MARKOWITZ: No. That would be
9 implied in the diagnosis of asthma.

10 MEMBER CASSANO: Okay.

11 CHAIR MARKOWITZ: I mean of -- all
12 right. Yes. So, are we ready to vote? So all
13 those in favor of this recommendation, raise your
14 hand.

15 (Show of hands.)

16 CHAIR MARKOWITZ: Mr. Griffon?

17 MEMBER GRIFFON: Yes.

18 CHAIR MARKOWITZ: Okay. So 14 votes
19 in favor. And there's all 14 of the board
20 members who are participating in this meeting.

21 We're going to revive Dr. Sokas'
22 recommendation that she sent after the discussion

1 yesterday from the Industrial Hygiene and CMC
2 subcommittee. If you could blow this up.

3 And so we're going to do this. And
4 then we're going to take a break and then we'll
5 move onto the Part B Lung Disease Subcommittee.

6 This is a recommendation that she
7 sent. And I edited the language a little bit.
8 Because that's what I do.

9 Assessment of quality, objectivity,
10 and consistency of CMC work. We request that the
11 DOL provide the board with resources to conduct a
12 quality assessment of a sample of 50 CMC
13 evaluations that have been associated with claim
14 denials.

15 The quality review will assess the
16 nature of the medication information reviewed by
17 the CMC, the use of standards of causation, the
18 reasoning of the CMC, the scientific basis for
19 the CMC conclusions, among other items.

20 The assessment will likely require
21 contracted services of worker centered
22 occupational physicians who are not associated

1 with the current CMC contract. The review may
2 lead to recommendations including development of
3 guidance materials.

4 So, it's open for discussion. Dr.
5 Welch?

6 MEMBER WELCH: I think it's great.
7 Let's vote.

8 (Laughter.)

9 CHAIR MARKOWITZ: All right. Other
10 comments?

11 (No response.)

12 CHAIR MARKOWITZ: Okay. So, is there
13 a motion to accept the -- and there's a second.
14 Okay. Any final discussion?

15 All those in favor raise your hand.

16 (Show of hands.)

17 CHAIR MARKOWITZ: And Mr. Griffon?

18 MEMBER GRIFFON: Yes.

19 CHAIR MARKOWITZ: So 14 members of the
20 board who are present all vote in favor. Let's
21 start with the Part B Lung Conditions report from
22 Dr. Redlich.

1 MEMBER REDLICH: Oh, let me get the --
2 yes, I'd like to give the -- sorry, I had my
3 PowerPoint program kept crashing last night.
4 Yes. So let me -- the email's not working.

5 CHAIR MARKOWITZ: Yes. While we're
6 waiting, what we had planned to do if there's
7 time after this report is consider a solvency in
8 hearing loss presumption. And then handle
9 associated items including scheduling the next
10 meeting, so.

11 Anybody experiences any cold induced
12 asthma, there are some pulmonologists in the
13 room.

14 (Laughter.)

15 CHAIR MARKOWITZ: And Ms. Vlieger has
16 an inhaler also.

17 Well, let me say that this is a -- the
18 Joint Outreach Task Group for Energy Employees
19 Occupational Illness Compensation Program is
20 holding two town hall meetings today, one at two
21 p.m. and one at six p.m. at the Red Lion Hotel in
22 Pasco. Is that where we are?

1 PARTICIPANT: No. We're at Richland.

2 CHAIR MARKOWITZ: Okay. Okay. And
3 these are the JOTG meetings. And representatives
4 from the Department of Labor EEOICPA Program, the
5 ombudsman office of the Department of Labor, the
6 NIOSH of the Health and Human Services, the
7 ombudsman to NIOSH, and the Department of Energy
8 will be in attendance to answer questions and
9 provide information on Part B and Part E parts of
10 EEOICPA.

11 Representatives from the Former Worker
12 Medical Screening Program will provide
13 information on the free medical screening
14 programs.

15 Representatives from the Hanford
16 Resource Center and the Cleveland District Office
17 will also be in attendance to receive new claims
18 and answer claim specific questions. If you have
19 any questions regarding this meeting, you can
20 speak with Mr. Nelson or Mr. Levin in back. Or
21 call their toll free number.

22 But for those of you on the phone

1 actually, let me give you that toll free number.
2 It's 877-662-8363. That's 877-662-8363.

3 Attendance at the meeting is strictly
4 voluntary. And registration is not required.

5 So we could take our -- we're due for
6 a break in seven minutes. So if you want, we can
7 take the break now and come back. It's up to
8 you.

9 MEMBER REDLICH: Yes. Maybe we should
10 just take the break.

11 CHAIR MARKOWITZ: Yes. Let's take a
12 break for ten minutes. We'll be back a little
13 bit before 25 of 10:00. Thank you.

14 (Whereupon, the above-entitled matter
15 went off the record at 9:24 a.m. and resumed at
16 9:35 a.m.)

17 CHAIR MARKOWITZ: We're going to get
18 started again. I want to point out the -- it's
19 the professors on the board who don't appear to
20 be back at school -- back in class on time.

21 SPEAKER: How long do we have to wait
22 for them?

1 CHAIR MARKOWITZ: Well, I'd say two
2 minutes. Some of the professors have made it
3 back, but, notably, the people who are really the
4 only people absent.

5 MEMBER VLIEGER: The workers are here.

6 CHAIR MARKOWITZ: Exactly. One Board
7 member is arriving on his bicycle. So, that's
8 good. He's a preventative medicine physician.
9 He has his helmet. His helmet is, however,
10 draped on his bicycle, not on his head.

11 Okay. We're going to -- we're only --
12 Mr. Griffon, are you there? Mark? Okay. Let's
13 get started.

14 MEMBER GRIFFON: Yeah. Sorry, Steve.

15 CHAIR MARKOKWITZ: All right.

16 MEMBER GRIFFON: I am on.

17 CHAIR MARKOWITZ: Okay. So, Dr.
18 Redlich, all yours.

19 MEMBER REDLICH: Okay. And it's --
20 it's 9:30 and just to keep an eye on the time, we
21 need to be finished -- when should I be finished?
22 I am --

1 CHAIR MARKOWITZ: Just proceed through
2 your portion.

3 MEMBER REDLICH: Okay. So, I'm going
4 to give an update on the Part B Subcommittee. We
5 actually did do quite a bit since our last
6 meeting.

7 So, I was going to go over -- we
8 reviewed approximately 60 Part B cases. I was
9 going to give a summary of what we learned.

10 Also, the sarcoid presumption,
11 clarification of beryllium exposure, and then I
12 was going to mention a few of the -- responses to
13 a few of the issues and questions that the DOL
14 and also others have raised concerning various
15 parts of Part B.

16 So, and, actually, I did want to thank
17 the other members of this committee, John Dement,
18 Kirk Domina, James Turner and Laura Welsh. And
19 Faye is -- Vlieger is not an official member, but
20 she has been very helpful. So, thank you.

21 So, the cases that we reviewed
22 included beryllium sensitivity, CBD, sarcoidosis.

1 As you can see, chronic silicosis,
2 pneumoconiosis.

3 The numbers, there was a little bit of
4 overlap between some of the cases, so -- as one
5 or two fell under more than one category, but we
6 don't need to worry about that.

7 So, I -- and I should say that the
8 materials that we received, we did not get a
9 thousand pages on each case.

10 We got some of the key documents,
11 accepted facts, the CMC referrals. And as I --
12 since we did not have medical records, there
13 could have been issues that we are unaware of,
14 but this was based on sort of the -- those pieces
15 from the case.

16 And not all of them had all that so
17 that something like IH reports was only on a few
18 of them. The questionnaires was on most, but not
19 all of them as far as the -- as I said, there
20 were different pieces, but what we had very
21 little was the actual medical records. But now
22 that I've heard about all the thousands of pages,

1 I am glad that we did not get those.

2 So, I think we actually felt like what
3 we saw, we did have a better feel for what was
4 happening with these claims.

5 I would say that there was -- we
6 agreed with a number of the decisions, but areas
7 that we found that there were some problematic
8 decisions predominantly related to sarcoidosis
9 and CBD claims.

10 And most of them actually fell into
11 the group of either a misapplication or a
12 misunderstanding of the sarcoid presumption.

13 I should say that almost all of the
14 claims that we reviewed were ones that had -- in
15 the final decision, had been in the last few
16 years.

17 These were not really ancient,
18 historic claims. So, these were in the last two
19 to three years. So, that was one group.

20 And then there were some where I think
21 the CMC based on the information we had, we felt
22 had made a somewhat narrow interpretation of the

1 clinical information. There were few of those.

2 A couple -- and we wanted to raise
3 this -- brought up the question of what is a --
4 the definition of a beryllium worker. Because
5 there were, for example, someone who worked for
6 many years at what we thought was a clear
7 beryllium site, but the list then sort of
8 concluded that they had no beryllium exposure.
9 And that was not -- that was one or two.

10 And then, also, another finding that
11 was evident from several of the cases, was
12 eventually there was a correct decision, but the
13 number of years and the number of re-decisions
14 and -- it was just a lot. And I think, ideally,
15 those could have been diagnosed sooner.

16 And I think that is an issue in terms
17 of all the time, manpower and the stress that
18 someone goes through for many, many years
19 advocating a claim.

20 So, and then the pneumoconiosis and
21 chronic silicosis we did not review as many. A
22 number of them, there were issues which -- that

1 are beyond us related to the uranium workers,
2 RECA and what -- the different criteria.

3 And the other problem that we
4 identified has already -- has been addressed by
5 the SEM Committee, which was that some of them
6 identified a very limited group of exposures. I
7 think that issue has been addressed by the SEM
8 committee.

9 And then other issues that were -- we
10 noticed, one was that -- so, the ones that we
11 had, half of them had -- 30 of about the 60 had a
12 CMC report in them. Of those, 30, over half of
13 them, were a single CMC.

14 And he was a pulmonary physician with
15 appropriate credentials, but I -- this was not
16 just me. I think there was a clear attitude
17 problem that this person had.

18 And I think to use one CMC for so many
19 cases -- he was more on the East Coast, also.
20 Not that there weren't, but there were a lot of
21 West Coast cases, who -- I think that was -- that
22 raises the issue for the CMC Committee or one of

1 the other committees, but I do think oversight of
2 the people doing this. And this was quite
3 noticeable.

4 So, and then the other issue that came
5 up on a number of cases, and I don't know if this
6 is something that can be addressed, is that
7 sometimes they were asked a quite narrow
8 question.

9 And I can understand doing that, but
10 there -- for example, there might be a worker who
11 was asked a question about silicosis and it was
12 clear bilateral pleural plaques and asbestos
13 disease on the chest x-ray, but the person wasn't
14 asked that question.

15 So, I mentioned this. If the report
16 had a, you know, have you identified another
17 occupation -- or another possible occupational
18 lung disease, at least for the -- if it was a
19 user-friendly system for the workers, that would
20 at least be an opportunity to then, okay, we'll
21 look into the asbestos or the COPD or another
22 disease.

1 So, I think that would be something
2 that would be helpful. Then, obviously, people
3 would have to be instructed.

4 So, does anyone have any questions
5 about the review of the cases or anyone else on
6 our group who wanted to comment, Kirk and Laura,
7 everyone else who reviewed them?

8 MEMBER WELCH: Since I haven't seen
9 how you finished the slides, are you going to
10 make a specific recommendation about what you
11 just said adding a -- adding that the CMC asks --
12 I mean, that the claims examiner ask the CMC a
13 broader question about occupational lung disease?

14 MEMBER REDLICH: I hadn't, but I think
15 that is a good suggestion.

16 MEMBER WELCH: Okay.

17 MEMBER REDLICH: And maybe we could --

18 MEMBER BODEN: Just a brief thought of
19 that attitude. In other areas, particularly in
20 areas involving some sort of adjudication, there
21 have been studies that essentially measure
22 attitude. They measure liberalness or

1 strictness.

2 So, if we're thinking about evaluating
3 CMCs, which we talked about before, then you
4 could actually -- you have to check a little bit
5 on the details of how the CMC cases are
6 allocated, but you could actually look for
7 outliers scientifically.

8 CHAIR MARKOWITZ: Sure. Dr. Cassano.

9 MEMBER CASSANO: What you're asking,
10 obviously, is sort of contingent on some of the
11 other recommendations that we've made.

12 Obviously, if they only ask the
13 question about silicosis and the SOAF didn't
14 mention anything else and they didn't get the
15 medical records which showed the chest x-ray that
16 had the bilateral pleural plaques, there's no way
17 for them to comment on other occupational
18 disease. So, what you're asking has got to be
19 contingent upon them seeing the entire record.

20 And I think we'd want to clarify -- I
21 think that the -- currently, the process -- the
22 procedure is the CMC only asks -- answers

1 questions that are asked.

2 So, seeing the rest of the medical
3 records and knowing that there's an asbestos-
4 related disease if this claims examiner hadn't
5 asked about it, the CMC is not supposed to
6 comment on it.

7 So, that's something that would need
8 to be explicitly recommended to change, that the
9 CMC should, you know, doing the medical records,
10 note other potential occupational diseases and
11 send it back.

12 I mean, you know, the claim comes in
13 and the worker may have written down silicosis,
14 when what they had was asbestosis. And it seems
15 to follow that way and nobody stops and says, oh,
16 this is really asbestos-related.

17 And it seems like a simple fix, but I
18 think we have to understand -- and that's kind of
19 your --

20 (Simultaneous speaking.)

21 MEMBER WELCH: Yeah. I think it is
22 the --

1 MEMBER CASSANO: Yeah. And I think it
2 also applies not just to I get Part 2 cases.

3 MEMBER WELCH: Yes.

4 MEMBER CASSANO: It applies to
5 everything, you know. If somebody -- we see this
6 all the time. Somebody has a particular
7 contingent, it's this disease, this exposure, and
8 it's a different exposure that actually is
9 causing the disease.

10 There needs to be a process by which
11 the CMC can render an opinion on that. And
12 without the entire record and without the
13 guidance to do that, they're not going to be able
14 to.

15 MEMBER REDLICH: Yes. And so, I think
16 that falls under your jurisdiction. Exactly.
17 So, I will -- I just wanted -- this is sort of
18 what we -- I will also say that because we were
19 limited in what we were given, cases that seemed
20 like a reasonable denial of, let's say, CBD, it's
21 possible that there was evidence of lung disease
22 somewhere in the chart that, you know, we didn't

1 see.

2 So, this was based on the records we
3 had, but I still think that these -- and as I
4 said, I think that most of these are fixable
5 problems.

6 Okay. So, moving on, the next item
7 was a sarcoid presumption and we had discussed
8 this before.

9 And there is already a presumption of
10 chronic beryllium disease in situations with a
11 diagnosis of sarcoidosis involving the lungs in
12 an individual who meets the definition of a
13 covered beryllium employee.

14 So, I think last time we decided we
15 don't necessarily need to make a recommendation
16 that already exists, but the issue was more the
17 implementation of that recommendation.

18 So, I did bring up -- and in the next
19 few slides I wanted to not spend too much time on
20 this, but I think reviewing the records that we
21 did made it clear what some of the problems with
22 this implementation were and also some of the

1 problems with the wording.

2 So, I didn't know whether there was a
3 value in us voting again on sarcoid -- not voting
4 again, but voting on this or not. And I'll defer
5 to you.

6 CHAIR MARKOWITZ: All right. So, for
7 the sake of clarity, we did not vote on a
8 recommendation previously.

9 MEMBER REDLICH: Exactly. Yes.

10 CHAIR MARKOWITZ: So, this would be a
11 new recommendation. But what we're looking at,
12 is there additional text with this
13 recommendation, or is it just what we're looking
14 at right now?

15 MEMBER REDLICH: So, since the
16 recommendation is already there, there's not
17 additional text to the recommendation.

18 CHAIR MARKOWITZ: Oh, okay. So, what
19 we're looking at now, those four lines, does this
20 involve -- is this recommending a change in the
21 policy of DOL, or is this just confirming --

22 MEMBER REDLICH: It's not.

1 CHAIR MARKOWITZ: It's confirming.
2 So, if it's not a change in their policy, I don't
3 see the need for a recommendation to confirm what
4 they're doing.

5 MEMBER REDLICH: Yes. So, where there
6 could be a potential recommendation, although I
7 did not write it out, was to clarify the wording
8 of the implementation of it.

9 But I think that that needing
10 clarification actually is relevant to a number of
11 parts of the whole Chapter 2 that relates to the
12 B conditions.

13 I was just going to show one or two
14 examples of some of the wording issues.

15 CHAIR MARKOWITZ: Sure.

16 MEMBER REDLICH: So, we're in
17 agreement that because there is a presumption, we
18 don't need to vote on it again. I just -- my
19 memory from the last time was a little -- okay.

20 So, we're already on to the last item
21 here, the responses to some of the questions.
22 So, we had originally been given a number of

1 questions and have a more detailed response that
2 I had planned to have it on the website before
3 our meeting, but we'll get to people.

4 I wanted to highlight one or two of
5 the key issues that have come up more than once
6 and what our decision regarding these are.

7 So, not necessarily in the exact
8 order, one of the questions was, what is a
9 chronic respiratory disorder?

10 And so we don't need to read every
11 line of this, but there are currently several
12 definitions in these documents that refer to, you
13 know, define what a chronic respiratory disorder
14 is.

15 So, and this is from the -- what's it
16 called -- the Chapter 2 in the procedure manual.
17 Thank you. So, this is in Chapter 2 of the
18 procedure manual for a chronic respiratory
19 disorder.

20 This is also in Chapter 2 of the same
21 procedure manual and -- let's see if this pointer
22 -- oh, there it is. Okay.

1 So, it starts, you know, the last list
2 had specific conditions of a chronic respiratory
3 disorder. Some of them, you know, respiratory
4 infections -- it's a broad list.

5 So, this one had some wording:
6 pulmonary testing performed are not appropriate
7 to document unless interpreted as such by a
8 physician.

9 So, any PFT report does get an
10 interpretation. So, I think it's just an example
11 where the wording, to me, at least, is somewhat
12 confusing as far as what a chronic respiratory
13 disorder is.

14 And then this is from the slides that
15 I believe are used to train; is that correct?
16 They were under your category, but I found them.

17 (Laughter.)

18 MEMBER REDLICH: So, I spent a lot of
19 time on that website, but -- okay. This then
20 says -- it lists the pre-1993 criteria, which I
21 think all of these, I think -- we were asked for
22 clarification on a number of these criteria,

1 which we have tried to do.

2 But two things here: One is that at
3 least one of the documents must show that the
4 claimant received treatment for -- received
5 treatment. And previously there's wording that
6 says -- I don't have the exact words, it's in one
7 of these, but it was either treated for or
8 diagnosed.

9 So, treated for or diagnosed is
10 actually different than treated. And it may seem
11 like a minor change, but this is the type of
12 thing that I think creates a lot of confusion and
13 anxiety.

14 Another thing I will just mention,
15 which I think -- is that it says here immunologic
16 tests. And the first test it mentions is a skin
17 patch test.

18 And one of the comments -- I went
19 through all of the comments we've gotten since we
20 started this from various other places to make
21 sure we address the different ones, but one of
22 them mentioned a patient calling around, spending

1 time trying to find where they can get their skin
2 patch test done.

3 So, this is an easy fix. It should be
4 out, you know, find, delete any mention -- skin
5 patch testing is not indicated.

6 So, some of the rationale for these
7 points is in our more detailed response, but that
8 -- it would help to remove a reference to skin
9 patch testing throughout.

10 So, I mean, this is just an example of
11 one area where there is confusion in the -- some
12 of the different versions of the wording.

13 And I apologize. My PowerPoint was
14 crashing multiple times last night.

15 I did have a slide that showed what we
16 thought would be reasonable wording for what
17 constituted a chronic respiratory condition,
18 which was basically symptoms with -- chronic
19 symptoms with one other objective piece of
20 evidence for a chronic respiratory condition.
21 And so, that could be specified.

22 I felt like to start getting into the

1 -- each one of these points as a recommendation
2 was probably sort of nitpicking.

3 I think the more general
4 recommendation to sort of review the wording for
5 consistency and -- that would make more sense
6 than sort of each specific point.

7 But one of the areas that does need to
8 be addressed for consistency is, what is a
9 chronic respiratory condition.

10 So, then, the area of sarcoidosis
11 presumption where, as I said, that there is a
12 presumption, but the wording seems to vary.

13 Let me see, one of these -- this was
14 the original sarcoidosis presumption in 2008.
15 And it says: Presumption of chronic in situations
16 with a diagnosis of sarcoid and a history of
17 beryllium exposure.

18 The purpose, a diagnosis of
19 sarcoidosis is not medically appropriate if there
20 is a documented history of beryllium exposure,
21 period. So, that is a sarcoid presumption.

22 And if that -- you believe in that

1 presumption, then we don't need many, many pages
2 after that of what to do with this BeLPT or all
3 these other possibilities. So, this presumption
4 was the original presumption.

5 Then there was another circular after
6 this that said that this circular was then,
7 whatever, receded. And now that -- the current
8 version of this is the wording that is in Chapter
9 2.

10 And there were some other pieces of
11 this wording I don't, you know, it goes on to say
12 here: Because a diagnosis of sarcoid for a
13 covered beryllium employee is not medically
14 appropriate, in any instance where this occurs,
15 CBD is to be the presumed diagnosis.

16 And then when we start getting into
17 all the howevers, things get sort of more
18 confusing. And so, I think with a lot of the
19 cases that we reviewed, it's understandable why
20 there was confusion about presumption.

21 And I guess before we go on to Chapter
22 2, I think Dr. Markowitz discussed the basic

1 principle of a presumption yesterday. And that
2 any presumption, I mean, there are a lot of
3 advantages, as he mentioned, to a presumption.
4 But when you do have a presumption, there is the
5 potential that one would be either over or
6 undercompensated.

7 So, this is the current wording. And
8 so, it's -- it recognizes that a diagnosis of
9 sarcoidosis especially in cases with a pre-
10 diagnosis date, could represent a misdiagnosis.

11 Now, I don't know why it would be
12 especially in these cases. It seems that either
13 pre- or post-1993, if you have a presumption --
14 so that is confusing.

15 So, then -- so, and I'm also -- the
16 differentiation between Part E and Part B gets
17 confusing, because -- and I didn't want to go
18 into a whole discussion here of, you know, are
19 they the same disease or are they different? I
20 know that has generated some confusion.

21 I think the point is that
22 pathologically and clinically they can be

1 indistinguishable. And although certain features
2 may be more common in one than another, such as
3 extrapulmonary involvement, they can exist in
4 both. And I think if there's going to be a
5 presumption, then they should have a presumption.

6 So, and then also it continues with
7 Chapter 2 for Part E claim, the CE can evaluate a
8 claim as CBD. However, a positive is necessary
9 to accept it.

10 So, this is under the discussion of a
11 presumption. So, if it's a presumption, then I
12 don't know why we have to have a, however, you
13 need a positive BeLPT.

14 The other thing is this, too, wording
15 is also like a little bit confusing. This is the
16 actual name of the test that's currently
17 performed, a BeLPT.

18 So, then, without affirmative evidence
19 of a positive, the CE is to proceed with the
20 adjudication of the claim as one for a diagnosis
21 of sarcoidosis.

22 So, I mean, if you're confused with

1 the wording here, I'm confused and I'm -- this is
2 my area of expertise. So, I think you've got the
3 idea and we don't need to -- so, there's internal
4 inconsistencies.

5 And then this is all -- this was
6 actually then describing CBD on or after 1993.
7 And it's relevant to the sarcoid presumption,
8 because, in claims that contain a normal or
9 borderline, and the biopsy confirms the presence
10 of granulomas consistent with CBD, the CE may
11 accept the claim. The lung biopsy is considered
12 the gold standard, period. But then we have the
13 however. So, it's very confusing.

14 And the current document does explain
15 why you can have a negative BeLPT test and still
16 have CBD. For instance if you were on steroids.

17 So, if it is a presumption, then do we
18 need to have exhaustive efforts, you know, to go
19 find every LPT and -- so, if it's, you know, you
20 wouldn't need those exhaustive efforts.

21 Then there's other -- just there's
22 areas that I think create confusion and there was

1 a case -- one of them I reviewed was denied
2 because of this. I don't know if it was
3 eventually accepted, but this is on the post-
4 1993.

5 And I should also just clarify when
6 cases were denied, it's important that people
7 recognize that the organ that you biopsy when you
8 diagnose sarcoid, is usually the one that would
9 be least risky to do. So, sometimes skin or
10 nasal. Someone could have pulmonary involvement,
11 but the actual tissue was obtained from the skin.

12 And there were some cases like that
13 denied where -- without an appreciation that
14 there was pulmonary involvement.

15 And if the physician was tuned in
16 enough to actually highlight, yes -- and we
17 mentioned that you can document pulmonary
18 involvement in those situations by chest CT scans
19 showing the findings that would be consistent or
20 pulmonary function testing and that is commonly
21 done.

22 But getting back to -- they discussed

1 that the mediastinal lymph node biopsy is
2 consistent with CBD, may be used to establish.
3 So, they say that it's okay to use a mediastinal
4 lymph node biopsy.

5 Then it says that the lymph node
6 biopsy is not the equivalent of a lung biopsy.
7 So, a mediastinal lymph node is in your chest.
8 It drains -- these lymph nodes in the chest drain
9 the lung.

10 So, then it says it does not
11 substitute for the assessment of a post-CBD
12 claim. The evidence has to be interpreted as
13 lung pathology. A mediastinal lymph node is not
14 dispositive proof of CBD in the same way as a
15 lung biopsy.

16 So, this is a lot of wording, as a
17 pulmonary specialist, I don't really understand.
18 I think if you have a -- if you have disease
19 involving, you know, the chest and the lymph
20 nodes in the chest, then that is consistent with
21 CBD.

22 Laura.

1 MEMBER WELCH: I think some of the
2 what looks like jumping through hoops, is because
3 the legislation defines diagnostic criteria for
4 CBD.

5 So, and it requires -- I don't
6 actually have it up in front of me for Part B
7 cases, requires certain steps that -- and I think
8 it requires some evidence of sensitivity.

9 But you have to kind of compare this
10 to that, because, you know, the first one you put
11 up, however -- it said: However, Part B has
12 specific legislative requirements, so, therefore,
13 blah, blah, blah.

14 So, I think what it is, is it's, you
15 know, the claims examiner can't just say the
16 mediastinal lymph node biopsy is -- shows
17 granulomas and that's good enough. They have to
18 have a physician say that that's part of the
19 lung, because the legislative language may say it
20 has to be a lung biopsy.

21 So, it's sort of like -- I mean, I
22 think we have to -- maybe it makes sense to --

1 MEMBER REDLICH: No, I do understand
2 that factor, but I think that one could address
3 this problem and also be very scientifically
4 valid and provide guidelines so that each
5 individual person didn't need to know the full
6 literature on these issues.

7 And I think they've done that in some
8 regards, and I think there has been attempts such
9 as explaining why you could have a negative
10 BeLPT, you know, document that the person's on
11 steroids.

12 So, I think there's been an attempt to
13 do that, it's just I think it could be done
14 better and sort of simplified.

15 And I think it is a point that we
16 obviously have to -- okay. So, I won't spend too
17 much more time on this, but the skin patch
18 testing is just -- I mentioned that already.
19 This is pre- and includes -- and it includes skin
20 patch test and beryllium blood tests. So, that
21 should go.

22 And then there was a question about

1 the wording -- you know, with -- in a number of
2 places there's wording that is characteristics or
3 consistent with. And I actually didn't fully
4 understand the question that the DOL was asking
5 related to this.

6 I think it's just important to
7 recognize that for CBD and sarcoid and for most
8 pulmonary conditions, there are findings that you
9 do see whether it's the, you know, chest CT scan,
10 the PFTs or the chest x-ray, that are consistent
11 with, but any given one of those is not unique or
12 pathognomonic for the disease.

13 So, I think that that wording is -- I
14 understand that people would like one to be able
15 to say, well, that CT scan finding is it, you
16 know, and is only in CBD and not -- but that
17 actually is not the case.

18 So, if there are other concerns or
19 questions about the wording that I didn't
20 understand. And then just another area where I
21 think wording is creating unnecessary confusion,
22 this is under discussion of characteristics,

1 chest x-ray findings.

2 Under that, there's a discussion of
3 caseating granulomas. You don't see a caseating
4 granuloma on a chest x-ray, it's histologically
5 what you would see on a biopsy. So, having this
6 discussion under the x-ray findings is somewhat
7 confusing.

8 And then it -- and it says, are
9 sometimes considered characteristic, and then --
10 so, this, again, is an example of confusing
11 wording.

12 And then calcification, there was, I
13 think, one case that was denied because there was
14 some calcification noted somewhere.

15 Now, so you can have calcifications
16 with CBD, and this is documented in the
17 literature. So, this is a wrong statement and
18 just should be removed.

19 And, again, it's an area where -- I
20 mean, this whole discussion is confusing and
21 unnecessary and has nothing to do with a chest x-
22 ray finding.

1 Sorry. I hit the wrong -- do you want
2 to get back to just the next slide? Yeah. I'm
3 not used to this little -- I think we're just
4 about --

5 CHAIR MARKOWITZ: I think that was the
6 last slide.

7 MEMBER REDLICH: Okay.

8 CHAIR MARKOWITZ: Granulomas.

9 MEMBER REDLICH: Yes. So, I'll just
10 go back to one earlier here. I think -- yeah,
11 the one topic that I did not have a slide for,
12 but we discussed, was the question of
13 indeterminate BeLPT. And Laura Welch helped with
14 this.

15 It was mentioned -- so, as people
16 know, a BeLPT can be abnormal or normal.
17 Abnormal being considered positive. And the DOL
18 uses a standard of one positive test.

19 The question has come up of what to do
20 when sometimes you can get what's called an
21 indeterminate -- I'm sorry? Borderline, excuse
22 me. That's my fault. Borderline BeLPT. I will

1 correct that.

2 And for a borderline BeLPT, it was
3 mentioned yesterday the Department of -- that the
4 state of Washington considers three borderline
5 BeLPTs to be the equivalent of a positive.

6 Given that our DOL standard for
7 sensitivity is one positive BeLPT test, if one
8 looks at the literature of the predictive value
9 of borderline tests, two borderline BeLPT tests
10 is -- gives a similar predictive value as a one
11 positive test.

12 So, we felt that two borderline BeLPTs
13 should be considered the equivalent of one
14 positive or abnormal BeLPT.

15 I did not put that in a formal
16 recommendation, but I think that that is
17 appropriate.

18 And Laura can -- if you want to
19 comment further ---

20 MEMBER WELCH: Well, I do think at
21 some point it has to be a formal recommendation,
22 because the board has to vote on it.

1 MEMBER REDLICH: Okay.

2 MEMBER WELCH: And we have to vote on
3 specific language, but I leave that up to our
4 chair to decide.

5 CHAIR MARKOWITZ: Sure. Well, you
6 know, we can communicate this discussion to DOL,
7 but -- and at the next meeting, to formulate a
8 specific recommendation and have a complete
9 rationale to go along with it.

10 MEMBER REDLICH: Well, you know, if we
11 want, we can formulate a recommendation now. I
12 wrote the rationale in our response to all the
13 questions as a rationale, but --

14 CHAIR MARKOWITZ: We could also, by
15 the way, have a telephonic -- I think telephonic
16 meeting of the board in the interim between our
17 face-to-face meetings if you want to consider a
18 recommendation.

19 So, we could have one, you know, in
20 six to eight weeks.

21 MEMBER REDLICH: Okay. You know, I
22 didn't know if that fell to the level of needing

1 a specific recommendation. But if people think
2 that that is --

3 CHAIR MARKOWITZ: Yeah. Well, Dr.
4 Boden.

5 MEMBER BODEN: So, a question. What
6 would a recommendation look like?

7 So, one thought of what a
8 recommendation could look like is recommended
9 rewording of a document, but we could also --
10 that is specific recommended rewording, but we
11 could also simply recommend to DOL that it takes
12 certain things into account when it rewords.

13 So, I'm wondering what people are
14 thinking.

15 MEMBER REDLICH: It is true that this
16 -- some of the other points I made were more, I
17 think, you know, wording that needs to be
18 clarified.

19 The -- currently, there is no -- no
20 sort of decision about how to handle borderline
21 BeLPTs.

22 And what, in practice, happens, is

1 that people that have borderline lungs, you know,
2 go for more tests and need more testing.

3 MEMBER BODEN: Let me --

4 MEMBER REDLICH: And so, the only --
5 I think the only real -- people have decided that
6 they are -- mean something and the only issue is
7 whether it's three that are a positive or two.

8 And I think given that the standard
9 for -- the DOL uses is one abnormal BeLPT, that
10 the equivalent of that would be two borderline.

11 CHAIR MARKOWITZ: So, is the
12 recommendation simply that two borderline BeLPTs
13 be considered equivalent to a single positive
14 BeLPT?

15 MEMBER REDLICH: Yes.

16 CHAIR MARKOWITZ: If that's the
17 language, then without getting -- if it gets more
18 complicated or, you know --

19 MEMBER REDLICH: No, it's not.

20 CHAIR MARKOWITZ: -- starts other
21 issues, then I think --

22 (Simultaneous speaking.)

1 CHAIR MARKOWITZ: If that's the
2 specific language, I think we can discuss it and
3 vote on it.

4 So, Kevin, if you wouldn't mind just
5 typing that out?

6 MEMBER REDLICH: Yeah. I --

7 CHAIR MARKOWITZ: Is there any further
8 discussion we need to have on this?

9 MEMBER CASSANO: Given how complicated
10 all of the language is in the procedure manual
11 and the training documents and everything else, I
12 think making one specific change added onto all
13 of this is going to be even more confusing.

14 And I think without the rewrite -- the
15 recommendation to rewrite Chapter 2 completely
16 and including that might just add more confusion
17 to something that's already confusing.

18 CHAIR MARKOWITZ: Ms. Vlieger.

19 MEMBER CASSANO: I don't know. My
20 thoughts.

21 MEMBER VLIEGER: The recommendation to
22 actually be put forward to the Department of

1 Labor as a bulletin to supplement whatever you
2 guys end up with a draft PM that's on -- the
3 procedure manual that's going on right now, I do
4 think this is significant and it affects a number
5 of workers.

6 So, to wait for the procedure manual
7 rewrite, I think, is going to be too long.

8 CHAIR MARKOWITZ: Other comments?

9 Dr. Silver.

10 MEMBER SILVER: It's disheartening for
11 someone who naively read the statute upon passage
12 to see that what we thought was going to be a
13 simple set of presumptions has been turned into
14 another science project for physicians and claims
15 examiners.

16 In each of our public comment periods,
17 we've heard from one of the advocates, Stephanie
18 Carroll, about the idea of established beryllium
19 disease per the statute.

20 Was that framework at all helpful to
21 you in analyzing where DOL has gone wrong with
22 this part of their procedure manual?

1 MEMBER WELCH: Well, I actually think
2 that we probably -- I think we should think about
3 -- you've said a lot of things, but I don't think
4 it's specific enough for DOL to know how to
5 change the procedure manual.

6 So, I think those two -- there's two
7 issues. There's the simple, straightforward one
8 that we have that Kevin is typing out right now
9 about handling borderline BeLPTs. So, we could
10 address that.

11 And then the rest of it, I think we
12 have to look at it in terms of legislative
13 language.

14 Part E doesn't have any specific
15 diagnostic criteria, but Part B does. And so,
16 how you can take current knowledge about
17 beryllium disease and sensitization and make it
18 fit -- I think what we've seen is many attempts
19 to kind of make it fit with the legislative
20 language.

21 And it's been tweaked so many times
22 it's -- there's not one instruction about what to

1 do.

2 So, I actually think it would probably
3 be helpful if we made recommendations, what to
4 change.

5 MEMBER REDLICH: Yeah. So, I didn't
6 mean to overly confuse -- I partly want just an
7 example of some of the language. I mean, I
8 agree.

9 I think that the borderline test is a
10 specific issue that should be fixed and really
11 does not have to do with, like, the confusing
12 wording in the text.

13 So, I would vote that we suggest we
14 vote on that.

15 MEMBER CASSANO: Question: Is this
16 for both beryllium sensitivity and beryllium
17 disease as in both Part B and Part E as we may
18 need to say that, but it's for both sensitivity
19 and disease, as well as under both parts?

20 MEMBER REDLICH: I think throughout --
21 there is consistency throughout the -- all the
22 documents that when they are referring to

1 sensitization, that it is one positive BeLPT.

2 So, if one says that two borderlines
3 are the equivalent of one positive, that piece is
4 consistent.

5 CHAIR MARKOWITZ: Dr. Friedman-
6 Jimenez.

7 MEMBER FRIEDMAN-JIMENEZ: I don't know
8 this literature, and I'm wondering if you could
9 maybe give us some references of the test,
10 because I'd like to know what the gold standards
11 were and what the predictive values were.

12 MEMBER REDLICH: Yes. So, Laura Welch
13 can describe, but there are a couple papers that
14 looked at the predictive value of the borderline
15 test.

16 And I don't know if we here want to
17 get into how many positive --

18 MEMBER WELCH: Yeah. I mean, I could
19 send you some of that. There's no -- there's
20 sort of no gold standard, but you can look at the
21 predictive value clinically and use that as the
22 gold standard. And I'll send you those pages.

1 MEMBER REDLICH: And I think that so
2 much of the convoluted language and the like, the
3 one piece of the Act that if one could go back in
4 time and change, was the -- such an emphasis on
5 the BeLPT test, because the -- post-1993 it's
6 almost -- it's sort of been a bottleneck.

7 And I put it in our longer response
8 and rationale, but there's a number of reasons
9 for why you could be sensitized and have CBD and
10 have a negative BeLPT test that go beyond just
11 being on steroids.

12 And it's shown that when you do, it's
13 not a perfect test. And when you do lavage and
14 peripheral blood, each of those can be falsely
15 negative and falsely positive.

16 And, in fact, when you actually have
17 active disease, the sensitized lymphocytes may go
18 to the lung and cause one disease. And then when
19 you measure peripheral blood, they're not in the
20 peripheral blood, because they're in the lung.
21 And so, you can have a -- definitely have CBD
22 with a negative BeLPT.

1 Unfortunately, because of the wording
2 of the Act, a lot of the convoluted wording in
3 the various manual circulars, updated guides, you
4 know, are trying to solve that problem.

5 But I think hopefully moving forward,
6 there would be a way to do this that created less
7 confusion.

8 CHAIR MARKOWITZ: Mr. Whitley.

9 MEMBER WHITLEY: At that last meeting,
10 we had a lady that spoke that had eight
11 uninterpreted --

12 MEMBER WELCH: Eight borderline.

13 MEMBER WHITLEY: No, she had eight
14 uninterpreteds.

15 MEMBER WELCH: Okay. Uninterpreted is
16 a different question.

17 MEMBER WHITLEY: Did we change
18 anything on that?

19 MEMBER WELCH: It's a sort of
20 technical thing. There probably are -- someone
21 shouldn't be just repeatedly retesting if that's
22 uninterpretable. There are ways to try to run

1 the test differently to get it to the
2 interpretable.

3 Uninterpretable usually means the
4 cells didn't grow or they overgrew or a bunch of
5 things. It's not -- borderline, there's a
6 sensitivity to beryllium, it's just not a high
7 signal.

8 Uninterpretable is a problem with the
9 test. So, I mean, it's -- we do it differently
10 and we can -- sometimes there are people for whom
11 you just can't get a BeLPT. But then at some
12 point, you stop and why keep sending them.

13 If their serum and their cells always
14 come up with an uninterpretable result, you have
15 to accept that's how that person is and deal with
16 it in that context.

17 So, it could be -- there's probably
18 ways to find ways for a claim to be accepted for
19 people who have an uninterpretable BeLPT as well
20 and we can look at that specifically for people
21 who you just can't get a real -- can't get a good
22 result.

1 MEMBER REDLICH: I think it's also
2 important to understand that the whole beryllium
3 lymphocyte proliferation testing literature and
4 the sort of guidelines were developed in the
5 setting of where you're doing surveillance on
6 healthy workers and you don't want to go crazy,
7 deny someone a job, start doing a ton of invasive
8 procedures when you have a positive test.

9 So, there's been concern about, you
10 know, why do you want to have repeated tests,
11 because you -- and that's doing a test with the
12 purposes of surveillance of healthy workers.

13 The perspective where I see patients
14 with beryllium disease are people who are
15 diagnosed with sarcoidosis or interstitial lung
16 disease and the -- and then what is the
17 predictive value of a test and the utility of
18 doing it in that situation?

19 And so, that is different in someone
20 with, let's say, preexisting disease who has
21 known beryllium exposure.

22 If you look at -- let's say

1 preexisting granuloma disease in their lung and
2 known beryllium disease, the literature on all of
3 the predictive values and the like have been done
4 -- and the -- sort of the rationale for the whole
5 test and how many repeats you need, was done
6 thinking of what would be best in the
7 surveillance of healthy workers, not -- now, that
8 sort of literature and wording has been taken,
9 you know, sort of more broadly and -- but in the
10 setting of someone who has known granulomatous
11 lung disease and a history of working with
12 beryllium, the overwhelming likelihood, you know,
13 which would be more likely just in terms of
14 probabilistically sarcoid or CBD, sarcoid is a
15 rare disease, you know, whether it's one in
16 10,000 or one in a thousand. Especially sarcoid
17 that involves symptoms and lung disease.

18 So, is one in 10,000 -- how does that
19 compare to the probability of having CBD if
20 you've, you know, had beryllium exposure?

21 And that, you know, whether it's 0.1
22 percent or one percent or five percent, that is a

1 much higher probability than having sarcoidosis.

2 So, I think part of the confusion
3 about the BeLPT is the setting that you're doing
4 it for.

5 CHAIR MARKOWITZ: So, we have a
6 recommendation and does the -- the recommendation
7 language we look at now need to be modified in
8 any sense? Does it need to be specified, as Dr.
9 Cassano says, under Part B, subpart B and subpart
10 E?

11 MEMBER CASSANO: I would -- I've seen
12 how recommendations can get screwed up when they
13 end up being promulgated. And I think the more
14 explicit we are, the better.

15 CHAIR MARKOWITZ: So, after
16 evaluations, add under subpart B and subpart E of
17 EEOICPA.

18 Any other suggestions on the language?

19 Mr. Whitley.

20 MEMBER WHITLEY: You probably should
21 change should to shall.

22 CHAIR MARKOWITZ: Change the should to

1 shall?

2 MEMBER WHITLEY: It means it will be.

3 CHAIR MARKOWITZ: Right. Think big or
4 go home? Is that what you just said?

5 (Laughter.)

6 CHAIR MARKOWITZ: Okay. So, if there
7 are any other final comments, we'll take a vote.

8 Mr. Griffon, by the way, do you have
9 any comments you wanted to add?

10 Okay. Ms. Vlieger.

11 MEMBER VLIEGER: I'm not sure
12 evaluations is correct. I think it would be
13 claims adjudication.

14 CHAIR MARKOWITZ: Okay. Change
15 evaluations to adjudication?

16 MEMBER VLIEGER: Yes.

17 CHAIR MARKOWITZ: Okay. Is there a
18 motion to approve this recommendation? A second?
19 Okay.

20 All those in favor, raise your hand.

21 (Show of hands.)

22 CHAIR MARKOWITZ: Anybody -- oh, Mr.

1 Griffon?

2 Well, while we're waiting for him, all
3 those opposed? Any abstentions? One. So, of the
4 committee members present, of whom I think we're
5 13, there are 12 in favor, one abstention and no
6 no votes.

7 And, Mr. Griffon?

8 Well, if he comes back on the line, he
9 can vote. But otherwise -- so, that's done and
10 we're done, Dr. Redlich?

11 MEMBER REDLICH: Yes.

12 CHAIR MARKOWITZ: Okay.

13 MEMBER REDLICH: So, I guess the only
14 thing --

15 MEMBER GRIFFON: You didn't hear me.
16 I voted yes.

17 CHAIR MARKOWITZ: I'm sorry. I'm
18 sorry. Mark?

19 MEMBER GRIFFON: Yes. You didn't hear
20 me. I voted yes.

21 CHAIR MARKOWITZ: Okay. Thank you.

22 MEMBER GRIFFON: Okay.

1 MEMBER REDLICH: So, the only question
2 I would raise is, what are the possibilities or
3 options to revise the manual?

4 CHAIR MARKOWITZ: Well, I guess that's
5 a question for Ms. Leiton.

6 MS. LEITON: So, the -- the
7 recommendations from the Board are going to be
8 considered in one of our procedures that we
9 develop, you know, one way or another.

10 So, a lot of the recommendations
11 you're making today with regard to presumptions
12 if they were to be accepted, we're going to be
13 making changes to the procedure manual.

14 If you have specific wording that you
15 think should be considered in the procedure
16 manual and it's presented to us as a
17 recommendation, obviously it's something we would
18 consider.

19 I'm not sure that answers the
20 question, but --

21 CHAIR MARKOWITZ: That does, actually.
22 That does. Thank you. Okay.

1 So, we're not going to be able to
2 fully consider the final recommendation we wanted
3 to look at, but I do think we should present it
4 at least initially, because I would favor
5 actually trying to have a telephone meeting of
6 the Board before our next face-to-face meeting so
7 that we can address this particular presumption
8 and not wait the additional several months.

9 So, if you could bring up the -- which
10 -- it says that there were solvents and hearing
11 loss.

12 MEMBER REDLICH: So, while we're just
13 bringing that up, if I understand if -- I have a
14 version of B that has been edited.

15 Would that be helpful to give that to
16 you?

17 MS. LEITON: When you say a version of
18 --

19 MEMBER REDLICH: I'm sorry. I'm
20 sorry. Of Chapter 2, the 1000.

21 MS. LEITON: I think the one thing to
22 keep in mind is that -- I think a couple of

1 people have mentioned it, is that the statutory
2 criteria are very specific.

3 So, as long as it's within the
4 framework of what the statute says as pre-CBD,
5 post-CBD, those, you know, within that framework
6 -- obviously you can edit and submit whatever you
7 want to, but that's what we would have to be
8 considering first and foremost, is what is in our
9 statutory language.

10 So, you know, the presumptions on
11 sarcoidosis are really -- we're saying we'll
12 consider sarcoidosis CBD under certain
13 circumstances, and then it reiterates what the
14 CBD criteria are and how they interpret the CBD
15 criteria pre and post.

16 So, any language you would propose for
17 that section, obviously, yeah, we'll consider,
18 you know, what you propose to us.

19 I recognize that one has to --

20 MEMBER REDLICH: Because it's so
21 specific that we don't want to have to go to
22 Congress.

1 CHAIR MARKOWITZ: Okay. Thank you.
2 Dr. Welch.

3 MEMBER WELCH: Okay. So, we did
4 discuss noise and hearing loss at one of our -- I
5 mean, solvents and hearing loss at one of our
6 previous meetings.

7 And I went through the literature in
8 more detail, found some additional things that
9 were very helpful, and put together something
10 for us to think about for a presumption.

11 As you recall, there currently is a
12 presumption for solvent-related hearing loss.

13 And this is what I have here.

14 They have to have sensorineural
15 hearing loss in both ears, they're exposed to one
16 of the listed chemical solvents and worked in one
17 of the listed labor categories for required
18 concurrent and unbroken 10-year periods.

19 Now, I'm just trying to remember, and
20 somebody else can help me out, there might have
21 also be in that, a calendar year cutoff.

22 (Off the record comments.)

1 MEMBER WELCH: Ten years prior to
2 1990.

3 CHAIR MARKOWITZ: Ten consecutive
4 years prior to 1990.

5 MEMBER WELCH: So, I'll be sure to add
6 that back in.

7 And the solvents that were -- are
8 listed -- and so, if these are reported as --
9 from the individual or, you know, their labor
10 category has these exposures in the SEM, they can
11 be considered.

12 And then they have to have that ten
13 continuous years before 1990, but the specific
14 solvents are established as the cause and
15 accepted in the current presumption.

16 Here's the labor categories which you
17 can see that are on the big screen, probably, but
18 it's a, you know, it's a pretty good list of
19 people who would have used organic solvents in
20 their work.

21 As we know from many discussions,
22 there will be people who work as an instrument

1 mechanic or instrument technician, but their job
2 title may not be instrument mechanic or
3 instrument technician.

4 So, there has been a problem with
5 implementing this particular presumption in that
6 people are doing equivalent work to one of these
7 listed job categories, but there's no way to
8 accept them if they're not in the job category.

9 So, in terms of what the literature
10 shows, recent reviews conclude that both animal
11 and human studies clearly establish effects of
12 solvents on hearing.

13 The animal studies are specific
14 solvents. There are animal studies that are
15 multiple or mixed solvents so that what
16 information we have on mixed solvent exposure
17 comes from human studies.

18 But the solvents that were listed --
19 I have another slide that kind of shows the
20 certainty of it.

21 There are consensus statements
22 available from NIOSH and EPA that solvents cause

1 hearing loss -- that organic solvents cause
2 hearing loss.

3 Because issues of dose-response or a
4 threshold, meaning -- threshold meaning there's a
5 level below which there's no injurious exposure,
6 you can't really identify those in animal
7 studies.

8 And the human studies are -- because
9 the exposures are complicated and usually mixed,
10 there's not a lot of data that helps us on dose-
11 response, which is what we need to establish
12 years.

13 So, there was a paper I hadn't read
14 before, which is a systematic review that was
15 done by NIOSH and the Nordic -- the Nordic Expert
16 Group for Criteria Documentation of Health Risks
17 from Chemicals.

18 And they -- and this was published in
19 2010. And there is some data, but not a lot
20 since then. So, I think this is probably a
21 really good evidence-based review to rely upon
22 for this presumption.

1 So, styrene, toluene, xylene and
2 carbon disulfide cause hearing loss at or below
3 the current OELs. Which would then say
4 immediately that any cutoff date such as 1990
5 where we presume exposures were higher prior to
6 some period of time really can't apply. Because
7 even if the exposures are controlled to the
8 current OEL, there's a risk of solvent-induced
9 hearing loss.

10 So, xylene and ethylbenzene, there's
11 more limited occupational data, but this
12 evidence-based review concluded that animal data
13 shows effects at or below the current OEL. So, I
14 would put those in the same category, styrene,
15 toluene, xylene, carbon disulfide and
16 ethylbenzene.

17 Then TCE and solvent mixtures, there's
18 an effect in human studies. Not really enough
19 data to say whether it's at or above what level
20 below the -- above or below the current OELs.

21 The mixtures that were studied in the
22 human studies most often were MEK, MIBK, xylene

1 and toluene, which are already on the list of
2 solvents that have been identified and were
3 accepted in the current presumption to cause
4 hearing loss.

5 So, I think that list of solvents is
6 pretty good and those are the ones for which
7 there is evidence.

8 I think the question for that, and
9 we'll talk about it when we talk about the
10 specific presumption, is how do you establish
11 those exposures.

12 Many people know they worked with
13 solvents, but they may not know they were working
14 with MIBK.

15 And so, then you're relying primarily
16 on the SEM to identify those exposures and then
17 we get back to some of the limitations with the
18 SEM. It may be not a solvable problem, but --
19 so, we're really looking at these particular
20 compounds. Carbon disulfide is not on the
21 previous list and we're going to need to add
22 that.

1 And then I want to include a
2 recommendation that DOL develop some direct
3 disease work links for the tasks with exposure to
4 those solvents that are in the range of the OEL.

5 And there is -- that's something
6 potentially the Board could help with or
7 industrial hygiene could help with.

8 It would help get around the problem
9 that the labor categories that are listed --
10 can't include all the jobs within the DOE complex
11 that would have performed those tasks.

12 So, if we can identify the tasks and
13 have a direct disease work link, I think that
14 would really, really streamline processing these
15 particular claims. So, that's one
16 recommendation.

17 And then the larger one -- so, I'm
18 recommending we keep the ten-year exposure
19 requirement, but that it be cumulative and --
20 rather than continuous. And that if the -- let
21 me just do the first one.

22 So, ten-year cumulative years in any

1 of the job titles on the list in the current
2 presumption.

3 No requirement, then, that they had to
4 also report exposure to those specific solvents
5 or that the solvents be present in the SEM.

6 If they did those jobs, we know
7 they're exposed to mixed solvents and many of the
8 solvents on the list.

9 If they weren't in one of those job
10 titles, then we're looking for reported exposure
11 to styrene toluene, xylene, ethylbenzene, TCE or
12 carbon disulfide on the OHQ, or evidence for
13 exposure to those solvents in the SEM for at least
14 ten years cumulative.

15 And also, report exposure to solvent
16 mixtures. As I said, that those -- the mixtures
17 most commonly looked at in occupational studies
18 include the specific solvents that are
19 recommended in the paragraph above.

20 Or exposure for ten years cumulative
21 established through work history and a direct
22 disease work link process.

1 So, that would be that if someone's
2 got ten years of work in a particular task that's
3 been established to carry these exposures -- and,
4 again, that's not in the SEM yet, but I think
5 this is a good target for the -- for development.

6 So, people would either be in the job
7 list for ten years, they've reported exposures on
8 their occupational history questionnaire and
9 relevant tasks allowing them to -- the evaluation
10 of those for ten years, or solvent mixtures for
11 ten years, or relevant tasks for ten years.

12 And I think -- okay. Yeah. So, the
13 claims examiners should not routinely deny claims
14 if the worker has fewer than ten years of
15 exposure.

16 So, if they don't meet those four
17 bullet points above, claims that did not meet the
18 requirements set forth here, but do have reported
19 exposure to organic solvents for at least five
20 years cumulative should be sent to the IH and/or
21 the CMC for review.

22 Which would, again, as part of a

1 presumption, the data suggests that you do need
2 at least five years to get solvent-related
3 hearing loss.

4 And if more research comes out to put
5 it at a lower level, this presumption could be
6 adjusted down the road. But currently it's
7 saying if you have ten cumulative years, you're
8 going to get in with one of those ways of
9 documenting what the exposure is.

10 If you have five years, then you need
11 an individual assessment. If you have fewer than
12 five years, you wouldn't be able to file a claim
13 under this presumption. And that's it.

14 CHAIR MARKOWITZ: Okay. So, thank
15 you, Dr. Welch. So, obviously we're not going to
16 discuss this, but I have just a couple questions.

17 One is, could we address -- as opposed
18 to waiting until our next face-to-face meeting,
19 which will probably be in October/November, could
20 we have a telephone meeting of the Board in June
21 or early July specifically to address -- to be
22 able to discuss this and consider it?

1 You know, claims for hearing loss come
2 in all the time. And if we're going to settle on
3 a recommendation that might significantly change
4 the policy of the DOL, then I feel like we should
5 get to it sooner rather than later.

6 And then the second question is that
7 before that meeting, I think if we had a draft
8 rationale for this, as well as some of the
9 references so we could look at that, that would
10 also be helpful in discussing that.

11 So, how do people feel -- first of
12 all, let me just ask Doug whether it would be
13 possible to have a telephonic meeting of the
14 Board.

15 MR. FITZGERALD: It's theoretically
16 possible.

17 (Laughter.)

18 MR. FITZGERALD: The time frame, I
19 think we're really probably looking at July, not
20 June, only because of the internal clearance
21 process. I think that would be the earliest.

22 Carrie, would you concur with that or

1 --

2 (Off the record comments.)

3 MR. FITZGERALD: Okay. Well, we just
4 know it took about seven weeks for the last
5 approval process to go through.

6 CHAIR MARKOWITZ: Okay. And it will
7 be a simple agenda.

8 MR. FITZGERALD: Yeah. And the only
9 other issue, and I don't think it's a big one, is
10 just to check our budget for the costs associated
11 with a meeting.

12 CHAIR MARKOWITZ: Okay.

13 MR. FITZGERALD: But since it's
14 telephonic, it shouldn't be that much.

15 CHAIR MARKOWITZ: Okay. And how about
16 the board members? Is that okay to do that?

17 Okay. And, Dr. Welch, in terms of
18 providing a draft rationale and the sources, that
19 would be possible?

20 MEMBER WELCH: Yes. And, you know,
21 this -- our subcommittee -- we've talked about
22 it, but I'll make sure that they get a chance to

1 look at it first, submit comments, et cetera.

2 CHAIR MARKOWITZ: Right. Okay.

3 MEMBER WELCH: And in addition by the
4 time we all see it again -- I mean we already
5 have the rationale. So I would need to get that
6 out to everybody six weeks before the call, at
7 the time we schedule it.

8 And since it's going to be a
9 convenience between scheduling the other --

10 CHAIR MARKOWITZ: We wouldn't have
11 time -- I don't think we'd have time for a
12 subcommittee call.

13 MEMBER WELCH: No. No, no.

14 CHAIR MARKOWITZ: Right. Okay.

15 MEMBER WELCH: I'm just saying if --
16 my deadline if we were to have the meeting in the
17 beginning of July -- as long as it's after May --

18 CHAIR MARKOWITZ: Well, I don't -- we
19 need -- well, it depends whether we publish the
20 draft -- the recommendation or not, but we'll
21 settle that. We'll settle that.

22 MEMBER WELCH: Yeah.

1 CHAIR MARKOWITZ: We'll settle that.

2 MEMBER WELCH: I think that's
3 possible.

4 CHAIR MARKOWITZ: Okay. Okay. Good.
5 So, just a few miscellaneous items before we
6 close the meeting.

7 The charter for this board is up for
8 renewal in July 2017. And that process has been
9 initiated by Department of Labor.

10 We, as individual members, our
11 individual term expires in February 2018. And
12 the start of that renewal process begins in
13 September of 2017.

14 And we don't know exactly what that
15 renewal process consists of, but I'm sure the
16 Department of Labor will let us know at the
17 appropriate time.

18 You need to -- if you haven't done so,
19 you need to complete your financial disclosure
20 forms prior to next Wednesday. Prior to next
21 Wednesday.

22 Okay. So, if you haven't sent in

1 those forms, you really need to be so that we can
2 remain in compliance with the regulations.

3 MEMBER BODEN: Can I ask a favor of
4 DOL folks?

5 You just sent around to everybody a
6 request if you haven't completed it.

7 Would you send to the people who have
8 a confirmation, that we have -- I believe I have,
9 but I want to make sure you got it.

10 CHAIR MARKOWITZ: Right. So many
11 financial disclosure forms in so little time.

12 (Laughter.)

13 CHAIR MARKOWITZ: So, in terms of just
14 to remind the subcommittee chairs that if you
15 want to have a call as a subcommittee, you need
16 six weeks advance notice for it to appear in the
17 Federal Register.

18 So, you need to start thinking in the
19 next couple of weeks about scheduling that call
20 and then make the request to the Department of
21 Labor.

22 In particular, I'm thinking that July

1 and August might be problematic in terms of
2 people's schedules, so that really brings us to
3 the decision of the next couple weeks about that
4 so that you can schedule it during June. You can
5 figure out the timing yourself.

6 In terms of the next board meeting, it
7 will likely be in October. We will -- I think
8 we'll circulate the potential dates and potential
9 sites.

10 I don't really want to have a full
11 discussion of locations now, but I would note
12 it's been extremely useful and helpful to the
13 Board to be in the field, to be at sites where we
14 get a tour of the site, get a better sense of the
15 -- what happens, what occurs within the complex.

16 And we also emphasize sites in which
17 there are large numbers of claimants so that
18 claimants have -- and DOE workers, in general,
19 have access to these meetings. So, we will
20 continue to follow that -- those ideas.

21 The public comments that have come in,
22 Carrie Rhoads will be cataloging and figuring out

1 some way that we can work with her to keep track
2 of those comments, make sure they're circulated
3 both to the Board as a whole, but also to the
4 relevant subcommittees.

5 We also -- the Board receives letters
6 from individuals, from organizations which are
7 circulated among us. Most of them don't require
8 responses from us, but they will be sent to all
9 the board members and also to the subcommittees.

10 And they raise items -- they're also
11 raised in the public comments as well, but other
12 items as well. So -- but if -- I should say that
13 if you don't -- if members of the public or
14 organization send us letters and you don't
15 receive a response from us, it's because the
16 letter didn't require a response or because we
17 haven't really engaged in that kind of back and
18 forth with that kind of communication.

19 I think that's pretty much -- in terms
20 of -- do members of the board have particular
21 issues, last-minute issues, administrative or
22 otherwise, questions that we should discuss?

1 MEMBER POPE: I have a question.

2 CHAIR MARKOWITZ: Ms. Pope.

3 MEMBER POPE: I'd just like DOL to
4 keep us informed or keep us updated as to when
5 our recommendations will be implemented.

6 CHAIR MARKOWITZ: Okay. Mr. Griffon.

7 MEMBER GRIFFON: No comments, Steve.

8 CHAIR MARKOWITZ: So, then we've
9 reached the close of this meeting. Let me just
10 thank the members of the Board for all the hard
11 work that we're doing.

12 Also, members of the public for
13 hanging in with us through some interesting and
14 sometimes complicated discussions.

15 We appreciate your attendance. We
16 appreciate your input, really, into the process.
17 And that includes the members of the public who
18 are here, and also people who are on the phone.

19 I want to thank Department of Labor
20 for helping us have these board meetings,
21 especially Doug and Carrie.

22 And I'd like to thank Ms. Leiton for

1 attending and being very responsive to the
2 questions we had.

3 And of course we're thankful to the
4 other members of the Department of Labor, Mr.
5 Nelson and colleagues; Department of Energy, who
6 are no longer here, and the like.

7 So, with that, I'd like to close the
8 meeting.

9 MR. FITZGERALD: Okay. Thank you, Mr.
10 Chairman. And I just want to thank you and the
11 board for all your hard work on behalf of the
12 Energy program.

13 I want to thank the public for being
14 here and providing their comments and
15 participating with us.

16 And that brings us to a close and this
17 meeting is officially adjourned.

18 (Whereupon, the above-entitled matter
19 went off the record at 10:55 a.m.)
20
21
22

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Before: US DOL

Date: 04-20-17

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