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convenes the

THIRTY-FIFTH MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE PANEL (CAP) MEETING

August 11, 2016

The verbatim transcript of the Meeting of the Camp Lejeune Community Assistance Panel held at the ATSDR, Chamblee Building 106, Conference Room B, Atlanta, Georgia, on August 11, 2016.

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C O N T E N T S

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P A R T I C I P A N T S

(alphabetically)

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BREYSSE, PATRICK, NCEH/ATSDR
CANTOR, KEN, CAP TECHNICAL ADVISOR
CORAZZA, DANIELLE, CAP MEMBER
DINESMAN, ALAN, VHA
ENSMINGER, JERRY, COMMUNITY MEMBER
ERICKSON, LOREN, VA
FLOHR, BRAD, VBA
FORREST, MELISSA, NAVY/MARINE CORPS
FRESHWATER, LORI, CAP MEMBER
GILLIG, RICHARD, ATSDR
HODORE, BERNARD, CAP MEMBER
MUTTER, JAMIE, ATSDR
ORRIS, CHRISTOPHER, CAP MEMBER
PARTAIN, MIKE, COMMUNITY MEMBER
RUCKART, PERRI, ATSDR
TEMPLETON, TIM, CAP MEMBER
UNTERBERG, CRAIG, CAP MEMBER
WHITE, BRADY, VA
WILKINS, KEVIN, CAP MEMBER
WOLFE, HERB, ATSDR

P R O C E E D I N G S

(9:00 a.m.)

WELCOME, INTRODUCTIONS, ANNOUNCEMENTS

DR. BREYSSE: So why don't we dispense of a little bit of the greetings and get started, since we're running a little bit late. So good morning. I'd like to welcome everybody to start off the August 11th ATSDR Camp Lejeune CAP meeting. We're getting a little bit -- a little bit late start but hopefully we'll be able to make up with some of the time.

So I'd like to begin again by introducing myself. My name is Patrick Breysse. And I'm the Director of the National Center for Environmental Health at CDC as well as the ATSDR, and so I'm here in my ATSDR capacity this morning. And so I'd like to say a few welcoming remarks but I want to go around the room and have everybody introduce themselves first. So why don't we start with Dr. Sarah Blossom.

DR. BLOSSOM: Hello. I'm Dr. Sarah Blossom from the University of Arkansas for Medical Sciences in Little Rock.

MS. FORREST: Melissa Forrest, Navy

representative.

MR. WOLFE: Good morning, Herb Wolfe from ATSDR. And I'm currently on a detail to Dr. Clancy's office at VHA.

DR. ERICKSON: My name is Loren Erickson. I'm a physician working at Veterans' Affairs. I also probably ought to tell you that I'm a 32-year veteran of the U.S. Army.

MR. TEMPLETON: Tim Templeton, CAP member, a victim of Camp Lejeune '84 to '86.

MR. ORRIS: Chris Orris, CAP member.

MS. CORAZZA: Danielle Corazza, CAP member.

MR. WHITE: Brady White. I'm the program manager for the family member program.

MR. FLOHR: Brad Flohr, senior advisor and compensation service from VA.

DR. BOVE: Frank Bove, ATSDR.

MS. RUCKART: Perri Ruckart, ATSDR.

MR. GILLIG: Rick Gillig, ATSDR.

MR. HODORE: Bernard Hodore, CAP member.

MR. UNTERBERG: Craig Unterberg, CAP member.

MR. PARTAIN: Mike Partain, CAP member.

MS. FRESHWATER: Lori Freshwater, CAP member.

MR. ENSMINGER: Jerry Ensminger, CAP member. Brady, I didn't recognize you with all that hair. I

didn’t know you, I didn’t.

DR. DINESMAN: Good morning, I'm Dr. Alan Dinesman. I'm the medical officer for the office of disability and medical assessment at VHA.

DR. BREYSSE: Fantastic. So I'd like to remind people about some of the ground rules and rules of conduct. So I'd like to remind people that it's important to be courteous and respectful of other participants during the meeting. And as we try and stick to the agenda I'd like to ask that we try and stick to the time limits established for speaking, and as the moderator of this meeting, I'll try and keep us on track. We want to refrain from profanity and personal attacks on either... And we'll stick to the agenda.

So this is an open public meeting, and I'd like to address the members of the audience right now and remind you that, members of the audience, that you're here as observers. You may participate in the meeting when a CAP member asks the questions to the audience or when they are recognized by myself. And there'll be time at the end of the meeting if you have any questions you want to jump in. So other than those circumstances we ask that you please keep your thoughts to yourself. And ask

people to silence their cell phones.

And I'd also like to recognize that -- to the CAP members, you may see that Sheila Stevens is not here today. Sheila Stevens is on the detail, helping out with the Zika efforts, and Jamie Mutter will be taking over her duties. So Jamie --

MR. ENSMINGER: Where is she?

DR. BREYSSE: Yeah, when she comes back I'll introduce her to everybody. So there's Jamie.

So again, good morning, welcome. And we'll start off by looking at the action items from the previous CAP meeting, and I'll turn it over to Perri Ruckart.

MR. ENSMINGER: I think there's somebody on the phone. Do we need to find out who's on the phone?

MS. RUCKART: Ken. I think I heard Ken dial in. Ken Cantor, are you on the phone?

DR. CANTOR: Yes, I am.

MS. RUCKART: Okay, I want to --

DR. CANTOR: Can you hear me?

MS. RUCKART: Yes, we can hear you.

ACTION ITEMS FROM PREVIOUS CAP MEETING

MS. RUCKART: So in the interest of time, let's try to go through our action items quickly so we can

get back on track. We have quite a few action items from the VA so let me start with those. One of the action items was that Dr. Clancy will clarify the relationship between the ICD-10 codes and the VA's unique codes for conditions. An update on that?

MR. FLOHR: This is Brad Flohr. I think I've mentioned in the past, there really is no relationship between ICD codes and VA's -- VBA's unique diagnostic codes. There are thousands and thousands and thousands of ICD codes. They are codes for not just disabilities or diseases but also for medical procedures, and quite often used for billing and for services provided. VBA's diagnostic codes, we have just over 800. They've been in place since 1933, if not earlier. It just allows us to -- when someone in Congress or someone from the CAP, or whoever, is submitting claims for kidney cancer can come to our kidney diagnostic code for that and find that out. Much different than ICD codes.

MS. RUCKART: Okay. The next item for the VA...

MR. TEMPLETON: Yeah, is there any kind of cross-reference between the two?

MR. FLOHR: No, there's not.

MR. TEMPLETON: No cross-reference. Okay.

Then I'll just make a real quick comment, then we can go on. That may be an issue here, especially as it pertains to the classification of the claims. When people claim that they, let's say, have breast cancer, and there are several different ICD codes that go for that, but there are, I assume, maybe a couple of different ICD -- or excuse me, VBA codes that work for that. So we're having an issue right now with the very low number of breast cancer, and maybe we can cover that a little bit later, but with a very low number of them, and one of the answers that I got to a question recently on that will have to do with the classification of it, whether it actually was breast cancer or not, when there are several different places that it can manifest and ways that it can be diagnosed versus the number of codes. So I guess maybe I should put the question in that kind of a format here. Is that is there any correlation, any way to make a correlation between the diagnostic codes that, like you said, sometimes are used for billing but also pertain to diagnosis of an illness, and I would think that that would have some kind of a correlation to VA. If not then I can see where there would be a big disconnect and why some of them might not be classified as breast

cancer, when they probably do.

MR. FLOHR: Well, not necessarily. I mean, for our purposes, VBA purposes, someone files a claim, says I have breast cancer or... And we investigate it. We, you know, schedule an examination with VHA, if we need one, if we don't have private medical records that we can use. But when we either grant or deny the claim, you know, we use the diagnostic code for that. That allows us to go back in time and find out how many people have filed a claim for breast cancer, whether it is or is not.

MR. TEMPLETON: Right, but with the private medical records, they're not going to have a VA code.

MR. FLOHR: We don't need those from private medical records. This is only for our own tracking purposes.

MR. TEMPLETON: Okay. So then you would have to take what's basically the ICDs that are being used within the private medical records and correlating that somehow.

MR. FLOHR: Not really.

MR. TEMPLETON: I don't -- they're -- they're --

MR. FLOHR: We try --

MR. TEMPLETON: -- they're all over --

MR. FLOHR: -- we track -- we track the claims, Tim. We don't track medical usage, medical care.

MR. TEMPLETON: Right, but the evidence going into the claim is --

MR. FLOHR: We track the evidence that goes in the claim.

MR. TEMPLETON: Not any of the -- well, you -- how -- then how would you decide the claim if you're not looking at the private medical records?

MR. FLOHR: Well, you look at them, and then make a decision to grant or deny the claim. We identify -- okay, we've considered breast cancer, either it's granted or it's not.

MR. TEMPLETON: Okay.

MR. FLOHR: In either condition the same diagnostic code identifies the issue.

MR. TEMPLETON: But I guess the issues -- as far as we can settle it, it's already -- it's settled as far as I'm concerned, but I would just make the point that the ICD codes are fairly precise as far as what they mean, and they have to be for insurance purposes.

MR. FLOHR: And that -- for VHA, yes. And that's, that's -- they do use ICD codes.

MR. TEMPLETON: Okay.

MR. FLOHR: But for our purposes, no, they don't need to be that precise.

MR. TEMPLETON: I just see a disconnect there. There's no cross-reference of any way. I could see why you have a bunch of denials for what is not breast cancer when it is breast cancer. I'll just say that and leave it out there that way. All right, thanks.

MS. RUCKART: So the next item for the VA, the CAP requested that Brad Flohr clarify what it means to not solely rely on the NRC report, and he will determine what weight is being put on the NRC report. And the CAP also requested that the VA justify why the NRC report is still being used for determining claims.

DR. DINESMAN: Good morning. This is Alan. Thanks, I'll go ahead and answer that since I'm involved with the examinations themselves. The NRC report is just one of many articles that can be used as far as looking at evidence for a specific case. Every individual is looked at as an individual, so it's not a cookie-cutter type of evaluation. And again, we look at all the evidence that we can to try to find support for the veteran's claim.

MR. ENSMINGER: The NRC report should not be used for anything. It is not a study. It was not a study. Let's get that straight right up front. It was a committee that was formed that did a literature review of studies that had already been completed. And then they cherry-picked through it and picked out what they wanted to use in that thing to benefit the Navy, who paid for it. The thing was skewed from the beginning, and we've proven that that thing is null and void. They didn't even take into consideration all the contaminants that were at play at Lejeune. So you need to quit using the NRC report completely.

DR. DINESMAN: Well, if I can just comment. The fact that it is not a study is not uncommon. It's what is called a meta-analysis, where --

MR. ENSMINGER: It wasn't even a meta-analysis.

DR. DINESMAN: -- where people will go back and do summaries. It's important that whoever is reviewing the evidence looks at the evidence in accordance with how it relates, and so there may be information in there that is still up-to-date; there may be information that is not. And it comes from not a single report. I don't think anybody is hinging their decisions just on what the NRC report

may say. It has to do with all of the literature available.

MS. FRESHWATER: Well, the question --

MR. PARTAIN: Well, I mean, how come, with these decisions that we're getting back for the veterans, the most common reference cited in them now is the NRC report and permutations? They've called it the National Research Council, they've called it all kinds of things. But the NRC report appears time and time again as the primary reference in the denial.

And going back to what Jerry was saying about the report, it is not a meta-analysis; it is a literature review that was completed. And there was significant problems, including a review by a scientist and also the former director of the ATSDR back in 2010, citing that the report was, you know, basically scientifically not valid.

MR. ENSMINGER: Furthermore, not only did that report, or that -- the NRC report not cover all the contaminants at play at Camp Lejeune, for God's sake, that report was written before TCE was reclassified. It's null and void. It should not show up in anything, any decision anywhere.

MR. TEMPLETON: Two good points on that. One

is that the NRC report, and in fact some of the places within the NRC report, that I have seen cited in the denials that I've seen, ignores many of the other parts of the NRC report that supported. In fact it is, quite definitely and curiously, cherry-picking, to get only the parts that would deny the claim. And I've seen several instances where they ignored several parts of the report that had evidence in support of the claim. That's number one.

Number two, I think that it's important for everybody to know and I think it's very curious that, when we started complaining about the citation of the NRC report in denials, then all of a sudden the words *NRC report*, as Mike was saying, disappeared. And then they started referring to it as something else, as Camp Lejeune task force experts or something like that, but essentially it was the same thing. So why would -- after we had complained, if it's legitimate and it's on the up-and-up for use in that, why would, then all of a sudden, it would be at least an attempt to conceal it have been done within the -- within the denials?

DR. DINESMAN: First, what I'd like to clarify is the examinations are opinions. So we say

examination but it is an opinion; it's a review. Think of it as medical expert testimony, all right? The examiners do not deny a claim; they do not approve a claim. We are there just to provide medical opinions. Think of us as the expert witness on the stand, and then think of VBA, the raters, as the judge and jury, all right?

So we have to look at the two different parts, and so you have to be able to say, well, are you giving a correct or an adequate opinion? And then we can talk about whether the adjudicator is applying the legal aspects correctly, all right?

And the difficulty that we have here is that much of the data that is out there right now is based on occupational studies. This is an environmental study and -- or environmental issue. And so there is a certain amount of uncertainty in any piece of literature, all right? And you would expect that the clinician who is reviewing that literature is going to look at that literature and determine, in their mind, as an expert, you know, as an expert witness, whether or not it meets a certain criteria. And while there may be concerns about what one study says versus another, again, it's up to that individual to gather all the available

evidence and use that in accordance to the way that they are mandated to do their exam or evaluation.

And the evaluations, I've got to say, are very veteran-centric. Just because you may see a negative opinion it doesn't mean that they're not trying, all right? They are looking at it for the possibility of applying it.

Now, you also have to keep in mind, and I do have to kind of make an important consideration, from the examiner. You know, we all have rules that we have to follow, and the rule to follow is, for the examiners, is it as least as likely as not? All right, that's a 50/50 --

MS. FRESHWATER: Can we get back to where we started? I'm sorry to interrupt. Can you reread the action item?

MS. RUCKART: Okay. The CAP requested that Brad Flohr and the VA clarify what it means to not solely rely on the NRC report and that the VA will determine what weight is being put on the report. And then the CAP requested that the VA justify why the report is still being used for determining claims.

MS. FRESHWATER: I don't think we've gotten an answer to that, and I would like to just kind of

redirect our attention back to that question.

DR. DINESMAN: All right, let me answer that a little more directly, but thank you. The VA, VHA, the subject matter experts do not necessarily look at one single piece of evidence upholding any more weight than another. All evidence --

MS. FRESHWATER: But this has been debunked. This is -- the scientists say that this is not good science; that it's outdated. I want a justification as to why you can't just take it out. Why, why -- I need the justification as to why it's still used. There's plenty of other science that you can be relying on, so why must that stay in there? Because the only logical conclusion that we can draw is that so that you can keep denying claims.

DR. DINESMAN: Again, it is still part of the literature, and it still must be addressed. We can look at all sorts of --

MS. FRESHWATER: Why must it still be addressed? Who is it that's saying that this is so important that it still must be addressed?

DR. DINESMAN: It is still part of the evidence.

MS. FRESHWATER: What -- who says?

DR. DINESMAN: It's a part of general medical

evidence. You review the literature.

MS. FRESHWATER: But who, who says that? Who makes that decision?

DR. DINESMAN: The clinician who's reviewing the information is -- it's up to that person to review the data that is out there, that is published, and --

MS. FRESHWATER: So that this clinician can overrule your decision, to say that this report should not be used as -- in this process anymore because of the complaints about it and because of what the scientists are saying?

DR. DINESMAN: This is a subject matter expert. This is expert testimony.

MS. FRESHWATER: So they can just choose to use Wikipedia, which is what you've done in the past.

DR. DINESMAN: I can't say that personally. I'd have to look at the individual cases to answer something like that, but --

MS. FRESHWATER: But this should not be used. Why -- and we've been going on with this for years. Years. It should not be used anymore. We formally request that it's taken out as a source, and I would like a justification as to why that can't be done, and I'm not hearing one.

MR. PARTAIN: Okay, quick question --

DR. BREYSSE: I think we have a million. I'm only kidding a little bit. I think we asked the question, and we have an answer. It might not be to your satisfaction, but I think --

MR. TEMPLETON: I don't know if we're going to get anything different.

MR. PARTAIN: But here's a point that I want to make about the SME issue, and this is out of the denial here, when you're talking about reports and stuff. The National Academy of Sciences' National Research Council published this article contaminated water supplies at Camp Lejeune, assessing potential health effects in 2009. This report included a review of studies addressing exposure to the chemicals found to contaminate the water at Camp Lejeune. The report's cited in there, very prominently, very formal.

Now, I deal with experts, medical experts, engineers, in my line of work, and any expert that's worth their grain of salt, when they produce a report, are going to include the references of which that report is based, yet I don't see these references in these denials. How do we know what reports and what reviews that you're reviewing if

you don't cite them? The only time -- the only things I see cited in these denials, time and time again, is the NRC report.

MS. RUCKART: Mike, this leads to the next action item, so.

MR. PARTAIN: Okay. So well, and here's my point. If you are going to review and you're going to be providing a decision, that is life and death to these people, you should, and you shall cite where you're making these decisions off and what information you're using. I mean, it's only fair to these veterans that you do so.

MS. RUCKART: So that's a perfect segue into the next agenda item, which is the CAP requests that the VA make public the bibliography of studies used by SMEs for determining claims.

MR. PARTAIN: Well, not just the bibliography of the studies, but what studies you're actually just making your decision on, because, I mean, you got literature out there. Yes, the NRC is a body of literature and everything, but there are plenty of things that have come out since the NRC that have more weight, even the report that the VA accepted in February of last year recommending that the VA give benefit of the doubt to veterans with kidney issues,

and you guys still have not used that. I've not seen that in any of the reports, and I've seen plenty of kidney cancer denials since that report was issued. Why? I don't understand.

MR. ENSMINGER: Well, another thing is your examiners, from what I can tell, most of them, they only have family practice credentials. But yet a veteran will come in with a nexus letter, or maybe even two, from an oncologist, who's their treating physician, and your examiners overrule their oncologist. I mean, how's that work?

DR. BREYSSE: So I think we've got to stay on track. That's a different issue. So I think it's clear that there are concerns about the literature that's being relied on and how these decisions are being made. And the VA has attempted to answer that, and it's clear also to me that not to your satisfaction. But can we stay on track a little bit? Is there a response to the action item that Perri Ruckart has mentioned about the bibliography?

MR. FLOHR: This is Brad Flohr. We provided that last December.

DR. ERICKSON: Yeah, because I sat here with my computer at the last meeting --

MR. ENSMINGER: I remember it. I remember

seeing it. It looked like you all did a Google search and just wrote stuff down.

DR. ERICKSON: Well, actually we were accused of being unresponsive. There had been a mix-up between ATSDR and VA of providing perhaps the list that we were working off of, and so in trying to be responsive instantaneously, I actually brought it up on my computer at the last meeting. That's why my computer's open now, in case there's something we need to get, and reach back to VA for this.

I have a recommendation, Mr. Chairman, as you run your meeting, and that is that, with this being Dr. Dinesman's first time in the barrel, and hearing the issues that are really important to the community, as expressed by my friends and colleagues from the CAP, if you could package these for him? This will give him something to work off of. In other words, I've heard seven or eight very specific issues you've brought up, some of which we've been able to convey to him. But again, work with us, work with him to bring forward, again, your concerns.

And I think Brad had provided in particular a release form. You know, in other words we cannot talk about very specific cases without a release

from that individual. But if there is a specific case that really sticks in your craw, and we have a release from that individual, then we can -- you know, Brad, Dr. Dinesman, we can talk more directly to that specific case. And if there's an issue that needs to be corrected, we can take corrective action. But if we keep it sort of in the abstract I don't think we get to where we want to be as a team.

MS. FRESHWATER: I agree, and that's why I was trying to redirect this out of the abstract and back to the question at hand, which is the NRC report. So if you can help me how I can help you as a colleague, how can we get to a place where we can get like an answer? Like I -- that's all I want. So if you can tell me, then I will gladly table this, and we can do that, but I just need some way to know how I can get an answer.

MS. RUCKART: A lot of the next action items, I think, are more concrete and do lend themselves to a specific answer, so would it be okay to keep going? I mean, we're going to have another chance later on in the agenda to talk to the VA. Did you want to say something?

MS. CORAZZA: No, I would just reframe the question. So if the VA experts are subject matter

experts providing expert testimony, why are they not being -- or is there a formal training? Are they required to be trained a certain amount of hours per year to maintain that expertise, because if they were they would be on board with us in realizing that that report was useless, and they would not be citing it on a regular basis. So it's hard for us to embrace their credibility when they are continuing to use bad science, that we are sitting in front of some of the top scientists in the country that have worked on this. And so that's where the frustration lies. They should be aware of this too, but we're getting -- consistently getting claims that are quoting it and using Wikipedia. So it's hard to, you know, justify that.

MS. FRESHWATER: And maybe I'm just not being clear enough. I don't want this report used anymore. What do I need to do -- my question to the VA is what do I need to do, as a representative of the community, to stop you from using this report to deny veterans' claims?

MR. TEMPLETON: And just to piggyback on that real quick, in the interest of time, I also wanted to point out, as far as dealing with the law, is that we've also seen several instances where the VBA

has sent a -- has remanded a case. In fact remands in Camp Lejeune are one for every two at this point, which is extremely high.

But in addition to that we have seen some that came back from VBA where VBA told the SME to reconsider and make the decision, and had some basis for that. But it was sent back down; they ignored it. So I don't know how that's consistent with the law. I know that CAVC is actually the governing authority on that too, but VBA, I think, should hold some weight when they send these back down. It hasn't happened once; it hasn't happened twice. It's happened more than that, where they actually cited this evidence when the VBA was sent back down as a remand to them to redo, and they stood on their original decision.

MR. PARTAIN: And Dr. Erickson, you know, this is not a new issue, and I do understand -- I haven't got his name down, but the gentleman here that's with you from the VA. Has any of the information that we've been bringing up over the past two years now been funneled down to him? You mentioned the release form. We didn't -- we asked for the release form in May, at the last CAP meeting. It's now August. We got the release form, I think, two days

ago or three days ago, which, I mean, we could've gotten some information, been more prepared and giving you some people's signatures, but three days before the meeting doesn't fly.

And lastly, going back when we were talking about, you know, my big beef with the SME is you're using experts and you're essentially hiring a hired gun to do these reports. They're not providing any references in the reports. And you're moving the bar up for the veteran, because the veteran, to do a comparable thing, has to go out and hire their own expert. And in the interest of the veteran and in doing the right thing for the veteran, their references in what they decide on the report is not just a bibliography that you release to us. It needs to be specifically cited on there so that when the veteran gets the denial they can look at it.

When I have a claim and I'm working on it, and I hire a subject matter expert to evaluate a person's home, or something like that, and I get the report, and I deny the claim, my denial letter has that report, complete with references, photographs, a write-up and everything in the hands of the policyholder. A veteran should expect no less.

DR. BREYSSE: Okay. So in terms of packaging,

Dr. Dinesman, you hear a lot of concern about the SME process: The information that they rely upon, the training that they have, and how that's communicated back to the veterans via a letter. So if we can move forward with some of the more specific action items.

MS. RUCKART: The CAP wanted to know the percent of people who have received letters letting them know their claim is being held until new rules are developed. Is that Brady?

MR. FLOHR: No, that's not Brady; that's us. I don't know the percent. I do know that, as of the other day, we had staid about 920 claims that we can't grant at the moment until we publish regulations. And we have worked with Louisville. I've talked with their director there, and the service center manager, to try and find a way around that, perhaps, and just grant these claims, whether to deny it, or however kind of presumptives there are. And actually I drafted something that would make that happen. It got through a couple layers of concurrence, and then our lawyers said, no, we can't do that. But we have tried, and continue to work that as much as we can. And I know Louisville wants to grant them; we want to grant them. We just can't

do it at this time.

MR. ENSMINGER: Well, on the subject of the presumptions, where are we at on that?

DR. ERICKSON: Well, I have a whole section of the agenda on that.

MR. ENSMINGER: Okay.

DR. ERICKSON: Mr. Chairman, I want to recommend that in the future maybe the VA formal presentation be moved up right at the very beginning, and then the due-outs follow that. I think that would be more efficient. I know a few of the meetings I've attended, we tend to have a lot of interest from the community, from the CAP, for all the issues that we're going to be discussing in our presentations, and that just sort of steals the thunder, it sort of gets it off kilter. And if we had an opportunity, for instance, at the next meeting, perhaps Dr. Dinesman presents about DMA process and some of the issues that have been brought up, you know, Brad can provide some updates in his, and then we can look at the due-outs. I mean, we may very quickly see that the answers have been provided in those presentations.

MS. FRESHWATER: Dr. Erickson, can I just go back? So were you trying to, I mean, answer that

question that I asked you about, what I need to do as a CAP member to get the NRC report to stop being used and cited? I mean, you don't have to do it on the spot right now, but I would like -- I just want to put that on the record that I want an answer to that.

MS. RUCKART: I've captured that as something you've requested.

MS. FRESHWATER: Okay.

MS. RUCKART: And plus I read through the transcript and I pull out anything, you know, major from there, so.

DR. ERICKSON: Well, and let's -- at the break let's talk about it directly.

MS. RUCKART: So the next item, I don't think, needs to have a lot of discussion or hopefully no discussion, but just wrapped up in the discussion about the SMEs, the CAP requested information needed to FOIA the ethics review of the SMEs. If you keep that in mind as you further discuss that SME issue.

The CAP requested a copy of the form to release information to speak on behalf of a veteran. We know that you've received that.

The VA was requested to provide an update on the process of getting an ombudsman to help with the

claims process.

MR. FLOHR: I think, Lori, that was your request. No? What was yours? Yeah, I know. Whoever's it was, ombudsmen, we have some ombudsmen in the VA, not many, I don't think, but there are some, and it is a actual position that has to be approved by office of personnel management, that has to be budgeted. I know our people in Louisville, that I mentioned, they have an ombudsman or have one, they say they don't have anybody currently.

It would have to be a new position created, have to be staffed, it'd have to be announced, it'd have to be budgeted. So at this point I can't say that we could or would do anything at this time. If you could provide some -- something which would really show a need, specifically what that need would address, and then we could take it from there. Okay.

MS. RUCKART: Okay. There was a request to invite a representative from the office of disability and medical assessment. Is that where you're from, Dr. Dinesman? Okay. And also to have you participate in monthly conference calls so we can talk to you about that and see about facilitating that?

DR. DINESMAN: Please.

MS. RUCKART: The CAP requested that the VA provide information on how many reported male breast cancers were confirmed to have the condition and how many were not breast cancer. Did you want to do that now or during your VA session?

MR. FLOHR: Well, no, we provided this to the CAP in January of this year, and I sent it to you again. But we did a review of male breast cancer cases, and how many actually were breast cancer and how many were not. And you have that report. I gave it to you in December, and I sent it to you again.

MS. RUCKART: Was that forwarded too? I can't recall. Brad sent me a few emails earlier this week. Yeah? Okay, good. Okay, the CAP requests from the Camp Lejeune family member program with the VA the current treatment position report, active versus remission status. Is that for you, Brady?

DR. ERICKSON: I think I've got that. Just so you know, it's the treating physician report. I don't think the word *position* is in there. I think it's physician. Am I right? Okay.

I made sure that I had the updated information on this. In order to give the answer to this I'm

going to sort of steal some thunder from the agenda, which is why I asked --

DR. BREYSSE: If you'd rather hold it 'til the --

DR. ERICKSON: Well, can I hold it? Is that okay? Because there is a coherent answer that will pull together.

DR. BREYSSE: Sure.

MS. RUCKART: All right the next item is the CAP requests an explanation of Dr. Clancy's oversight role.

DR. ERICKSON: Okay, I have that.

DR. BREYSSE: Do you want to hold that for your presentation or is that...

DR. ERICKSON: Well, I'll just do it very quickly. So Dr. Clancy, her involvement here was when she was the interim undersecretary of health. It's a very, very senior -- it's like a four-star general position within the VA. I think that the issues that we were dealing with at the time were important enough that we wanted to bring the most senior leader we could to the meeting, and she was very much concerned that we be as involved as we could be from Veterans' Affairs. She's unfortunately not able to be here at this meeting.

Let you know that she has a new job right now. With some of the reorganization with the fact that there was a new undersecretary named, she's now a deputy undersecretary. I'm just reading from the website. I'll make it very quick. She's the deputy undersecretary of health for organizational excellence, Veterans' Health Administration, so organizational excellence. And what that means is she leads, I'm just reading here, she has oversight over VHA's performance, quality, safety, risk management systems, engineering, auditing, oversight ethics and accredit issue programs. So that's directly from the website.

I will tell you that I respond to her probably three times a week. I see her frequently at meetings, and we talk directly about where things are going, some of these subjects you're going to hear in a minute. She sends her greetings to you, and tells you that she still remains concerned, and is certainly very much involved, just was unable to come today.

MS. RUCKART: Okay. So the next item is related to the previous discussion about the SME reviews, so just to make you aware, and you can keep that in mind when you're formulating your response

to that. The CAP requested the number of claims where the VA made a decision without needing an SME review. And then Brad had said previously that it was difficult to get that, given the way you currently collect data. And then the CAP asked you to revisit and see if that would somehow be possible.

MR. FLOHR: I did ask our folks in Louisville if they had done such a claim. They canvassed their decision-makers that make the decisions, and at least one of them said yes, I did use one. I granted one, granted one on the basis that the private medical opinion was complete. It was as good or better than the SME opinions that we get, and they granted the claim. They did not remember the veteran's name. It was never at that time, but yes, it has been done. Maybe only once but it's been -- I think there's been a few of them, but they remembered that one in particular.

MS. RUCKART: Okay. The CAP asked if the VA could handle claims differently for the conditions on the presumptive list before the rule takes effect instead of staying the claims. So is there any update?

MR. FLOHR: Yes, what I just mentioned, that we

looked at that, and so far we've not been able to do that.

MR. TEMPLETON: Was that OGC that made that decision for you?

MR. FLOHR: It’s on the transcripts.

MR. UNTERBERG: Did they give you any insight on a legal basis for that?

MR. FLOHR: Just that it would be contrary to our current statutes and regulations.

MS. RUCKART: Okay. The VA was asked to follow up to see if any actions were taken regarding the VA employee who posted erroneous information on social media.

DR. ERICKSON: Okay, so I had that. One of my associates, directly followed up with this individual, discussed, provided new information.

But I want to underscore something that's really important here. If the folks in the community, and the CAP members in particular, see egregious things, where someone is identifying themselves on social media, identifying themselves as a VA employee, and it looks like they're off balance, they're misrepresenting something, basically, I mean, contact me directly or contact me through ATSDR, ask me to put direct -- direct

action. I'm not going to talk about, you know, action that may relate to this employee's discipline, et cetera, but I will tell you that we did interact with this individual directly.

MS. RUCKART: The CAP --

MR. UNTERBERG: Thank you, by the way.

MS. RUCKART: The CAP asked that the VA can see about including the SME opinion in the denial paperwork that gets sent out to a veteran or family member.

MR. FLOHR: This is Brad. I'm not aware that we have talked about that. I think it should be possible but let me check on that, and I'll get back to you.

MS. RUCKART: The next few action items are for the DoD, so I'm looking at you, Melissa. The CAP requests nondisclosure agreements from DoD for reviewing documents that have not been publicly released. They wanted to know if there's a mechanism for how they can work with the DoD attorneys.

MS. FORREST: This is Melissa Forrest. The Marine Corps recognizes that the CAP has an important role to provide input and community perspective to ATSDR. Nondisclosure agreements are

signed by federal government employees or contractors working in an official capacity. Therefore as a community group, a nondisclosure agreement wouldn't be applicable. Documents released to the CAP are also considered a release to the general public. Such releases require that a proper review be completed before providing any documents.

And on the second part of that action item, DoD attorneys advise staff, unless they're not generally available for direct questions from the public. However, any legal issues that arise through discussions with the CAP are provided to attorneys for resolution. The Marine Corps recommends that any legal questions for resolution be submitted as any other action items through the Department of the Navy's representative to the CAP.

MS. RUCKART: Okay. The next item for you, the CAP requests information on what the Marine Corps does as follow-up in litigation for children with elevated blood lead levels.

MS. FORREST: I apologize in advance. This is a very long response, because there are a lot of actions that are taken, but I'll try to read it quickly.

MS. FRESHWATER: Can we get a copy of that, Melissa?

MR. ENSMINGER: And then you don't have to read it.

MS. FORREST: Okay. Yeah, because it's quite long. I'll give you my copy that I have here.

MS. RUCKART: The CAP requests an explanation of why the Marine Corps will not send a uniformed representative to CAP meetings. The CAP requested that this be addressed to former Marines in the audience and not to the CAP.

MS. FORREST: Well, I'm addressing this to everyone present. The Marine Corps remains committed to the founding purpose of the Camp Lejeune CAP and to receiving useful input from the CAP. Based on past experiences with sending a uniformed representative to the CAP the Marine Corps did not find their presence to be productive or useful to the CAP discussions. To that end the official Department of the Navy CAP representative remains the most effective means of participation with the CAP, and will continue to relay information back to the Marine Corps and the Department of Navy team so they can determine how to best support CAP principles.

MR. ENSMINGER: So they're hiding.

MS. FRESHWATER: Could you once again assure the Marine Corps that we will not be threatening and that we will follow our rules of code of conduct and that they will be safe among a room full of community members and other Marines and veterans. And could you please request that they send a uniformed member to the next CAP meeting? Thank you.

MR. PARTAIN: To dispense with the formalities, I mean, that's a load of crock, as what Jerry would say. The Marine Corps provided contaminated water to a million Marines and their families. In the media statement the Marine Corps consistently states that they are concerned about the Marine family. Their absence here is duly noted, and it is a slap in the face to those one million Marines and their families, including myself.

MR. ENSMINGER: And furthermore, for the first several years there were representatives from the Marine Corps, active duty, in uniform, that represented at our meetings, until it got to the point where they couldn't answer the hard questions they were getting. And then they hid. That's whenever your predecessor started being fed to the

sharks, okay?

DR. BREYSSE: So Lori's request is on the table for you to take back.

MS. FORREST: And I will say that I passed on your comments. I will pass them on again.

MS. FRESHWATER: Thank you.

MR. ENSMINGER: To Scott Williams?

MS. FORREST: There is a large group of people who work on these responses. It's not just a --

MR. ENSMINGER: Oh, I'm sure of that, but who do you report to?

MS. FORREST: There's a group. I report to -- I discuss all this with people at Marine Corps headquarters, at Camp Lejeune. It's a large group of people. Yes, Scott is one of them.

MR. ENSMINGER: And then attorneys.

MS. FORREST: There's a large group of people that I --

MR. PARTAIN: And just out of curiosity, the statement that you just read, is there someone who signed off on that, an officer or somebody from HQ?

MS. FORREST: There is not one particular person, no. It's --

MR. PARTAIN: Can we get that in writing from somebody in a position of authority, not just a

general, like it's from Powell, but somebody in -- a uniformed officer to sign off on that statement? I mean, it's just -- there's too many people affected here, and it just -- like I said, they constantly state that their concern is for the Marine Corps family. Well, I mean, as a -- if a member of my family was affected by something I did, I would be very involved in that. And to not have somebody here, it's just -- I mean, like Jerry said, they were here when nobody was in the audience. They were here for years, and when we started getting down to the bottom and started getting the documents together, the truth together, and started asking questions, they vanished and said that we were a distraction. That was what they put on the internet.

MS. RUCKART: Okay, we've recorded the concern --

MR. PARTAIN: Okay.

MS. RUCKART: -- and I think --

MR. PARTAIN: Well, I understand that. But I'm going to -- you know, rather than just have the blanket statement, I'd like to have -- I request a formal letter to the CAP from somebody at HQNC. Put someone's name on it and see where it goes.

MR. TEMPLETON: And when they say -- Ms. Forrest, we're happy to have you here, enjoy your presence and your contributions here, so, you know, don't take this in the wrong way as being aimed towards a statement. When they say effective, I think they really need to consider who it's effective for. Right now the effective piece, in my view, seems to be for the Marine Corps.

MS. FRESHWATER: And we're going to be in Jacksonville, so we're going to make it very easy for them to be able to travel to our meeting.

MS. RUCKART: I think that your points are well-taken, and we'll record them. The next action item, the CAP requested a copy of the statement read previously about base-wide vapor intrusion investigation that they conducted. And they would also like to know the last date of testing at the Tarawa Terrace school. They'd like to know what screening level is being used.

MS. FORREST: Okay. This is Melissa Forrest again. I've confirmed that the statement I read aloud at the last CAP meeting regarding base-wide vapor intrusion investigations was added to the CAP meeting transcript, which is available online on ATSDR’s website.

With regards to the Tarawa Terrace school testing, also discussed at the CAP meeting, a vapor intrusion evaluation was conducted in 2010 and 2011, due to a nearby volatile organic compound ground-water plume. Shallow groundwater, soil gas and indoor/outdoor air samples were collected, and multiple lines of evidence indicated that vapor intrusion was not occurring at the school. A similar investigation was conducted at the nearby child daycare center, and vapor intrusion was also found not to be occurring. Currently soil gas samples are periodically collected near the Tarawa Terrace school in order to evaluate the potential for vapor intrusion as part of ongoing remediation efforts for the groundwater plume.

The last soil gas sampling event near the school was done in September of 2015, and benzene, and naphthalene, the two primary chemicals of concern at this site, were not detected in the soil gas samples. Indoor air samples pertaining to vapor intrusion testing at the school have not been taken since the 2010-2011 investigation because data has not indicated the need to resample inside the school.

All data related to the schools is screened

against residential screening levels, by its industrial, to be more protective, and these ongoing studies are being conducted in coordination with the North Carolina Department of Environmental Quality.

MR. ORRIS: Can we get a copy of that citing?

MS. FORREST: A copy of what was done for Tarawa Terrace?

MR. ORRIS: Yes, please.

MS. FORREST: Rick, wouldn't that be part of your vapor intrusion investigation that you're doing?

MR. GILLIG: Yes.

MS. FORREST: So is it something that you need before Rick's is done or?

MR. ORRIS: No. If Rick's going to have it I can wait for that.

MR. PARTAIN: Is it part of the 45,000 documents that the Marine Corps is reviewing to release to the public and the CAP, or?

MS. RUCKART: Well, you keep bringing me to my next action item. You just read my mind. So the CAP would like to get access to documents as they become available for public release instead of waiting for all documents to become available before releasing them.

MS. FORREST: I'm sorry, when we skipped ahead, I don't know why, I got all out of order here. Hold on a second. Was that the action item: The CAP would like access to documents as they become available?

MS. FRESHWATER: Yeah.

MS. FORREST: Okay. The manner in which documents are released to the public depends largely on the circumstances, and requires careful review for quality assurance and control. In most instances large groups of documents must be reviewed at the same time, to ensure quality and for other practical reasons. In other instances it might be appropriate for partial releases, such as with a portion of the soil vapor intrusion-related documents that have already been released to the CAP via an FTP site.

Still, the remainder of the documents are processed as a group and will be released as a group as soon as possible rather than piece-meal. Please note -- here's to answer your question, Mike -- that the primary review process has been completed for the remainder of the SVI documents, and they are now in the final stages of review for quality assurance and quality control with both the Navy and Marine

Corps, and these documents will be provided to ATSDR for release to the public as soon as possible.

MR. TEMPLETON: And as a follow --

MR. PARTAIN: Melissa. This has been going on for two and a half years for these documents. Now they're in a quality control review? Is this going to be another two and a half years before we see them? I mean, I know you can't answer --

MS. FORREST: I can't give you a time frame, but from, you know, the discussions I've been included on, I can't imagine that. No, you're not talking anything like that.

MR. PARTAIN: I mean, 'cause the initial batch of documents that were released to ATSDR, put on DVDs, did not take two and a half years.

MS. FORREST: Yeah, and this is a much larger batch, from what I understand, and this is something, I think, maybe Rick can help with, again. But I think that they're pretty close.

MR. PARTAIN: I mean, are they reading them page for page, word for word?

MS. FORREST: Well, see, my understanding is the primary review's already been down. Now is when they go back and do the double-check, the quality control, you know, to ensure that they are --

MS. FRESHWATER: To the civilians like me in the audience, could you explain what that means, quality control, of this document?

MS. FORREST: I don't do the process myself, but it's like anything else. It's not another full review. They've already done the full review. It's having another set of eyes go back and look, you know, over -- there's a process, to check and make sure that we're releasing things, that things -- that all reviews have been reviewed -- that all the reviews have been conducted and that, you know, things are cited properly.

MR. TEMPLETON: I take serious issue with the comment that they made, that they are only going to release them as a group and not release them piece-meal. They need to be releasing them piece-meal. Everyone here would agree that they need to be releasing them as they become available. Otherwise, as Mike was saying, it may be another two and a half years.

These, as Jerry has pointed out several times in the past, are part of the administrative record, and they should be released immediately, as soon as they can be released, not to be withheld and released, necessarily, as a group. I think that's -

- my formal request here back to you regarding that item would be that they consider releasing them -- strongly consider releasing them piece-meal. And at least in the interest of the people in this community who have waited so long for answers.

MS. FRESHWATER: And I would like to ask that you give the community an explanation as to what, what is the -- what is the exact thing you said? Quality --

MS. FORREST: Quality control. Quality assurance/quality control review.

MS. FRESHWATER: Could I get a definition of what that is, please?

MS. FORREST: Yes.

MS. RUCKART: Our next group of action items is for ATSDR. The CAP requested a comparison of the lead levels at Camp Lejeune with Flint, Michigan. I'll turn that over to Rick.

MR. GILLIG: Yeah, everyone should've received a copy of that. I do need to point out a couple limitations to the data. The data for Flint, Michigan was collected by residents, so there isn't really any quality control over the way they collected those samples. And the samples taken at Camp Lejeune, a much higher degree of quality

control. The Flint samples were taken from homes. The information for Camp Lejeune was taken from a variety of buildings, and they targeted those buildings most likely to have issues with lead. So we did -- you have summary statistics from both data sets, and on the back of the handout there's a table showing the distribution.

DR. BREYSSE: I'd like to also add that most of the Flint data reflected well after the contamination cleared up. So these data are from last fall and spring, and the switch happened a year before. So in fact we don't know a lot about how high it was in people's homes during the crisis. So this is data kind of at the tail end of the crisis, so it's a complicated comparison.

MR. ENSMINGER: We're running way over Dr. Blossom's start time, and I don't know, is this going to be cutting into your travel arrangements?

DR. BLOSSOM: I don't leave until seven.

MR. ENSMINGER: Oh, okay.

MS. RUCKART: I think that there's some other areas on the agenda where we can make up some of the time. I think we're okay. We have a few items left. Let's just breeze through this.

MS. FRESHWATER: I just want to say thank you

to everyone for doing this. Thank you. I know I talked to you and asked you personally to do that, and I appreciate it.

MR. TEMPLETON: And then the last little piece, Lead and Copper Rule, it's come out kind of publicly that that's kind of served -- has not served the public properly. Because there's been some contamination that occurred that, because of the way that the rules are, they don't report them. They don't have to report them, and things like that. So I wonder, just real briefly, I mean, how that might play into the data that we are seeing here from the samples?

DR. BREYSSE: So I'm not sure how to answer that other than to say the Lead Copper Rule is under review right now. They're re-evaluating the rule in terms of the levels, the sampling strategy, the approach to addressing kind of compliance with the rule across the board. So they recognize there's some issues with it, and they're reviewing it as we speak.

MR. TEMPLETON: That sounds like we'll wait for their review. Thank you.

MR. ORRIS: Rick, just one quick question on this. I noticed that the total number of samples at

Camp Lejeune has been 586 over the last nine years, roughly. When was the last time that a blood lead level was detected above the ranges for Camp Lejeune? Do you have that information? If not, can you get it for me next time?

MR. GILLIG: Danielle, do we have that? Excuse me, Danielle, do we have that in the revised health assessment?

MS. LANGMAN: We have the data. There was a report done by Camp Lejeune where they looked at the blood lead levels, and they provided that report as part of the comment period, so that indeed is included in the public comment health assessment that you all have. We don't have the blood lead data itself, so all we did was provide their summary in our report. So no, I could not state when was the last elevation. That would be something that Camp Lejeune would need to look at.

MR. GILLIG: Okay, I do know that at Camp Lejeune, if they detect a level over 15 parts per billion in the water, they go back and resample per the Lead and Copper Rule. And when they resample the levels are below. And so they have an active program.

MS. RUCKART: The next agenda item just relates

to getting the word out earlier on social media and our website about the upcoming CAP meeting, and we did that. We posted this, you know, months in advance, to give people enough time to register. Our office of communication has since told me that they were sending daily tweets for the last couple weeks before the meeting, directing people to the meeting announcement page. They sent out an email notice to 25,000 people who are on our distribution list with the Agency, letting them know the meeting was happening, and they sent a reminder email about that last night.

The CAP requested a copy of the cancer incidence study protocol and that copies be given to the VA and the DoD. I believe that's been addressed.

The VA requested that we publish our assessment of the evidence for health effects related to Camp Lejeune drinking water so that VA assessors can cite it in their reviews. I'll turn that over to Frank.

DR. BOVE: Yeah. That briefing document is being peer reviewed. We're starting to get the comments back. We'll look at the comments, respond to them, and get moving on this as quickly as possible.

DR. ERICKSON: And not that I want to quote anybody, but do we have a timeline for that, please?

DR. BOVE: We're waiting for one more reviewer, a very important reviewer. And he's going to take a little more time, so I expect the review to come to us maybe by the end of this month. And so once -- you know, so we'll work on the reviews we have already, and then we'll work on that one and try to get this thing out.

DR. ERICKSON: Okay. And we'll talk about this in a minute, but as you can imagine, having a peer review published, public document from ATSDR will help VA do the tasks that we'll be talking about.

DR. BREYSSE: And we recognize that, and we're doing our best to get it to you as quickly as we can.

MS. RUCKART: Okay. There was a request that we post the charter on the Camp Lejeune website, the ATSDR/Camp Lejeune website. We did that.

There was a request that we re-evaluate if any studies can be done on the in utero population at Camp Lejeune. Frank, respond?

MS. FRESHWATER: Yeah, just wait, 'cause it was done, so anyway.

MS. RUCKART: Well, we can talk about this with

Chris. That was something of interest to him.

The CAP requested that the action item list be sent to the full CAP. We did that.

And the CAP -- and this is for you guys on the CAP. ATSDR requested that the CAP provide written feedback on their concerns about the PHA so they can be formally addressed, so.

MS. FRESHWATER: Just going back to the social media thing very quickly, Christian used to attend the meetings. Is he here today?

MS. RUCKART: He is actually on leave today.

MS. FRESHWATER: Okay. Can we ask that he come to the next meeting or, you know, get back into the emails and stuff, because, especially planning for our next off-site, so that we can work with him?

MS. RUCKART: Yeah. We can request someone from the office of communications. I'm not sure who it would be --

MS. FRESHWATER: Anybody. Yeah, I don't mean -- I'm not trying to ask for him specifically.

MS. RUCKART: Sure.

MS. FRESHWATER: But it would be nice to have somebody here that we can kind of work with as a team, you know. Thank you.

DR. BREYSSE: Awesome. Thank you very much,

Perri.

So what I'd like to do right now is turn the floor over to Dr. Sarah Blossom, who is here at the request of the CAP, to have a presentation on immune function associated with chemical exposures at Camp Lejeune.

EFFECTS OF TRICHLOROETHYLENE ON T-CELLS/AUTOIMMUNITY

DR. BLOSSOM: Thank you all so much. I really thank you all for inviting me here. It's an honor and a privilege to get to talk about my research. Hopefully it's -- you won't fall asleep during it. But I've been working on trichloroethylene and its effects on the immune system in the brain, primarily in mouse models for about 16 years, so since I was a little bitty kid -- no. For a long time. So I just hope that you all get something out of this, in that it affects the immune system and promotes autoimmune disease.

So I'm primarily going to talk about mouse models. And why mice? But it's very difficult to establish cause and effect in human populations. With mouse models we can control exposures. We can look at end points that you normally can't look at in human populations. And so this is why I've spent

most of my time doing research in mice.

So this is just an overview of all the research that I did in my lab. I'm certainly not going to talk about everything today. I'm primarily going to talk about how trichloroethylene affects the immune system. And what we are seeing is inflammation associated with this that is causing an autoimmune type of response in our mouse model.

The brain and the immune system have this unique bidirectional communication, and I've also done quite a bit of work trying to determine how the immune system affects the brain behavior, but I won't be talking about that today. It's just way too much.

In order to have our immune systems working optimally, we need a balance in the immune system. So when our immune system is not working very well we become more susceptible to cancers, infections. When it becomes overactive we see things like autoimmune diseases and allergic responses. So this is a very simplified way to look at how important our immune system is in certain diseases.

So what is autoimmune disease? Basically our immune systems are designed to attack foreign invaders, like bacteria, viruses and things like

that. But in some instances, and nobody really knows what causes autoimmune diseases, our immune systems attack self-tissues. And this is -- I found this little thing on the internet. Tried to bring a little humor in the situation, but it is basically your immune system attacking itself.

So autoimmune diseases are a widespread problem. They're chronic. There's no cure. The treatments are not good at all. There are over 80 different diseases that have been identified, and there's at least one for every organ system in the body. Some are confined to organs; others are multi-systemic.

The latest estimate is about 23.5 million Americans have at least one type of autoimmune disease. So about 8 percent of the U.S. population. And this is by no means a comprehensive list that you see in the graph, but it shows you that many autoimmune diseases primarily affect women, mainly during their child-bearing age, 20 to 40, and so there is a gender disparity. Some of them, not all of them, Type I diabetes, is an exception as well.

So studies show that genetics are not the primary cause of autoimmune disease. There is an important role for environmental factors. And these

are very broadly defined: Lifestyle factors, different endogenous factors that we may have, underlying problems, bacterial and viral infection, but also exposure to environmental chemicals, primarily toxicants like trichloroethylene have been associated with autoimmune diseases.

So I think that this is a slide I've used when I give my talks to pediatricians or different scientists but most of you know what trichloroethylene is. It's a solvent, very widespread use in the mid-20th century. It's declined in use but it's still being used as a degreaser for metal parts, and less commonly in copy supplies and spot removers.

Humans can be exposed in many different ways. People are getting exposed through occupation, non-occupational exposures through environmental contamination, and also exposure from living near industrial waste sites, Superfund sites. And one big problem that we're starting to work on is drinking well water. A lot of rural areas rely on the use of private wells, and these are not monitored for TCE or other chemicals. So this is also a problem and a way that people are exposed to TCE.

So in terms of disease, human disease, there have been associations with TCE exposure and scleroderma. And this is an autoimmune response that targets connective tissue, and it is a systemic autoimmune disease most commonly associated with occupational exposures. And nobody knows how it triggers scleroderma; they just -- there have been associations with this disease.

Another autoimmune disease in humans, primary biliary cirrhosis, has been associated with autoimmunity. In particular, in proximity to Superfund sites there have been clusters of this disease. And there are other non-viral hepatitis-like diseases and autoimmune hepatitis has been associated with TCE.

There is some evidence that TCE exposure is associated with lupus, and this is primarily known through exposures, or end points, such as autoantibodies, antibodies against cellular DNA, increases in T-cell numbers and different T-cell-derived cytokines that are inflammatory.

There's also an increasing prevalence in this hypersensitivity skin disorder primarily found in Asia that is associated with a long-term exposure through occupation. So these people are not being

protected, basically. And this is not a contact dermatitis. It's believed to be T-cell mediated, and it is associated with fevers, it's long-term and also liver dysfunction accompanies this skin disorder.

MR. PARTAIN: And Dr. Blossom, on the skin issues, one of the common things that we do see with the veterans and dependents on Lejeune is, you know, the contact dermatitis.

DR. BLOSSOM: Right.

MR. PARTAIN: When I was born I was covered in a red rash, and I've had issues with that throughout my life. Like if I, when I was younger, would wear dry-clean clothes, I would break out in red rashes. Is that similar to what you're talking about, or is that something different?

DR. BLOSSOM: Well, I can't really speak to what you were experiencing. I mean, if you touch the TCE it's going to cause some kind of skin reaction, but this seems to be more -- less of a contact media and more of a -- it's activating the T-cells in the body to react and cause inflammation in the skin, so it very well could be something.

MR. PARTAIN: Yeah, I've had it all my life. I've learned to manage it but it's something that

shows up periodically, and what have you, but it's -- you know, I hear it over and over again with dependents and the veterans, and everything. And those that work with it, you know, we do -- I mean I've seen their hands would be -- they're red all the time and scaling and stuff.

DR. BLOSSOM: Right.

MR. PARTAIN: But the dermatitis issue is something that we see a lot of from Lejeune.

DR. BLOSSOM: Yeah. And I just came across this because there's a lot of information on it in Asia where they're working with really, really high levels of this TCE in the work place. And it is often, as you can see from these pictures, these people are very, very sick. So it tends to be more of a systemic problem and not just, you know, like you have an itchy skin problem. But I think it very well could be. I think the problem with a lot of these studies in looking at humans is that just people don't know.

So some of the challenges that I've already kind of touched upon, it's very difficult to study these diseases in humans. It's -- cause-and-effect relationships are difficult, so defining toxicant exposure as a risk factor is hard. People aren't

aware of their exposure. They don't know how long they've been exposed or if they're being exposed. There are very few biomarkers of exposure, especially with regard to TCE, because it is metabolized so quickly. And people are very rarely exposed to just one single chemical, so how can you accurately assess the contribution of a single toxicant in mixtures?

So this is why we use animal models to study the effects of TCE on the immune system. So people use mice to test different environmental chemicals to see if they're toxic in different organs. So what we wanted to do, because we are looking at autoimmunity, and there is a genetic component, we wanted to use a mouse that is autoimmune-prone. So these mice, for some reason, have, you know, an undefined genetic predisposition to developing autoimmune disease. So these mice, if you don't treat them at all, and let them live, they will eventually develop lupus. They will get glomerulonephritis, and they die. But it's a very mild, long-term process for them.

So our hypothesis was: Will TCE accelerate the presence of autoimmune disease in these lupus-prone mice? No one has ever looked at a lupus-prone mouse

before. So and the way we administer the toxicant is we try to make this more environmentally relevant. We don't barrage them with a certain amount. We let them drink it in the drinking water. So we mix the TCE in ultrapure Milli-Q water, because the chlorinated by-products can confound the results, with an emulsifier because this -- it's a solvent; you can't really get it into a solution. We put them in glass bottles with cork stoppers. We change the water a few times a week because it will degrade. We measure the volume and calculate how much is consumed, and we weigh them. So we get a rough estimate in terms of mgs per kilogram per day of how much they're actually being exposed to.

So the U.S. EPA has established the MCL, about 5 parts per billion. And contaminated sites, as you know, often exceed this limit quite, you know, drastically. TCE is detected in over half of Superfund sites. And in terms of occupational exposure, people are allowed to be exposed to about a hundred parts per million for an eight-hour exposure limit, which comes to roughly 76 mgs per kilogram per day. So the doses that we are using here in all of our studies represent both occupational and environmentally relevant kinds of

exposures. Toxicologists get really wrapped up in what dose you're giving the animal. So we try to be very reasonable and use lower levels than what would maybe cause cancer, for example.

So this is our experimental design. We used female mice because they are more prone to autoimmune disease, exposed them to TCE in the drinking water. We did both acute exposures and chronic exposures. And we looked in their serum for biomarkers of autoimmune disease, antinuclear antibodies and also T-lymphocyte subsets, because T-cells are very important in driving autoimmune responses. And we looked at organs for different pathology because a lot of times the antinuclear antibodies don't really tell you much of anything. It's primarily what you see in terms of pathology. And when you're working with mice you can look at pathology, so.

So what we found was that TCE exposure for four weeks increased autoantibodies in the serum. We did not see this after a long-term, 32-week exposure, and we think it's because all of the mice start to develop these autoantibodies, so it kind of masks any effect that TCE might have. So we weren't really surprised to see that the autoantibodies were

not affected by the part concentration of TCE.

So this is a very busy slide, but T-cells are really complicated, and I don’t know if you've had an immunology class before. T-cells can be defined both phenotypically, the molecules that are expressed on their surface, and also functionally by the different cytokines that they release. So phenotypically we look at T-cells based on different markers on their surface. So an activated T-cell will express low levels of a marker called CD62L and high levels of a marker CD44. And naïve, or unactivated, T-cells will express high levels of CD62L and low levels of CD44. And again, Th1-type cells and Th17 cells are important in autoimmune responses. So we wanted to characterize these T-cells that are -– for the mice that are being exposed to TCE.

And what we found, we can do this by flow cytometry. We take T-cells, we can incubate them with the antibody-specific ^TCE molecules. And as you can see, after four weeks the TCE-exposed mice expressed more of an activated phenotype than the controls, based on expression of CD62L and CD44. So TCE is activating a T-cell.

MR. PARTAIN: What does that mean?

DR. BLOSSOM: Well, it's basically -- you know that picture I showed you, the naïve T-cell? It's supposed to stay in that state until it encounters a bacteria or a virus. But if TCE is in the body it seems to be activating this naïve T-cell to differentiate to become a really dangerous T-cell, but it expresses these markers, pre-cytokines, and can cause pathology.

MS. FRESHWATER: Like leukemia or are we talking only like... Has it been linked to any kind of pathology like cancer or are you talking about only the autoimmune?

DR. BLOSSOM: Well, we're focusing more on autoimmune. I think that the levels we're using are relatively low. We don't see cancer in our animals.

MS. FRESHWATER: Okay.

DR. BLOSSOM: But I think that if you would use higher doses, you might see some sort of phenotype associated with that.

MS. FRESHWATER: Okay, thank you.

DR. BLOSSOM: And our T-cell cytokines that I talked about, and again, the gamma interferon represents a cytokine that's pro-inflammatory, associated with autoimmunity. We see an increase in gamma interferon at four weeks, and also at 32

weeks. IL-4, which is not associated with autoimmunity, we do not see an effect with TCE.

And I wanted to show this because we've done several different studies, mainly acute and chronic. We wanted to look at a more subchronic exposure. And interestingly, we looked at -- this is gene expression fold change and also it’s secreted protein. We see a decrease here. And at first we were a little bit surprised to see a decrease in these pro-inflammatory cytokines. But it's known to autoimmunity that it's a five-phasic kind of response. So in the body the cytokines are going to go up, and then you have compensatory mechanisms that make it come back down. So it's not always up; it's up and down. We're just looking at one window of exposure. And so it's important to know that, like in real life, it's doing this. It's going up and down.

So in terms of pathology we expected to see lupus because these were lupus-prone animals. We didn't see anything in the kidney which would indicate lupus pathology, so we were kind of surprised. So we have liver tissue. We had all kinds of tissues. And we -- as you can see, this is a liver stain, pathology stain. And this represents

mononuclear cell infiltration. So this is not normal. These are like T-cells that have come into the liver. And this causes all kinds of problems in the liver.

So patients with autoimmune hepatitis develop antibodies specific to liver proteins. So we didn't know if these T-cells here were actually auto-reactive. I mean, just, they could be any old T-cell. So we did an assay where we looked -- we took liver proteins and ran them down the ^, and we put the serum into the mice, the control of TCE-treated mice. And we saw that the serum from the TCE-treated mice were recognizing these self liver proteins. So what we think we're seeing is an autoreactive response in the liver with mice exposed to TCE chronically for 32 weeks.

So to summarize we see pro-inflammatory CD4 T-cell effects, autoimmune hepatitis, like liver pathology. We did subsequent studies where we blocked compounds to inhibit metabolism, and we were unable to see any of the T-cell effects. So we ask the question: Can we see these effects if we just use the metabolizer? So this gets more into the mechanism of how things work, 'cause, as scientists, we want to know why, and not just do exploratory

kind of studies.

So I won't go over the whole -- this is a very simplified picture of the metabolism of TCE. But it's mainly metabolized in the liver. And we were interested in this metabolite in particular. It's an aldehyde, and it's been shown in many different systems that aldehydes are very reactive. So we did some experiments with this aldehyde, the primary approximated metabolite. And we saw some of the very same effects that we see when we just exposed mice with the parent compound. This is just a picture of increased CD62 -- or a decrease, sorry, of CD62L, meaning it's an activated T-cell. And we see increases in our gamma interferon. And this is after a 40-week study.

So in terms of pathology, we started to see in about 24 weeks, the mice were starting to lose their hair, and they were developing these kind of ulcerative skin lesions. And we were not expecting this, so we started to monitor the hair loss, and towards the end, or at the end of the experiment we took skin samples. I see you laughing. Skin samples of the pathology, and saw that there are T-lymphocytes that are infiltrating the skin, the hair follicle, and this is an ulcerative lesion

here. So now we're thinking why is this causing, you know -- it's very, very interesting, but we really don't know why it seemed to target the skin and cause hair loss in these animals.

MR. TEMPLETON: But this is with exposure to TCAH.

DR. BLOSSOM: Yes. Not with TCE. They do not lose their hair when they're exposed to TCE, so I don't know. It's primarily in the liver when they're exposed to this.

MR. HODORE: Dr. Blossom, I have a question. Is this the same incident as a Marine cleaning a weapon, like in the armory, like TCE? Like cleaning their weapons?

DR. BLOSSOM: Well, it's really -- it's hard to extrapolate what we're giving the mice to what a person might be exposed to. I mean, we -- I don't know, if you could give me like the dose or whatever, I can possibly do that but, you know, it's hard to answer those kinds of questions. But I mean, that's a very relevant question.

MR. PARTAIN: Well, Dr. Blossom, also, when -- you know, I might be jumping ahead in your study, but you've got the exposure in the dose that you're doing with the mice, and you're seeing the effects

with the liver. Once the exposure was stopped was there -- did the liver issues progress? Did they -- were they at recess or continue or what happened. And one of the reasons why I ask that is a lot of the Lejeune people, including myself, and like when I was a young child, I had liver issues. And back in my late teens or early 20s my primary doctor's, well, you need to quit drinking alcohol. I'm like, I don't drink. But all through my life I've had increased liver enzymes showing up on all my blood tests. Every time I get a new doctor, when they freak out, I'm like, no, I've had that since childhood.

DR. BLOSSOM: Well, I am -- you are jumping ahead a bit, but that's okay. We have done cessation experiments, where we stopped the exposure, and the mice are allowed normal drinking water, regular drinking water, and look at the liver. And we're writing the paper right now, but the pathology is actually worse. Why that is, I don't know.

MR. PARTAIN: That makes me feel really good.

DR. BLOSSOM: It's a sustained, long-term effect, so if the exposure goes away, that doesn't mean you're -- it's automatically going to get

better, sadly. I'm sorry.

MR. ENSMINGER: Well, how many mice were you using in each one of these studies?

DR. BLOSSOM: Well, these --

MR. ENSMINGER: And then how many of them exhibited these effects? Did all of them exhibit them or?

DR. BLOSSOM: No. We get a percentage of mice. Like in this picture, for example, this is percent with alopecia. So it gets -- you see, the lower doses you don't get as much. This is control, zero percent, 10 percent, 40 percent, up to 70-ish percent. We don't get 100 percent. We get a lot of variability. And we're looking into that variability right now. Even though they have the exact same genome, there are other factors, epigenetic factors that played a role too. That's kind of what's next for us, to try and understand this variability. And especially in human populations there's variability, in particular.

So, and you asked how many mice we... We try and keep these -- these are very long-term exposures that we're doing, so it's a lot of money. So we probably ran eight to 15 mice per group, is what we use. We just cannot process that many animals at

once. I mean, it's too difficult for these.

MR. ENSMINGER: You know, at different levels how many of those mice in each group demonstrated the effects?

DR. BLOSSOM: In the liver, are you talking about specifically? We get about 50 to 60 percent, maybe, in our TCE-treated groups that will have really like fibrosis. And then a higher percentage of the mice, maybe 70 to 90 percent, will have infiltration, a milder form of pathology.

MR. ENSMINGER: So that's pretty high.

DR. BLOSSOM: It's pretty high, yes.

MR. PARTAIN: Also, Dr. Blossom, did you get any comparisons between mice who had been -- had an acute exposure, like an occupational exposure, versus mice with a chronic exposure over a period of time at a lower dose? Was there a comparison done with that?

DR. BLOSSOM: With the pathology, no. Because we don't -- we did an earlier study looking at four weeks, or acute exposure, and we did not see any pathology at that time.

Now, you have to keep in mind that mice age differently than humans, too, so if you're -- you know, a four-week exposure in a mouse is not a

four-week exposure in a human being. I mean, that's like a lifetime, almost, in a mouse. Not really but you do have to keep those things in mind when you think about this in context as well.

MR. PARTAIN: Well, the reason why I asked that is, you know, we get pushback from, you know, a lot of the studies that are done, like when you heard us talking about the VA earlier and their occupational studies. And they used to quote, you know, that the occupational exposures were much higher and didn't produce cancer, and how could it produce cancer or produce an issue with a veteran who was exposed for a much lower dosage. But our exposures were lifestyle exposures.

DR. BLOSSOM: Right.

MR. PARTAIN: We were exposed 24/7, 365 days a year, and, you know, in the home and work --

DR. BLOSSOM: Right.

MR. PARTAIN: -- and things like that. In my case and Chris's case, we were exposed from the moment of conception to birth, plus whatever time we spent on the base.

DR. BLOSSOM: Right. And I'm going to talk about these kinds of things too.

MR. ENSMINGER: Well, let me ask you, though,

were there other scientists replicating these studies?

DR. BLOSSOM: There is one group that uses our exact same mouse model. They're looking at different end points; they're looking at more of oxidated stress kind of mechanisms. They're not looking at what we look at in particular. Others have done these experiments in non-autoimmune-prone mice. They don't see quite the same things that we see. As far as I know we're really the only people that are doing these kinds of studies. I mean, I welcome anyone to expose a mouse for 40 weeks. I'm certainly happy to share data. I'm happy to collaborate, talk to people, but as far as I know we're it. It's really hard. We rely on funding from the National Institutes of Health, so if we don't get the money we can't do the experiments, so funding is really hard to obtain, for various reasons that I don't want to talk about or I'll get mad.

MR. PARTAIN: Maybe you should contact HSIA. I'm sure they'd be glad to fund you.

DR. BLOSSOM: Okay.

MR. PARTAIN: Yeah, I'm being sarcastic. That's the Halogenated Solvents Industrial Alliance.

DR. BLOSSOM: I don't know. Okay.

MR. ORRIS: I have a quick question for you.

DR. BLOSSOM: Okay.

MR. ORRIS: When you were looking at the liver were you also seeing elevated triglyceride levels associated in these mice?

DR. BLOSSOM: You know, we didn't look at those. We did look at ALT, and we didn't see any difference in that. So I don't think that it is producing an extreme damage. I mean, we were just getting some kind of autoimmune response that it caused problems. If we perhaps look later, I mean, there might. So there eventually the study has to be terminated. But it's very possible that those kinds of things could go up much later.

MR. ORRIS: And have you done any multi-generational studies on these mice?

DR. BLOSSOM: Not multigenerational. We are doing developmental, and that's what I'm going to talk about next, because the National Academy of Science has put out a document, and I was reading this document in order to enhance my knowledge. So and this struck me, more researchers need to assess the different life stages at which humans might be more susceptible to the effects of

trichloroethylene. So no one had done any developmental exposures. Here we go. So this is in a human, not a mouse; it's very different. But as you can see the immune system matures starting at conception -- well, a little bit after conception, not quite immediately, and then it continues after birth and also adolescence and adulthood. So the immune system matures continuously. So we were just looking at adult mice. So we were thinking that possibly even at lower levels of exposure the immune system might be more susceptible to the effects of TCE.

So what's known about the maternal, early-life exposure in humans? We know that TCE can cross the placenta. It's detected in cord blood, and it has also been detected in breast milk samples. There was a study conducted a few years back. They looked at a population of urban school children, and they counted TCE in about 6 percent of the kids, which is remarkable considering the half-life of TCE. It's not in the blood very long. So they were probably being continuously exposed.

In terms of immunotoxicity in any end points, not a lot is known, and I don't have the references here. But there have been some studies looking at

leukemia, adverse pregnancy outcomes, childhood cancers and different pregnancy outcomes associated with TCE. So no one's really looking at the immune system with development.

So we started out doing -- because the immune system matures for so long we did a continuous exposure. We started at gestation. We bred the mice ourselves, which was a whole new thing for me. We looked postnatally. Also the NIH wanted us to look at different windows of exposure, so postnatal only, prenatal only, and continuous. These were big experiments. So we looked at different immune parameters in the mice, different ages, representing the relative ages of infancy, childhood, adolescence and adulthood. So this stands for postnatal day. So this is a child; this is an adult, in mouse age.

MS. FRESHWATER: Do you mean like literally -- is that literally ten years old or?

DR. BLOSSOM: No, no, no. Yeah, ten days old.

MS. FRESHWATER: Ten days old.

DR. BLOSSOM: Postnatal day, yes.

MR. PARTAIN: And the previous slide, what did CHD mean?

DR. BLOSSOM: Congenital heart defects. Sorry.

MR. PARTAIN: Okay.

DR. BLOSSOM: Anyway, so we used a range of doses in previous studies. Again, there was no standard. We didn't really know what -- we wanted to see an effect so we used these adult types of exposures. And this is just a different assay to look at gamma interferon intracellularly instead of secreted. And as early as postnatal day 28, this is very young, we see an increase again in interferon. And I do not have the pictures.

Our veterinary pathologist literally disappeared and we could never track the pictures down, but we did have the data. And we were starting this early science of liver pathology. So basically when the pathologist looks at the liver, we don't do it ourselves. So we rely on a veterinarian who's an expert in this, and they give it a score based on severity. So it's a relatively low score, but when you compare the trichloroethylene with a control, it's different. It's significantly different. And this is at postnatal day 42, and we've never seen such -- any kind of liver problems with amounts so young.

So they wanted us to look at postnatal only exposure, so not during gestation. And you see a lot of the same effects: Increase in activated

T-cells. And these -- we just didn't just look at gamma interferon. We looked at other pro-inflammatory cytokines as well. Postnatal day 42, that's a young adult mouse.

And so the next experiment, this is another cessation type of experiment. So what if we exposed the moms while they were pregnant and stop their exposure, and then look at the results? I mean, this probably doesn't happen in real life but, you know, we have to do these kinds of experiments to possibly design interventions, if we want to help people who are exposed. I didn't think we could see, but each dot -- we replicated this. Each dot represents an individual mouse. And when you look at the mice when they were adults, we see these effects maintained. Activated T-cells and T-cells that secrete gamma interferon. And we also looked at IL-17, which is -- that's pro-inflammatory autoimmune protein.

We looked at the liver, and this time we got a little more sophisticated. So our pathologist had left, so we didn't have another one. We still had the liver samples. This is a relatively recent study. We did gene expression in the liver, and found an increase in these inflammatory biomarkers,

and repair. EGR-1 is a repair protein, indicating that, with TCE exposure, just during gestation, there are -- the liver genes are still activated in inflammation and repair.

So, I think we've talked very long. I just want to thank everyone in my lab, not individually, but in particular Kathleen Gilbert, who I've worked with for 16 years, and we've done these studies together, partners in crime, and everyone else associated with these studies. And I also have to thank research support at the NIH, and local funding through the Art and Biosciences Institute, we would not be able to do these things.

MR. PARTAIN: Dr. Blossom.

DR. BLOSSOM: I'm done.

MR. PARTAIN: On that last side that you -- before the credits, when you were talking about the prenatal? What -- I mean, what does that translate to for the fetus, what, what you're seeing there? I mean, what's the -- what's the result, I guess I'm asking. And then second, could we get a copy of your presentation? Maybe if you could email it to us or something like that?

DR. BLOSSOM: Yes. And I have it annotated as well, so it'll have words associated with it.

MR. PARTAIN: Great.

MS. RUCKART: Would you like me to forward that on to the CAP?

MR. PARTAIN: Yes, please.

DR. BLOSSOM: Yes.

MR. PARTAIN: And is this on the internet anywhere?

MS. FRESHWATER: And we'll put it on the CAP website. I just had questions from behind me, I'll put it up on the CAP Camp Lejeune website, so everyone can see it.

MR. PARTAIN: Going back to my first part.

DR. BLOSSOM: Right. So this -- your question was, how does this relate to the fetus, right?

MR. PARTAIN: Yeah, what does it mean?

DR. BLOSSOM: What does it mean. Well this is an adult animal that was exposed during fetal development. So we don't know. We are thinking it's some kind of maternal factors when the mom is being exposed. The TCE is getting to the fetus. So we are thinking there's something going on, and we're in the process of trying to test this right now -- we need the funding -- epigenetically, that's occurring.

MR. PARTAIN: Are you working with that guy,

Dr. Skinner, in Washington?

DR. BLOSSOM: No. I know -- I know his name. But we do have collaborators who are experts in epigenetics, Dr. Craig Cooney. He's known for studies looking at maternal diet and offspring epigenetics. So I think we've got some experts on board on this. We have a grant on it, actually. We just need more funding, 'cause these studies are expensive. But we do need to look at that. But some kind of fetal programming is going on.

MR. PARTAIN: So they're seeing a continuation of the damage in the fetus as it's developing.

DR. BLOSSOM: Well, we haven't looked at the fetus specifically.

MR. PARTAIN: Okay.

DR. BLOSSOM: Only after they are born.

DR. BREYSSE: Fascinating. Thank you very, very much. I have two very short questions. One, do these studies you -- in cytokine chronization, are they in the mice that were pre-exposed to autoimmune disease or were they --

DR. BLOSSOM: Yes. We did all of these that I've presented here today in these autoimmune-prone animals.

DR. BREYSSE: And are these male mice or

female?

DR. BLOSSOM: These are female that I'm presenting to you today. We've done some work in the male mice. We have a side-by-side male/female study that's going on right now, and results suggest that we're seeing similar effects. And in terms of neural toxicity, which I didn't talk about, we're seeing a lot more adverse neurological effects in the males versus females.

DR. BREYSSE: And then can I just ask you one quick favor.

DR. BLOSSOM: Favor, okay.

DR. BREYSSE: Can you -- so obviously this meeting here is to help inform the community members about the risks potentially associated with what happened at Camp Lejeune. What's the bottom line, do you think, from your talks about TCE and autoimmune disease?

DR. BLOSSOM: I think TCE is immunotoxic. I think it's activating the immune system inappropriately. In certain individuals I think it's causing autoimmune disease. What that is, I'm not sure. Which disease, I'm not sure. But we have not specifically looked at autoreactive T-cells. We may have just looked at T-cells. But I do think

it's turning on some kind of autoreactive response. I think more studies need to be done in humans too. This is -- always seems to be a bottleneck with people trying to get things accomplished, and -- well, these are -- these studies were done in mice. Does it matter? It does matter. The immune system of a mouse is remarkably similar to the immune system of a human.

MS. RUCKART: Dr. Blossom, will you be available during break so that after we end our meeting and people in the audience have questions for you?

DR. BLOSSOM: Yes. I will be here. My plane does not leave 'til seven.

MR. PARTAIN: And Dr. Blossom, there are about 16,000 or so children who were conceived and born at Camp Lejeune. We do have their dosage and what we were exposed to and the duration and everything. I and Chris are included in those. We'd be glad if you'd work with ATSDR to maybe trying to write some funding or some grants or something. See what they can do because they've collected a lot of information, and yeah, I don't know how feasible it is, but I mean a lot of the stuff you talked about, we lived through it.

MS. FRESHWATER: So I have a question. I was not exposed in utero. I was around ten years old to 13 or so. So when you were talking about the immune system -- because I'm having really, really terrible autoimmune. I've had -- in the past year I had a biopsy on an ulcer in my nose. You know, and my doctor's like, I've never seen an ulcer in someone's nose. But it, you know, -- so I have had a lot of issues with this. So would -- how -- like so am I better off that I was ten than five? Like you know what I mean? Does it mature to a point where it becomes more ready to kind of fight this off as you get older, you know, into your teens?

DR. BLOSSOM: Yes. I do think that -- I mean, it's a progression. When you are more immature your immune system is more immature. And as time goes on, it becomes a lot better, or better equipped at toxic insult. Now, we do see adult-only exposures causing disease. But, you know, in your particular circumstance it's hard to say five versus ten, or whatever, but definitely childhood is a very sensitive time for exposure.

MS. FRESHWATER: I had two siblings who died of neural tube defects, and my mother died of two types of leukemia. So I was exposed to the same water

that caused -- you know. So, you know, I know that there are benefits to these wonderful scientists who -- of being a child, because of cell turnover and that kind of thing. So I was just curious about the immune system, since that's the particular thing that I seem to be dealing with the most. I see a rheumatologist.

DR. BLOSSOM: Right.

MS. FRESHWATER: Okay. Thank you so much.

DR. BREYSSE: Let’s -- for questions, and then I think we need to be closing for Dr. Blossom.

AUDIENCE MEMBER: Yeah, my question is that is this information being shared with the toxicology ^? Is this information being shared with the member community?

DR. BLOSSOM: It is definitely being shared. It is on ^ public access to my journal articles. I'm presenting this at toxicology meetings. In terms of physicians who are seeing patients, I doubt it.

AUDIENCE MEMBER: Okay, the reason why --

DR. BREYSSE: I think that -- sir, you can really bring that up with Dr. Blossom during the break.

DR. BLOSSOM: Yeah, I can only do so much.

AUDIENCE MEMBER: Okay. All right.

DR. BLOSSOM: Sorry.

MR. TEMPLETON: Dr. Blossom, we want to thank you so much for taking the time to come down here and delivering us the results of your past and current work there. It's very, very eye-opening, at the least. One quick question though. As it appears to me, for the end points of it, and especially with the tendency ^ that a potential end point would maybe be arthritic, or arthritis in humans. Would that be a reasonable suspicion, that that might be an end point?

DR. BLOSSOM: Such as like rheumatoid arthritis as opposed to osteo?

MR. TEMPLETON: Not necessarily rheumatoid, but arthritises that are associated.

DR. BLOSSOM: Definitely, because they're immune-mediated. And anything that's going to cause TCE to sort of inappropriate activation of the immune system, it's going to affect many different things, not just autoimmunity, as we're seeing in the brain. We're seeing a lot of inflammation in the brain, either an indirect effect through the immune cells, which it could very well be, some of these cytokines can cross the blood/brain barrier,

or a direct effect as well. So there's just -- there's so many questions.

DR. BREYSSE: So on behalf of ATSDR and the CAP, I'd like to thank Dr. Blossom for coming today. So to try and get back on time, Loren?

DR. ERICKSON: I need to speak to Dr. Dinesman just quickly.

DR. BREYSSE: Okay, we were going to try and shift to you guys real quick.

DR. ERICKSON: Well, stick with the schedule. We'll be right with you.

MR. ORRIS: Dr. Breysse, if I may real quick, based on Dr. Blossom's study, would an epidemiological health survey of the 16,000 children exposed in utero at Camp Lejeune help identify some of the trailing conditions, based on what Dr. Blossom has assessed today?

DR. BOVE: Well, that's what the survey tried to do. It had questions about lupus and questions about scleroderma. It had the TCE skin hypersensitivity, which is really quite similar to a reaction you have -- when you have a drug reaction. It's that kind of a skin sensitivity. There's actually three or four components to diagnosing that. I don't have it with me, but if you want I

can get it, but it's back in my office.

So we did try to look at these autoimmune diseases because that's one of the main mechanisms, we think, that TCE causes non-Hodgkin's lymphoma, for example, liver cancer, possibly also leukemia as well. So that the immune dis-regulation, it's a key mechanism they're thinking about for a variety of these cancers, and, as I said, scleroderma is -- it's definitely associated with TCE exposure in occupational components.

But we attempted -- we had 12,598 births from the birth defect study survey that we did, many years ago now, to identify birth defects. And we were able to identify neural tube defects and clefts, and did a study of that. And we had a difficult time and really could not ascertain the heart defects very well. And so that was a problem back then.

And then we had a recent survey, relatively recently, that we're still finalizing as we speak. And we had difficulty finding these people. I just went back over to look at the breakdown, and about -- out of that 12,598 about 44 percent we could not really locate. Actually it's probably closer to 46 percent. And then 40 percent did not

respond. Maybe they didn't want to participate or maybe we still didn't have the right address for those people. And so at the end of the day we had less than 15 percent responding and filling out a survey. So that was the problem with that approach, and it's going to continue to be a problem 'cause there's no -- all we have on these people from the earlier survey is name, date of birth, race and sex. The name's going to change for a lot of the people. And tracing, we used the -- one of the top tracing companies in the survey, and we just could not find most of these people.

So I don't think that's the approach that we need to take. I think maybe we -- you know, we need to find another population that is exposed to TCE and is easier to identify and locate or we're going to have to rely on other possibilities like animal studies to look at this. Again, occupational cohorts are always important but that doesn't account for prenatal exposures, which, as Mike puts, different outcomes than adult exposures. But adult exposures –- as you see the occupation letters -- do cause autoimmune diseases like scleroderma, so that's the best I can answer.

MR. ORRIS: With all due respect, Dr. Bove, I

mean, we've been over this a couple of times, my mom doesn't know my conditions, and sending my mom the health survey asking about my current health conditions, certainly --

DR. BOVE: That's not what we did. That's not what we did.

MR. ORRIS: Well, I never got a survey.

DR. BOVE: And that points out the problem. We tried -- we asked the tracing firm to find the children as well as the parents.

MR. ORRIS: Well, I mean, my, my problem --

MS. FRESHWATER: We've been over this, Chris. We've been over this, and I don't -- I just like --

DR. BOVE: I don't know how else we can do it. We went to the best tracing firm we know of that's experienced in tracing people, and they could not find them. Without additional information it's very difficult. Even with Social Security Number, we had difficulty with some of the Marines in getting their proper address because they move so much. It was very difficult to trace them. But if you're talking about people with just name, date of birth and sex, really, it's very difficult.

DR. BREYSSE: All right. So with the VA's consent we'd like to shift the agenda a little bit

and have the VA updates before we break for lunch, and we'll come to the public health assessment updates after lunch.

VA UPDATES

DR. ERICKSON: Absolutely. In the interest of time -- and thank you, Mr. Chairman, for moving us up on the agenda. We will try and be succinct, pithy, to-the-point. What I recommend is that there are four of us that are on speaking parts, again, the four of us coming to this meeting, I hope, is representative of our engagement with the Camp Lejeune community and ATSDR, looking for solutions. The fifth member, of course, being Mr. Herb Wolfe, who's joined us.

Let me just say the order of events will be, quickly, Mr. Brady White will give us a quick update on the veteran family member healthcare program. As you know he's talked about this in past CAPs and got up some numbers for you, I believe. I will go second and give the update on the clinical practice guidelines, where they stand, answer the due-out that was on the list related to that. Mr. Brad Flohr will go third and talk about the status of the proposed presumptions for Camp Lejeune veterans, and

perhaps talk about claims a little bit. And then lastly we'll come back to Dr. Alan Dinesman, who will talk again about disability medical assessment, SME and process. So Brady?

MR. WHITE: Thank you guys for having me again, and sorry I missed the last meeting. There was a big snow storm that hit, and I was unable to make it in-person. This time I had a flight on Delta. Almost missed it. From a personal standpoint, I just want to thank you for your support. A lot of you guys know I was dealing with Hodgkin's lymphoma and going through all the chemo and radiation. Just had a update from my oncologist a couple weeks ago, and everything is checking out great.

MR. PARTAIN: And your hair does look great. I wish mine came back like that.

MR. ENSMINGER: Nobody recognized him.

MR. WHITE: So I've had this presentation with you guys before, but in the interest of time, I just tried to email it to you but it looks like my email may be snagged up. So you can share it later on, if anybody has any questions about any specific data points.

But I just wanted to highlight, as you know, the Camp Lejeune law was passed in 2012, and we

started compensating family members for their care in October of 2013, and taking care of the veterans right when the law was passed. So as of July 1, we have provided healthcare to 25,364 veterans. 2,515 of those were for a specific Camp Lejeune -- one of the 15 conditions.

MR. ENSMINGER: How many?

MR. WHITE: 2,515. And of these veterans 211 received that care this fiscal year.

And then I've got a breakdown of the 15 conditions specifically, and how many veterans we're seeing. There was a question earlier about breast cancer. And right now we have 58 breast cancer veterans, that are receiving care specifically for breast cancer. And of those, 15 are male and 43 are female.

For the family member side, you know, we've done a lot of outreach with the U.S. Marines, and they've been really, really good about helping us, you know, get the word out. We sent out hundreds of thousands of letters, and I've got some specifics of what outreach that they've actually done for this program. You know, they've put a lot of information in various publications. But, you know, we're still having a challenge of finding these family members.

So one of my focuses this upcoming year is going to be, you know, what are some other outreach that we can do that we haven't thought of, and any input any of you guys can provide for that would be very much appreciated.

Because of the family members that have applied, and it's 1,525, I have less than 200 that are currently receiving benefits. So, you know, we anticipated about 1,100 a year who have been applying, and we're not quite there. So, you know, again, any outreach activities that you can think of that would help us would be greatly appreciated. So those are kind of some of the bigger numbers. Again, I'll make this presentation available to you, if anybody has any questions.

MS. FRESHWATER: I got it. I'll forward it.

MR. WHITE: Excellent. All right, any questions for me?

DR. ERICKSON: Brady, do you have some colleagues that are with you here, that you had mentioned?

MR. WHITE: Yes. Thank you for reminding me. I asked the health eligibility center -- they have done a tremendous job in helping us establish veteran eligibility, answering questions regarding

the family members, but I'm not sure if they're here yet. They were going to be here. And I actually haven't ever met them. You know, they're based here in Atlanta, and I'm in Denver. They told me they were going to be here so I'm hoping that they will be. Maybe after the break or after lunch they might show up. So in the audience, if you have any questions for me for the family member program, you can approach me during the breaks or lunch, or we're going to be here after the presentations as well, to answer any questions.

MR. TEMPLETON: Brady, a question for you. How is the process going on proving residency? I know that was a difficult thing for you guys to do. Have you gotten any cooperation from the Marine Corps in streamlining?

MR. WHITE: Absolutely. Thanks for asking. We actually have a process established that is, we think, as beneficial to the family members as we can make it, because, as you guys know, how difficult is it for a family member to, you know, show some kind of document showing that they were at the base, right?

So the process we've established, and I got this cleared through our Office of General Counsel,

was the Marines have a database, a housing database, that shows, you know, who was on base housing. And what we've done is we've made the connection that says, if a family member can show that they had a relationship with the veteran during that covered time frame, we can use that housing database, even though they're not specifically identified, we can use that housing database to put the family member on the base. So we've actually been pretty successful in getting most people that have applied through that method.

MR. TEMPLETON: Does that use the MCI east database? Marine Corps installations east database and FOIA process that they have? They have like a FOIA process through Martha White and...

MR. WHITE: Yeah. I'm not sure of that process. The Marines have created this database, and certainly they share it with us.

DR. BOVE: In fact we computerized it first, and then they -- we went back and forth. It's on index cards from the housing office.

MR. ORRIS: Brady, can we get a breakdown of the types of processes that are being approved? Can we get some idea of what --

MR. WHITE: Sure. That's one of the slides

that you'll have, for both the veterans and the family members, based on the 15 conditions.

MR. PARTAIN: Hey Brady, what about situations where, say, an extended family member, a father-in-law, comes in to stay at the home while husband is deployed, to care for a newborn, and he's there for two years, and the father-in-law comes down with one of the 15 conditions. And he's residing at the onbase residence. Is there a way to verify that or extend coverage for people in those situations?

MR. WHITE: Yeah, Mike. That was a question we had early on, you know, what, what does it mean when the law states, you know, who's going to be eligible? And our Office of General Counsel, basically we made the determination that, in order to qualify for the program, the family member has to have a dependent relationship. Anything else?

DR. ERICKSON: Thanks, Brady. So I'll try and pick up from there. Just want to sort of underscore that what Brady's been talking about and what I will continue to talk about is a very narrow, discreet program that was called into effect in 2012, with legislation that was named after Jerry Ensminger's daughter, and this is the provision of healthcare

for 15 conditions. It's not related to compensation. It's not related to claims, but frequently there's some confusion about that.

To let you know that within the process Brady is at the front end as it relates to administrative eligibility. A few of those issues you just talked about have to do with administrative eligibility. The medical eligibility piece is handled by the folks that work under me, and this is a different set of medical SMEs. It's a different set of subject matter experts than who will work under Dr. Dinesman, and I will just describe this very quickly. At each of our war-related illness and injury centers we have physicians, so there's a total of three centers, or three sites for the risk.

There's three physicians who will do the medical review of the records for the claims that are put in. And as it relates to how that goes, and I want to be able to be responsive to the due-out here, there is a clinical practice guideline that was developed, that we then asked the Institute of Medicine, now called the National Academy of Medicine, that they review this. We mentioned this at the last meeting, that we were -- we thought we were coming into the final rewrite of those

guidelines based upon the input from the National Academy of Science. We slowed down as we went through the lawyers -- sorry, Craig, I'm not picking on the lawyers here -- but it slowed down a little bit, and we can say it's their job to always go back to the original legislation, read the law, make sure that what we're recommending is still consistent with what Congress intended, et cetera. So I will tell you that in a general sense the new set of clinical guidelines are approaching very quickly the signature by our undersecretary, Dr. Shulkin. I will tell you that they have taken into account the excellent input from the National Academy of Science, National Medical Academy, formerly the IOM.

I will tell you that we have -- we feel pretty good about this, and in particular I want you to know that the people who concentrated the work on the rewrite are the same folks that are working with Brady, working with me to make the process work as efficiently as possible. And the goal here is to get the information that allows us to get to *yes*. And I'll just state that for the public record. That's what we're looking for.

And so I want to be able to now answer the due-out by telling you what I mean by getting to

yes. Once an individual, let's say a family member, has been deemed administratively qualified, because of residency, dates and all these types of things, and then they're starting to submit claims, because again remember the government in this case is the last payer of -- for claims. And so they have bills. They want those bills paid, and they're submitting those. There are -- there is a number of documents that often times will accompany that claim, and in particular there's one document that is quite important, and that is the treating physician report. Not the treating position report, it’s in the due-out. Right, the TPR. And I say this for those from our community, some of whom I've met today, who are filing claims on behalf of family members or who are a family member, that treating physician report is going to be real important because we pay direct attention to that. Who would know better than in fact that physician who is treating that individual patient, that family member, who now has the condition. And there will be information in there about the diagnosis, about the treatment, about, you know, how this is tied to the claim as it relates to the cost that would need to be reimbursed.

The TPR, the treating physician report, is the first place that our medical SMEs go to. And we're hoping that in that document we will find what we need to say claim looks like it's squared away; let's go. If it's not clear in the TPR, in the treating physician report, then at that point we look at medical records. And there have been times when perhaps the TPR has not been written as well as we would've wanted, maybe it wasn't as comprehensive or as detailed. But these three medical SMEs of ours will go into the medical record and will look, and will look actively for information that talks about, you know, hospital stays and outpatient visits and diagnostic tests, and things that would support those diagnoses that are being claimed and how those are tied to certain bills.

If in fact it looks like, looking at the medical records, we don't quite see enough, there's a third step that we actually do, and we will reach out. We have nurses that work with these three SME physicians as well, and the nurses will actually contact the folks who have submitted the claim, and will say we need more. We need more. You know, we've looked at the treating physician report; we've looked at the medical records; we're not saying we

don't believe you but give us more to work with. In some cases there may be a trail of medical records -- I'm sorry, of medical bills or medical -- or part of the medical claim that's been ongoing, that tells the story in itself, okay. In the case of somebody who's been treated for cancer.

Now, the due-out asked the question about remission versus active disease, and I know a few of you on the CAP have wanted some clarification on this. Within the process that I've just described we recognize that if an individual has one of the 15 conditions -- don't -- you're too late, Tim. You could give me a heart attack here -- if the person who's submitting the claim has one of those 15 conditions, we understand that the medical care that would be provided, either to the VA for the veteran or the reimbursement for the medical bills to the family member, is first and foremost to that treatment for that medical condition. But we realize there are other medical conditions that are associated with it, because a few who have cancer, they're receiving chemotherapy. There can be lots of other things going on with you physically that are related to that initial disease.

MR. PARTAIN: Dr. Erickson, is there -- and I

don't mean to interrupt you here, but do you have a list -- I mean, for example, I went through chemotherapy. Every year I have to go back for an oncologist review. I'm on gabapentin because of neuropathy. I've got severe neuropathy in my feet because of chemotherapy. I also became diabetic during chemotherapy. You know, I understand what you're saying about the TPR and going through all this, but, you know, kind of cut to the chase. Is there something that you guys need to establish to where, when I put my claim in for the medical reimbursements and things, I can -- I know what I need to get or what I need to tell my doctor to put in mine so I can get this stuff taken care of? I mean, and I'm sorry to interrupt, but like my primary insurance, I have a $3,000 a year yearly deductible. My yearly cancer visit at Moffitt Cancer Center is at least 6- to $800 out-of-pocket for them because of the deductible, plus my yearly medicals and everything. Basically just because the residuals of cancer, you know, I'm not actively treating for male breast cancer, I usually incur about $3,000 out-of-pocket medically.

DR. ERICKSON: Yeah. So that's a great, great question. So my recommendation to you, and to

anyone else that's hearing my voice who would perhaps have a similar question or a similar circumstance, as you talk to your physician just say, look, you know, you realize that in addition to my cancer, in your case, I have things that have happened. It's what we call sequelae, second- and third- order effects that occur, and some of them are going to be chronic. They'll be lifelong. They'll be with you. And the therapy with gabapentin, et cetera, is a case in point. You can ask your physician, put into the TPR, put into that letter that you're writing that in fact you, as my treating physician, you recognize that these conditions, in your professional opinion, are tied to that covered condition, that one of the 15 conditions.

But you've touched on something else, and I'm going to talk about this in the context of cancer. So an individual comes in. They've filed the claim, and it's a cancer; it's clear they've got it, and it's one of the 15 conditions. Our SMEs take a whole-body approach. If an individual has active cancer -- they're, you know, they're getting surgery, you know, they're having chemotherapy, radiation, and all of this is tied into their claim

in terms of the bills that they need to have paid, we take a whole-body approach. We don't start to nit-pick and say, well, this thing doesn't fit; this thing doesn't fit. At least that's the way we're doing it right now. That's how we're operating.

But at the point in time where an individual goes into remission -- and remission, for all of you, could be a really good thing to be told by your physician. It means your cancer is no longer progressing. It may not be that you're absolutely totally out of the woods, but at least your cancer's not progressing, okay. You can be treated and it looks like you're doing well at this point in time.

We recognize that there is a period of time where you're still going to be getting care for certainly those related things that spun out from having the cancer and from the treatment, like you were talking about, Mike. Likewise we recognize that in some cases you may be under continued surveillance by the medical system because of your cancer. You may be on some type of maintenance, okay. There are now medications that are given to cancer patients that they'll extend out through years because these medications have been found to prevent a recurrence of cancer, and we recognize

that as well. Does that help?

MR. PARTAIN: Yeah. And what about the -- you know, like the guy who had the side effects? From treating cancer there is, you know, substantial damage that's occurred, such as diabetes, such as neuropathy and things like that.

DR. ERICKSON: Right. And so of course that will be on a case-by-case basis, but there is a rational basis for that, and this is how our group operates as we review those claims.

MR. ORRIS: So can we circle back to the TPR real quick? The treating physician report, is that the same one that was initially put on the site where it requests from your family physician, basically your primary care doctor, whether or not that that illness was caused by exposure at Camp Lejeune?

DR. ERICKSON: Brady, did we change that on the website or is it?

MR. WHITE: Yeah, it's the same report.

MR. ORRIS: Okay, and what kind of weight do your SMEs take that statement from the doctors? What weight bearing is that in the approval process?

DR. ERICKSON: Yeah, so it carries considerable weight. And as I tried to describe a minute ago,

there's a three-phase process. That's the first spot. And if that looks like that is sufficient and has things in there, then, you know, our medical SMEs don't have to go a lot further, but are willing to go further if in fact it doesn't look like that quite gives us what we need. And again, the going further is looking further through the medical record ourself, is looking at previous claims for a pattern, is calling the individual.

MR. ORRIS: So one of the concerns about what's happened with that is a lot of your, you know, physicians are not very familiar with Camp Lejeune and with what the illnesses are and whether they were caused by those illnesses, and so what happens if a physician states that they don't think that that's the case, even though it's a covered condition? What kind of weight does that bear in the SME process?

DR. ERICKSON: Okay. That's a good question, because you're right, there's a whole universe of treating physicians and this is a little sector, et cetera, that may not be up-to-date on Camp Lejeune and such. I will tell you for sure the medical SMEs, the three that I mentioned, they are up on it, and they realize that not all their colleagues will

be fully schooled, and so that's the reason for those additional steps that I mentioned. If it looks like the TPR has been fumbled or, you know -- and if you think about it, I think most -- even though those physicians that are in the field, that are civilian physicians, may not be working with veterans and Camp Lejeune families, et cetera, most of them want the best for the patients they're treating, you know, and so work with them, you know, especially those of you that are members of the CAP. You'll know more than they do, and you'll be in a good position. But for that matter, for the public, you know, we have information on the websites. There's other ways to access information. Feel free to share that with your treating physician so as to bring them up to speed.

MR. ORRIS: And would you still accept the claims if the treating physician report would not indicate one way or the other what their opinion was based on that?

DR. ERICKSON: Right. So again, if the treating physician report doesn't really take a stand or it's a little wishy-washy or it's, you know, has some gaps, again, our folks will go in the medical record ourselves. We will look for the

diagnostics. We will look for those procedures. We will look for the diagnoses, ICD codes, et cetera -- in this case, yes, ICD codes -- we will -- and again, beyond that we'll look at the claims history. We'll look at other evidence. And if it's still not there we will make the phone call.

MR. WHITE: And Dr. Erickson, if I can add to that. So when somebody applies for the program, and they're approved for a particular condition of the 15, anything associated with that condition or with the treatment of that condition, once that's documented, we also cover the treatment for that.

So the reason why it's important for cancer treatment that we distinguish between active phase of cancer and something that's in remission is, again, we cover what Dr. Erickson refers to as the whole body. So anything that comes in during that active phase of cancer, as long as it's not, you know, prohibitive, we will cover that care.

And then to help the family members, we automatically grant a six-month extension of coverage. And if we see we're continuing to get medical bills for whatever that treatment is for, we basically extend it another six months, so the family members don't have to jump through a lot of

hoops just to fill in another form.

But at a certain period of time we do have to confirm that, yes, they are still continuing to get active treatment.

MR. ORRIS: And just a quick follow-up, would that also including cancer screening in the future indefinitely?

MR. WHITE: Once that active phase of cancer is done, anything associated specifically with that cancer or with one of the associated conditions, we will cover that.

DR. ERICKSON: Right. In particular we reference the U.S. preventive medicine task force, which makes recommendations for diagnostics for screening. And that's a document that is living, that continues to be updated by HHS, I think, Health and Human Services? Yeah. For the sake of making sure that it stays current for, you know, those diagnostics.

MR. WHITE: But let me make sure I understand your question. So for screening, until somebody gets the illness we actually can't cover that screening. But once they get it -- like let's say you screen for breast cancer or whatever, we will pay for that screen visit but we can't pay for, you

know, if you had screening visits for five years before you were diagnosed.

MR. ORRIS: So after you're diagnosed, let’s say you go into remission, you'll continue to pay for the screening.

DR. ERICKSON: Absolutely.

MR. ORRIS: Okay.

MS. CORAZZA: So where are those captured? They're not in the clinical guidelines that are in the process now, so when are those going to be put into more available?

DR. ERICKSON: Well, you've not seen a copy of the --

MS. CORAZZA: Well, I have.

DR. ERICKSON: Oh, you're going to tell me you have a copy.

MS. CORAZZA: Well, I saw a copy several months ago, but then we brought it up at the last CAP meeting that there were not a lot of diagnostic tests indicated or like what the clinical guidelines would be for getting to some of these answers.

DR. ERICKSON: Again, I don't know what version of the draft this has gone through, you know, staffing at VA you would've seen. It certainly would not have been deemed a product that would've

been accessible by FOIA because it is a working document. You know, I mean, Danielle, I know you have friends and spies.

MS. CORAZZA: No, no, no. My question is just what -- is there a plan to get those captured?

DR. ERICKSON: Right, right. So again --

MS. CORAZZA: This is the first I've heard that it was.

DR. ERICKSON: -- when I say it doesn't list all the -- you know, the document would be defeated if we tried to have a very specific list of the diagnostic screening tests. And that's why we referenced the U.S. preventive medicine task force, because that list is published and is updated periodically. If we put our list into the document, within a year or two, you know, people -- I mean, maybe you guys, members on the CAP would be bringing that to our attention that it wasn't up-to-date. We're sticking with a recognized authoritative source for screening. We think it's just the best document.

MR. TEMPLETON: I just wanted to make one brief point about, you know, I'm hearing the whole-body approach and what we're doing, but I'm seeing a little bit of a difference than what I'm hearing.

I'm hearing this but I'm seeing something different, and primarily in the SME comments that I see is saying that it didn't happen during service. They didn't complain about it in the period directly after service. And that comment is almost throughout every one of the denials that I see. And that seems to kind of contradict the whole-body approach in that they're not recognizing that it could be a latent illness.

MS. FRESHWATER: And didn't we address this already, Tim? Am I wrong that we addressed this and asked that that not be included, or that it be clarified, that they did not have to have the symptoms while serving?

DR. ERICKSON: Okay, so just to make sure, are we still talking about the 2012 healthcare law or now we've moved over to disability? Because that's -- someone else is going to talk about that in a minute. That's a different set of SMEs, different set of rules. I'm more than happy to have Brad Flohr answer those questions.

MR. FLOHR: I think you took up all my time.

DR. ERICKSON: That is -- yeah. Just very quickly, if within the 2012 healthcare program, based upon the Janey Ensminger Act legislation, you

think there's a disconnect, contact Brady or myself, and we can look at specific cases.

All right, so Brad, why don't you take over, 'cause they want to hear about presumptions, Buddy. And I'll help you too, if you need help.

MR. HODORE: Well, Dr. Erickson, I have one last question for you. Under the 15 conditions, the health effects conditions, what is covered under neural behavior defects?

DR. ERICKSON: So this is something that we asked the Institute of Medicine, now called the National Academy of Medicine, to help us understand, and they provided input to that end, as to what questions fall under that. If you've read it, and I'm not going to be exhaustive in my answer, but one of the things was they said you should include Parkinson's disease as a neural behavioral effect.

Now, just very quickly, it's not an effect. We know it's a disease with very specific symptoms. It's named. It has an ICD code. But their recommendation was that we include it. I can't show you the updated document. I mean, sounds like Danielle may have it. She may have a more updated version than I have. But we have clarification that's coming on that. You just have to wait for

that; I'm sorry. Okay, Brad.

MR. FLOHR: Okay. This is Brad Flohr. Briefly, just to recap, what had happened was that in December of last year Secretary McDonald went to meet with Senators Burr and Tillis and Isakson, and I was there, and Dr. Breysse was there as well.

MR. ENSMINGER: That was July.

MR. FLOHR: No, that was December last year, Jerry. And he announced that he wanted to have maybe three presumptions. And we went back and we started a press release, and subsequently the list increased after Dr. Breysse and his staff worked to provide us with some relevant information about potential exposures.

I got to tell you we drafted a regulation about as quickly as has ever been drafted in the VA, and gotten through VA, through all of our attorneys, all the various levels, VHA, VBA, and was approved from the secretary's office, and then went to OMB. And that's where it still is. And we've met with OMB on several occasions in-person, who most recently last Tuesday. They had concerns, questions, and we're trying to address them. And you know, we want to do things a little bit differently than they do. Like we'd like to have an interim final rule be

published, like the C-123 reservists rule was, which would allow us to pay compensation the day it's published, and then address comments afterwards. OMB does not want to do that. They believe basically an interim final rule they will approve when there's not a lot of potential for lots of comments, both negative and positive. And we're still working on that. I don't know if we'll be successful. That remains to be seen, but it is in the works. And they are working with us. They've provided us with some language we can put into our reg. which might make it easier for them to approve and easier for the public to understand. And so we're doing that now. We're rewriting our reg., just making little -- just inserting some language they gave us. It's not really rewriting it. And that will be going back to them soon.

The Secretary, accompanied by Dr. Erickson, as the director of OMB, at least once, if not twice, where the Secretary expressed his concerns and his willingness to go over OMB, if necessary. He is dedicated to getting this done, as are we. Doing all we can and working very hard on this.

DR. BREYSSE: And if I can just add an amendment to that. So OMB reached out to us

yesterday, and we have a call with them tomorrow to talk about it. I'm not sure what they want to ask us but we'll sort that out. And we also recognize that getting our document, which we provided, if you remember, on relatively short notice at the request of the Secretary, peer reviewed out in public, and we understand that's a crucial component of getting this through the process of OMB.

MR. ENSMINGER: And the director of OMB is the one that's digging his heels in on that?

MR. FLOHR: Not so much the director.

MR. ENSMINGER: All right, who is it, then? I mean, I want to know.

DR. ERICKSON: So I've been to the White House twice on this and part of very, very intimate phone calls with that office. You know, there is process within the federal government that is sometimes is slow. I will say that in this case this particular action has the attention of the Secretary of Veterans' Affairs, Mr. Bob McDonald, and has the attention of Mr. Shaun Donovan, who is director, OMB. And they have spoken directly, extendedly, on this issue with the goal of finding a way to get the rule on the street. And so it's, just say, we're at the point right now it's not a matter of yes or no.

I think that this is probably important to add. It's not a matter of yes or no. It's putting on the street the best written rule so that it will hold up, it will quickly go through public comment and go into effect. And so it's become a team effort that now involves -- I mean, this is pretty cool, it involves two Cabinet-level officials. It's not stuff with muckety-muck staffers like me, okay? It's two Cabinet-level officials. They are now taking this thing through its final paces.

MR. ENSMINGER: But, you know, Dr. Erickson and Brad, these people need to understand that we have veterans out there that, thank God, they are getting treatment, okay? But they're healthy but homeless now because they can't work with a debilitating disease. They can't make their damn house payments. They can't buy food. They can't support their damn families. And here we are playing damn games with OMB. Now, something's got to give.

MR. FLOHR: Jerry, we've made that point to OMB as late as just this last Tuesday.

MR. ENSMINGER: And I'm not blaming you guys. I'm not --

MR. FLOHR: We are making this point. We are trying to get it to them, but understand, the people

are in need. I said if you wait another year to get this done more people are going to end up being terminally ill and dying.

MR. ENSMINGER: Yeah.

MR. FLOHR: I made that point.

MR. ENSMINGER: Well, not only -- maybe not dying, 'cause they're getting treatment, but they're living in their Buick.

MR. FLOHR: Well, people will -- you know.

MS. FRESHWATER: No, they'll die waiting, and they'll die not knowing their families are going to be taken care of.

MR. FLOHR: Right. And that -- we brought that up to them, trying to impress that that -- this is an important thing they need to get back.

DR. ERICKSON: We brought a lot of information from the CAP, from ATSDR, from other sources to bear in building what we think is a very strong case. And the indications are that we're going to get this rule. Again, it's that final -- exactly how does the rule read, because you know, we've got other cooks in the kitchen at this point, and they have expertise as it relates to writing rules and regulations, and it's -- so the science piece, I'll tell you, is looking really good, but it sounds like

Dr. Breysse's going to hit a homerun here with his phone call that they're going to have.

MR. ENSMINGER: But, you know, I know who Shaun Donovan is, and I know he's the director of OMB, but who else over there is digging their heels out? And no, it's not Mr. Donovan, okay? There's somebody -- his underlings. Who are they?

DR. ERICKSON: Yeah, I don't think it's an issue of people digging their heels in. They have very specific jobs that involve reviewing all --

MR. ENSMINGER: Why don't you want to tell me who these people are? I'll find out.

DR. ERICKSON: Okay, okay. I just -- you know, it's -- I guess I would rather you be left with some encouragement from what Brad has just conveyed rather than, you know, putting the war paint on, because we --

MS. FRESHWATER: But we have to go back to the community --

DR. ERICKSON: -- really are -- we are --

MS. FRESHWATER: -- with, with -- they're not -- they are tired of hearing our encouragement. I mean, we don't have war paint on. We have to go back and represent a community that is in deep, deep pain, and they don't understand what we're all doing

here.

DR. ERICKSON: I understand.

MR. PARTAIN: And Dr. Erickson, one thing to tag onto this. I know I've brought this up before, and I know the answer that Brad has provided concerning the commencement of the date. There are several, you know -- I don't know the number, but there are many veterans out there that are in a situation where they've had a claim put in, sometimes for years, for the conditions that are going to be covered. I'll give an example specifically. Last year Don Murphy died in July of 2015 of kidney cancer, okay? His claim was denied, denied, denied, and it's currently on a hold until the regulations are finalized. His widow is trying to make ends meet, get through life, what have you, and stuff like that, but my understanding is that once the regs are approved and everything begins, everything begins at that day and point in time, that there's nothing retroactively awarded. Has that been discussed? Has that been addressed as far as these veterans that have been in a holding pattern now?

MR. FLOHR: I'm sorry, Mike, what was your question again now?

MR. PARTAIN: Okay, we've discussed this before. Veterans that have a claim for these nine conditions that have been in the hopper, sometimes for years now, Don Murphy, I think he's been 2012-2013. He's since passed away.

MR. FLOHR: Yeah.

MR. PARTAIN: Now, the question is, once the regulations are implemented and they begin the presumptive service connection, has there been discussion to grant that retroactively back to the veteran from the date they filed the claim? 'Cause I know in the past you have said that the award would only begin the date that the regulations are in the Federal Registry.

MR. FLOHR: Actually by federal law the regulations will only be effective 30 days after they're posted -- published.

MR. PARTAIN: So there's no retroactive?

MR. FLOHR: There's no retroactive.

MR. UNTERBERG: And Brad, it sounds like -- I mean, you guys are butting heads with the OMB, and that's what it sounds like.

MR. FLOHR: Little bit.

MR. UNTERBERG: And so, I mean, when you said your attorneys would not let you use those

presumptions, you know, in helping make your decision, I mean, we make analysis all the times, kind of a risk-based analysis. If you can't get the OMB to move, maybe the VA just takes a little bit of risk on their interpretation, or takes a more aggressive interpretation, and you press your lawyers to find a solution instead of saying no.

MR. FLOHR: That was part of my idea, and it got through certain number of layers of concurrence until it got stopped at one point. We have about 920 claims that are staid right now for one of the presumptive conditions that will be presumptive. Louisville wants to work them. We want them to work them. We want to grant these claims right now. And that was my idea and what I'm trying to do. But I can only go so far as where people I report to just say no, we can't do this.

MR. UNTERBERG: What is the risk to the VA?

MR. FLOHR: Well, the risk is that it's contrary to law and statutes, per our attorneys.

MR. UNTERBERG: And that risk results in what?

MR. FLOHR: That results in improper payment of benefits.

MR. UNTERBERG: But if you’re ultimately going to approve this, then the damage would be pretty

much you wouldn't have damages because you would've paid --

MR. FLOHR: Craig, I can't talk to you anymore about this than what I just told you.

MR. UNTERBERG: Yeah. I would love to talk to your attorneys, but then I'm going to get like an answer from Melissa, that you can't give the names of the attorneys.

MR. FLOHR: No.

MR. UNTERBERG: It seems like maybe we can help you guys come up with creative ideas, and that's what we do in the private sector, and working together with the public sector could we help find a creative solution?

MR. FLOHR: If you have a creative idea you can send it to me but I don't think we have any more creative than what I come up with.

DR. BREYSSE: Okay. So is there anymore on the update?

MS. FRESHWATER: I would like to know what we can do, just before we leave this, what can we do, then, to help, if we can't get the attorneys' names and we can't get the names of the people that are holding it up, what can we do as a community to put pressure? Politically, is there anything we can do?

MR. PARTAIN: And Brad, can we have the name of the person who shot down your idea?

MR. FLOHR: That's --

MR. PARTAIN: I mean, roadblocks can be overcome.

MR. FLOHR: Yeah. No. He's not even -- no longer in our organization at the moment.

MR. PARTAIN: Then refloat the idea.

MR. FLOHR: I have, Mike, but still...

MR. HODORE: Mr. Flohr, I was told on yesterday by Congressman David Scott that in Louisville has been overwhelmed by claims, and they've brokered those claims back out to the regional office. They're no longer in Louisville. Is that a true statement?

MR. FLOHR: I am not aware of that.

MR. HODORE: Well, I was just told by David Scott, Congressman David Scott office on yesterday. That's what response to him was.

MR. FLOHR: Again, I have not heard of that. You know, we have a new -- you know, right now we're a hundred percent fully electronic in claims processing. Something I never thought I'd see in my lifetime, let alone in my career. All of our work is done electronically, and we have established what

we call a national work queue, which allows us, when one office becomes overburdened with claims and another office may have some ability to take on some more work, we can electronically send claims to those other offices. We don't have to send claims files anymore, mail them out to them. We send them an email; we send it electronically. We give them a claim number, they go into our systems, and they would process the claims. And that's going to be a big benefit down the road, but I believe -- I'm pretty sure that Camp Lejeune claims were excluded from that, the same as radiation claims were excluded; they're done in Jackson, Mississippi. I will check on that but I have not heard that. I would be surprised.

DR. BREYSSE: Okay, so we're right at the lunch break. Is there any other VA updates we need to touch on? Okay. So why don't we take a break 'til one o'clock, and we'll come back at one o'clock and continue.

MR. PARTAIN: Dr. Breysse, one thing, when we do come back, since we have the -- I do want to spend some time talking about the SME reviews and programs.

DR. BREYSSE: Well, if you want to do that why

don't we do that now then before we break?

MR. PARTAIN: Well, after we break.

[Lunch break, 12:00 till 1:00 p.m.]

DR. BREYSSE: Okay, we'd like to spend a few minutes before we go on to the public health assessment updates, just to wrap up the VA discussions a little bit. And there will be some questions about the SME process once we get our CAP members in here. So Kevin, before we get started, everybody introduced themselves this morning. Do you want to introduce yourself?

DR. CANTOR: Yeah, this is Ken Cantor on the telephone.

MR. WILKINS: This is Kevin Wilkins, CAP member.

DR. BREYSSE: All right, so well, why don't we reconvene, and we're going to wrap up the discussion on the VA updates. There are some questions about the SME process for deciding compensation. So Mike, would you like...

MR. PARTAIN: Well, I know we deferred some of it to the discussion with -- what's your name again? I'm sorry.

DR. DINESMAN: Dr. Dinesman.

MR. PARTAIN: Dr. Dinesman. But going back to

the point where I was talking this morning, what would it take to get the references used to make a decision at an SME review printed in the denial for the veteran?

DR. DINESMAN: Thank you for the question. Let me give a little background, I think, that will answer that real quickly. And that is that you've got to remember that, if this was a clear-cut, black-and-white issue none of us would be here, so it is a very complicated process. We know that we're looking at occupational studies, environmental, you know, and try to correlate them. As Dr. Blossom said, you know, there's no biomarkers, there's variability in humans, there's dose dependencies. You know, we can say that, while you had a toxicant in one location, it was at, you know, this dose or that dose. We have people that can be exposed to a carcinogen and not know, a cancer. We can have people who develop cancers who were not exposed to known carcinogens. And so it gets very complicated, as we all know.

What the SMEs do is look at the information that is out there, and they don't answer the yes-or-no question. That is the rater, all right. So as I'll go back and state, it's up to the rater

to make that yes-or-no decision of whether it is considered service-corrected or not.

The SME is posting answer, and there are rules. We know that the VA is a rule-based program, or process; there are rules. And what the clinician is supposed to answer is a statistical answer. It's not a yes-no. And the statistical answer is whether or not, in this case, you can state that it's at least a 50/50 probability or ^.

Now, if you think about it logically, let's say that we have two -- three cancers from Camp Lejeune, and two of them we know occurred, you know, because, you know, everybody in their family's had this, whatever. And so we now have this one additional cancer. We can go back and argue back and forth, go look at this article, go look at this article, it says this and said this, but statistically speaking now, we've got an issue that says that only one out of three chance of this actually being related to Camp Lejeune, so it is less likely than not. Now, notice I did not say it is not due to, all right? I would be wrong in saying that. But statistically speaking, all right, we are saying that here is where this falls statistically.

Now, to go directly to your answer, sir, on a

single piece of information, I think Brad Flohr answered this very, very nicely, and I don't think he realized he answered it, all right? And that is, if you heard, he said that there was a case, at least one case that he knew of, where there was a well-defined and well-argued opinion by a specialist that gave some information, and the rater said yes, all right? So you've got to keep in mind that it's not a matter whether you tell the expert what they should say. I think it's wrong to tell an expert what opinion they should give when it's their opinion. I think that's -- there's some legal terms for it, of coercing the -- et cetera. But what should happen is, if you believe, and understandably so, that that is incorrect information, then that should be also submitted as part of the claim, so that when the adjudicator -- again, this is the judge and jury -- when they look at it they will have the information that says, here is why we think this is incorrect. Here is a presentation from our standpoint of why it is so, and they can look at the opposite. Because I've honestly seen cases, and not Camp Lejeune cases but others, where the clinician said no, as far as their opinion, and VBA granted. And so it's not the clinician necessarily that's

making the decision. They're providing VBA, the rater, with information that either supports or denies a claim.

DR. BREYSSE: Thank you very much for that background. Mike, I want to make sure I understand your question. So you want to know if, when a letter gets written denying a claim, that the literature basis for that denial, you want to know, can that be put in the letter? Is that what that --

MR. PARTAIN: That's what should be put in the letter.

DR. BREYSSE: And right now the letters will say the claim's denied because we don't think it's --

MR. PARTAIN: Well, the verbiage is *least likely than not*.

DR. BREYSSE: Okay.

MR. PARTAIN: And what's missing -- you know, they'll reference the NRC report time and time again in these denials, and even in the good doctor's -- I'm sorry, I cannot get your name.

DR. DINESMAN: That's all right.

MR. PARTAIN: But, you know, he's discussing dose-related exposures. I mean, is the VA's position that, if you're exposed under a certain

level that there's no chance of cancer? And when I hear dose-related, that's going back to the NRC report again, because that -- they just -- they went all into that. And when you discuss these reports in these reviews, there have been, since the NRC report, and in these denials that we've looked at, there is no discussion about the EPA's classification of TCE as a human carcinogen due to kidney cancer, there's no discussion about IARC, there's no discussion about the IOM report that was written for the VA, specifically for Camp Lejeune, in which they discuss kidney diseases and that veterans should be given the benefit of the doubt. And we were seeing -- now, granted we're not seeing the denials because they're on hold, but up until they were placed on a hold last year, late last year, we were consistently seeing these denials and this literature not reviewed.

MR. TEMPLETON: Let me add, just real quick, a little nugget to that is that typically when a veteran receives a denial it does not have the VA notes in it that came from the SME. It doesn't -- and in those VA notes is where it usually contains the references that the SME used to come up with their opinion. So I guess the question is, why

couldn't that be added to the denial letter?

DR. DINESMAN: That, you'll have to ask the VBA folks. We supply it to them, and they've got it after that. But I would like to kind of add just one thing to this. Science and medicine is a constant change. Let's look at eggs, low-fat diet. You know, we saw for many, many years people said be on a low-fat diet; it's heart-healthy, all right? And if you would've come out and said, I want you to sit down and eat the -- you know, a pound of bacon and some lard and some other good stuff, you'd say, you're trying to kill me, all right? But now we have people saying, well, you know, the research is showing that the low-fat diet's probably the worst thing you can do. And so we can turn around and say, well, you know, based on science now, maybe the people that said good things about the low-fat diet are trying to kill me.

MS. FRESHWATER: What is your point?

DR. DINESMAN: The point is science changes.

MS. FRESHWATER: All right, we all know that.

DR. DINESMAN: And so, and so -- so we can -- you can argue whether the science is appropriate or not. If it is backed up by the literature you can use that as your evidence. So if you disagree with

that -- just like in a court case --

DR. BREYSSE: Just to kind of close this --

DR. DINESMAN: Yeah.

DR. BREYSSE: -- I think that what we're hearing, though, is that exactly what you said is not happening. The letters appear to be relying on old science, not on more recent science. So for example those IARC classifications, that are not. There's the NRC report, that predated that, is being cited. So in fact I think it's -- what I'm hearing is this concern that you're not keeping up with the science.

MR. ENSMINGER: And let me make one more point. I have a person sitting right over here, Norm Maclane, who was denied. Last January his decision was made -- dated, for kidney cancer. His initial denial read that -- written by the SME, that they had conducted a thorough evaluation of all the meta-analysis that had been done for the last two decades, and they could find no evidence that TCE causes any kind of cancer. When I saw that I said, what? This is a subject matter expert? Now, wait a minute. When I went to my senator with that denial, and they went back to the VA, the VA reissued him another denial with all that stupid language taken

out of it.

MR. PARTAIN: And while we appreciate your --

MR. ENSMINGER: I mean, wait, wait, wait, wait, wait, wait, wait. I'm not done yet. Whenever you have somebody that writes, for lack of a better term, bullshit like that, and you don't take any steps to correct it, then why would you even sit here and wonder why we doubt what you tell us? I mean, I'm serious.

DR. DINESMAN: Yeah, let me, let me answer that for you, and I think that -- so again, I think you're confusing the issue of a expert opinion and denial, okay? Again --

MS. FRESHWATER: How many of the denials went against the SME? How many times has an SME said, you know, deny this, and the final decision was no, we're going to grant it. I've asked that every time, and I can never get an answer.

MR. ENSMINGER: How many times has an SME been overruled?

DR. DINESMAN: I can't answer that question, but --

MS. FRESHWATER: Who can? Because nobody ever in this room can.

DR. DINESMAN: Well, and we just do -- let me

just answer it, because I think it's important. And that is that, again, if you think about this is a legal process, and you have somebody that is the judge and jury; this is the adjudicator. And then you have the expert. You can have more than one expert. You're not -- if you're in a court you're going to have two experts, and they're going to be arguing against each other, and you can't say which one is right and which one is wrong, because they're their own opinions. And they're going to base their opinions on the information that they feel is appropriate. So --

MR. ENSMINGER: But what my point is --

DR. DINESMAN: Wait, wait, wait.

MR. ENSMINGER: No, my point is, when you've got proof.

DR. DINESMAN: You've got proof.

MR. ENSMINGER: No. He wrote the denial. He wrote that language in that denial.

DR. DINESMAN: No. He wrote an opinion. He didn't write the denial.

MR. ENSMINGER: All right, well, when you got somebody that writes an opinion -- for God's sake, the EPA reclassified TCE in September of 2012 to a known carcinogen. IARC followed suit the following

year. The NTP followed suit. This person wrote that decision in January of 2015.

DR. DINESMAN: The trick is is not to say whether this is a carcinogen.

MR. ENSMINGER: But he's an expert. I'm asking you.

DR. DINESMAN: Well, but here's the thing --

MR. ENSMINGER: I mean, one of my Marines ever did something to embarrass me like that, they would never do it again because they wouldn't have been there.

DR. DINESMAN: The difference here is you're not saying yes or no. Again, the expert is saying statistically. And so we're not saying yes or no. And if you have a better argument, then supply it.

MS. FRESHWATER: So, so you expect a veteran to blindly challenge. You want to go in court, well give us discovery. Let us have the SME's name and everything that they used to make their case. Because what you're asking a veteran to do, who is sick and not very well financed, is to be able to challenge your secret SME, who we don't know how qualified they are --

MR. ENSMINGER: Who are even challenging their own --

MS. FRESHWATER: -- and they're supposed to go supply their own to challenge this. And then you're so flippant, and you're talking to us as if like we're five, ten years ago, like you -- have you been following the CAP at all? Like I mean, this is really, really upsetting because, I mean --

MR. FLOHR: Excuse me, as Dr. Breysse mentioned a little bit ago -- let me ask you a question first. Your issue is you want the SME opinion to be a part of the noticed decision for the veteran.

MR. PARTAIN: My issue is I want transparency, Brad.

MR. FLOHR: Is that what you want, the SME opinion to be part of the decision, but --

MR. PARTAIN: Yes.

MR. FLOHR: If they're not getting it now, how are you getting it when you bring it in to these meetings?

MR. PARTAIN: We're getting snippets that are being put in there, in these denials, that people come to us, and they're snippets. They're not complete decisions, okay, but we are getting in there where they're referencing the NRC report, like I read this morning.

MR. FLOHR: Okay, well --

MR. PARTAIN: And we've been bringing this up for --

MR. FLOHR: -- well, --

MR. PARTAIN: -- the past two years.

MR. FLOHR: -- and we'll talk about it, and we'll see if we can do that.

MR. PARTAIN: Okay. Well, and to finalize this, I mean, and the good doctor here, and I apologize for not getting your name down.

MR. FLOHR: Dinesman.

MR. PARTAIN: I've got to write it down. But I appreciate you being here, okay, and I hope you're here in the future, because a lot of what you're talking about has been discussed. Science is a body of evidence that grows and changes. Part of the problem we're having with the VA is that the decisions that your people are making don't reflect the current body of science.

Now, the other thing too is, understand, and we were talking about the legal aspect of this, part of Dr. Walters' slide show that we got that last year said that the purpose of the SME is to create a legally defensible decision. The veterans do not have the legal resources to go and hire an independent expert of their own.

MS. FRESHWATER: Right.

MR. PARTAIN: There is one claim that I am work -- been working on where a veteran with bladder cancer went and paid an SME on his own, and was still denied, even though the SME -- their SME had the proof. I've seen SMEs challenge treating doctors, oncologists, and these SMEs are not Board-certified in their areas, and they're writing back to the oncologist that wrote that their cancer was connected to Camp Lejeune, saying, prove it. How is that fair? I mean, yeah, if you're going to go to court -- and I understand the role of experts 'cause I use them when I'm defending cases -- but when you go to a court it's heard by a jury. These VA claims are not heard by a jury. If you've got an expert from the VA saying this is not, yeah, of course the decision-writing officer is going to say, oh, I agree with you, and deny that part of the claim. But the VA -- to equalize the battlefield, and the playing field, I should say, I mean, you have the VA creating this program where they're writing these -- or asking these independent medical experts, IMEs, or whatever you want to call them, to provide an opinion. But the veteran has no, no recourse, or very little recourse, other than hiring

their own IME. And if you're going to use them, be transparent. Put these decisions in writing, how they got to them, the literature that they got to. That's what I'm asking for, because at least the veteran can look at the literature, and say, oh, well, you forgot about the 2011 EPA TCE regulation.

DR. BREYSSE: I mean, that's something you guys can consider.

DR. DINESMAN: And if I could just real quickly say, I think you brought up some very good points. Number one, understand that the clinicians that are doing these subject matter expert opinions, by nature, as a clinician, it's in your mindset to try to help the patient, or the person. We can argue that --

MR. ENSMINGER: You can sit there and blow all that smoke you want. You can't prove that to me.

DR. DINESMAN: Okay. And, and so by nature, though, when somebody gets a negative -- an opinion they don't like, they're obviously going to have --

MR. ENSMINGER: No, I've seen too many of them.

DR. DINESMAN: So, we don't have -- we don't --

MS. FRESHWATER: So can you get me -- are you the person who can get me the amount of times that an SME recommends that, if there is a denial, or

however you want -- your language, and the person who makes the decision goes against what the SME says. I would like to know how often that happens. And I've asked at every meeting, and no one has ever told me.

MR. FLOHR: We don't have --

DR. DINESMAN: What I think would be more important --

MS. FRESHWATER: Somebody's got to have that.

MR. FLOHR: We don't have that.

MS. FRESHWATER: Who?

AUDIENCE MEMBER: You should have it. Everything's --

MR. FLOHR: If somebody wanted to go through 16,000 decisions that have been made, you can look at that but I don't know who's going to --

MS. FRESHWATER: But I'm asking for one. Find me one.

MR. FLOHR: I just told you one.

MR. PARTAIN: Well, but the one this morning -- that's not a --

DR. DINESMAN: It's not a systematic assessment. They're anecdotally -- it's probably not.

MR. PARTAIN: The one that was provided this

morning is hearsay. I mean, there was nothing written on paper.

MR. FLOHR: But we can go over this claims process forever. The SMEs do not make decisions on claims; that's the adjudicator in Louisville.

MR. PARTAIN: We understand that.

MR. FLOHR: They review all the evidence. There has to be some positive evidence before we'll even request a medical opinion unless it's for one of the nine presumptions that we have --

MR. PARTAIN: And for two years, Brad, we have brought up case after case after case where it is blatantly apparent --

MR. FLOHR: The adjudicator reviews all the evidence, both positive and negative, decides the value of the evidence, the weight of the evidence, the legal-type process for evaluating evidence, they make the decision.

MS. FRESHWATER: So how -- what -- and can you explain to me how the benefit of the doubt is given to the veteran?

MR. FLOHR: Any time the -- when the adjudicator reviews the evidence and decides it's equal, the benefit of the doubt gets given to the, to the veteran.

MR. ORRIS: I'm having a hard time understanding here. We listened to Dr. Erickson and Mr. White talk about this wonderful family member SME program that's run through for the physicians. Why is there such a glaring difference between the SME program for family members, which evidently is designed to help the family member, and what we're seeing on the VBA side?

MR. FLOHR: There's no difference. It's part of the claims process. It's -- look, in order to get service connection there has to be something happened in service, either disability, an injury, a disease or an exposure, in this case. There has to be a current disability, and there has to be a medical nexus between the current disability and what happened in service. So when you're talking about environmental exposures, there is no clear-cut in most cases. You're relying on evidence review, scientific evidence, and their opinion.

MR. ORRIS: So why the difference between family members and veterans?

MR. FLOHR: It's just Congress enacted law providing healthcare for veterans, for healthcare. They have passed no such law for benefits.

MR. TEMPLETON: Can I just -- my question has

to go to the process is helping the veteran, like what we're talking about -- and Brad, feel free to chime in -- then why is the VBA remand rate on Camp Lejeune claims at one for every two? Fifty percent, that means that the court, or whoever is adjudicating this beyond VBA, is saying something's wrong here. It's saying that it's not working in 50 percent of the cases. That's a failure. That's a huge failure.

MR. FLOHR: I can't talk about that, but I can tell you that the VBA remands a whole lot of cases.

DR. DINESMAN: Let me put a -- let me make a positive comment, because really there is a positive side to this, and I think we're focusing on the negative, all right? And that is, you know, if you look at it, and you say, you know, here we have a case that's denied; why was it denied? The fact that it's denied doesn't mean that it was wrong, and where we really have difficulties here is in proving, as I said, that a given person, there's no biomarkers, there's no other things, that you can say just one person is actually, you know, the one who got -- you know, had this as a result of their Camp Lejeune exposure. So you can't really say one hundred percent on either side, but that's the

beauty of what we're doing here with the -- and what has been done with the presumptives, is we're removing that burden by a policy decision. So what we're saying is we understand -- we, the VA, understand that this is confusing. We understand that you can take a stance on either side, all right, and we can sit and argue it 'til, you know, 'til whenever. But the policy on the other hand is what's important, and the policy's saying we do understand this is an issue and this is how we're going to take care of it, and make sure that we give the veterans the care that they deserve.

MR. ENSMINGER: When the VA -- when the VA first started coming to our CAP meetings, Brad, you sat down and gave a lengthy explanation of the claims process. That explanation had nothing about any subject matter experts. Why were they created?

MR. FLOHR: After we started processing claims in Louisville from Camp Lejeune, we had a group of individuals from VHA and VBA that went there to review the decisions being made, to ensure that there was consistency in the decision-making, and it was noted by the people who went to do the review that there was no consistency. Therefore it was decided to create a group of occupational

environmental health specialists to be subject matter experts to provide good opinions. That was not --

DR. BREYSSE: This is all stuff we've been through before, and I'm not sure we're breaking any new ground here today, but Dr. Dinesman, I think it's great that you're here, and get to listen to the CAP members express their concerns about the transparency of the process. And I think that's something that maybe we look forward to you going back and thinking about how to improve it for the sake of the Marines.

MS. FRESHWATER: I just have one more very quick and specific question, I promise. What is your opinion on the SME being listed on each veteran's paperwork, so that they know who the SME is?

DR. DINESMAN: The same as the rater listing their names on -- I'm just not sure what value that would add. You know, this is -- we're not looking for character assassination. You can look at --

MS. FRESHWATER: Stop acting as though we don't know. We're not looking to character assassinate anybody; we're looking to --

MR. ENSMINGER: Vet them, to see what their

credentials are.

MR. PARTAIN: And speaking of which, I missed that --

MS. FRESHWATER: If they're such experts, if you are so confident in them, why don't you let them have them?

MR. TEMPLETON: They're required that you list them to people --

MR. ENSMINGER: Where else --

MR. TEMPLETON: -- and so that their credentials can be reviewed. It's required. It's by law.

DR. DINESMAN: So the law also states -- and this is a very interesting topic and is discussed in other realms besides the Camp Lejeune site, and I believe this issue is right now even being discussed in the federal circuit. But what we see is the rules that have been in place is that the VA, in vetting this person and doing their credentials, gives them that assurance that this person is credentialed and appropriate.

Now, we -- I'm not here to argue whether that's right or wrong. That's getting argued right now before the court system, and so that is an important component. Now, one other thing to remember,

though, is subject matter expert is not necessarily something that means somebody who is Board-certified in X or has a certain practice type, or whatever. If we were looking at somebody that you wanted all opinions to come from Board-certified, let's say occupational medicine clinicians, then that would be a different story. That -- you would be setting it.

I will tell you that the opinions that y'all have been seeing so far, the far, far majority, are oc-med. Now, that said, you have to understand that 80 percent of oc-med components are taken care of by primary care, out in the private sector. There's a shortage of oc-med folks.

MS. FRESHWATER: We don't want oc-med. I'm not sure where you're getting that idea.

DR. DINESMAN: Well, again, so when we start talking subject matter expert, then how do you define that?

MS. FRESHWATER: Well, that's what we want to know: How do you define it?

DR. DINESMAN: Well, so I can tell you how we define it. We have folks that have either occupational medicine or environmental medicine training. They have experience in the occupational medicine side, or they've gone through course work,

and lord knows there's enough information out there for you to read and become familiar with the literature and the understanding, and they go through that course work and get appropriate training. And then on top of that there are monthly meetings, where we sit and discuss amongst those SMEs, new conditions, new literature, new information that is out there. Difficult cases, how -- you know, I can't find this in the literature. How do you -- you know, how would you look at this? Tell me where I can find information to --

DR. BREYSSE: All right, Lori, I think we need to move on.

MS. FRESHWATER: Okay.

DR. BREYSSE: Thank you, Dr. Dinesman.

DR. DINESMAN: Thank you.

DR. BREYSSE: So I'd like to now turn the floor over to Rick Gillig who's going to give us an update on the public health assessments.

UPDATES ON PUBLIC HEALTH ASSESSMENTS

MR. GILLIG: Thank you. I've got two projects to update you on today, the drinking water public health assessment, as you know that was released for

public comment back in May. The comment period closed in July. We're in the process -- we've consolidated all the comments. We're in the process of making changes to the document and addressing those public comments. We expect to release the document, the final version of that health assessment, in December of this year. Any questions on that document?

If not, I'll talk about the soil vapor intrusion project. As you know, we've been in the process of pulling information out of documents we received from the Navy and the Marines. We expect to have all those data points pulled out by the end of September. At this point we've extracted about 90 percent of the information from those documents.

We'll do a QA/QC process. We're doing a QA/QC process of the information we're pulling out. We're about 70 percent finished with that.

Since we're pulling so much information, putting it in the database, we need to clean up that database, just to make sure we're using standard chemical names, contaminant units, remove blank spaces, so forth so on. We expect to have that database cleaned up by -- hopefully by the end of October.

Once we clean up that database, we can begin our analysis. As you know, we're going to go on a building-by-building basis, to see what the contaminant levels are, to see what the levels of contaminants may have been a result of soil vapor intrusion. Again, we'll start that as soon as we clean up the database.

We are targeting fall of 2017 to have that public health assessment up for peer review. Just as we did with the drinking water document, we'll provide a copy to the CAP. We expect to release it for public comment in spring of 2018, and then final version of that, December of 2018. Any questions or additional comments?

DR. BREYSSE: All right, can we move on then to the updates on the health studies?

UPDATES ON HEALTH STUDIES

MS. RUCKART: Okay. I just wanted to give some quick updates on our health studies. For the health survey we're currently responding to peer reviewer comments and revising the report. The next step is to submit for agency clearance, and our plans are to publish that as an Agency document. With our previous studies, we submitted them to journals, and

so then there's an additional time to publication, but in this case, since we want to do it as an Agency report, once it receives final clearance and approval we can publish that. However, we want to do a separate publication on the analysis of Marines that will be prepared and submitted to a journal, but that's separate from the report that will be published when it's available.

As far as the cancer incidence study, our internal staff are continuing to contact and submit forms to obtain approvals from the 55 cancer registries. That includes the states, the federal and the territorial registries. Contact has been made with about 48 of the registries. The required forms have been obtained from 44, and applications submitted to 29 registries. And to-date we've received approval five of the registries, so this is on track of our timeline.

DR. ERICKSON: Quick question, Perri. The VA central registry, you've got that included as well?

MS. RUCKART: We've begun interactions with them to get the approval of the --

DR. ERICKSON: With Mike Kelley?

MS. RUCKART: Yeah. I mean, it's a long process --

DR. ERICKSON: Right.

MS. RUCKART: -- to get the VA approval, so they're not one of the five approved, but we've begun that process.

DR. ERICKSON: I just encourage you. Yeah, don't leave that out.

MS. RUCKART: Oh, yeah. No, no, no, they're included, yeah. And the DoD ACTUR.

MR. WHITE: I had one question. These registries, so are there names, addresses, stuff like that associated with those?

MS. RUCKART: So we -- at this point we're just in the stages of getting their approval. And since we're working with 55 registries that takes some time. We want to obtain the data for the same time period for all the registries. So even if we're getting approvals now, the registries are being told we don't actually want to obtain the data until 2018, when the data is complete and available through 2016. So we haven't provided them with any identifying information yet. We're just, you know, getting approvals to do that later. When that happens we'll be providing them with the data that they need to identify, to match with the records in their cancer registries, which would include name,

Social Security Number, date of birth, sex, any address information that we have, and, you know, anything else that would be useful to them.

MR. WHITE: I'm just wondering if I might be able to use that for outreach purposes.

MS. RUCKART: You know, I -- so the data that we're using is the DMDC data, which, I believe, you also have access to. Now, since then we were able to get addresses as part of the health survey. And so those are addresses as of 2011 and 2012, so it's several years old. And I think that at the time that we were doing the health survey the Marine Corps had wondered if we could share it with them, and I'd have to go back and check, 'cause it's been several years, but I think there were some, you know, issues around that, but I'd have to revisit that, and see.

MR. WHITE: Okay. Thanks.

DR. JIMMY STEPHENS: So on the ToxFAQs -- first I just want to thank Tim for all your great comments on the ToxFAQs. We got, I don't know, about 12 or 13 comments, I think, at least, which is very helpful in terms of us helping to make the ToxFAQs more relevant for the community members that are -- need this information. We've, I think, addressed

everything except our one -- the one big obvious to-do on that is, as we get the epi -- the cancer epi document through clearance, we'll be going back and looking back and making sure that these are all consistent and we're using the same kind of language in terms of describing the, the evidence around the various cancer end points.

MR. TEMPLETON: Great, thank you.

DR. BREYSSE: Great. So we're gradually catching up. We're still a little bit behind. We now have half an hour that's primarily for community concerns and for CAP updates. And so we're going to open the floor, and I want to make sure that, if we can at least begin with CAP updates that are new things that we haven't already talked about already. So if there's new issues, now would be a time to bring them up, rather than spending time going over things we've already gone over. And I want to make sure that the community members have a chance to come up and ask a question and make a comment as well.

CAP UPDATES AND COMMUNITY CONCERNS

MR. TEMPLETON: Just a quick -- I have one. I reached out to the Department of Labor, to inquire

from them, via FOIA, as to whether they had any Camp Lejeune claims, whether they disbursed any of those claims, and whether they have a program to deal with any of the folks that happened to work at Camp Lejeune or civilian workers that were there.

And I have the letter, and I would like to add it to the record. I got it back from the Department of Labor. They said, no, they don't have a program. No, they have not received any claims. And no they have not disbursed any funds or given any kinds of services. So they struck out. But I would like that to be added because we had the dialogue. I know this is kind of -- but anyway, I wanted to add that record to the -- or add that document to the record.

MS. RUCKART: What do you mean add it to the record, because it can't be in the transcript unless it was like read now.

DR. BREYSSE: Well, the minutes -- the meeting will show that the letter was -- we'll have a copy of it.

MS. RUCKART: Yeah.

MR. TEMPLETON: Right. And you'll have the copy of that.

MR. ORRIS: Chris. Thank you, Dr. Breysse, for

deferring the in utero discussion earlier this morning until I was back in the room, but I don't think we have actually visited that, so if we could go over that real quick, I would appreciate it.

DR. BREYSSE: Oh, my gosh.

MS. CORAZZA: Actually, I don't know whether -- what can be done.

MS. RUCKART: But didn't we discuss that when Frank was mentioning about the people he contacted as part of the health survey and how many of them we were able to get addresses on?

DR. BREYSSE: I think this was one of the action items. So I guess we revisited it already.

MR. ORRIS: So was the answer no?

DR. BREYSSE: Let's read the action item again because I don't know if it was a yes or a no.

MS. RUCKART: ATSDR will re-evaluate if any studies can be done on the in utero population at Camp Lejeune.

DR. BOVE: And as I said, we tried to do that with the survey, and it didn't pan out. We could ask the registries, if we just gave -- see, that's -- no matter how I look at this I don't see that it's feasible because if we just have name, date of birth and sex, and we know the name's going

to change for some people, and we know that it was even difficult for some of these registries when they did a match, a pilot match, for us when we had Social Security Number, to adjudicate between a number of possible matches, even with Social Security Number. But I really don't think it's feasible to evaluate this population in any way I can see. We tried.

We have looked at neural tube defects, oral clefts, we looked at birth weight, and we tried to do it in the survey, but in order to really evaluate a population like this you would want to have a registry, a disease registry, for example, that you could follow, and there was none in place at Lejeune at the time to look at birth defects. And the population, it's very difficult to enumerate. I mean, we had to -- we had these birth certificates to identify. We had to use word-of-mouth for the birth defect study. And so I just don't think it's a -- a credible study could be done with this population, given the information we have on it.

MS. RUCKART: Let me really answer what we did do though. For the health survey, we did send the health survey to those people who we could get addresses from, and we had about a 15 percent

response rate where people, you know, participated. And an analysis -- just a descriptive analysis of what they reported will be included when we release the health survey report, because, as I think Frank said, we have nobody to compare them to, because, for the Camp Lejeune Marines and civilian workers, we have the comparison population from Pendleton, and there's just really no way to get dependents from Pendleton, but...

So we are doing more than just the birth defect study; we are reporting on what they said in the health survey, so, you know, we did try to include them, to the extent that we could, in the health survey. And as part of the health survey we did get confirmed cancers.

DR. BOVE: But again, we had less than 15 percent participation.

DR. BREYSSE: Before you jump back in again, you know, we appreciate the value in being able to do a study like that. We know how important it could be. But these are just notoriously difficult, slash, unfeasible studies to do. And there's a reason why there's not many of them in the published literature; 'cause it's hard to look back after many years to identify people who were born with birth

defects from a long time ago, when the literature that we do have comes from studying exposures that happen now and identifying cohorts of people as they're being born.

And that's really the most feasible way to do these studies. They're almost impossible to look back that far and identify these people, identify what birth defects they had, and then compare them to a group of people who didn’t have that exposure.

I appreciate, you know, the value that such a study would have for you in the community, but it's just truly something that I don't think we can do.

MR. ORRIS: So thank you for that. I just -- Frank, I've got a lot of experience with skip tracing. Skip tracing technology has rapidly changed over the last decade, and I don't -- I'm not sure, when you talk about difficulties of skip tracing, people who were born at Camp Lejeune over a 10-year period of time, that that is potentially as difficult today as it might have been when you were doing the initial epidemiological studies that you did.

DR. BOVE: Well, the survey tracing was done in 2011, okay, with a firm that is expert in tracing. The problem was, as I said before, that over

40 percent, close to 50 percent, we could not locate. The advanced tracing methods that are available ^. You know, I would like to -- I'd like to do the study, okay? I mean, but if I say there can't be a study done, believe me, there can't be a study done, because I will try to get a study done if it's at all possible. If I think it could be credible at all, I'll pursue it. And I'm willing to listen to another epidemiologist who can explain to me how this can be done, okay? I'm open to that, you know. I just don't see it.

MR. PARTAIN: Frank, how about a low-cost --

DR. BOVE: ^ you're getting two or three epidemiologists ^. I'd like to hear from other epidemiologists. I'll discuss it with anyone you want me to discuss it with.

MR. PARTAIN: Frank, here's a low-tech, low-budget idea. We know -- put out a public service announcement that we are looking for children born at Camp Lejeune between a certain period of time. You know what the number is that are out there, and if we can locate, through social networking, using us and using the media, and have them call into a place or email to a place, and if you reach that member you can do the study, do the

study. It's low-tech, you can put a web page up, and put in there: Email your information here.

DR. BOVE: The issue would be doing a credible study, because if you do a crappy study, that will have no impact whatsoever.

MR. PARTAIN: Well, Frank, if there's -- I'll use numbers. If you've got 12,000 babies born on Lejeune --

DR. BOVE: But we couldn't get it through a locating firm.

MR. PARTAIN: Well, just, just listen, Frank, for -- Frank, I want -- I don't want to spend a lot of time on this but... Say there's 12,000 children out there. You know that there's 12,000 births, and you need 10,000 to do a study. And we social network, and we find 10,000 that come in --

MS. FRESHWATER: But each one has to be vetted, right?

MR. PARTAIN: But the thing is you can --

MS. RUCKART: Let's say you had 10,000, but when you're looking at different conditions, if you get down to specific conditions, the numbers get very, very small. So let's say you want to look at a particular outcome, some kind of liver disease or something, out of --

MR. PARTAIN: But that's not the issue Frank's talking about. Frank's saying we can't find the people. I'm saying if we can find the people and we could do it low-budget, and at least try. I mean, science --

DR. BREYSSE: People have tried for years, and the social networking that you're suggesting would produce some names, but there's going to be a huge potential bias that we can't quantify based on who identifies themself and who doesn't, so you have to be systematic about how you do it, and you can't just rely on people hearing about it and self -- identifying themselves. And then -- but I don't think he meant to say crappy study, but ^ because of the bias it can't be quantified, it wouldn't be credible. And we wouldn't do anybody a service if we published a study that was so flawed that, if it saw something positive, it would be meaningless. If it saw something negative it would be meaningless.

And we thought this through, and not just us. People across the country are trying to answer these questions. Every day there's a new chemical that comes out that's got reproductive outcome issues associated with it. And if it was easy to identify people a long time ago or born who may be exposed,

we would see thousands of studies, and we're not seeing them. And we're not answering those questions. And I'm sorry, we're environmental health scientists, and we can't, you know, give you a more satisfying answer, and I wish we could, but I think that's just the fact.

MS. FRESHWATER: Are we moving on? Because I wanted to do something real quick with the CAP concerns.

MR. ORRIS: I have one more question in regards to this, and just for clarification purposes, because I was able to identify my mom's form birth certificate and find it, you know. And on my mom's form birth certificate it lists my parents' address as Inchon Street in Tarawa Terrace. You know, if you're talking about qualifying for an epidemiological study there's something in my birth certificate that lists the parents' address at the time of birth, a qualifying condition, because if so I mean, I'm pretty sure that we could identify, you know, quite a few kids, based on that information.

DR. BOVE: That's how we did it in the birth defects study, using that information. Otherwise we couldn't have done that study. Yes, that information is useful during the study. If you

wanted to do something else with that, that's a problem.

MR. ORRIS: I want to do a health survey, kind of like what we did.

DR. BOVE: We just did that.

MS. FRESHWATER: I think at this point we need to give the scientists --

DR. BREYSSE: We have a half an hour before we're supposed to adjourn, and I want to make sure that the community members have a chance to question --

MS. FRESHWATER: Yeah, so I just wondered, is Dr. Cantor still on the phone?

DR. CANTOR: Yes, I am.

MS. FRESHWATER: Hi. We miss you. Dr. Cantor, I was wondering if you have any comments about Dr. Blossom's presentation, or questions, just because I know that you and I have spoken about this in the past, and I just wanted to make sure that you were brought in and given an opportunity to chime in on that or anything else?

DR. CANTOR: Yeah, well, thank you. I don't have many comments, but there does seem to be a parallel finding between the studies I reported, I think, was it two meetings ago, the studies that

were done and charted by my colleagues at the National Cancer Institute, that are finding similar prediagnostic results to what she was describing, so that's about all I have to say. And there is a close comparison between the two.

MS. FRESHWATER: Thank you. I appreciate it, and I appreciate all of the help that you gave us in trying to get Dr. Blossom here, and I just wanted to personally, again, thank you for coming. And I really feel like it was very informative to the community, and looking forward to getting the information out to them. Thank you, Dr. Cantor.

DR. CANTOR: Yeah, you're welcome.

DR. BREYSSE: So any questions from the community members who are here, or comments?

MR. ENSMINGER: Just make sure, I mean, don't attack anybody in the room, you know. Keep it civil. This is not a Trump rally.

DR. BREYSSE: And introduce yourself, please.

MR. HIGHTOWER: My name's Tony Hightower. This is for Mr. White. Mr. White, what is the VA actually doing over at the Atlanta VA to register Marine vets on the toxic water?

MR. WHITE: Your question is basically what kind of outreach are we doing?

MR. HIGHTOWER: Yeah, what kind of outreach is -- example the CBOCs and the VA itself is outreaching to the Marine veterans to get them registered up under the toxic water act of Camp Lejeune?

MR. WHITE: Well, thank you for your question, sir. We have worked closely with the Marines, and we paid for different mailings to go out. They sent out letters to hundreds of thousands of veterans that they have on their registry. And then they've also -- I've got the specifics, if you want to get with me afterward, but they have advertisements in like USA Today and some other national publications.

MR. HIGHTOWER: Well, what are they doing at the VA hospitals and the CBOCs to reaching out to vets since they're no longer the majority of the Marine vets are going to the VA for healthcare?

MR. WHITE: Well, when a veteran comes in to sign up for eligibility, and I wish my health eligibility folks were here 'cause they could really answer this question in more detail, but when a veteran signs up for care they're asked certain questions, and there's a form to fill out. On that form there's a box that they can check saying were they at Camp Lejeune, and if they were they're

immediately enrolled. So there's no -- there's no specific outreach, as far as, you know, any particular CBOC or VA medical center, but we have given training to the eligibility intake people, specifically for Camp Lejeune and how they're supposed to be registered.

MR. HIGHTOWER: And where has this training been taking place? Is it for the Atlanta or Macon or the CBOCs or --

MR. WHITE: It's for the national. So it's basically it was an online training.

MR. HIGHTOWER: Online training?

MR. WHITE: Yes, sir.

MR. HIGHTOWER: 'Cause I've spent a lot of time with eligibility and informing them of the proper procedures of getting Marines registered, and throughout the hospital and the CBOCs there's no posters. There's no literature throughout the hospital to encourage a Marine to register.

MR. WHITE: Well --

MR. HIGHTOWER: And I thought this was something that was supposed to have been settled a couple years ago, about notification within the system.

MR. ENSMINGER: Yeah, there's a good idea,

because you were asking how you could get the word out, especially to the family members and stuff. If you put more information out at these VA hospitals, the veterans, they see that about their family members, they're going to let their kids know. So I mean, and I've heard this complaint time and time again by veterans at all these -- all over the country, that are going to these VA health centers and clinics, and they never see anything about Camp Lejeune. It's not visible. I mean, it's like, you know, somebody's trying to, you know, hide it or, you know, keep it out of --

MR. WHITE: I mean, that's a great idea. That's something I can take away from this meeting and find out what it would take to, you know, get some posters up? You know, where would they go? Who I would need to contact.

MR. HIGHTOWER: And especially with the VA system, with the new program of the ambassador and information officers that are throughout the hospital assisting vets getting to their appointments and information on a variety of things, 'cause that's exactly what I do. I physically escort Marines to eligibility and get them to register. And then they come back and say, well, I

didn't get no information. I said, you didn't go to booth 6 or 7, 'cause that's the only two people that has the program that goes on the registry.

Since then in the last few weeks finally got it on all the computers. But still there's a lot of people that's walking in, going to appointments, walking out, no literature, no posters, no notification. You know, we need for you to register for results and surveys and everything else. I don't even know if a survey has been handed out in eligibility.

DR. ERICKSON: Mr. Hightower, I want to say, first of all, thank you for serving as an ambassador at the medical center. That's a tremendous service, and I've been to a number of medical centers, and, you know, that, that is something that is just incredible in terms of -- you know, the staff appreciate your work, the veterans appreciate your work. You make so many things, you know, function that otherwise wouldn't.

But I may just also echo what my ^ here had to say. We'll take this as a due-out because we do want to have better outreach, not just multimedia outreach and mailings and such. But if the battle now needs to be fought at the CBOC level more

effectively or at the medical center level, then we have some means that we'll discuss, that we can put that into effect. I appreciate you bringing that forward.

MR. HIGHTOWER: I found it to be interesting.

DR. BREYSSE: Thank you. Any other community comments?

MS. FRESHWATER: I was --

MS. KENDRICKS: I have one.

MS. FRESHWATER: Let me -- just to finish up on what you're saying, I've been involved with on-the-ground VA work through personal life, and I first wanted to say everybody has been wonderful that we worked with at the VA centers, including a social worker who held the door for an appointment because we were caught in traffic. So I certainly always want to point out how many good people are at the VA, and we appreciate that.

But it just made me think of what you've been saying, and Brady, maybe the social workers also might be somebody that, you know, if they have their own groups, and if they have their own kind of meetings, or what have you, the social workers talk to a lot of people, you know, when they first come in, and that type of thing. So just might be

something to think about, because they're used to this kind of thing as well.

MS. KENDRICKS: Okay, my name is Louita Kendricks. I am a retired disabled veteran. I also want to follow up to advocate for women veterans. Dealing with that statement, you said that now there are ways that, when people check in for their appointments at that point you ask about Camp Lejeune for new people that are being vetted at the VA. What about those that -- prior, that has been there, because I know in my appointments they don't ask me anything about Camp Lejeune. I bring it up; they look at me like... They don't know.

So that being said, those of us that were in the system for the last 15-plus years, or whatever, how do we get them to recognize that we were at Camp Lejeune without having to go through a whole bunch of malarkey?

And my other questions are what are they going to do about the families with children who were stationed at Lejeune who are developing cancers, and their children developing cancers? So what are you going to do about that?

MR. WHITE: So let me tackle your second question first. Basically in order to qualify for

the program as a family member you have to have been at the base, and they have to --

MS. KENDRICKS: Yeah, they were born there.

MR. WHITE: -- have been exposed to the water. Well, if that's the case, then they should qualify for the program, and they should be able to receive the benefits, medical benefits.

MS. KENDRICKS: Okay. Now the big question is you state that a lot of them are unable to be found. When I was in the Marine Corps I was Kendricks. I married and retired as a Wright, but they still found me. I retired in California, but they found me here, so what is the problem with finding where the dependents are? If you can find the parents why can't you find the children? Because there are no records of emergency ^.

DR. BOVE: They key thing is Social Security Number; that's the difference. If we had Social Security Number on all the kids we, could follow them.

MS. RUCKART: Well, also I'll tell you, the housing --

DR. BOVE: That's a key thing.

MS. RUCKART: -- the housing records, they might list, you know, that you had a dependent or

other records that the Marine Corps kept might list that you had dependants and the number, but that doesn't necessarily list the names of your dependents, and certainly not their Social Security Numbers.

MS. KENDRICKS: But Headquarters Marine Corps has all that information. I worked admin, so all that information, we send that report Marine Corps. It's in the DEERS and everything else, so why is this so hard for you to find where those dependents are?

DR. BOVE: We have Social Security Number for Marines from the DMDC data, right? Through -- there are no data on dependents going back then, okay.

MS. KENDRICKS: Not even in DEERS.

DR. BOVE: Not even in DEERS. No, we don't have it. And the housing records just give you the Marine who was assigned the house, the unit. So that's what we have to work with. We have Social Security Number from their personnel records. We have it for civilian workers and we have it for Marines, okay? And to get it for Marines, we had to -- there had to be historical research done to know which units were at Camp Lejeune and which units were not, and there were probably mistakes

made, actually. Now the Marine Corps has scanned all the muster rolls, so that'll help resolve some of those issues. So this is the situation with the information we have to work with, okay? There are a lot of issues with the information we have to work with, okay?

MS. KENDRICKS: So you couldn't get a list of all the babies that were born at Camp Lejeune naval hospital?

DR. BOVE: The way we did that was used the birth certificates from North Carolina, and then narrowed it down to the county where Camp Lejeune was, and work from there. The hospital could not -- did not provide that information to us. And again, they don't store the records there. They sent them off to, apparently, to St. Louis. In other words, it's not easy to get this information.

AUDIENCE MEMBER: They don't have death records, birth certificates for hundreds of children, so how are they going to find them?

MS. KENDRICKS: Okay, what she said, they don’t have death records, birth certificates for hundreds of children, because I lost babies at Camp Lejeune. She lost babies at Camp Lejeune. They don't have any kind of records.

AUDIENCE MEMBER: So what you supposed to do next?

MS. KENDRICKS: So then what do you do?

MS. RUCKART: That's exactly the issue that we're facing.

MS. KENDRICKS: You still have those that were born, living.

MR. PARTAIN: And there's another woman Marine that texted in and asked me to, you know, say her statement. She's calling -- her name is Paula Twitty Bushman, a woman Marine at Pendleton/Lejeune. List here just a base hospital on record. Husband, Marine, also passed at an early -- or passed at an early age. Not included in the survey. A woman Marine -- I'm having to read through the choppy text here. A woman Marine when first came out. ATSDR said woman Marines were not included. All three born with pre-existing low birth weight, NICU for long periods of time. Dead child at birth, two. Now she's suffering from autoimmune problems, CFS, fibromyalgia. Claims all denied and -- claims all denied but they currently agree that I was poisoned, which just this week noted more likely conditions related to poison. My service record both scanned illegible via microfiche, and they can't find her

information.

MS. RUCKART: Well, I would just want to let her know, and anyone else who's listening, that the health survey did include female Marines, and we did analyze miscarriages. And the questions on pregnancies in the health survey did ask about the outcome of each pregnancy: If it was a live birth, a still birth, et cetera. So that is something that will be included in the health survey, the miscarriage results.

MS. KENDRICKS: So you said you interviewed some women Marines?

MS. RUCKART: Surveys were sent out in 2011 and 2012 to -- we tried to reach about 300,000 Marines, and this was based on the DMDC data, and I don't know if you want to have a, Frank, full discussion about this right now. I know you may not have been here in the past, and we talked about that maybe we can discuss this separately, not to use up the time. I know there's a lot of questions out here, but we did send out surveys, and like I said earlier, we are revising that report based on peer reviewer comments, and then it will go through Agency clearance, and then it will be published, and you'll be able to see what we found.

MR. WHITE: And ma'am, if I can follow up too, I think you asked me a question that I'm not sure if we got to, about the veterans that are coming into the medical centers that aren't being told.

MS. KENDRICKS: Those that have been in the system for a while.

MR. WHITE: Right.

MS. KENDRICKS: But you addressed the ones that are coming in, and now they have the check box down at the bottom of *were you ever stationed at Lejeune*? But those of us that were in before, you go to your physician, and they -- like mine, I told her. I said, well, you need to -- we need to go through my records because I was stationed at Camp Lejeune, and she looked at me like I was speaking foreign language.

MR. WHITE: I'm going to follow up on that. Right now I don't remember the specifics, but it was about a year ago, I asked our office, that I work under, if we can just run some kind of data analysis and find the veterans that we currently have in the system, that somehow we know were stationed at Camp Lejeune during the covered time frame, if we can just automatically enroll them into the system.

MS. KENDRICKS: And because you don't just have

Marines. You have a lot of sailors that were stationed there also.

MR. WHITE: But there was -- it was some kind of legal issue with being able to do that automatically. I don't recall what that was now, but that was the reason. But what I can do is follow up and see if there's other things. Maybe we can just send them out some literature and some information, individually. I mean, we can't just send it out to all the veterans we have in our system. There's like nine million of them. But we can -- we can somehow --

MS. KENDRICKS: Why not.

MR. WHITE: -- narrow that down.

MS. RUCKART: I want to mention, when we use the word *Marines* we are also including Navy personnel. Our surveys have included the Marines and Navy personnel, and we often just shorten it to Marines, but we're including the Naval personnel as well.

DR. BREYSSE: Do we have time for one or two more comments or questions?

MS. WILEY: I have a question.

MR. ENSMINGER: Who's that?

DR. BREYSSE: Can you introduce yourself?

MS. WILEY: This is from Dawn Wiley. And Dawn asks how far back on birth studies are you going?

MS. RUCKART: Well, we have two studies that we published, and we have some fact sheets, and, you know, I think Q&As up on our website. We were able to go back to 1968. That's because when the birth certificates began to be computerized in North Carolina it would've been extremely difficult to go, you know, back in time further than 1968. But we do say that the results that we found would apply to births before 1968 if the mothers were exposed in a similar way.

DR. BREYSSE: Okay. Next question?

MS. BAILEY: I'm Tina Bailey. I'm here with my husband, Daniel. This is the first meeting that I've attended. I wanted to thank everybody for their hard work and trying to get coverage for the Marines and their family members and the Navy members.

I've been sitting here listening, getting very frustrated, because I'm Navy personnel too. I'm medically retired, and I always thought very highly of being a Navy corpsman and protecting my country. And it hurts me, and I'm -- you can ask anybody, about five years ago I spoke very highly about the

VA, 'cause I'm a disabled vet. And all that they -- how they helped me and everything. And it hurts me -- and I don't know where the VA lost their -- you know, I read over and over the VA's mission statement and their core values, and the acronym that they use of ICARE.

When I sat here and listened today about every excuse -- and I'm not attacking any of you guys. I'm just saying I'm frustrated -- every excuse, about well, they don't meet this criteria or we got to set up this experiment. How much money is being wasted on all these board experiments and studies and all that, that could be paid to these family members and the military members that are hurting, that are sick.

You guys send out the surveys. I work with the insurance companies every day. I fight for people that pay big money into their insurance companies to be -- to beg them to please let them get an MRI because they don't want to pay out the money. And that's how I'm feeling that the VA is becoming, in not wanting to pay out this money to people that served and protected our country and their family members. And it's very frustrating, and it hurts because it's an honor to have served. It's an honor

to sit there and look at our sons and daughters that are fighting for our freedom every day.

You guys send out these surveys. Who wants to fill out a survey when they're fighting cancer or their husband is sick, and they're barely being able to pay their bills every month? Do you think I'm going to fill out a survey? I'm not going to take the time to fill out a survey because nothing is being done, except we're fighting over everything.

Why can't the VA sit there and say we presume everybody that was stationed, and you can prove you were at Camp Lejeune between this time and that time, why can't you give them the benefit of the doubt 'til you can prove that it did not come from there? Give them their paycheck till you have it, prove beyond a reasonable doubt that you can fight their doctors that they see every day saying they have cancer, and you can prove with your specialists that that's not where it came from, and then stop their money. Why does it have to be the opposite? What happened to the ICARE? What happened to your core mission? That's my question. Where did it go wrong? Where did it change?

You know, in the beginning, when I look at the history of what the VA was, it started out with the

pilgrims. They said anybody that served in their country, served and fought in battle, was going to be covered. They were going to be taken care of, family members and that. What has changed? Why does the service member and their family members have to fight so hard to prove to you that they deserve it? Why can't it be the other way around? Why can't you give them the benefit of the doubt, give them their money, and then you fight with their doctors on why you feel it's not covered. Thank you.

DR. BREYSSE: Thank you very much for your comment, ma'am. I'm not quite sure there's a direct way to address that other than to say that your pain is well heard.

So I think I'm going to wrap up the public concerns section of the meeting. And can we spend a few minutes to talk about our planning for the community meeting coming up in 2017? Jamie?

PLAN 2017 COMMUNITY MEETING

MS. MUTTER: Can you hear me? All right, well, first I want to say --

MR. ENSMINGER: He quit.

MS. MUTTER: First I want to say thank you, and

it's an honor to be joining -- helping with the CAP today. And you'll be seeing my name a lot more 'cause I'm going to be helping Perri with the CAP, so thank you.

I did want to just talk about the next meeting. It most likely will be January time frame, but we can talk about that further. But we just wanted to basically confirm location. From what I've heard in the past Jacksonville, North Carolina is the location. Unless I hear differently I'm going to go with that in planning.

Just to make you aware there's really only one hotel that's capable of hosting it with the AV needs that we have, so I'm hoping that they're available on the dates that we choose. So if they're not we might have to figure out another game plan, but that is the plan right now. And do I hear anything saying differently than Jacksonville, North Carolina?

MS. CORAZZA: No, but if you have an issue start looking at like Cherry Point is the next base, 30 minutes over, and they have several large hotels there.

MR. ENSMINGER: Well, you've also got Coastal Carolina Community College there.

MS. MUTTER: Yeah, I think Perri had mentioned that before.

MS. RUCKART: Where is that, Jerry?

MR. ENSMINGER: It's in Jacksonville. Coastal Carolina Community College, not Coastal Carolina; that's down in Myrtle Beach.

MS. MUTTER: Okay. I'll look at that and see what they have as far as rooms and whatnot. Okay, that's all I really had to ask about, so unless there's any comments I'll be done.

MR. PARTAIN: Well, the big comment that I'd like to make, and Dr. Breysse, I don't know if there's any part you can play in this too, but being that this is going to be in Jacksonville, North Carolina, I think there should be some type of formal invitation for the Marine Corps to participate, and have, you know, full representatives at this meeting. I don't know if there's something you could do, as director, to pen a letter to somebody and get a formal denial from the Marine Corps since they don't seem to want to come, but to see if we can get this proactive so that way, if there is a formal denial, that we as a community can talk to our members of Congress and see if we can get the Marine Corps to come to it.

MS. FRESHWATER: I would also like -- I know in the documentary there was a press tour. It was the press, right, Jerry?

MR. ENSMINGER: No, it was --

MS. FRESHWATER: Was it the CAP?

MR. ENSMINGER: -- community members.

MS. FRESHWATER: -- of the sites, and I would like to request that we have one of those again, that we are able to be taken on base and shown the sites, and would be able to see what is -- you know, has been done and that type thing. If they did it before I don't see why we couldn't do it again.

MS. FORREST: You're saying a site visit for the CAP members.

MR. ENSMINGER: No, everybody.

MS. FORREST: I'm just trying -- I just want to make sure I understand what you're asking, 'cause it's a much bigger -- there's a big difference between 10, 12 CAP members and a much larger group, so I just wanted to understand what you're asking.

MS. FRESHWATER: And the way they do it, with the Beirut remembrance in October is we have to -- if we are going to go on base to Camp Geiger in order to go to the ceremonies, we have to turn in our driver's license number and our name and

everything well in advance.

MS. FORREST: Oh, yeah, that'll have to be --

MS. FRESHWATER: Right. But I'm just saying I know that that's doable, and then I just -- they have it ready. I have a pass, and I'm able to go on -- you know, I don't want to go into it, but...

MS. FORREST: Oh, no, I know it's doable. I just wanted clarification to know if you were saying just CAP members or possibly a much larger group.

MS. FRESHWATER: Because I know how long things take to get from one place to another, if there's a no to the larger group we would still like the CAP -- we would prefer to have the CAP members as opposed to no one. Does that make sense, Melissa?

MS. FORREST: Yes. That's what I wanted to clarify 'cause I want to make sure.

MS. FRESHWATER: Okay. Thank you.

WRAP-UP

DR. BREYSSE: So we're right at the end, with a few minutes to spare, but that's okay. So I want to thank Dr. Sarah Blossom for coming today and having a great discussion with us.

And as usual I'd like to thank the representatives from the Department of Defense and

the veterans -- VA for being with us today. Dr. Dinesman, hopefully this is not your last time with us.

DR. DINESMAN: No, I don't think so.

DR. BREYSSE: With a room like this how can you pass it up?

DR. DINESMAN: Thank you.

DR. BREYSSE: Well, thank you all very much, and with that, we'll adjourn the meeting.

MR. ENSMINGER: And I'd like to say welcome to Jamie as our new facilitator.

MS. MUTTER: I'll take it.

MR. ENSMINGER: You seem like a real mutter.

DR. BREYSSE: With that comment the meeting's adjourned. *

(Whereupon the meeting was adjourned at 2:22 p.m.)

CERTIFICATE OF COURT REPORTER

STATE OF GEORGIA

COUNTY OF FULTON

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of August 11, 2016; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither relation nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 7th day of Sept., 2016.

_____

STEVEN RAY GREEN, CCR, CVR-CM, PNSC

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