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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FRIDAY,
NOVEMBER 17, 2017

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The Advisory Board met at The Lodge at Santa Fe, 750 N. St Francis Dr. Santa Fe, New Mexico, at 8:00 a.m. Mountain Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

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

MEDICAL COMMUNITY:

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

CLAIMANT COMMUNITY:

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

DESIGNATED FEDERAL OFFICIAL:

DOUG FITZGERALD

AGENDA

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

8:04 a.m.

MR. FITZGERALD: Good morning, everybody. I'm Doug Fitzgerald, the Designated Federal Official for the Advisory Board on Toxic Substances and Worker Health.

I'd like reconvene the Board Meeting for its second day. And, I'll turn it over to Dr. Markowitz.

Thank you.

CHAIR MARKOWITZ: Good morning. We're going to do just quick introductions for the benefit of the public, if there are any here or people on the phone.

I'm Steven Markowitz, City University of New York, Occupational Medicine Physician in epidemiology.

MEMBER SILVER: Ken Silver, Associate Professor, Environmental Health at East Tennessee State University.

Yesterday, you heard a statement from the daughter of Ben Ortiz, a gentleman I

worked with very closely and when I lived here in New Mexico.

You've been hearing a lot about presumptions, a big fancy word. When Ben was making his case like a voice in the wilderness about the lab having made him sick, he'd punctuate every statement, que no? Don't you agree?

And, that's a presumption. It doesn't he deserve the benefit of the doubt with these climates?

MEMBER POPE: Duronda Pope, United Steel Workers, also a former worker of Rocky Flats.

MEMBER REDLICH: I'm Dr. Carrie Redlich. I'm a Professor of Medicine at Yale and Director of the Yale Occupational Environmental Medicine Program. Also, a pulmonary and occupational medicine physician.

MEMBER CASSANO: Tori Cassano. I'm a Retired Navy Occupational Medicine Physician, Radiation Health Officer. And, now, I have my

own private consulting business.

I worked for many years at the VA dealing with Veterans issues that are very similar to the issues you're dealing with now.

MEMBER DEMENT: I'm John Dement, Duke University Medical Center, area of interest and expertise is industrial hygiene, exposure assessment and epidemiology.

And, I've worked with the BTMed program for construction workers for the last 20 years.

MEMBER GRIFFON: Hi, I'm Mark Griffon. I'm an occupation safety health consultant.

MEMBER DOMINA: I'm Kirk Domina from the Hanford Atomic Metal Trades Council in Richland, Washington. HAMTAC represents about 2,600 active workers through 14 affiliated unions.

I'm a current worker and have been out there going on 35 years.

MEMBER TURNER: I'm James Turner. I

worked at Rocky Flats Nuclear Weapons Plant for 26 years. I was diagnosed with Chronic Beryllium Disease in 1990.

MEMBER SOKAS: Rosemary Sokas, I'm a Professor of Human Science and of Family Medicine at Georgetown. And, I'm an occupational physician.

MEMBER BODEN: Hi, I'm Les Boden. I'm a Professor of the Environmental Health Department at Boston University School of Public Health. And, have been involved at the Nevada Test Site for some time and the predecessor for this Board.

MEMBER VLIEGER: Good morning, Faye Vlieger, former work package planner at Hanford, injured in a chemical exposure in 2002. I currently advocate for injured workers under this program.

MEMBER WELCH: Laura Welch. I'm an Occupational Physician. I'm currently the Medical Director for the Center for Construction Research and Training which is a

research institute devoted to improving health and safety for construction workers and the Medical Director for the Building Trades Medical Screening Program.

MEMBER WHITLEY: I'm Garry Whitley. I worked at Oak Ridge National Nuclear Complex for 42 years, was President of the Metal Trades Council there. I represent about 2,300 people.

I retired in 2011. I'm now working with Worker Health Protection Program in Oak Ridge and we have about 14,000 retirees.

MEMBER FRIEDMAN-JIMENEZ: I'm George Friedman-Jimenez. I'm an occupational physician, Medical Director of the Bellevue NYU Occupation Environmental Medicine Clinic. And, I'm also Assistant Professor of Epidemiology and Medicine in the Department of Population Health NYU School of Medicine.

CHAIR MARKOWITZ: So, who needs to leave before 11:00 a.m. this morning? I think Dr. Boden is what, 10:30 or so? 9:15?

MEMBER BODEN: About 10:00.

CHAIR MARKOWITZ: 10:00?

So, we're going to review the agenda for this morning.

We're going to discuss the final recommendation we did not discuss yesterday regarding the occupation health questionnaire.

We're also going to hear the committee report or a discussion on the site exposure matrix in particular around the recommendation we had made previously regarding the use of the IOM recommendations.

We're going to have short reports from the Part B Subcommittee and from the Presumptions Working Group.

And then, we're going to deal with several miscellaneous topics first on changes in the procedure manuals where we, as the Board, can get a better understanding of what's happening -- with what's happened and is happening with the procedure manual and how we can stay up with those kinds of changes.

I think if we have the time, I'd

like to spend a few minutes reviewing some of the public comments from yesterday.

And, also addressing how the Board can better integrate public comments, written and oral comments, into our deliberations.

And then, finally, if we have time, we can discuss our ideas and recommendations on how the Board can function better in the future.

MEMBER SOKAS: I just have a question about whether we could also include an update on the solvent hearing loss recommendation that went forward, because that wasn't included yesterday.

CHAIR MARKOWITZ: Right, okay.

So, that, when Ms. Leiton comes, we can hear from her.

But, those are from June 2017. Those are still within DOL. They haven't returned to us responses yet. I expect we will have those responses before the next Board Meeting which is going to be by telephone

sometime in January. And, we'll happy to discuss it then.

I don't think we're going to have time to --

MEMBER SOKAS: That's fine.

CHAIR MARKOWITZ: -- be able to discuss it as a subcommittee report before that meeting.

One thing I forgot to do yesterday, which, Kevin, would you bring up the first set of recommendations from yesterday? I forgot to get writing assignments for these. Who wants to draft the -- our comments on DOL's responses?

And, I think we could do this pretty quickly.

If we go back to the first set of recommendations that we submitted, Recommendation 2, if you just go over to the next page, which had to do with the use of the IOM report and recommendations.

We're going to discuss that and

that's probably the kind of thing Dr. Welch might want to take on because you're dealing with that.

The third recommendation is about hiring former workers to administer the occupational health questionnaire.

That requires, I think, just a brief comment from us on their response. If someone wants to take that on, that's fine. Otherwise, I'd like to take care of that.

A fourth recommendation is at the bottom of the board, a process whereby the industrial hygienist may interview the claimants directly.

They basically -- my -- our interpretation of the response is that they agreed to do that. So, I don't really think it requires any comment from us unless someone disagrees.

Recommendation Number 5, DOL isn't interested in publishing its policy teleconference notes. We, obviously, disagree,

but does anyone feel that it's any need to comment on their response?

Dr. Sokas?

MEMBER SOKAS: I don't think we need to comment. I think we can handle it as a procedure for asking for updates for the Board in the future.

CHAIR MARKOWITZ: Recommendation Number 6, which has to do with making claim files available electronically to the claimants. DOL agrees with that.

Recommendation Number 8, this has to do with our notion of making the file available to the CMCs industrial hygienists and Dr. Cassano jumps right in there.

And then, Recommendation 7, which has to do with restructuring occupational medicine within DOL.

Dr. Sokas?

MEMBER SOKAS: Yes, I'll write with that.

CHAIR MARKOWITZ: So, you know, in

writing these up, we're going to probably need, Kevin, the transcripts or the minutes from this.

So, what's the timing of the minutes? I have to sign them, but what's the timing of production of the minutes and the transcript?

PARTICIPANT: Transcript, 30 days; minutes by 90 days.

CHAIR MARKOWITZ: Okay, okay.

So, yes, we'll have to speed up the minutes.

So, let's go to the second set of recommendations.

The first one is on asbestos related disease which I will prepare a response and we can get more input.

The next is work related asthma. And, Dr. Redlich is on, I give to her.

The next is COPD and, Dr. Welch, do you want to take that on?

MEMBER WELCH: Sure.

CHAIR MARKOWITZ: We're going to discuss the revisions to the occupation health questionnaire recommendations, we haven't covered that yet.

The Recommendation Number 5 is enhancing the scientific and technical capacity. I'm not sure that there's much to respond to or for us to comment on, actually.

So, I've not -- I'll put my name down with a question mark about that.

Recommendation Number 6, interpretation of BeLPT. What did we decide? Did we decide that we had something to --

MEMBER WELCH: I'll do it.

CHAIR MARKOWITZ: Okay.

MEMBER REDLICH: So, I'll do it with Dr. Cassano.

MEMBER WELCH: Well, I have a -- you and I work good.

MEMBER REDLICH: Okay.

CHAIR MARKOWITZ: Dr. Redlich and Dr. Welch.

And, then the quality assessment of contract medical consultants, Recommendation Number 7. I do think this deserves a comment.

MEMBER SOKAS: Yes. So, I'll do it with Dr. Cassano.

CHAIR MARKOWITZ: Okay.

MEMBER CASSANO: I have a question. Are we going to vote on the combining of the two individual -- for the two subcommittees or not?

CHAIR MARKOWITZ: At this point, I don't know if it requires a vote.

MEMBER CASSANO: Okay. So, do we consider ourselves combined now?

CHAIR MARKOWITZ: Sure.

(LAUGHTER)

MEMBER CASSANO: All right, then.

CHAIR MARKOWITZ: We're in the waning months of this Advisory Board. So, I don't -- and, again, our work agenda is laid out for us for the next couple of months.

Okay, so let's -- Dr. Welch can do

that. Dr. Welch, I don't if you want to do the SEM recommendation first or.

MEMBER WELCH: I can do that first.

CHAIR MARKOWITZ: Or the OHQ. Why don't you assign special interests?

MEMBER WELCH: Did you try that?

Okay, this is Laura Welch and I'm going to, as we discussed yesterday, we made recommendations to the Department about how to incorporate some of the recommendations in the IOM report by reviewing the 11 databases that IOM had in the table and incorporating the health effects of that into the SEM.

And, the response from the Department was that that was essentially too big a task and they needed more help.

So, I along with the SEM Subcommittee looked at the list and we would recommend that that the Department start by integrating the data from IARC, the International Agency for Research for Cancer and the EPA IRIS database.

And so, what we have up here, I'm going to describe -- just describe how the IARC does their assessments and we have a slide about the -- yes, that's good -- about how EPA does their assessment.

Can people see that? Is that worth looking at? It's a little fuzzy. So, maybe it's not that helpful unless you can make it much -- quite a bit bigger.

The reason there's -- let me just explain -- the reasons that we're recommending those two databases is because it's the, in a way, the most bang for the buck, or the EPA IRIS one is.

The 11 data sources that IOM recommended, very comprehensive. They do overlap to some degree. It makes sense, it's different agencies looking at health assessments of toxic chemicals. So, it's going to make sense that ATSDR and EPA may have the document that addresses the same question.

It's very likely that they have the

same health effects and they're basing it on the same information.

But, our committee thought that since EPA is very thorough and ongoing and active in terms of the assessments of chemicals, that's a good place to start.

So, basically, EPA develops -- gets chemicals proposed to them by other agencies or by outside groups and they frame the scientific questions specific to the assessment, develop a draft. It's reviewed by health scientists within EPA and by interagency scientific consultation, so other federal agencies.

It's reviewed for public comment. It goes through an external peer review and those comments are incorporated into a final Agency -- an interagency science discussion.

I mean, it's about as much scientific input as you can get for government documents, both with experts that produce the document, both Agency, cross-agency and public comment review.

It takes a long time. There's, for any one of these chemicals, there are organizations and individuals with strong opinions about what EPA should say. So, and it's all very public.

So, it's very -- I think, it's definitely a database that the Department of Labor can rely on. It's developed by a federal agency.

And, if one just pulls up and reads an IRIS assessment, it's very clear what health effects are caused by those chemicals, what the -- what the --

What they do and the most sensitive health effect. They calculate an acceptable exposure to the public. It's not focused on occupational standards, but the health effects are the same whether the exposure is in the environment or in the work environment.

And then, they focus it around the most sensitive end point. But, of the -- there are about 500 assessments within IRIS.

And, of those, 110 have an assessment for oral -- or for inhalation exposure, which is probably the most relevant to the occupational exposures.

So, we're talking about 110 reviews that would identify health effects.

The IARC Group I carcinogens which are accepted as known human carcinogens are most likely already incorporated into SEM by SEM relying on Haz-Map.

But, since Haz-Map hasn't been updated, the new IARC monographs have probably not been added to the SEM except maybe in, you know, kind of high priority ones that someone noticed.

And, we would also recommend that the Department incorporate the Group II IARC carcinogens which are probably human carcinogens and that's really consistent with the statute, I think, and the intent of the law that compensation is for -- it's more likely than not that this compound contributed, caused

or aggravated the condition.

And, probably human carcinogens, using the IARC assessment, are way above that more likely than on standard.

So, again, it's not -- there's not a big number in the IARC documents. There's just one table on the IARC website that lists the chemical, the organ system where it causes cancer, the number of the monograph and we just need to incorporate that table.

The IARC peer review is similar to the EPA IRIS in terms of its scope, although they don't have a public comment. They don't incorporate public comments.

But, they do have, the Agency chooses the people to be on the panel, creates a working group for each chemical they assess. And, they invite additional specialists to report to the panel.

The staff puts together a document with all the information to give to the panel. And then, when the working group meets, which

is for seven or eight days to assess one particular chemical, they have representatives from national and international health agencies who are there and the IARC Secretariat.

Then, once the staff puts together this information and the working group develops a draft, they have specific subgroups that work on the areas within each IARC monograph. They reach a consensus.

And, also very importantly, there's a very strong conflict of interest review for people who are going to sit on this panel, sit on the IARC working groups because, you know, when IARC says something is a human carcinogen, it has impact for actions on the industrial level across the world.

So that they work really carefully to get the best scientists and people who don't have a conflict of interest.

It's a very impressive organization. Anybody who's worked with it would -- you can absolutely, totally rely on what they come out

with.

It's not -- we, as the Institute of Medicine said and as this Board has said, we're not -- we wouldn't expect the Department of Labor to conduct independent peer review of the relationship literature to come up with relationship between a toxic exposure and health effect.

But, what we're recommending is that the Department set up an internal process, either with the current staff they have or bringing in additional consultants.

And the Board would be happy to review what that process is. We have some ideas but we think it makes more sense for the Department to come up with a process and then we can -- the Board can help making sure that that's reasonable.

To look at the list of chemicals in IRIS and match it to the list of chemicals in the SEM. And, if there's a chemical in the SEM, then they should add that health effect

from that chemical that's identified by the EPA assessment or by IARC to the SEM.

And, you know, as I said, it's about 110 chemicals in IRIS, so maybe 50, 100 at most in IARC that are known and probably human carcinogens. I think the number may be 110, something like that.

So, that's the overall recommendation. And, it's not that that would be the end of it, but it's a -- with those two data sources, with -- I think that the Department would be garnering maybe, you know, 75 percent of the information that's in the ten data sources.

The National Toxicology Program is also something we could add. But, I think that it overlaps pretty significantly with IARC. Not completely, not completely, but it's -- but what we hear from the Department is that 11 data sources is too much.

So, we could start with two, we could start with three. You know, the National

Toxicology Program is very similar in terms of its -- the robust transparent process experts, peer review, public comment.

So, you know, I wouldn't object to that, I just want to -- I want to recommend something that it's impossible to say it's too much work. That's my goal.

You can't -- the Department can't come back and say this is too much work. This is not too much work. And, I guess it's not impossible, right?

But, it's like, you know, if we look at what the IOM recommended and then we, you know, pull that one recommendation from that and elevate it even more feasible, then it's understandable these documents are -- they are technical, you need technical people to read them. But, there's not a lot of interpretation that needs to be provided.

It's going through the documents, finding the health effects and the chemicals and matching it into SEM. It's a fairly simple

process.

And then, once those are completed, the Board could then say, okay, well now, go on to others.

So, open for comment or discussion if people feel strongly we should add NTP, I don't mind at all. George does? Okay.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Yes, I do feel strongly that we should add NTP. I think that they do overlap with IARC. In some ways, they're driven by the IARC evaluations, but it is fairly independent. And, I think it's an excellent group.

I served on the Board of Scientific Counselors Carcinogen Review Committee and Steven is serving now. And, I don't know if you agree with me, but I think that that does add, and I don't think it's a lot of additional work.

And, there is overlap but NTP has, I

believe, a lot more substances that they've evaluated. And, they have a different classification system of known human carcinogen, reasonably anticipated to be a human carcinogen. And, it's somewhat different than IARC's.

So, I believe there is value added by including NTP as well.

CHAIR MARKOWITZ: So, Dr. Welch, I think you made -- there may be a slide at the end of the NTP review process.

MEMBER WELCH: There is.

CHAIR MARKOWITZ: But, anyway, we don't have to go through it, but maybe we should just put it up so we can look at it while we --

MEMBER WELCH: Yes, Kevin, if you can scroll down, I think it may be the last one in this slide. That -- yes, there it is.

So, that's the National Toxicology Program process.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: And, just to support what everybody's been saying, NTP includes not just carcinogens, but other end points which is important.

CHAIR MARKOWITZ: Dr. Boden?

MEMBER BODEN: So, a question. Can you give an approximately amount of effort that it would take for the DOL to do this? Even though I understand we won't hold you to it, but it might be helpful for DOL to know if you're talking about a day, a month or a year of somebody's time.

MEMBER WELCH: This is Laura Welch.

Well, I tend to underestimate the amount of time things take for myself. But, you know, I would say, depending on -- it depends on how much the Department wants to assure itself that IARC is authoritative.

I think we can assure them IARC is authoritative.

So, to incorporate the IARC carcinogens, to decide which ones to

incorporate? Half an hour. I'm not kidding. There's a list.

(LAUGHTER)

MEMBER WELCH: There's a list, it's like here's the cancers, here's the organ systems. That's it. Then you have to do the work to get it into SEM.

IARC and NTP are a little more complicated because there's not a table. They haven't made a table that -- so, you have to read the documents and determine what the health effects are.

And, I think it would probably be reasonable for the Department to have two people do that and assure they, you know, be sure that people come up with the same end points as you read through the documents.

So, that's, I don't know, you know, a month full-time. I mean, I -- to do all those things, a month full-time. That would be my estimate because it did -- you don't have to read any scientific papers, just read through

the documents.

It could be less than that, but -- and then, to -- it's not a lot of time. That's what I would say.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Yes, the one thing, I remember one of the concerns of the Department was the fact that they can -- some of them conflicted.

And, I think what, you know, obviously, different organizations put out their consensus documents at different times.

So, you know, if you tend -- if you see a conflict, then you should look at the one that is done most recently to determine what the more current science is, obviously, with backup with the others, if you're talking about the same chemical.

I mean, this is what I did at VA for years is turn scientific evidence into policy. And, if you're dealing with one chemical, it may take you a day or two if you have to

supplement -- if you want to supplement your knowledge.

But, of course, I went further in that. We did -- I would look at literature past the latest consensus document.

But, it doesn't really take that long because you've got it all laid out for you either in a table or just by reading the conclusions of the consensus document or the beginning of it. It's not hard.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: There's not a lot of conflict between IARC and NTP. They tend to agree in most cases.

Sometimes, one is more recent than the other, as you said.

I want to correct what I said, IARC has more -- has 114 Group I known human carcinogens, NTP has 62. So, there's a difference there.

And, there's a 2A and 2B under IARC

which is probably carcinogenic and possibly carcinogenic. And, that's a big distinction from our perspective.

So, IARC gives more information, whereas, NTP says reasonably anticipated to be human carcinogen.

But, I think there's value in both of them. And, as Rosie said, this opens the door to using NTP evaluations for non-cancer outcomes which could be very valuable because they do extraordinarily detailed reviews of neurotoxins, respiratory toxins, immunotoxins and a variety of other non-cancer causing chemicals.

CHAIR MARKOWITZ: So, just to be clear, when we refer to NTP then we're discussing two types of documents. One is their report on carcinogens which is parallel but doesn't completely overlap the IARC review.

And then, there's something called from Table 3.1 of the IOM report, the health assessment and translation evaluations which

are non-cancer outcomes of which there are deep evaluations, but a limited number, I think.

It's not -- we're not talking about dozens and hundreds the way we are with the carcinogens with these health assessments.

So, just to put it into perspective.

Dr. Dement?

MEMBER DEMENT: Well, the IRIS documents are going to get more to the non-cancer influence. I mean, they look at cancer as well, but they look at non-cancer end points.

I think this probably will extend the NTP list considerably as well.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: So, there's this clause in DOL's response we found that some of the information is not relevant to occupational exposure. We know that.

In an environmental database, there might be some chemical where the most sensitive end point was observed in children through oral

ingestion of water, that's fine. But, it doesn't vitiate all the other valuable information in an environmental agency's database. So, get on with it.

CHAIR MARKOWITZ: So, you know, the comment was made that perhaps we'd heard from DOL that it was too much work to look at all the sources that the IOM recommended. That's not my interpretation of Mr. Steinberg's letter which, unfortunately, I don't have here.

But, I interpret that their response is assistance from us in triage and, you know, where we should start and how to proceed. And, I think we're responding to that.

But, we shouldn't, in any sense, convey that we believe that start -- by starting by, frankly, the easiest and most directed sources that it ends there. Because the other sources that list them in Table 3-1 in the IOM report are very important.

And, some of them are difficult to work with. You know, the pocket, the NIOSH

Pocket Guide. I don't know when the last time it was put out, but it's not necessarily the easiest thing to integrate.

So, DOL should get there and it needs to build the capacity to get to the rest of the sources.

But, moving ahead with those authoritative sources initially makes no sense.

George, did you -- is your card up because you wanted to say something?

Dr. Welch?

MEMBER WELCH: So, I was looking to see if I had the language, too. And, I think that your interpretation is more appropriate really.

And, I think it's a better way to say it, so it's sort of like -- and that's kind of in some ways what we're saying is, if you start with these two, one, they're relatively easy to use and because the information is formatted and it will -- and start with these three, with the three of them, it'll cover the

majority of what's going to be in the remainder, as you said.

Because some of them are updated, out of date.

And, I wanted to also follow up on what Dr. Silver said about not being relevant to occupational exposures.

The data within IRIS, and the reason the EPA develops it is to look at health effects to the general population to the environment. They're not setting regulations for occupational exposures.

But, the same chemicals, if they're used in occupational environment, can result in the same health effects.

So, it's a very broad picture, an assessment done for environmental exposure is very relevant to occupational exposures.

Now, obviously, if the end point isn't one that we would see in this population, then you don't include that end point. And, a lot of the end points for -- in the IRIS

database are reproductive, so that's something that could be included, probably generally hasn't been included in the SEM because it's an effect on the unborn kids. That's a -- that would take another discussion.

But, the big picture that the assessments are done for the purpose of assessing environmental exposure that are really highly applicable to occupational environment.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Yes, you know, usually it doesn't go the other way because, you know, see a lot in literature, well, those effects only occur in occupational environments. They don't occur, you know, in the general population in the environmental exposures because the exposure is so low.

But, when you go the other way from an environmental exposure to a higher level of exposure, if the end result occurs at a low level environmental exposure, it almost

definitely will occur at a higher occupational level exposure.

So, to continue what Laura said, they become very applicable to occupational health. And, the route of exposure is not necessarily always that important, in some instances, it is.

CHAIR MARKOWITZ: So, I'm very concerned about actually the DOL's capacity to do this work.

And, I think Mr. Steinberg's request letter to us about helping -- he's seeking help in triage and figuring out where to -- basically where to start, to me, reflects the insufficient expertise that the program currently has access to.

The Board, I think, just to reflect what Dr. Welch said, at least this Board is very happy to help with this process to monitor. We'd like to, I would say, monitor this.

This is a very important issue here.

But, to me, this is just added information, added evidence, really, that there needs to be an enhanced capacity of the program to have access to scientific and medical industrial hygiene, toxicological expertise in order to do this.

I don't know if that's needed in order to do the first set, the IRIS, NTP and IARC. But, it would be needed to move beyond that.

So, I would sort of reiterate that I know that's a different recommendation we made, but, to me, this is evidence that underlies our recommendation on that.

Dr. Sokas?

MEMBER SOKAS: And, just to be clear, I think the Board would also probably be happy to review, if the Department of Labor has a contract with someone to accomplish this, if the internal resources are already maxed out and not able to do this, that the Board would be happy to review the qualifications of the

contractor.

And, I would suggest that there are other agencies within DOL like OSHA that have these large contracts available with groups that may have more expertise than the ones currently under OWCP.

So, for example, you know, I wouldn't want to necessarily see Paragon do this if they haven't been capable of doing it in the past with the SEM. So, it may be that there would be other organizations -- other contracts available across the Department that would be accessible.

CHAIR MARKOWITZ: Actually, Ms. Leiton, I have a quick question for you, just a factual question. Paragon, I know they work with you in terms of the SEM.

Do they also -- do they have epidemiologists? Do they have physicians? I imagine they have industrial hygienists, people whose area really is on the exposure side.

But, do they also have health

experts such as epidemiologists? Because that's really -- epidemiology is really key to interpreting these various databases and using them.

MS. LEITON: They have -- they definitely have IHs. They don't have a medical team there. But, everything that goes in in terms of health effects is reviewed by our team which includes doctors and toxicologists, not an epidemiologist, but a toxicologist.

We do use IARC already, but only the first group. We haven't gone on to the second group yet.

And, the clarification about not having the resources or the time to look at this stuff, it wasn't that. It was just that there's a lot of tables. Some of them were inherently inconsistent with each other when they did the review. Some of them were, as you indicated, not really related to occupational exposure.

And so, limiting it was helpful.

And, we do have the resources to look at these things. It's just that we didn't want to just kind of -- when you're looking at all those different tables and they did look at all of those different tables, they said, well, we didn't -- they didn't think that some of them were related to the work that we do, weren't sure that they were all actually consistent with each other.

So, the narrowing down you're going to do is going to be helpful.

We do look at them -- everything that we add in is looked at by a team which includes, as I said, doctors and toxicologists.

CHAIR MARKOWITZ: As you develop a plan to integrate these sources, make sure that they're in the SEM, can you provide us with a copy of that plan so we know sort of what's going to happen when and how things are happening?

MS. LEITON: Absolutely.

CHAIR MARKOWITZ: Thank you.

Other comments, questions?

Mr. Whitley?

MEMBER WHITLEY: While we're dealing with the SEM, I know we talked a little bit about it here, are we going to deal with the job categories and the chemicals that those job categories use?

Because that's -- they use that in the -- when they're doing claims a lot. And, if a job category is not listed as using certain chemicals, then it's kind of like they don't -- they deny it.

Are we going to tackle that or are we going to make a recommendation?

CHAIR MARKOWITZ: Well, I have my own view of that. But, if anybody else wants to respond first?

I think that we need to re-look -- I'm not sure to the extent to which the Board has really critically looked at SEM beyond our initial look at its structure and its limitations and the IOM report on that.

But, 18, 19 months have passed for this Board and I think we should at the next Board Meeting -- I think we should recommend they re-look at the issue of SEM, how it's updated, what's happened in the past 18, 20 months as we learned about it.

What are they doing in the absence of contracting Dr. Brown? What's happened with Haz-Map with the connections between the exposures and the diseases and are those updated beyond what we've discussed so far?

So, I think I agree with you. I think it should stay on the agenda as an issue that needs to be examined.

Ms. Vlieger?

MEMBER VLIEGER: Again, while we're on the topic of SEM, there must be some rationale documents associated with each addition or subtraction from the SEM.

Is that database available to us or can we get a report from the contractor on those additions and subtractions to the SEM?

CHAIR MARKOWITZ: I guess that's a question for Ms. Leiton.

MS. LEITON: So, you're asking us to provide you with a report of everything that's been added or subtracted in the SEM?

MEMBER VLIEGER: No, ma'am, there must be a rationale for -- I mean, they don't just add something and walk away. There must be some work done behind it. There must be some rationale.

Are there rationale documents for when they add and subtract things to the SEM?

MS. LEITON: They have a process, but maybe we can provide you with the process they go by when they do that. That would be easier than trying to give you a description and rationale behind every move they make in SEM.

So, I can probably provide a basis of the process for how they do that.

MEMBER VLIEGER: Okay. Well, but the actual question is, is I believe

rationally, there should be documents of how they do things.

So, when something's added, why it's added. I believe there should be a library of their work of their, you know, who decided what and on what basis.

So, I don't want names, I would just like to see the documents where they're adding and subtracting things, because, from my perspective, the rationale is not rational.

MS. LEITON: Okay. Well, I see what I can do contractually.

CHAIR MARKOWITZ: Yes, Mr. Whitley?

MEMBER WHITLEY: Hey, Rachel, the question I think I've got is, there was chemicals put in the SEM database and they removed chemicals. Why would you remove a chemical if you said, now, we use that chemical in 1975, why would you take it out of the database today? What rationale would there be to remove a chemical from the database?

MS. LEITON: I'm going to have to

get back to you. And, I can look at what they -- what their processes are. They have processes. I know they have rationale behind them. I'm going to have to look at what documentation they have and what we can provide within our contract.

CHAIR MARKOWITZ: Other comments?

Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I thought the discussion of IARC and NTP is very important and useful. And, I'd like to expand that and ask a question.

I don't really have an understanding of what the system is for ongoing updating of the SEM and exposure information and exposure health association information to reflect advances in science.

For example, COPD 20 years ago wasn't really thought of as an occupational disease and there's been a lot of science in the last 15 years that has changed our view of it.

And, I saw in the manual a good number of sections that read more like 20th century science.

So, it seems to me there needs to be an ongoing process. And, I'm wondering what that is and if that's -- if we need to discuss that?

MS. LEITON: I think that that might have been a question for me.

What I'd like, if we can get back to you on these questions, this round of questions just so that I can make sure I give you a proper, thorough answer, that would be really helpful.

I mean, to our entire process for how we -- I mean, I can tell you that we have, you know, we have a process whereby our SEM team does research. We get documents from the public in our SEM mailbox.

When they, you know, they are constantly updating it based on the research they can do. Like, for example, they went to

DOE Record Center. They looked up a lot of records there to look for additional toxic substances.

When we get information from the public or we get documents from our claim files about toxic substance exposures that are links that we might be able to put in the SEM, that's when our team looks at the health effects and they add a document -- a toxic substance link into there with a particular health effect.

The SEM team itself, in terms of adding toxic substances, they will do the research. They'll say, oh, we found, you know, 10,000 toxic substances at Santa Susana, for example. And, we have added those based on maybe members of the public or what we found in other records or what they've done in research.

And, they'll go and they'll say, we think these should be added. Here's why they give it to our government staff and policy.

We review it and consult with our toxicologist and our IH and then they'll add

them.

It's a pretty simple process for adding things.

Deleting things is a little bit different and it's rare that they do that, but if they do that, it's because they had found some conflicting evidence to say, this really wasn't there or, you know, there's various reasons and they always have a reason for it and I'm sure it's documented.

But, I -- that process is interactive with us. It's, as I said, very -- it's a lot easier to add things than to subtract things.

And, the health effects, since we don't contract with Dr. Brown anymore, is a little bit more challenging. He does -- there are things still added through in the LEM to that database which we will take.

But then, we do research with IARC and we do research that comes in through various sources.

So, it's -- that's kind of the high level of how we do it.

CHAIR MARKOWITZ: Thank you, Ms. Leiton.

Dr. Silver?

MEMBER SILVER: Because of the ambiguity about the Board's future, you're probably already on this, but I wonder if our Chair is keeping a list of recommended issues for the next version of this Board to tackle.

And, I think, Garry, with these concerns about job categories and that aspect of the SEM, you know, it would be a big chunk of important issues for the next Board to bite off.

CHAIR MARKOWITZ: I would say that Mr. Whitley's concern is on the list.

We need to fill out that list over the next couple of months and that will be one of the agenda items on the next Board Meeting -- the telephone Board Meeting is what issues that we think are a priority that we are still

working on, we haven't gotten to, whatever, that the next Board should take up.

Ms. Vlieger?

MEMBER VLIEGER: This is a question for Carrie. Carrie, are you keeping track of what we're putting forward here as ideas or is it just --

(OFF MICROPHONE COMMENTS)

MEMBER VLIEGER: -- in a minute's great, thank you.

CHAIR MARKOWITZ: And, Ms. Rhoads, are you keeping track of the things that the Department is saying that they're going to provide for us, a record of things?

MS. RHOADS: Yes.

CHAIR MARKOWITZ: Okay, thank you.

Other comments or questions on this topic?

(NO RESPONSE)

CHAIR MARKOWITZ: Okay, if not, let's move on.

MEMBER WELCH: Can I make one

clarification? So, I'll -- should I write this up as a recommendation that then we would consider more formally at the -- at our phone Board Meeting or do you think it doesn't need to be a recommendation?

CHAIR MARKOWITZ: What you should write up is a comment on their response which we will review in January in the Board Meeting and vote on.

Okay, let's move on to the occupational health questionnaire. This is the final recommendation that we haven't looked at yet. So, Kevin, if you can bring up the second set of recommendations?

And, I think Dr. Welch is going to lead this discussion. But I want -- let me just summarize this recommendation that everybody's oriented.

It has to do with enhancing the occupational health questionnaire. And, by way of background, the SEM really doesn't have information of frequency, duration, intensity

of exposure within the complex.

And, that's a problem for people who are trying to make a judgment about work related diseases and relevant exposures.

So, our recommendation was that -- and I'm just going to summarize, that the revised occupational questionnaire expand the current list of hazards and exposures and materials that are listed.

That, for those exposures, the workers should be asked how he or she was exposed, including getting text on their own description.

The frequency of exposure that the worker had. And then, if the worker used the material directly or was a bystander in the area where that chemical was used?

We further recommend that the occupational health questionnaire -- there could be the list of specific exposures, but also the opportunity for the worker to add additional exposures that they know about that

aren't on the routine questionnaire.

Then, we provide a list of some hazards. It's a limited list of -- but an additional list.

And then, we also recommend that the OHQ add the list of tasks that's currently used in the construction worker, former worker, project.

And, finally, or almost finally, the -- our recommendation was that a question be asked about -- specifically about vapors, gas, dust and fumes then that echoes our conversation yesterday about COPD, getting details about those exposures including frequency and the like.

And then, finally, then a new version of the occupational health questionnaire be tested and be piloted before put into use.

So, that's the summary of our recommendation.

Now, if someone wants to read the

response -- DOL's response. We had some excellent readers yesterday. You couldn't possibly be exhausted.

MEMBER WELCH: Can I ask a question --

CHAIR MARKOWITZ: Sure.

MEMBER WELCH: -- that shows my lack of preparation that the comments say that the draft OHQ is attached, but I don't have it.

MS. RHOADS: It was sent in an email.

MEMBER WELCH: Okay. And so, you know, I'm -- I can't -- so, I got up this morning trying to be ready to talk about it, I realize I don't have the draft, so I can't really respond. But, other people can probably help in terms of responding.

CHAIR MARKOWITZ: Let's read the response. I don't think the intent here was for us to go through line by line of their draft and see the extent to which it comports with our recommendations.

That wouldn't be the kind of work we'd do. Wouldn't have time to do that as a Board. But, nonetheless, it would be useful to be able to access it.

But, let's start while I guess someone -- Carrie's sending it around -- if we can just start with reading the response.

MEMBER WELCH: Yes, I can start with that.

So, upon review of the Board's recommendations in Section A, OWCP agrees that claimants who provide detailed accounts of work processes, labor activities and other operational descriptions of an employee's work activity are the most reliable and substantive mechanism for assessing employee occupational exposures to toxic substances.

In fact, OWCP has revised the OHQ and the Board's recommendation that the worker be asked to describe how he/she was exposed to each material using free text is included.

The draft OHQ also provides more

room for a description of job tasks and requests that the claimant advise as to whether he/she was in a particular union or was part of the former worker program.

In the draft, OWCP reduces the list of toxic substances. And, instead, lists broad categories under which the claimant may provide specific toxic substances, for example, high explosives or metals.

Over the last 10 years of conducting OHQ's, OWCP has found that the ability of a claimant, particularly a survivor, to affirmatively self-select toxic substance exposures from a list, often times does not produce reliable or useful information.

With regard to the list used by BTMed, and it references a website, this list refers solely to construction and trade positions and, therefore, would not be applicable to a general OHQ that applies to employees in all occupations.

With regard to the Board's

recommendation in Section B that proposed to add a section on reported exposures to vapors, gases, dust and fumes, our concerns are contained in our response to Recommendation Number 3 regarding the use of this language.

If the Board develops a list of toxic substances that represents vapors, gases, dust and fumes, OWCP will consider how that list may be addressed in the OHQ.

OWCP agrees with the Board's recommendation in Section C that the new version of the OHQ be tested multiple times prior to becoming final and will have the resource centers conduct these tests.

Attached is a copy of the draft OHQ OWCP recommends, welcomes specific recommendations concerning modifications to the draft that the Board may have.

CHAIR MARKOWITZ: Okay, comments?

Dr. Dement?

MEMBER DEMENT: I think we, in principle, agree with the intent of the change

in the occupational history to allow more detailed description of tasks performed with the material.

And, I think the question that we were faced with is how to -- how best to get that information from workers who may or may not have a good level of recall.

I think what we found in the BTMed program, rather than saying, you worked with this material, we also say -- ask, you know, we ask the question, you worked with this material and then, based on that experience over the last 20 years, give them a list of common tasks that construction trade workers would have done with this material and ask them did they do and how frequently they did it.

And, I think what we found is that providing that list, and we acknowledge that the list is not complete for production workers and that's something that I think is subject of continuing development, but these general categories of tasks.

But, we've found that by providing that list, it actually helps to stimulate recall of the worker to provide that information.

So, that's the intent of it all. And, I'd say from the outset, you know, we collect these types of data in the BTMed program. We know that we're missing lots of information with regard to exposures.

But, our intent is to at least to be able to identify individuals who had substantial exposure versus those who had lesser exposures.

And, I guess the final comment is, based on taking that information and relating it to specific outcomes -- health outcomes -- we found it to be a useful process in that type of separation of exposures and identification of higher and lower risk groups.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: I'd like to agree wholeheartedly with Dr. Dement. I have seen

the difference between the questionnaires that come from the worker medical programs versus the old OHQ and now this proposed OHQ.

I was a planner at the Hanford site. Our right to work station looked like two Gutenberg Bibles set edge to edge with pages in them.

At the time of my accident, when I said please tell me what happened to me, what was I exposed to? And, I was told, well, go look it up yourself at the right to know station.

For those of you who don't know what a right to know station is, that's an MSDS bank of records for everything you could possibly be exposed to.

Now, as a planner, I was supposed to know what my workers would be exposed to and I took great diligence to figure that out.

But, after 20 years and retirement, no one is going to remember that list. So, without providing some guideline as Dr. Dement

has said, for the chemicals they were exposed to by labor category, this new form looks, to me, much more worker unfavorable than the previous one.

I know it's an attempt to fulfill our request, but without linking it to those groups of chemicals and most of the workers don't know how to use the SEM. Some of our workers don't have computers nor do they want to learn how to use them.

So, I think at the process, using the new form, if there's some way to attach a group of chemicals for their known labor category and then anything they'd like to add.

But, otherwise, I see this as an epic fail again.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: I want to strongly agree with Dr. Dement and his evidence-based comments about recall. Recall is certainly a major factor in identifying past

exposures.

But, in light of what Ms. Vlieger is saying, I think there's another problem which may be as important which is lack of knowledge of what the exposures are.

So, if someone doesn't know exactly what they were exposed to, they may not identify it on a specific list.

And, what I would not like to see, I agree with providing a list, but I'm really worried that if the list is provided and someone doesn't answer that they were exposed to a certain chemical but they say they were exposed to vapors, gas, dust or fumes, that they will be considered unexposed because they didn't answer yes to the specific toxin.

So, I would like to propose that it be either or. Either they answer yes to the vapors, gas, dust or fumes or they answer yes to a specific toxin. And, the specific toxins would then act to jog people's memory and identify specific exposures.

But, I think that -- I've seen so many patients that just did not know what they were exposed to. And then, when we threw research and identifying products, identify it, we see that there's a clear relationship.

So, I just wanted to point out that possible issue.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Just a comment on some of the chemicals, like some of the ones that were used at Hanford are so exotic, there is no health studies. And also, I believe there's still some of them that aren't classified.

And so, that has to be dealt with also. And, that leaves people out on occasion.

And, I guess that's it.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: Laura Welch.

One of the things that we proposed when we proposed a list of hazards, we proposed both asking people about hazards and tasked.

And, we proposed if people describe that they were exposed to a particular chemical that then they asked to describe how they were exposed. What was the task?

Usually, I mean, when I am looking at, you know, our BTMed former worker questionnaires to determine if somebody had a particular exposure, if their exposure might -- their work might be related to the disease they have.

I find the task is the most useful to me because, not only is it I generally know what people were in the construction trades, if they did a particular task based on the year, I have some idea about what they were exposed to.

And, the task gives me some idea of the intensity of exposure, too.

So, the task information in, you know, sort of an expert assessment, not necessarily what the claims examiners would do, but what the industrial hygienist would do. The task is really, really important.

And then, the task and the list of substances have to be integrated. Having just a list is not very helpful. I mean, Department of Labor and in their response, the Department in their response says that it's not -- just having people self-select toxic substances from a list often is not reliable or useful.

I think it's useful if it's then linked to the actual activities. So, if you think that people are just checking things off on a list, asking for more information when they check a particular agent, then how they used that agent would then allow someone reading it to say, that makes a lot of sense, yes that makes sense. We know that that particular agent would have been used in this activity.

But, as we know, many of the agents in this complex were -- they had numbers, they didn't have names. So, task is still going to be, I think, one of the most valuable ways to assess exposures.

But, again, that has to be looked at by industrial hygienists to really interpret that task.

CHAIR MARKOWITZ: The -- Steven Markowitz.

The, you know, construction in large part does your work, yours and Dr. Dement's and others at the CPWR, is an identified and limited universe of tasks and hazards. You can capture most of them in a finite list.

You know, in our chores at the DOE complex, the heterogeneity of activities that are undertaken at DOE, we certainly couldn't describe ahead of time a list of tasks for production workers for the whole set of other types of workers, engineering workers, administrative service workers, et cetera.

And so, they can be asked about what their tasks are and they should be. The problem with the OHQ is that the interviewer probably has limited expertise and an ability to actually ask about them to get a relatively

complete set of tasks on those types of jobs.

So, it gets back to what we've discussed before, who's doing the interview?

Industrial hygienists clearly can do that, but theyaren’t administering the OHQ. So, there's a problem there.

I don't know who was next. Dr. Cassano?

MEMBER DEMENT: Just to follow up on Steven's comment.

You know, so, what we're trying to do in the OHQ is sort of as a hygienist would transmit, you know, what we would ask if we were sitting in front of this worker.

Okay, you tell me you worked with benzene. Then, the next obvious question is, describe how you worked with it.

So, really the task is what we're looking for. And, we can do better with construction workers. We have lists we can -- and they're reasonable.

We're missing that for production in

large part, you know, it varies by site so tremendously.

But, nonetheless, as a hygienist, if you can tell me what you did with benzene, even it if was at a different site, but the process itself, were you cleaning parts with benzene? Were you pouring -- transferring benzene from container to container? Those are the things that are so helpful.

The difficulty is trying to use a second party to collect that information.

So, there's two things that we thought were helpful.

One, former workers doing that work are in a better position to know some of that anyway. They may not have done that exact task, but they're familiar with the site and they are familiar with what I would call industrial work.

The second process we thought was useful would be to allow, even after that process is done and that information is there,

if the worker has a claim and it doesn't meet one of the presumptions a priority, then the hygienist has the ability to go back and ask more specific questions of the individual by direct discussion.

So, that was the thinking process beyond -- behind, you know, this version of the OHQ.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Yes, I agree with Dr. Dement and Dr. Welch.

And, you know, the production workers is a lot different. And, you know, like I said, the prime example is walking into that machine shop. As soon as they open the door, you can smell cutting oil.

That building's been there for 65 years. And so, you can't leave out secretaries, clerks, anybody else because they are in the process production areas of any of these sites across the country.

Most of these areas vented to the

atmosphere and so the concentrations, day after day, year after year.

And, I, you know, I hope, you know, that we -- and, I know it's extremely difficult to do that, but you have to have somebody that has knowledge of those buildings, how many different air zones there may or may not have been, upset conditions, wind, all those things when they pressurize the building.

So, you may have supposed to be negative in your building, but when you have a lot of wind, as we do, it pressurizes the building and then all bets are off.

And, yes, the job categories I think for construction trades is a little bit easier. But then, we have construction then they go to the production side for us. And then, it's just all the different things you can't leave any stone unturned, in my opinion.

And, I know it's going to be inherently difficult, but I don't -- no one should be left behind.

CHAIR MARKOWITZ: Well, I mean -- Steven Markowitz.

Say that in our recommendation, we did add a question about bystander exposure. And so, the OHQ should at least have the opportunity to collect that information that you're referring to as bystanders.

The problem there is, they won't know what they were exposed to, but, nonetheless, getting it down that they worked in that building and they were a bystander and there were some exposures is a start for the responses to the questionnaire.

MEMBER DOMINA: Just a quick comment. Sometimes, you know, there should be documentation for certain things because, like, you might have had a campaign for some certain deal that ran for a year, two years, or something. And then, another time, it may be routine.

But, I think that hopefully there's documentation for some of that.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: A couple of comments.

First, on the OHQ, I mean, as far as the bystander problem, what we've done in the past many times is asked someone on a questionnaire to diagram the workplace and what processes were going on and where they were in relationship to that.

And, sometimes, that's very helpful in determining what someone like a secretary or whatever would be -- would have been exposed to. They may not know what the process is, but they know that there was some chemical thing going on here.

And, that's been very helpful in some situations.

The other comment I had was about the BTMed questionnaire. It may not be relevant for all of the workers, but you should really audit the two questionnaires and, if there is something in that BTMed questionnaire

that is not in the OHQ, it should be added. Because, that's an additional piece of information that people that are very smart about this have developed.

CHAIR MARKOWITZ: Dr. Dement?

Yes, Mr. Whitley?

MEMBER WHITLEY: When I go look at the SEM and I look up a supervisor or I look up a secretary, it says no chemicals. I just looked up two or three just now, it says no chemicals.

But, as Kirk just said, the secretaries office was out in the middle of the machine shop. The supervisor of the machine shop is out there walking around where they're cutting bars all day long.

So, I don't think the SEM can be used to deny claims. So, I don't know how it's such a large thing, it's very useful. But, it can't be used to deny claims because, it's like saying, the supervisor or an engineer both says no chemicals.

So, if you looked on the SEM and it says they didn't have any chemicals around them. All those, I just looked them all up.

CHAIR MARKOWITZ: So, you know, the strategy is that the OHQ should be able to capture enough information to overcome that deficit in the SEM.

Because it's specific to that individual and it should be able to capture more detail. That secretary may not know what those chemicals were, but at least it can be related that she or he worked in that location and, therefore, they have been exposed.

Dr. Dement?

MEMBER DEMENT: Yes, I agree with Garry. I think some of the more classic cases in the occupational literature actually occurred among non-production people.

There's some of the beryllium disease cases, I mean, they were clearly on the production. There were sometimes people working in the files in the offices.

But, I think another point for the OHQ, it may not answer everything, it's an attempt to gather as much as you can in the limited time with a limited amount of recall.

But, the other thing is to allow the hygienist to have that total package of information.

In many cases, there were comments made about tasks. It may not give the final answer, but it will be a red flag for the hygienist.

I want to ask specifically about a few of these tasks that are listed or exposures.

So, hopefully, some of those individuals who have this bystander or non-production exposure would be picked up in that process. And, we hope that by the process picked up in the overall process of adjudication in the IH evaluation.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: Did anybody see any

qualifying language in the boilerplate of the OHQ that tells the claimant that this is a start, it's only a start and it would be in your interest to supplement the record as your claim proceeds with additional information such as the questionnaire from the former worker programs, information provided by coworkers, oc docs you may be visiting?

And, your authorized representative often is a site specific advocate who knows a lot about the buildings and processes and materials.

I just feel that a lot of people go into this and they think they're going to be taken care of, kind of cruise control, fill out your 1040 and you'll get your refund down the road.

And, we should tell them up front that the OHQ is just a start.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Just a

small point, but it may be important.

I'm looking at the OHQ section under PPE, personal protective equipment, and it seems to me it may not be explicitly enough asked when did the person start to use PPE.

Because a lot of PPE became more available in the '80s and '90s and wasn't used, even though it was the same process earlier than that. And the PPE can significantly modify the exposure.

So, I think it might be asked a little more explicitly, when did the PPE become available and when did they start using it?

It does ask question like when did you use the PPE, but not explicitly when did you start using it?

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Yes, if we're going to get specific on PPE, and like we've discussed before, PPE was used for RAD. We didn't have chemical stuff available to us until late.

And, basically, yes, if there's RAD in the area and you're going in with a chemical to clean something up, it's when you got a headache is when you come out. That's how it was done year after year.

So, you've got to be specific and then the same thing with what kind of clothing you may or may not have been wearing, you know, standing in primary water that's just gone through the reactor, all that stuff.

And so, we have to be specific on that.

CHAIR MARKOWITZ: Dr. Dement?

MEMBER DEMENT: I think as a hygienist, for me, PPE is at the absolute last line of defense. And so, you wish to have engineering controls in place to minimize exposures.

And so, PPE availability in the absence of a program to properly train, administer, make sure this is used properly, can actually be to the determent of workers.

I've seen cases where workers were given an inadequate respirator, called a respirator, put into a high exposed asbestos situation. And, in my view, they thought they were protected. They did this work for hours and hours. They were given a great disservice by this PPE in the absence of a program to properly select the device, to make sure it's fitted appropriately and used appropriately.

CHAIR MARKOWITZ: Dr. Welch and Dr. Sokas?

MEMBER SOKAS: And, this is just to -- I think we've had this conversation in the past in this Board where the availability or the use of PPE is actually seen as a marker for exposure rather than a reason to say, oh, the person wasn't exposed.

CHAIR MARKOWITZ: Dr. Welch?

MEMBER WELCH: You know, my memory isn't what it used to be, but I think in our recommendations about the OHQ, we recommended they drop those PPE questions.

Because, that's something that the industrial hygienist could go back and ask about, but as Kirk pointed out and John, that's very complicated. And, particularly, the individual.

So, I'm not sure that it adds much to have it on the OHQ.

CHAIR MARKOWITZ: I'm sorry, did you want to -- John, do you want to respond directly top that? Go ahead and then we'll go to Ms. Vlieger and Mr. Turner.

MEMBER DEMENT: Yes, I just, if we're limited in time and resources, I'd much rather see resources trying to look at and determine the exposures rather than trying to go through the mishmash of when PPE was or was not used.

CHAIR MARKOWITZ: Mr. Turner?

MEMBER TURNER: There are a lot of worker, former workers, that have moved across the country and they are really sick. They don't know what type of work that they did,

what, you know, where they worked.

So, they have a representative that they called, you know, and tried to find out from some of their coworkers or some other person that knew this person to try to find out what type of work and what type of exposures that they had.

CHAIR MARKOWITZ: Which raises an interesting question. When the OHQ is administered, the person from the resource center is doing it by phone, right?

But, presumably the worker is permitted to bring a coworker or bring someone else with them to assist in that. Or, if by phone, to have a coworker or someone available? Not usually?

Ms. Leiton, do you want to respond to that?

MS. LEITON: There's no restriction against it. They can bring whoever they want to.

CHAIR MARKOWITZ: Thank you.

Ms. Vlieger?

MEMBER VLIEGER: For clarification, my point of not usually is normally these appointments are made at the claimant's leisure.

And so, the ability to bring lots of people with you is not normally accessible.

My experience with the OHQ, with any of the people that are starting a claim, I will give them a blank copy of the form and I say, put it next to your chair, think about it. I want you to mark it up like crazy before your appointment.

Because, a lot of times, there's brain freeze during the appointment and they can't remember things. And so, I give them advanced copies and I usually carry a few with me because people are starting claims.

I say, you know, this is really important because it will be used as part of your claim.

And, what I've found on the IH

reports is that they actually use the IHQ, but many times, they're misinterpreting when people say they often, always or infrequently used their PPE.

And, they apply that across their entire work history. And, as we discussed, PPE is mostly for radiological conditions at the sites. So, PPE is a broad spectrum of things and the list on the OHQ was adequate. But the use and the misuse of PPE is never addressed in the questionnaire because we know a lot of what has been used is improper.

So, I think if we're going to give the OHQ to them, give them some time to play with it before the appointment because the appointment can be mind blowing to them.

And, with the older claimants, especially, they're going into what they conceive to be a government office and they get a little what -- the equivalent of white-coat fever and they forget things.

So, I would recommend providing them

a blank copy well in advance that they can play with so that they know what's going on.

And then, I always tell them, think about, you know, what you were doing at the time of more like, what car were you driving? What house were you living in? To put a time frame on when things were happening.

But, to just give them it at the appointment, it freezes most of them up. And, when you are able to provide a supplemental OHQ when you remember things later, it's a little tougher to get it into the system, but you can always provide the supplemental information as well as coworker affidavits.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I just want to go back to the question about PPE and add on to what Laura said as using it as a marker of exposure rather than a marker of protection against exposure.

A lot of people don't know what they were exposed to. They don't know what they

were doing. They don't remember what they were doing, but they darn well remember that somebody gave them a respirator at some point or told them to use one.

And then, it becomes incumbent upon whoever's doing the questionnaire or the industrial hygienist to be able to dig through that and say, okay, you know, what processes were you -- do you remember approximately what you were building or what you were working on and that becomes then a way to dig down into what their exposures might have been.

So, I think it is a useful question as a general question, not as a, okay, you used PPE, you were protected, you weren't exposed.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: Just a comment, and this is probably an extreme case, and I'm sure Garry may know that guy at Y-12 wearing PPE that wasn't flame retardant welding overhead on a ladder and he burned to death because he didn't have a spotter and it caught fire behind

him and he was in PPE but not flame retardant.

So, you also, like Dr. Dement said earlier, where sometimes that is -- can be a hazard in itself.

CHAIR MARKOWITZ: So, we're going to take a break in a couple minutes, but I want to close out this conversation.

So, we have our recommendation and we have the draft OHQ which we haven't really had time to go through systematically.

But, we've had the comments we've had today. How should we move forward on this? Should we collect our comments on their draft OHQ and assemble them and submit? Or should we do that and look at them together in a Board Meeting and agree on them and then submit them?

I'm looking for suggestions on that.

MEMBER WELCH: Well, we could have the SEM Subcommittee do a, you know, we could have a conference call to talk about the new draft in light of what, you know, our goals have been with our recommendations and then

make some proposal to the full Board about how to respond.

CHAIR MARKOWITZ: That sounds good.

Dr. Friedman-Jimenez?

MEMBER FRIEDMAN-JIMENEZ: Just a question. I have some comments on form, content and even some errors in the manual. I'm going to have to leave. Should I just write them up and send them in? How are we going to discuss the manual?

CHAIR MARKOWITZ: So, Ms. Leiton, I'm sorry, a question for you. What Dr. Friedman-Jimenez is saying is he's got some comments, corrections, factual issues in the procedure manual. Should he just make note of them and send them directly to you or how should we proceed on that?

MS. LEITON: I think, ultimately, it's going to be -- that's going to be the easiest way because we can actually go through the manual along with your comments, read through them and make corrects as we need to

make them.

CHAIR MARKOWITZ: Okay. Having said that, I just want to make it clear that the Board is not saying that it's systematically going through the 748 pages and making corrections.

Dr. Silver?

MEMBER SILVER: Our request to the SEM Subcommittee, when you work up our recommendations, we should also look at the script that supposedly accompanies the OHQ and ensure that, up front and at the conclusion of the interview, the claimant is informed that it's really important to supplement this record.

Once the brain freezes over, people go home, they run into their buddies from work and a bunch of light bulbs go off and they need to understand the OHQ is just the first step.

CHAIR MARKOWITZ: Okay, between brain freeze and white-coat fever, we may need to look at the Haz-Map again.

Okay, so, we're going to -- next week, then, we're going to have to arrive on a common date for a meeting of that SEM Subcommittee.

So, when you get the request, that committee, when you get the request for good times, please respond rapidly.

We're going to take a 15 minute break and we'll resume at 9:45.

(Whereupon, the above-entitled matter went off the record at 9:30 a.m. and resumed at 9:48 a.m.)

CHAIR MARKOWITZ: Okay, let's get started.

MR. FITZGERALD: If everyone could please take their seats. We'd like to get started.

CHAIR MARKOWITZ: Okay, we're going to start with Part B Lung Disease Subcommittee Report which will be relatively brief. That's not a suggestion, Dr. Redlich, that's just a description to everybody else.

MEMBER REDLICH: This is Dr. Redlich.

While we're waiting for the slides to come up, I have included some from some of the prior presentations just as a reminder for both us and the DOL. And, I'm not going to go through them all.

But, this is an update on our subcommittee and the members, John Dement, Kirk Domina, myself, Jim Turner and Laura Welch.

And, I'm very briefly going to go over what we have actually done over the last almost two years.

We -- John Dement reviewed data we had received. We've reviewed about 80 Part B cases. We've made three recommendations.

And, I think unlike some of the other subcommittees, we have a list of specific questions that the DOL gave us that we responded to.

And, I put this slide second so I wouldn't forget at the end, but I just really

thank the other members of the Part B Subcommittee.

I needed remedial help because they all actually had much more experience with this program and the complexity of it. And, even just what all the abbreviations were. So, they and others were extremely helpful, and Laura with her expertise and experience with the program. And, also John Dement similarly and his analysis of the data.

And, Kirk, as we heard, and Faye, yesterday were extremely helpful in reviewing my cases.

But, just to remind everyone, I'm not going to go through all the data. I just copied the data slides that we had used before that Kirk -- I mean, that Dr. Dement, the analysis he had done.

And, you know, I appreciate -- I would also wanted to just say that the requests that we made to the Department of Labor for both data and cases were, you know, supplied

and in a timely fashion. And, that was very helpful.

So, but, the major point of this was that I think reviewing the data was very helpful to target specific issues and where we focused our efforts, especially trying to understand the magnitude of this program and problems.

So, this isn't a prior presentation, as are the conclusions but, as just a reminder, I think that whatever imperfections there may be in the data, it remains helpful to review and John did a great job of that.

So, moving on, the Part B cases, I think we've reviewed, as we heard yesterday, 80 of them. And, I think the point is that we did identify really some fixable problems. And, I think the problems that could be fixed in the short run.

And, the major things that we had identified were issues with CBD sarcoid cases that were denied both because the presumption

was not 94implemented or the clear beryllium exposure appeared to have just been ignored or denied.

And then, we had mentioned some of the other issues that had come up that do seem to be fixable such as this problem with CMC.

We made -- this subcommittee made three recommendations. The first one, we discussed yesterday related to the blood proliferation test.

The second and the third, we are waiting the DOL response on.

The second is a more technical issue that we had been requested to provide a definition of chronic respiratory disorder.

The third is one that we also refer to as just issues with the procedure manual that we hope can be improved in the future.

And then, we responded to specific questions that the DOL asked us. I am not going to go through all these questions, except we did give a 13-page reply to these questions

that have numerous references in it.

And, was based on quite a bit of information, review of the cases, the data, our meetings, our site visits, our expertise and the medical literature.

So, we are just hoping that the DOL carefully reads our responses to our questions and implements them where possible.

I think in terms of future directions, we are awaiting, as are the other subcommittees, a response to the second and third recommendations from the Part B.

We're hoping that these recommendations can be implemented. And, as I mentioned, the specific questions that we were asked our expertise on and provided, we're hoping that those answers can get incorporated into the procedure manual, the training documents.

There were, I think, some small, short-term, you know, some fixes are longer term and would take more time to implement such

as, you know, revise procedures and questionnaires.

I think there's some shorter ones -- short-term ones that we identified that someone could look into that could really impact people's lives, one of which would, for example, would be the CMC that had reviewed half the cases that we had been selected and provided to us.

And, I do think that it shows that there's a value to reviewing the data and selected cases.

So, I'm going to end there and if anyone else on the committee wants to comment.

CHAIR MARKOWITZ: Okay, so, if you could --

MEMBER REDLICH: I'm sorry, I did talk quickly.

CHAIR MARKOWITZ: No, no, that's -- no, no, that -- no, no, that was great.

If you could leave that slide up, I have a question, Ms. Rhoads. Can we make that

available on our website -- on the Board's website because that contained a lot of very useful information that people might want to access.

So, it's a -- okay. So, if we could do that.

I have a question for Ms. Leiton. So, there's some observations that the Board has made as we've discussed it and done our research that here haven't been part of official recommendations, such as what Dr. Redlich is talking here about.

What the committee considers to be the problematic consulting physician or cases that were -- that the committee believes were incorrectly adjudicated.

So, what kind of follow up can, does DOL do from these kinds of observations?

MS. LEITON: I was going actually ask about that CMC and that list and that evaluation. Were we provided with that, Carrie?

They did an evaluation of CMCs and they've -- we've been referring to the particular CMC. So, I don't know if that was actually submitted to us.

If we can get that, that would be helpful. We can review it. We can maybe follow up on some of the issues that have been identified.

I don't know that that needs to be a formal process. I'm not sure exactly the rules in terms of can you just provide us that, we can follow up on it and get back to you? Or, does it need to be published? I'm not really sure what the DFO rules on that are.

But, we're -- I would like to see it. I would like to be able to follow up on it however that needs to happen.

MEMBER REDLICH: Yes, that is correct. I did not mean to imply that you have not yet taken care it because that is -- we did not provide any specific names.

And, the cases were --

MS. LEITON: I mean, again, it would have to be --

MEMBER REDLICH: -- and that we could provide a list of those based by the event or by identifier --

MS. LEITON: Right.

MEMBER REDLICH: -- where we thought there was an issue.

MS. LEITON: And, I think that would have to be done informally and not on the website just because of the nature of it.

CHAIR MARKOWITZ: Sure. Like where we're discussing both issue of the particular CMC, but also the issues of the cases the committee thought were incorrectly adjudicated. Right?

MS. LEITON: Correct.

CHAIR MARKOWITZ: All right, thank you.

MEMBER REDLICH: Thank you.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: I'm interested in

how this issue of the problem with CMC is being framed? You did 80 cases, a lot of work. Out of a population of how many Part B cases for that relevant time frame? Do we have an idea, 80 was a sample of a much larger number, right?

So, using a poker metaphor, on the first deal, you got a royal straight flush recidivist CMC who had attitude, I think you said.

If you drew another sample of 80 cases, it seems to me there's a possibility of CMC B, bad attitude coming up in those files.

So, I think we may have a systemic problem or it could just be one bad apple.

MS. LEITON: I mean, I'm assuming you're referring to the analysis that was conducted by this subcommittee. So, I wouldn't know the answers to the universe or any of that off the cuff.

We provided the data. They did the analysis.

CHAIR MARKOWITZ: All right, well,

just to get some clarity on this particular consulting physician, the issue was lack of objectivity? Because we were referring in the discussions about attitude and other adjectives. But, let's formalize it a little bit.

Was the issue lack of objectivity in their analysis? Was the issue perceived conflict of interest because the person had an ideological conflict of interest?

I think we should -- we don't have to do it right now here, but we should use other more specific words.

Dr. Cassano?

MEMBER CASSANO: I think Rosie's going to ask the same question. You found this sort of incidentally to your analysis.

But, our subcommittee should really be taking this over so it's where the CMC Subcommittee. So, if you want -- I mean, I don't know how to work that --

MEMBER REDLICH: I'd be happy for

you to take it over.

(Laughter.)

MEMBER REDLICH: And, thank you very much for offering.

MEMBER CASSANO: Yes, but that's just --

MEMBER REDLICH: It was just incidental observation on them as we heard by Kirk.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: And, when we had asked for charts, we actually, again, there was a little bit of confusion. So, we wound up sampling some of the charts that had been provided for other people.

So, I'm assuming we reviewed some of those same charts. And, as an example, there was a, you know, a CMC who clearly refused to consider COPD as a work related outcome citing old -- and included a cherry picked citation from the literature in order to do that.

So, I mean, again, you could

certainly include that in the, did the CMC follow the published guidelines, you know, from the program?

I mean, I think when we talk about the auditing, the changes in the audit form, we can address some of those issues.

I think it might be also useful, I mean, we can get back in touch with Carrie, to make sure that we haven't missed some other ways that we can formalize that language.

CHAIR MARKOWITZ: Mr. Domina?

MEMBER DOMINA: When we stumbled upon this issue, they were cases that were provided to us by Labor.

And, I think the whole process needs to be looked at, too. Because, I think one of the other issues that came into play is the way the questions were framed from the CE to the CMC also was problematic.

And so, that, you know, we needed to look at all of it as a whole. Because, like I said, I think I had six cases that Carrie

assigned to me and when I -- after a couple, then I had another one and then Faye and I got together.

And then, we ran the whole list that was provided by -- from Labor to us. And then, it got inherently worse. And, that's why, you know, because, I had to ask Mark and I picked stuff out of there, it's like, wow.

CHAIR MARKOWITZ: Some of us disagree with at least one of the statements you made there.

MEMBER REDLICH: I think also one of the reasons that I've been harping on the procedure manual on the training materials that is the jurisdiction of the other subcommittee, is that, I think some of the adjudications which we did not agree with, it was probably multifactorial where things went wrong.

But, I think it just has to be a recognition that, you know, there could be a, quote, qualified CMC or the like that those positions are not going to be -- they

themselves may not be aware of the last 15 years of research on, let's say, COPD causation.

And so, there is a lot of, you know, a lot of the instructions is based on the decision making and the rationale of the physician either, you know, the CMC or the treating physician.

And so, there's a lot of expectations on these physicians that I think all of us who know who these physicians are, are concerned about them.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: I think we could, not being on the committee but only being an advisor to the committee, I think we could come up with the areas that we would need to look at in total in some sort of questionnaire.

But, what I find very disconcerting in the CBD cases that we reviewed and that I have seen personally is that, the doctors are using the wrong criteria and not using the

programmatic criteria for a diagnosis of CBD.

And, many of them are using the beryllium case registry criteria which is much more stringent than the DOL criteria.

And, when pressed through the program and when I asked, you know, they're using the wrong criteria, does anyone tell them they're using the wrong criteria at the CMC level?

I'm told that the CMCs are trained and that's what they do. There's no corrective action for that error in use of programmatic guidelines.

CHAIR MARKOWITZ: So, but, you know, some of this conversation demonstrates the importance of one of our other recommendations about taking a look at a sizable number of claims and really identifying the systematic issues.

MEMBER REDLICH: And, yes, and I did get that incorrect. Faye is correct that I think there are some discrete fixable things

that are not, you know, either so complicated or endless that they can't be fixed.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: Just a couple of things, I think this kind of thing, and we'll come up more information later is, it supports the quasi-recommendation we made at this meeting that you do more of a peer review type CMC process so that these individuals can be, you know, can be noticed earlier rather than the general one or the random one.

And also, who is responsible for the training? I know in some situations with contractors, you know, the agency trains the trainer and then they're responsible for training their CMCs. How does it work at Labor for the CMCs?

MS. LEITON: The contractor will train their -- the contractors that work for them. We will review the material and go over the training with the contractor who trains.

MEMBER CASSANO: So, you provide the

training material for them?

MS. LEITON: We will -- yes.

MEMBER CASSANO: Okay.

CHAIR MARKOWITZ: We need to move on. So, are there any other comments?

(No response.)

CHAIR MARKOWITZ: So, thank you very much, Dr. Redlich and the committee.

So, the Presumptions Working Group, if I can just summarize, we had a meeting, I don't believe, since the last full Advisory Board Meeting.

We do have a presumption recommendation that's still outstanding relating to hearing loss that Dr. Welch drafted that we submitted. So, we're waiting to hear about that.

Actually, considering other disease entities for presumptions, it's going to be more challenging because the nature of those illness. You can think about neurologic illnesses or kidney disease or the like.

And, we haven't really discussed those. Probably a good thing because we've learned a lot and about through the DOL responses about how presumptions are, I don't know how Dr. Boden expressed it exactly, but the importance of finding bridges between medicine administration and the law.

But, so, I think that's actually a good learning process for us in terms of developing additional presumptions.

But, we will recommend to the next Board that that work continue.

Dr. Sokas?

MEMBER SOKAS: And, I just want to quote Dr. Boden, again, that, in general, which is a big challenge, that the presumptions are positive, they're not construed to be negative. If you don't meet a presumption, it doesn't mean you're automatically excluded, it means you go to the industrial hygienist and you -- or, you know, you get further information developed.

CHAIR MARKOWITZ: So --

MEMBER SOKAS: And, that was one of probably the most important comments I think out of this meeting.

CHAIR MARKOWITZ: I think we've said that at every meeting. I think DOL has agreed with us at every meeting and I think that we need -- one of the functions the Board should do is actually to monitor that to see what happens in practice.

Because, that's the only way we'll know whether the universal agreement on this issue is actually applied. But, I'm not sure which committee that goes to.

But, excellent, that goes to your committee.

Any other comments on presumptions or --

(No response.)

CHAIR MARKOWITZ: The -- I wanted to just spend a couple minutes on the changes in the procedure manual, in part, because a Board

member raised this issue.

I don't know whether -- I have a comment on it, but I can start with that, I guess.

So, new version of the -- the integrated procedure manual came out and there was a transmittal letter with that in September, two months ago, actually, identifying the changes in the procedure manual.

I haven't -- I have a lot less familiarity with that procedure manual than people in this room. I think they're the ones who are not sitting around the table.

And, I have a hard time discerning when text has changed. And, I don't -- even after walking through the transmittal letter about what changes occurred, I still don't quite know how to look at the new version of the procedure manual and understand exactly what's different.

So, I don't know whether other Board

members have had the opportunity to try to do that, but I'm not sure how to approach this issue.

Dr. Sokas?

MEMBER SOKAS: Yes, I don't know that this is going to be feasible for the phone meeting that we're having coming up. I mean, again, this may be new business for the next Board.

But, that's the kind of thing that it would be really helpful for me to have a DOL presentation where somebody kind of walks through it.

I think at our very first meeting in D.C., there was a similar presentation about some document that changes were being, you know, considered for and that really is enormously helpful.

CHAIR MARKOWITZ: So, you're referring to the rule making process?

MEMBER SOKAS: Well, that was the example. But, really, in terms of something

like this, just to set aside some time on the next in person Board meeting to kind of go through it and have the person, you know, who knows this inside and out say, yes, we used to do this but now we do this and pay attention to this.

CHAIR MARKOWITZ: So, the issue is not just a thing on the Board on changes in the procedure manual, but actually changes in policy, guidance, you know, the circulars, et cetera, right?

So, which I think -- which we had requested before and DOL does provide us with lists of the changes, but actually a presentation at a Board -- a brief presentation at a Board meeting would be helpful.

Ms. Vlieger?

MEMBER VLIEGER: In searching for the new PDF version of the procedure manual, one of the things that comes up based in my semi-learned Google search is the old procedure manual still seems to be populated on the site

without any notice that it's been changed.

So, that's -- because it's the old procedure manual that pops up many times.

So, if we could look into correcting that with whoever runs the website.

And then, as far as the new procedure manual, it's a PDF version, but I still find it -- it's searchable, but it's hard to navigate and stuff. And so, the changes that have been made are pretty broad incorporation of a lot of things that were circulars, bulletins.

And so, yes, a briefing would be swell.

CHAIR MARKOWITZ: Dr. Redlich?

Other comments on this issue?

(No response.)

CHAIR MARKOWITZ: If you could put your name placards down because, otherwise, I'm going to keep going to you.

So, I want to just spend a few minutes talking about the public comments

because, you know, we have these sessions. They're usually at the end of the day when maybe we aren't as fully attentive as we are at other times of the day.

But, even if we were, the issue is we don't have a structured way of looking at those systematically and ensuring that the relative -- the relevant comments really inform our conversation.

And, I think Ms. Rhoads has come -- at least on the oral comments has nicely put them in a spreadsheet and our request was very useful. So we have one place we can go to.

It's not the written comments, it's the oral comments. And, we can look at them. But, we don't -- in a Board Meeting, we don't walk through them. The committees don't separately look at them. They're not particular comments that are relevant -- highly relevant.

Our discussions are not sorted by committee and then discussed.

So, I just wanted to spend a moment doing two things.

One is, discussing whether there are any comments yesterday that we might just want to briefly mention.

And then, secondly, thinking of a way that the newly constituted Board can actually do this a little bit differently so that there's more feedback.

Mr. Domina?

MEMBER DOMINA: I think a couple of the comments yesterday were more pertinent to the Part B Board that I heard.

And then, I also noted Ms. Smith from the Seattle Office took care of couple of them. I believe I saw her walk out with a couple individuals, too.

So, they got -- maybe on the Part B ones, maybe they need to be funneled to that committee. Because, not knowing the particulars of those cases, but it seems like they were talking about radiation more than

anything else.

Or else, you know, maybe somebody talk to them afterwards to clarify and see if that's where their case was. It's a Part B claim and not a Part E claim. And, that might clarify it.

I think at least two of them that I recall yesterday.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: So, I think that DOL having the Office of the Ombudsman represented is also incredibly helpful and that that's a huge advantage and to have the program represented here.

So, I think each of those things has been a big improvement over the, you know, the course of trying to address these particular comments.

I think some of the comments are clearly intended by the commenter to have us just appreciate the experiences that people go through.

So, some of that is not, here's a problem, fix it. It's this is how this has impacted our lives and that's valuable.

I think there was, perhaps, and this may be what Mr. Domina is referring to, there also seems to be a problem, perhaps, with the handoff between the radiation exposures and the toxic exposures.

And, perhaps some understanding of the relationships and how people get into and out of the different systems, you know, whether it's one portal and then they get --

You know, because that, I don't understand at all. And, that was an issue that came up.

And then, the other thing from yesterday that, again, there may be some new causality relationships that we hadn't considered or thought about that, you know, are kind of percolating in the back of our minds.

They're in the spreadsheet, so I don't know that we need to definitively respond

to them except to know that maybe at some point we would do them.

And then, the reminder that we hadn't heard back about the solvent hearing loss issue and that there were those recommendations sitting there.

You know, again, it's challenging because you can't -- you know, there's really -- this is not an appropriate forum to respond to individual questions.

But, again, I think that we certainly have, over the course of these different sessions, learned a lot and implemented and followed up on some of them.

I think your concern is, are we doing enough with that? And, you know, I'm sure we could always do more.

CHAIR MARKOWITZ: So, yes, I mean, my concern is not the individual claims of people who need help. And, it's great that there are resources in the room to help them.

But, I'll give you an example. Ms.

Hand raised yesterday, and she has before in written comments, about what's the difference between significant factor and the any factor, that any exposure should be or is considered to be a significant exposure?

Well, that reminds us that actually we haven't kind of looked at how DOL treats this issue of significant. I don't know that there's that much to look into, but it's something on -- it should be on our agenda.

It should go to a committee and it should be looked at.

Dr. Sood, yesterday, said that many of his patients have chronic bronchitis which is symptoms only, they cough and produce a lot of sputum.

So, the physical exam won't show much, x-ray may not show much, breathing tests won't show much. No objective findings. And, yet, they have documented chronic bronchitis.

So, that's a bit of a challenge for our discussion led by Dr. Redlich yesterday

about the issue of -- or the COPD, perhaps, discussion.

But, in any case, it's those kind of comments that need -- we need to somehow integrate and not necessarily address to that particular person, but because they raise issues that we should be discussing.

Ms. Vlieger?

MEMBER VLIEGER: Could we set up a matrix and categorize which ones should go to the local resource center, which ones should be referred back to the committee for review or comment? And, that way, we can at least disposition some of the comments and have done something on them.

CHAIR MARKOWITZ: Sure, we could. We could. I mean, if the DOL assembles them in a spreadsheet, we could classify them and identify which ones would be up to DOL to decide what to do with the ones might go to a resource center, a district office or the like.

And the ones -- and then, we could

also -- someone could assign them to a particular committee for follow up.

I think that's what we should do.

MR. FITZGERALD: Doug Fitzgerald, DFO.

We probably also get recommendations looking into things that are beyond the scope of the Board, so we probably just need to take a look at those and see which ones we will act on or refer somewhere else in the Department.

CHAIR MARKOWITZ: That would be one of our categories, beyond the scope of the Board.

Mr. Griffon?

MEMBER GRIFFON: Yes, a practice that we instituted at the other -- at the Radiation Advisory Board was to collect those comments in a matrix and then the next meeting, we'd come back and the Chairman would -- it'd be on the agenda.

We'd come -- we'd go through those comments from the prior meeting and say how

they had been dispositioned, whether it was individual claim, NIOSH dealt with it, whether it was something that was going to be moved to the Radiation Subcommittee to deal with, you know, et cetera, et cetera.

So, we track those that way. And, it's worked pretty well.

CHAIR MARKOWITZ: You know, I'm reminded of another topic that's been raised in public comments, use of consequential conditions. We've hardly discussed that at all as a Board.

And, it is something that falls within the purview of our mission and just hasn't been on our radar, despite the fact that it has been raised in public comment.

And, we've been busy and a Board should get to it, but it should be there.

Yes, Dr. Cassano?

MEMBER CASSANO: Sort of reiterating what other people have said. I think there are three different buckets that these belong to.

One is an individual claimant who has been having difficulty for years and years and years.

The other is the identification of what may be a systemic problem or a Board issues that should go to a subcommittee.

And then, the third is beyond the scope.

But, I think as far as, you know, and I think we can handle the last two categories very well by either sending it to the appropriate Board or referring back to the Department of Labor.

My problem with the first column is that I really feel deeply that we, in some way, need to make sure that there is some kind of a real handoff to somebody that can help these individuals, if it's not just that this is my sad story, I want you to know about it.

But, the lady today that we saw. Some of these people are desperate and if they come here and they spill their guts to this

committee and then nothing happens, we're just another bureaucracy that doesn't help.

And so, I really feel that we need to -- it shouldn't take much time to be able to do some kind of real handoff of these people to an ombudsman or a local advocate that they can work with.

CHAIR MARKOWITZ: Ms. Leiton?

MS. LEITON: And, I mean, I think in a lot of these cases, and I think Jolene being here yesterday, Jolene Smith who's our District Director, she can look into the cases. She can help them with their issues and look and determine where it is.

I think that if these cases can be referred to us since we have the case and we can work on making changes or fixing problems, I think that would be a big help just because we do have the case and we can do something about it directly.

MEMBER CASSANO: I think both, we may need to do --

MS. LEITON: Sure.

MEMBER CASSANO: -- in some instances, we may need to do both because there may be such frustrated -- and this maybe -- it may be perceived, but there may be such frustration with you guys that if that's all we do, oh, they're just referring us back to somebody that hasn't helped us for 10 years.

And, that's no disrespect to you, but that may be the perception. So, and dealing with veterans like this all the time, it really sort of breaks my heart when I see people that I can't help and I need to get them to somebody that can.

CHAIR MARKOWITZ: Dr. Markowitz.

So, you mean the -- you say both, you mean both DOL and -- I'm sorry -- OWCP and the Ombudsman office?

MEMBER CASSANO: Any of those and the Ombudsman officer or a local advocate so that, you know, if they have a perception of an adversary relationship with DOL already, they

have somebody that can work with them to try to mend that relationship.

CHAIR MARKOWITZ: That would be my preference, too. Because, we're not in the position to sort through this, if there are no objections to that.

Dr. Friedman-Jimenez? Okay.

Ms. Vlieger?

MEMBER VLIEGER: Getting back to the question on consequential conditions, I heard that there were some changes that were being contemplated in how those are processed. Could Ms. Leiton apprise us of that?

MS. LEITON: I did hear this comment prior to the meeting. I looked at our procedure manual, John Vance, our Policy Chief, looked at our procedure manual. I'm not aware of changes that have been made to consequentials or being contemplated.

So, if you have specifics you want to provide, I'm happy to look into it.

MEMBER VLIEGER: Could you tell us

how, just in brief, how they are processed now?

MS. LEITON: We've got an entire chapter in the procedure manual that's dedicated to how we process consequential illnesses.

I could take some time to go through that, but I don't know that -- I mean, I think that if everyone reads the procedure manual chapter, that might be easier first and then if there are questions afterwards, I am happy to answer them.

But, it's pretty straightforward about how we process them, I think.

CHAIR MARKOWITZ: Dr. Sokas?

MEMBER SOKAS: And, I think that's an area where clinician judgment comes into play and so that the CMC reviews are going to be important for that.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: At the Oak Ridge meeting, I had very strong feelings similar to Dr. Cassano. I'm not used to sitting like a

potted plant when members of the public come before us with these stories.

And, it may be wishful thinking, but I seem to recall that we decided to take pure Part B radiation testimony in our public comment period and integrate it with the Radiation Board's tracking system.

When Mark Griffon mentioned it at Oak Ridge or one of our earlier meetings, I believe we made a decision to integrate our pure Part B radiation public comments with your tracking system.

You're not on the Board anymore, it's not your system. It seemed like a great idea at the time.

MEMBER GRIFFON: No, I thought -- I'm not exactly sure what was, you know, what we discussed, but I thought it was the idea of a model that could be used similarly on this Board that was used on the other Board.

And, I think -- I mean, my experience on the Radiation Board side of

things is that, because we always, I think, have representation from the multiple agencies at our meetings or at the Radiation Board meetings, that like questions that came up yesterday, I know one of them was a site coverage issue and that's why it got referred to DOL and the person's frustrated.

But, all the folks were there, including DOE, who ultimately has to do the research to provide DOL on when this site coverage periods.

So, there is that exchange like if there's comments that should go to NIOSH, they know right away, they're there. DOL is also in the room, so they know, okay, this one should go to DOL. So, there's good crosstalk on that.

But, I don't know that we have -- I don't know if it would make sense to have one tracking system, you know, between Boards. But, it would be a first step towards dealing with the first bucket of cases that are clearly radiation. These people are coming to us

because we happen to be in town and they shouldn't have to have, you know, fly to your next Board location to give their testimony.

CHAIR MARKOWITZ: So, apparently, Ms. Rhoads has gotten -- received recently some -- the system that the Radiation Advisory Board uses in an email. So, we'll take a look.

MS. RHOADS: Just the spreadsheet.

CHAIR MARKOWITZ: Oh, okay.

(OFF MICROPHONE COMMENTS)

CHAIR MARKOWITZ: Oh, okay, okay.

Okay, any other comments on this issue?

Yes, Mr. Griffon?

MEMBER GRIFFON: Just a last follow up on that. I'm assuming that as we go and identify where -- how these are dispositioned, some of the people -- the staff are going to say, this is a Department of -- or this is a NIOSH issue and we'll forward this over to NIOSH so they can follow through. Yes, so there's follow through.

So, we don't have to have an integrated tracking system, I don't think, but we definitely should forward the disposition to the appropriate agencies to deal with.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I'm just wondering if in some instances some of the comments and the speakers could be dispositioned very quickly at the meeting if the Ombudsman raises his hand and goes, you know, I'll speak to her afterwards or something like that.

Or, you know, if it's something that's of interest to any one subcommittee, the Chair of that subcommittee say, you know, we'll take a look at that.

And, that way, they get some instant feedback and instant feeling of, okay, somebody's actually listening to me.

Because, usually, by 6:00 in the afternoon, we're all sitting here like this and we may not look like we're as attentive as we really are.

CHAIR MARKOWITZ: Well, you know, I'm not entirely sure we can do that because it involves interaction and some decision making.

I understand being attentive and to make sure people don't feel like they're high and dry. But, we have to limit the amount of interaction.

Thankfully, the part to maximize the amount of time they have to make public comments and also because it's not clear exactly where a committee might go to.

Oh, yes, I'm sorry, did --

MS. LEITON: No, I mean, I think I said it before. We were able to take care of a couple of them. We're happy to do that when we're here if there's a case specific thing, we might be able to help them with.

And, I'm sure that Malcolm and his team are willing to do the same. Sorry.

MR. NELSON: Malcolm Nelson, the Ombudsman.

Just to let you know, my office will

always have a representative at one of these meetings. We are always going to have a table. So, always feel free, we generally don't want to disrupt the meeting, but let people know, as soon as the meeting is over, we will generally have somebody manned at that table to assist anybody who has a question.

And, we feel it is our job to assist people who have complaints. So, you should never feel like you're imposing on us. If somebody needs assistance, you can refer them to us. We will, if appropriate, we will refer them to the Department of Labor, NIOSH or where ever.

CHAIR MARKOWITZ: Great, thank you.

Okay, so let's move on.

In our last half hour, I wanted to spend just talking about issues that we think the next Board might set as a priority.

We can continue this discussion at the telephone meeting of the Board.

But, also, our ideas about our last

18, 19 months to the extent to which we need to revise our structure, the way we work, things that have not worked particularly well or areas that we can make improvements in.

We should discuss that because we've been -- you know, we can -- the next Board can benefit from that.

So, the floor is open.

One issue, I'll kick it off, and I think the next Board should take a look at, we started to do this, which is how -- what it means to say that a condition is aggravated or contributed to by an exposure.

And, we started to do that when we talked about causation, but we haven't systematically looked at how the Board -- should we have a program that treats that in its consideration of claims?

Aside from just having this blanket phrase from the statute about contributing, aggravating or causing. Because that is a very liberal standard and they mean different things

for different illnesses.

In thinking about COPD, for asthma, for instance, readily aggravated by any of these exposures.

So, it's a topic I think that the next Board should look at the program's function and see how it's treated and whether there are opportunities to improve their treatment.

Other issues or other aspects of the Board you think might be improved?

Dr. Welch?

MEMBER WELCH: Well, I think Garry already pointed out that we need to revisit the site exposure matrix at a broad level. Because, I would say what our subcommittee did was dive into the question of exposure assess -- sort of broad.

The committee was -- the site exposure matrix committee, what we felt really we need to look at exposure assessment in general for the claims process and focus on

things that are really outside of them SEM rather than the SEM itself, except for this idea of adding new causation links.

And, partly, that's because the -- it's a little -- it's kind of an overwhelming project, the SEM.

But it -- but I think probably that, depending on what the composition of the next Board is, either this Board -- because there's a lot of turnover then, but would probably help to have this Board or our subcommittee make a list of some of the important points that we know have been raised by comments or in discussion that keep coming up.

Otherwise, if it's a big -- not that much turnover in the Board, then the actual memory of the people on the Board about the discussions would probably suffice for that.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: You know, I would just hope that continued look at the data. And, I know there's data in different forms and

I had spent a lot of time looking at the available data from the various sites on the internet.

The analysis that Dr. Dement did of the data we were given was, by far, the most useful in terms of understanding, you know, where to focus efforts.

And, given the magnitude of this system and, you know, exposures and everything we've been talking about, I do think our giving where the majority of the claims are, the majority of potential problems can just help focus efforts or prioritize efforts.

And, what I recognize, you know, that all data has issues and problems, despite that, and it's a complicated data set obviously.

But, I really think that can really help.

CHAIR MARKOWITZ: That's an excellent point.

Dr. Cassano?

MEMBER CASSANO: I think the combination of our two subcommittees will greatly help the work of both of them.

I think the direction that we need to go is actually in looking again at the whole process and where the weak links are in the entire process from CE to CMC and then the feedback back to them to see where that needs to be, what pieces need to be improved.

Obviously, some of that is dependent upon what presumptions get accepted and what other issues in our recommendations get accepted and some of the issues that we saw.

And, I think both of our subcommittees would go away. But, we still know we're going to have problems. And so, I think that's the direction we need to go.

CHAIR MARKOWITZ: Dr. Silver?

MEMBER SILVER: In dealing with exposure assessment, I think we'd all agree that it can't be done well unless a claimant's employment history is well documented.

And, we have seen how DOE has made great progress over the last 15, 20 years. Greg Lewis was at our meeting in October and was pretty impressive.

But, at each of our meetings, Ms. Blaze has submitted public comments about an ongoing situation at Santa Susanna where we can't even take for granted that first step of the exposure assessment process documentation of employment.

So, at some point, when we look at exposure assessment, we should revisit that issue.

CHAIR MARKOWITZ: Ms. Vlieger?

MEMBER VLIEGER: One of the areas under the program that we have never discussed is the durable medical equipment authorization and also the related services for DME, personal use DME and modifications to the home.

Sometimes this process is akin to getting a government contract and it can be quite burdensome to a client who's never done

any of that type of work.

The requirement to have the documents to back up the request, I understand. But, it is a burdensome program, even just to get oxygen once it's prescribed is burdensome on the employee.

So, I think if we could discuss that. I think we have an example here at the table of a claimant who cannot get a portable oxygen concentrator and not through some effort.

CHAIR MARKOWITZ: And, you know, the board bronchitis.

That would be a weighing medical evidence issue, is that where it would get?

MEMBER CASSANO: I believe at the very first meeting, there was quite a discussion about DME and the authorization for DME and that the Board -- that the DOL was having issues.

I think John Vance spoke about that and that how they did sort of want our input

into how that authorization -- I think primarily from the aspect that it's costing them a whole heck of a lot of money. Some of it may be legitimate and a lot of it may not be.

And so, it is -- oh God -- I guess it does come under our subcommittee unless we somehow want to, as you say, reorganize so that there are a specific group of people that look at the whole DME question.

Because, we've got a lot to do, I think. And, well, I'm -- it does fall in our purview in some way, I think it may benefit from having a smaller group actually looking at it.

CHAIR MARKOWITZ: This is Steve Markowitz.

The issue wasn't which committee should go to the issue I was raising, was it within the scope of the Board's mission. And, that next Board can determine.

We can list it, put it on the radar

and then say, you know, the next Board will consider this and make a decision whether it falls within the scope and then what to do about it.

I think that's --

(OFF MICROPHONE COMMENT)

CHAIR MARKOWITZ: Yes, no, no, and I realize it wasn't specific enough.

The way medical evidence, to me, was, you know, task one or two of the mission, not of a committee. But, I understand.

Dr. Sokas?

MEMBER SOKAS: And, just to accompany that, the issue of home care services in general belongs on that list because that's, obviously, comes up a lot and is a cost.

CHAIR MARKOWITZ: Small issue.

Mr. Domina?

MEMBER DOMINA: Now that Dr. Sokas just brought that up about the home health, I was wondering if Ms. Leiton could enlighten us, because I know that it seems that when people

are going through the renewal process right now, it's taking a fair amount of time.

And, I know -- I think we had an update at the last meeting about what they were doing to try and speed up the process. Because, it is important for the people that have it and then, they end up, they're out in no man's land when they still need the home health care.

MS. LEITON: So, home health care is a very big issue in our program, especially as we accept more claims and we have more elderly people who need this care.

The DMEs are also a big important issue.

So, we have determined in the last year to centralize our home health care process so that, when a person is referred to for home health care, it goes to a specific unit that is based out of national office.

The examiners themselves can be anywhere in the country, but they report to one

person in the national office.

And, the reason we did that is because it's become a very growing issue. And, a lot of home health care companies, a lot of issues surrounding it.

So, we centralized the process. We are looking at ways to make it more efficient. We're consistent in the way we adjudicate these claims.

In the process of doing that, we have had delays. And, we've identified those delays. We've worked with a couple of home health care companies who have given us lists of cases that have had problems.

And, we are working to -- we've actually got a project going right now to make sure that anything that might have fallen through the cracks in the midst of this transition, has been either authorized or -- well most -- anything that fell through the cracks that didn't -- that have a missing authorization has been corrected at this point.

And, we're notifying everybody about what the procedures are, what documentation we need and identifying the areas that will help us avoid any further delays moving forward.

I believe that any backlogged or lapsed authorizations have been fixed at this point and we have identified ways to ensure it doesn't happen in the future.

MEMBER DOMINA: Just a quick follow up. So, you got -- so there's nobody, I guess, out there in no man's land, for lack of a better term? So, you're pretty much caught up or --

MS. LEITON: I believe that we are. I was expecting to have all of the cases identified and any lapses completed by this Board meeting. I haven't got the staff's update today, but I'm fairly certain and fairly confident in saying that any gaps that occurred have been corrected.

MEMBER DOMINA: So, is it possible for you to forward those to Dr. Markowitz

whether they could be distributed if that --

MS. LEITON: I would need to check with the DFO to see if this is really within the scope of the Board at this point.

MR. FITZGERALD: Yes, I kind of question whether or not this whole issue is in scope here. Looking at the four areas of investigation the Board is authorized in and chartered to look into, I'm not sure exactly where that falls in the category.

I know it's an area of interest for advocates and for anybody in the community, but I'm not sure this is proper forum for that.

CHAIR MARKOWITZ: I think Ms. Vlieger is next?

MEMBER VLIEGER: I'm going to respectfully disagree with the DFO and Ms. Leiton because these are determinations that are made based on medical opinion to the claims and whether or not the medical opinion and supporting documents are sufficient. I believe it still falls under the purview of the Board.

MR. FITZGERALD: I wouldn't be taking issue with the fact about the medical determination or the weighing of medical evidence in these cases.

I think the issue is whether or not the program is processing the renewals.

CHAIR MARKOWITZ: Thank you.

Dr. Redlich, did you have a comment?

One thing I think that the new Board should do is we look at the most commonly denied claims, the list of the conditions which are most commonly denied to the extent that those data are available.

And, secondly, I think that one of the areas that the Board should look at is the neurologic illness. We see it in the procedure manual and Parkinson's disease.

We've had public commenters discuss it. Ms. Vlieger's mentioned toxic encephalopathy.

It's a very difficult area. It's much more difficult than respiratory disease or

cancer and the like, but it's common. The exposures were common in the workplace as DOE. And, I think the Board should take a substantive look at it and see if --

And, this is brought home in part by one of the comment -- public commenters yesterday, the neuropsychologist who spoke about this.

So, I -- to me, I would list it as one of the priority areas for consideration.

Dr. Redlich?

MEMBER REDLICH: I would just second that. And, from the lung data we looked at, there were clear changes in trends, you know, more asthma, COPD cases, less beryllium.

So, I think seeing where to -- what are the most common and uncommonly denied would be very helpful.

CHAIR MARKOWITZ: How about the functioning of the Board? I just want to open this up, we only have a few minutes left, but I would, in part, just to stimulate your thinking

over the next couple months.

Are there ways in which we should be structuring this different or functioning differently in terms of communication, decision making or the like?

Dr. Cassano?

MEMBER CASSANO: I think there was a suggestion a while ago that, in addition to all the subcommittee meetings that there be a phone -- some type of phone meeting between the Chairs of the different subcommittees in between so that we all knew what the other subcommittees were doing so there was no duplication of effort.

And, I think in all of the other work that we had to do, that sort of got dropped.

Some of our issues are going to go away because we're now combined. But, it's still nice to know like the issue with the CMC that you had a problem with. If we had known about it or Rosie had known about it, they may

have looked at more cases or something like that.

So, I think that's helpful in that we're not duplicating effort and not -- and if there's information that can be shared between the two subcommittees in between a large Board meeting to further our work, I think it becomes important.

CHAIR MARKOWITZ: Other comments?

(NO RESPONSE)

CHAIR MARKOWITZ: So, just to review then what we're going to do in the next two-plus months, I guess we have until mid-February.

I think we're going to need to have our telephone Board meeting, if we can, close to the end of January because we're going to need a little bit of follow up time after that.

And, the end of January would be the latest. We need six weeks prior for the publication in the Federal Register. So, if you work six weeks back from the end January,

then you're coming very close to where we are now.

So, we're going to have to set that meeting soon.

We're going to have an SEM Subcommittee meeting before that, so that then will be set presumably a week or so before the full Board meeting.

And then, there's work to do in terms of writing up our comments on the responses.

We will receive hopefully responses to our April 2017 recommendations which are, I think, there were only two. And so, we will discuss that at the telephone -- at our telephone Board meeting.

Is there any other piece of work that I've -- and then, we need to write up kind of our ideas of what recommendations for the next constituted Board might want to take a look at and change.

Anything other work we need to do

besides celebrate the holidays?

Dr. Silver?

MEMBER SILVER: I know it's an iffy proposition, but if we do get reappointed and we meet again in person, it would be nice to have a couple of outsiders turbo-charged topics for us with presentations.

We did a little of that in D.C., but have we ever had a presentation from the Ombudsman's Office?

(OFF MICROPHONE COMMENTS)

MEMBER SILVER: Yes, well, you know, a refresher might be in order and I think the new Board would appreciate that.

And, New Mexico has a State Office of Nuclear Worker Advocacy. They are swamped with cases, but if there are others like that around the country who, you know, have the track record and were looking to this Board for solutions, we should consider working with them in advance to give a brief presentation and, you know, shake the cobwebs out.

CHAIR MARKOWITZ: Dr. Redlich?

MEMBER REDLICH: We haven't interacted with any physicians from the Department of Labor. I'm not great with names, so I don't know who the government person is, but I think that would be helpful.

MS. LEITON: That would be Dr. Armstrong. I know that he's interacted with the subcommittee. I'm sure that we could arrange something, if that's what the Board wants.

MEMBER REDLICH: Because I think that at least the current manual suggests that -- I know you've used expert -- physician experts to help develop that, but it raises questions about the expertise of whoever you have been using in the past.

MS. LEITON: So, I think there's a couple of things. Dr. Armstrong is fairly new to our program -- to OWCP.

So, when I referenced other outside medical consults, there have been a number from

various universities helping us with beryllium disease and things like that.

So, I'm not sure how that would be addressed. We can talk about it.

MEMBER REDLICH: And, I suspect part of it is when a document gets revised many times, it can morph into something different than --

MS. LEITON: Yes.

MEMBER REDLICH: -- the original.

CHAIR MARKOWITZ: Any other comments or questions?

Mr. Whitley?

MEMBER WHITLEY: I'd almost -- I know we don't set the date because of it being a new Board, but I would hope that at least some of the Board will be on the -- because of continuity.

I'd almost think that our next -- the next meeting, the recommendation for this Board's next meeting might need to be back in Washington.

I know it's very helpful and very good to go to sites and, not that we shouldn't go to sites after that, but it's a -- let's just assume it's part of the new Board. We've got new people in Washington and these things we're asking for like the doctors and all that, that's where they are.

So, it would be real easy to get presentations, meet them and do that, if you had -- and it would be the new Board.

And so, I'm just -- this is a suggestion and it's really just a recommendation from this Board because it's a new Board.

CHAIR MARKOWITZ: Dr. Cassano?

MEMBER CASSANO: I think it might also be useful to have a presentation from somebody from the Radiation Board just to see how not only how they do business, but also maybe some -- I know we're sort of -- we're a unified set of null, but that may not be true.

I think there may be some issues

that cross over in general. So, that might be useful.

CHAIR MARKOWITZ: Any other comments?

So, later, I'll ask you what you what you mean by unified set of null.

(OFF MICROPHONE COMMENTS)

CHAIR MARKOWITZ: Okay, thank you.

So, we're going to close now. I just want to thank the Board members. You know, this meeting, I think, again, illustrates how complimentary the experience of people around the table, the people who worked at the DOE sites for decades, people who have represented DOE workers in the process, scientists and physicians who have worked on these issues for a long time and even those who are more recent, just how complimentary we've been able to work together in addressing important issues within the program.

So, I want to thank you for that.

MR. FITZGERALD: I also wanted to

thank the Board for all their hard work on behalf of the Department. It's very helpful.

I want to thank all the public participation we had. It really helped make the meeting much more full and rich, I believe.

And, if there's nothing else did you want to add anything else before I --

CHAIR MARKOWITZ: I wanted to thank Ms. Leiton, actually, for sitting on the hot seat with us for a day and a half, Mr. Nelson for coming and being available and for his expertise.

And, of course, Doug and Carrie for their work with us. And, Kevin Byrd and his group for the support working with us.

And, if I forgot to thank anybody else, forgive me.

MR. FITZGERALD: And, with that, we adjourn this meeting. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:54 a.m.)