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convenes the

FORTY – FOURTH MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE

PANEL (CAP) MEETING

FEBRUARY 13, 2020

The verbatim transcript of the Meeting of the Camp Lejeune Community Assistance Panel held at 1825 Century Boulevard, Atlanta, GA, on February 13, 2020.

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P R O C E E D I N G S

(9:00 a.m.)

WELCOME AND INTRODUCTIONS

CDR MUTTER: Hey, good morning, everybody. Thank you for joining us today on this wet, rainy day. We appreciate you coming out in the weather. For those on the phone, if we could ask you to mute your phone so we don't hear any background noise, we'd appreciate it. And just a few reminders. If you go to the guard station and take a left, the bathrooms are on the left and there's a break room on the right where you can get drinks and snacks, as well. Emergency exits, just follow the emergency exit signs. I'm looking for them right now where they are. There's doors out here. If you go out this way, there's doors to the left, and then there's doors at the front of the building, as well, and also, out this hallway, down the hall. If you are - have a cell phone, if you could put it on silent or vibrate, we would appreciate it. And for those sitting at the table, if you have a comment, we know to put our name tents on end so we can take comments from appropriate order for those that want to speak. So with that, can we make sure we - can we see - well, actually, we'll get that when we go around the table for introductions. Dr. Breysse, do you have any intro remarks you want to do?

DR. BREYSSE: Yeah. I want to thank everybody for coming. These are always interesting meetings and the - we're proud of the work we're doing at ATSDR and we're happy to give presentations and updates about the work that we're doing. I think we're really pushing the science forward. And as we talked about before, good science is what's best to serve the needs of the veterans and the Camp Lejeune people who are exposed to the drinking water there. So I think we'll take a minute now and we'll go around the room and ask the members around the table to introduce themselves so we have it on the record. Again, I'll start. My name's Patrick Breysse. I'm the director of the Center for Environmental Health and the Agency for Toxic Substances and Disease Registry.

DR. BOVE: My name is Frank Bove. I'm senior epidemiologist on the project.

CDR MUTTER: Please make sure you push the button so it turns green and speak directly into the microphone so those people that are watching us from Live Meeting can hear us, as well. Thank you.

MS. HODORE: I'm Bernard Hodore, CAP.

MR. ORRIS: Good morning. I'm Christopher Orris, CAP.

MR. PARTAIN: Mike Partain, CAP.

MS. CARSON: Laurine Carson, Department of Veterans Affairs.

MS. FORREST: Good morning. I'm Melissa Forrest from the Department of Navy.

MS. FRESHWATER: Hi. I'm Lori Freshwater with the CAP.

MR. TEMPLETON: Tim Templeton, disabled marine connected to Camp Lejeune, CAP.

DR. CANTOR: Ken Cantor, technical advisor to CAP.

MR. ENSMINGER: Jerry Ensminger, member of the CAP.

CDR MUTTER: Jamie Mutter, ATSDR Camp Lejeune CAP coordinator, and do we have anybody on the phone from the CAP?

MR. MCNEIL: John McNeil from the CAP with the flu, so I'm here on the phone.

CDR MUTTER: Hope you feel better soon. Anyone else on the phone from the CAP?

MR. ASHEY: Mike Ashey.

CDR MUTTER: Good morning.

MR. ASHEY: Good morning.

CDR MUTTER: Do we have Dr. Blossom?

DR. BLOSSOM: Yes, I'm here.

CDR MUTTER: Hi. Wonderful. Do we have the VA Family Member Program on the line?

MR. JONES: Yes. Good morning. This is Kip Jones from Denver and I have Mark Heroux with me.

CDR MUTTER: Okay. Would you like to start giving your - oh, sorry.

MS. CARSON: We also have the VA VBA folks on the phone. Do we have the MDE folks on the phone from the Medical Disability Examination group?

UNIDENTIFIED SPEAKER: Why aren't they here?

UNIDENTIFIED SPEAKER: Yeah, why aren't they here face to face.

CDR MUTTER: Will you talk in the microphone?

DR. BREYSSE: Well, firstly if they're here, their phone's - if they're on the phone, they're muted, because.

MR. PARTAIN: There are some veterans that do ask about speaking with a …

MS. CARSON: I said that I would have a presentation by this group, and so they're giving a presentation over the phone. I'm here.

UNIDENTIFIED SPEAKER: Yeah, well, this is unacceptable. Sorry.

MR. ENSMINGER: This is the second meeting in a row where -- -- what's her name? Dr. --

CDR MUTTER: Dr. Hastings.

MR. ENSMINGER: -- Hastings hasn't been here.

MS. CARSON: So Dr. Hastings is on her way. She text this morning. Her flight has been grounded since about 6:00 this morning at the airport in D.C. So she is on a plane sitting on a tarp trying to get here.

MR. ENSMINGER: Is it icing up up there or what?

CDR MUTTER: It's weather here.

MS. CARSON: It's the weather here that doesn't allow - they're not bringing any flights into Atlanta right now.

MR ENSMINGER: Oh.

U.S. DEPARTMENT OF VETERANS AFFAIRS UPDATES

CDR MUTTER: Okay, so with that, would the Family Member Program like to get started on their presentation?

MR. JONES: Yep.

CDR MUTTER: Wonderful. If you can just say --

MR. JONES: We would love to. Thank you very much.

CDR MUTTER: Wonderful. You just want to say next, I'll advance the slide for you.

MR. JONES: Okay. Next slide, please. The VHA Camp Lejeune program overview. The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, public law 112-154, was

enacted on August 6, 2012. Section 102 requires VA to provide health care to veterans who served on active duty at Camp Lejeune. And reimbursement of medical care to eligible family members for one or more of the 15 specified illnesses or conditions. Next slide. Camp Lejeune veteran eligibility. To be eligible for VA health care, a veteran must have served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987. The veteran does not need to have one of the 15 health conditions to be eligible to receive VA health care. Veterans do not need a service-connected disability to be eligible as a Camp Lejeune veteran for VA health care. VA health care related to any of the 15 qualifying health conditions is at no cost to the veteran, including copayments. Camp Lejeune veterans are enrolled in VA health care in Priority Group 6, unless, of course, they qualify for a higher priority group. Next slide, please. In response to the law, VA began providing care to Camp Lejeune veterans on the day the law was enacted, August 6, 2012. To support implementation of the statutory requirement, the final regulation for Camp Lejeune veterans was published on September 24, 2014. As of October 4, 2019, VA has enrolled 65,649 Camp Lejeune veterans, 3,471 of which were treated specifically for one or more of the 15 specified Camp Lejeune-related medical conditions. Camp Lejeune veterans interested in enrolling in this program should call 1-800 - no, excuse me - 1-877-222-8387. Next slide, please. Veterans who were treated for each of the 15 Camp Lejeune medical conditions between October 1, 2012 and October 4, 2019. Bladder cancer, there were 478 treated. Breast cancer, 81. Esophageal cancer, 160. Female infertility, 1. Hepatic steatosis, 460. Kidney cancer, 293. Leukemia, 229. Lung cancer, 395. Miscarriage, 0. Multiple myeloma, 100. Myelodysplastic syndrome, 29. Neurobehavioral effects, 182. Non-Hodgkin's lymphoma, 193. Renal toxicity, 844. Scleroderma, 26. For a total of 3,471. Next slide, please.

MR. PARTAIN: Before you go to the next slide, question. What about liver cancer? It's one of the presumptives.

MR. JONES: Yeah, I'm sorry. I don't have any data for liver cancer.

MR. PARTAIN: Well, that's fine, and also, kidney disease. Kidney disease, I believe, is on the 15, but it's not a presumptive.

MS. CARSON: Kidney cancer is on the presumptive.

MR. PARTAIN: Yeah, but kidney disease is a --

CDR MUTTER: If we can talk into the microphones so people online can hear us, please.

MR. PARTAIN: Yeah, the kidney disease, I believe, is one of the 15, is included in the 15. It's not included as a presumptive.

MR. JONES: Yeah, we just have the kidney cancer data of the 293.

MS. CARSON: Excuse me, if I may. This is Laurine Carson. The 15 conditions that are listed here are the ones that under the health care law from 2012.

MR. PARTAIN: And also, these numbers here, are these numbers reflecting people that are actively treating or what about people who have treated in the past. But are not receiving benefits because they're in remission or have been treated and, you know, but had the disease? Does that make sense?

MR. JONES: Yes. These are all programs October 1, 2012 between the two times that are listed, dates that are listed there, so October 4, 2019. If it's an increase in number from first reporting to now or a decrease in number, the numbers on the right in red will show the increase over last quarter. And the number that you see, like multiple myeloma is 100 and you see a 1 decrease. If it's in black, it's a decrease number.

MR. PARTAIN: Okay, so the 65,000 that register, someone wasn't actively treating between October 2012 and 2019 and received benefits, they're not counted in the number, these tables, correct?

MR. JONES: Yes, because there's - and I'm glad you brought that up because there's a delineation between administratively viable - not viable, but authorized, and medically authorized. So and that's something we actually wanted to bring to the table for the veterans' side. So we have a possibility of a few veterans being missed on the administratively-allowable procedures even though there's 65,000 that are registered. And then they - a lot of us usually wait - I'm a veteran, as well, from Marine Corps, so I apologize. I say us. A lot of us usually wait until we have a medical condition to be qualified for anything and then we put all of our stuff in all at one time, which, okay, that's succinct and everything's great. However, we can also apply administratively stating that we were there between '53 and '87, respectively to the month. And get that finished and get on the roster, which a lot of them have done, 65,000 of them versus the 3,471 that have already been treated for that timeline. So you'll see a huge disparity between the two numbers because we're allowed to administratively authorize them, and we've done a lot of that back end work on our own. But some people, we

can't prove were there, so we're trying to get that locked down with the veterans as they come in, as well. But you're correct. They will not be represented on this current slide that's up right now unless they've been treated within the last quarter, and that number shift will be there, as well.

MR. PARTAIN: Okay. And also, what I'm getting at, too, is you have individuals such as myself actively treated between 2007, 2008, as far as my breast cancer. But I have not treated as far as made any payments or anything between this period of 2012 and 2019. So my number is not being reflected in there. How are we capturing people who may have treated prior to 2012 and, you know, had a condition, you know? If we're counting numbers here, we need to count these numbers, as well. And the last --

MR. JONES: We can.

MR. PARTAIN: Go ahead.

MR. JONES: Yeah, I'll take it one piece at a time. I apologize. And I may be speaking out of place. I just got on deck about two or three weeks ago, so I'm still spinning up all new knowledge. If someone else out there can speak to this better. I think that these numbers are actually kind of reflecting what current budgetary requirements are for allowing medical services to be provided. So from '12 to '19, we're kind of saying this is what we spent over the time for medical conditions and allowables. That could be a different slide if we, you know, all agreed on putting that in there as to everyone who's been treated ever and separating out just who's administratively and had no medical conditions. And then people who have ever been treated, and then people on current roster for treating, if you will.

MR. PARTAIN: Well, these are one of the arguments that we have for having a registry for Camp Lejeune, a health registry. The last thing, going back to kidney disease, one of the 15 conditions is renal toxicity. Would not kidney disease fall in that category? And if so, then we need to have that count added to this list.

MR. JONES: [Inaudible] . Yeah, we didn't bring that down. If we - yes. If a specific condition has a different medical term than the 15 that's on here and VBA or VIBA [assumed spelling] are kind of classifying it within that, that number's captured in there, to my assumption. So we'll have to get confirmation on that. We're writing notes on that right now, so.

MR. PARTAIN: Yeah, renal toxicity is not on this list and - oh, here it is. I do see it. I'm sorry. I do apologize. So can we

verify whether or not kidney disease is being counted in this category? Can we delineate that one?

MR. JONES: Yeah, I love that idea. That's a great idea. Thank you for bringing that up. We will classify all of the subcategories that fall under the 15, that have different titlings, if you will, that the causes are for, and we'll make sure that we get that captured, as well.

CDR MUTTER: Okay. Would you like me to advance the slide?

MR. JONES: Yes, please.

CDR MUTTER: Thank you.

MR. JONES: Camp Lejeune Family Member Program. Camp Lejeune Family Member Program launched on October 24, 2014, the day the regulation became effective. Family members receive care by civilian provider and VA reimburses as payer of last resort any out-of-pocket medical cost associated with the 15 conditions. Family members may request reimbursement for covered expenses incurred up to two years prior to the date of their application. As of January 31, 2020, VA provided reimbursement to 509 family members for claims related to treatment of one or more of the 15 specified Camp Lejeune-related medical conditions. Camp Lejeune family members interested in enrolling in this program should call 1-866-372-1144 or visit their website at www.clfamilymembers.fsc.va.gov. Next slide. To receive reimbursement of medical expenses under the provisions of the law, a Camp Lejeune family member must be determined administratively eligible for the program. Must have had a dependent relationship to an eligible veteran during the covered timeframe. Had resided, including in-utero, on Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987. And have one or more of the 15 qualifying health conditions.

MR. ORRIS: This is Chris Orris. I have a question about the resided including in-utero. During the last meeting, I had brought up that exposure to the chemicals in-utero is a thing that can happen in minutes with one exposure. And I had asked for a second look at this 30-day requirement for in-utero exposure. Did you review that and has there been a determination on that?

MR. JONES: Yeah. We defer that to Dr. Hastings, perhaps, can answer that question.

MS. CARSON: Yeah. I wouldn't know because it's on the VHA side with Dr. Hastings.

MR. JONES: Yeah.

UNIDENTIFIED SPEAKER: Hopefully, she'll be hear soon.

MR. JONES: Thank you. So we'll defer that, and hopefully, Dr. Hastings can answer that, Chris. Next slide, please. Family member who were treated for each of the 15 Camp Lejeune medical conditions between October 1, 2012 and January 31, 2020. So we have listed the 15 conditions and the number of members who were treated. And these slides are available for anybody that would like them, so I didn't want to go through each condition unless you guys want me to read each condition and the numbers. But if not, we'll go to the next slide, please. Eligibility denials. Veterans. Of the 65,649 veterans who applied for care and services under the Camp Lejeune program between October 1, 2012 and October 4, 2019, 1,592 were ineligible due to not meeting the statutory requirements for veteran status. There were 470 veteran applications in a pending status. For family members, of the 3,261 applications received for eligibility in the Camp Lejeune Family Member Program between October 24, 2014 and January 31, 2020. There are 12 awaiting administrative determination. Family member administratively ineligible is 967. The top three reasons being not meeting Camp Lejeune residency criteria, relationship to eligible veteran, or the veteran eligibility criteria. Family members clinically ineligible is 414.

MR. ORRIS: So this is Chris Orris with the CAP, again. A couple of questions on this. You said that there were 1,529 ineligible veterans due to not meeting the statutory requirements for veteran status. I want to make sure, this is something we had gone over once before. That veterans who, and their family members, who received other than honorable discharges are not being discluded from coverage based on this status?

MR. JONES: Yes.

MS. CORDOVA: This is Andrea. That is correct.

MR. ORRIS: Okay, and also, for the 123 family members that are administratively ineligible, are those related to the veterans' status as a veteran? And are we making sure that nobody's being denied based on what I previously asked?

MS. CARSON: So this is Laurine Carson from DVA. Those are not the same tallies. Their tallies are for the health care based on the health care law. The benefits, I have some information about the number of claims in veterans that we have. I can tell you really quickly. We - in 2019, we completed 3,756 new claims for Camp Lejeune, of which 2,752 had a presumptive condition. VA

granted 1,871 of those and denied 881 of those. So I just wanted to let you know that that's where we are today. So we are still getting claims. We're still granting claims based on the evidence that's there in the prerequisite conditions for benefits. And I wanted to level set and make that clear. Because after the last meeting, I did have 15 different veterans and family members who I gave my business cards to, and they contacted me, and we tracked them through. We have ten people who we were able to establish benefits for from the last meeting, five that we could not. But people mixed up the VHA Camp Lejeune slides with the VBA data. So this data about with the breast cancer, and renal toxicity, and this data here is not the actual presumptive conditions for benefits. So I wanted to level set that.

CDR MUTTER: Lori, do you have a question?

MS. FRESHWATER: Can we get a better breakdown on the totals of the people that - I guess what I'm curious about is is it that they did not meet the requirement of 30-day residency? Or that they could not find a way to prove it? Because I know we had had some issues with people not being able to get correct documentation and that kind of thing, so is there any breakdown on those.

MR. HEROUX: For our side here at the VHA - Mark speaking here. We - so the two that you're looking at on that family member administratively ineligible you have not meeting Camp Lejeune residency. So we, as an organization, understand - and my wife's active duty spouse. So when she moves to a different base, I may be stuck here at Buckley for a little while longer until she picks up, and that means that she'll have been there longer than I have. So if there's a difference in that timeline where I wasn't actually on base for 30 days, or I was and I go ahead of her, let's say that, and I was on base longer than she was, and I lived on base hoteling. Let's say that. And then she gets there, and I find a house, and she's never actually lived on base but she was stationed there. There's like a lot of different variables that we have to take into account. So taking the veteran eligibility criteria into account, it's did the veteran get stationed at that base for a certain amount of time equaling 30 days of living on base and was I with her, if you will. Because she's the veteran in this manner, and/or did I move ahead of her and I can prove that I was in the hotel for 30 days on base inside of that zone. And then she moved and we weren't on the inside of the zone afterward. So those are kind of the separation in those numbers there. So I can be eligible without my veteran being eligible and vice versa.

MS. FRESHWATER: Okay, let me - I appreciate that. What I'm more referring to would be say a kid who lived on Camp Lejeune in the '70s and would be looking for records to prove that they were there. Sometimes, that's not easy to come by, so --

VHA: No, it's not, and we have issues with that, and I was speaking with my employee the other day. She's one of our subject matter experts and that's just to get some ground and some feet under me here. So there's different - and we will take almost anything into consideration, if you will. We've used a photographic album that someone photocopied and sent into us that their father had written, "Walking around for Halloween." And they wrote the time and date down, you know, that they - well, obviously it's Halloween, so they wrote the time and date down that the photograph was taken. And there, and, you know, and you can see in the background that it says, you know, Camp Lejeune, or what have you, or there's a picture of the hotel that we usually associate with finding them eligible. So there's many different things that we can take into account. Receipts from dry cleaners that were on there or - not necessarily dry cleaners, but utility bills to state that, you know, you paid a utility bill. Even though the Marine Corps may not have been tracking that you were in base housing, the electric company sure was, and your mom did her due diligence and kept all of her receipts for 70 years. Then, you know, that's - we take those into account, as well.

MR. ENSMINGER: If you were living in base housing, you didn't pay any electricity. If you were living in base housing, you didn't pay any electric bill. The only thing you would have paid is a phone bill.

VHA: Yeah, all right, then a phone bill receipt. Any utilities that you have. I'm just speaking offhand. I apologize. But yes, and we take all of that into account. Anything that you can bring forward that would state any kind of inkling that you were there, they take into consideration.

MS. FRESHWATER: So report cards, anything like that, you would -- -

VHA: As long as the report card is --

MS. FRESHWATER: It sounds to me what you're saying, like you're reading in - you're trying in good faith to --

VHA: Oh, yeah.

MS. FRESHWATER: -- give the benefit of the doubt to the person, the family member.

VHA: Yeah. If the report card is original, a photocopy, if you will, and it has the written house number for base housing that the child went through, then yeah. And if the school could only have been attended if they were on base housing, meaning like a veteran's child couldn't have gone to that school unless they actually lived on the base, you know. Those are things we'll take into consideration, as well. I'm not saying they'll all be approved necessarily because we have a lot of guidelines we have to follow. But we err on the side of caution, meaning the tie goes to the runner, more often than not.

MS. FRESHWATER: Okay. I appreciate that.

VHA: Yeah, no problem.

MS. FRESHWATER: Thank you.

CDR MUTTER: Bernard, do you have a question?

MS. HODORE: This is Bernard Hodore from the CAP. I wanted to know why the Camp Lejeune contamination don't have a registry. Registry.

MS. CARSON: So I know Patricia's not here. But I think this is a question that's been asked of her several times and I think she's answered it as and she said that she was willing to meet with this group to collaborate on the need for a registry. So I think that she said that previously, if you look at the transcripts. I don't know if that meeting occurred or not with anybody.

MR. PARTAIN: It did. I wasn't on that meeting, but still nothing's happened. I mean --

MS. CARSON: Right, but what did we - what did you guys decide? Because I wasn't on the meeting.

DR. BREYSSE: So, if I can try and recapitulate a little bit. So the conclusion was that we - the VA thinks that by taking the cohort that we've established for our health studies and maintaining that into the future. And analyzing that over time for new conditions and new mortalities is a more efficient way to continue to surveil the risks at Camp Lejeune. Than to establish a new registry with all the challenges with representativeness of a registry in terms of people self-nominating and who self-nominates, who doesn't. So the feeling was that the VA would commit, when we're done with our next round of studies, to maintaining that cohort. And that would be the mechanisms to which they will continue to look over time at the disease health experience of the veterans.

MS. CARSON: Do you have a tentative date in which you will have your next round of studies completed?

VHA: Who is that directed to? I apologize.

DR. BREYSSE: We'll answer that later.

CDR MUTTER: Okay, so should we move on?

MS. HODORE: I have another question.

CDR MUTTER: Oh, okay.

UNIDENTIFIED SPEAKER: Oh, yes, please.

CDR MUTTER: Sorry. There's one more question.

MR HODORE: If we don't have a registry and they have a registry for Japan in 2012, why they can get a registry and we can't [inaudible] for the airport in Japan, the airport in Japan.

CDR MUTTER: So I would suggest we wait till Dr. Hastings gets on the call and let's revisit this near the end because she's on a plane trying to get here. So can we revisit this kind of maybe near the end of the meeting?

MR. HODORE: Yes, yes. I'm just interested in that.

CDR MUTTER: Yeah, okay.

MR. HODORE: Okay.

CDR MUTTER: Let's circle back around near the end then.

MR. HODORE: All right.

CDR MUTTER: When we can get the right people on the call.

MR. HODORE: Okay.

CDR MUTTER: Okay, cool. All right, so I'm going to advance the slide.

VHA: Thank you. We should be on Slide 10, which is the top five reasons family members out-of-pocket medical expenses were not reimbursed. The medical bill was completely paid by primary other health insurance. The bill was previously submitted and considered. Diagnostic code on the medical bill is not covered for the approved condition. Family member provider did not submit a primary insurance, other health insurance explanation of benefits. And last, the prescription's not covered by approved drug formulary listing. Next slide, please. This is the total family member and provider reimbursements for each fiscal

year up to date. Next slide, please. And these were the questions from the last CAP meeting. The CAP requested information of the 931 family members administratively ineligible. Please provide a breakdown of that number based on the criteria mentioned in the presentation. So we have 976 family members that are administratively ineligible. Five hundred and twenty are ineligible due to the Camp Lejeune residency criteria. A hundred and twenty-three are ineligible due to veterans' eligibility criteria. And 272 were ineligible due to dependent relationship. CAP member requested how many of the administratively eligible but not clinically eligible are with conditions that have sufficient causation as shown by ATSDR. Camp Lejeune Family Member Program covers those conditions as stated in the law. The CAP requested, or excuse me, the CAP stated that in regards to benefits, people are being approved by the VBA after being denied by VA. The CAP would like to know how many and what major causes of the reversals are starting at 2010 and going forward. We here in Denver didn't have that information, so we defer it to the VBA and the Board of Veterans Appeals. Next page --

MR. ORRIS: Sir, excuse me.

VHA: Next page, please. Oh, yes, sir.

MR. ORRIS: Yeah, this is Chris Orris, again, on the CAP. When we were talking about the second question about the administratively eligible but not clinically eligible because of sufficient causation. There's in quotations here that, "PDHS is reviewing the science with ATSDR." First question is what is PDHS, and the second question is what does reviewing the science with ATSDR mean and what are the outcomes that you're looking for from that review?

MS. CARSON: Well, Pat Hastings' group, that former Dr. Erickson was also on that group. He retired. Pat Hastings and her group is the Office of Post Deployment Health. It's a VHA office and they're in the health care space, and they are the scientists and medical personnel who work with the ATSDR to look at these things. They're also the ones who maintain the registries, and so it's that group that Pat Hastings, Dr. Eric Shuping are all a part of within VA.

MR. ORRIS: Okay, so does that mean that the VA feels that they can - that there is a possibility that they can change some of the conditions from this? We had asked that question, at one point, whether the VB - or the VA's attorneys had any wiggle room as with the Camp Lejeune Family Member Program. I'm just

wondering why you're doing this VA or this review if the end statement is constantly we can only do what's required by law.

MS. CARSON: Right. So sometimes when - with the studies and the science, as ATR - as ATSDR also knows. We often may inform Congress with the findings of any new research, any new science or medical advancement that might point to additional disabilities that may need to be added to the list or other findings. So right now, that's what Pat's - there's some additional research out there that we're still trying to do, and I think they'll probably speak to some of that later. But that research is what is needed to inform us and we don't - and then they would determine, yes, we may expand the list. We would go to Congress and ask them to add these to the law. So that's what VA - usually when we get something like that and we have the science and the medical science publications behind it. We would then sometimes we can do a legislative proposal to Congress to extend - to add more disabilities. The Secretary may look at new presumptions. He has that authority to look at new presumptions. But until those studies and research are completed, there's not been anything added since the 2012 and then the 2017 law for benefits.

MR. ORRIS: So I'm glad you brought that up, because Senator Tillis had some questions that he submitted to the VA during one of the last appointments. And I know he's been waiting for a very long time for a response to those questions. Specifically regarding, you know, what is the VA's position on matching the causation that ATSDR is finding with Camp Lejeune Family Member Program. And I'm just wondering, at what point, does the VA plan on responding to Congress? You said that you want to work with Congress, but Congress asked these questions last spring and they are still waiting on a response.

MS. CARSON: So Dr. Pat Hastings is not here right now, but she would be the best person to answer that for the Family Member Program. And as you know, Mr. Orris, we also helped - my staff helped you with some of that, but we're on the benefits side, so I really can't answer that question. But I think we hold that question till she arrive or call in.

CDR MUTTER: Tim? Question?

MR. TEMPLETON: Thanks. I got a quick question. You were - just the subject we were just talking about as stated in the law, the first question there. Is Dr. Hastings heading up that effort?

MS. CARSON: Her - the staff that she works on heads up that effort. There are several other doctors there. I don't know who

actually is the primary director or executive director of that staff, but we could find out.

MR. TEMPLETON: I'll ask her, then. Yeah, that's kind of important, especially give the presentation that Dr. Hastings gave this last CAP meeting. That was one. The other, has anybody done a legislative request from VA for Camp Lejeune ever?

MS. CARSON: We've done a technical assist to a request from Mr. Orris. We have not done a specific legislative proposal to add additional benefits. Because we would need the science and we would need the public - we would need that research to be completed for us to then look at it. So on Dr. Hastings' side of the house, she's still - they're still working on some of that research, and on the benefits side of the house, we have not put a legislative proposal to add additional disabilities. We have - we rely on Post Deployment Health to advise us on what the science shows.

MR. TEMPLETON: Okay. Well, thank you. I appreciate that. I'd point out that there's a lot of science that's already out there that - and in fact, there's some recommendations that were passed along by ATSDR in 2017. After they finished their public health assessment. I would think we could probably pick up the pace a little bit here. We're three years after that. We're three years after that.

MS. CARSON: Well, I appreciate that, but I want to tell you that what we do with that is we have to make generally the secretary's authority is that he may recommend presumptive disabilities based on that information. He waits for all of those - all of that research to be concluded. We generally would advise the secretary based on the research and based on that information and we would make a recommendation to him. I don't know that that has happened and we have to wait for Dr. Hastings to come for you to be better informed on that issue.

MR. TEMPLETON: Okay, thank you. I'd mention, also, that you used the word wait a couple of times. And I want to point out that there are a lot of members in our community that don't have time. We are wasting their time here, if we're not moving forward as quickly and as expeditiously as we can.

MS. CARSON: And I'm sensitive to that, sir, but I can't answer your question at this particular time because that is certainly with Dr. Hastings' staff and I don't have that information.

MR. TEMPLETON: Thank you. I'll follow up with her. Appreciate it.

CDR MUTTER: Shall we move on?

VHA: Yes, thank you. Next slide. CAP member requested the number of times a child who has been exposed in-utero and has been denied eligibility based on the 30-day residency requirement for a child in-utero. Zero. CAP member requested to know how many people are being denied due to not meeting administrative criteria, the eligible veteran, residency, etc. Nine hundred and sixty-seven. The CAP requested the number of claims filed for renal toxicity. Four. The CAP requested the numbers for breast cancer are broken down to male and female. Four male, 438 female. Next slide, please. And that is it. Thank you for allowing me to present to you.

MR. PARTAIN: I do have one question on the family members. If there is an issue with a bill or something that's not being paid, is there a point of contact to - for them to reach out to?

VHA: Hang on real quick. Let me get some data together for you real quick.

MR. PARTAIN: Okay, thank you.

CDR MUTTER: While we're waiting on that, if we could have the contract examination (CE) program prepare and I'll pull up your slides.

MS. MILLER: Good morning. Thank you. We are prepared, and if it's okay with you, ma'am, we'll take this opportunity to introduce ourself. We missed the attendance intro opportunity.

MS. CARSON: This is Laurine. That's perfectly fine.

DR. BREYSSE: Was there going to be a response to Mike's question, first?

MS. CARSON: Mike's question was -- -- so I would ask family services. Do you have a point of contact for an unresolved bill for a family member?

VHA: Yes. If it's a bill for a family member, they should call the 1-866-372-1144.

MS. CARSON: Can you repeat that one more time, please?

VHA: 1-866-372-1144. And that's from our Slide No. 6.

VHA: So I came from the call center, believe it or not, and both the veterans' side and family side. If you do call a standard family number or a standard veteran phone number for the VHA, you're going to wait for their wait time, which is anywhere from 20 to 45 minutes. And then they're going to transfer you to that

FSC number he just gave out for the family member side. So it behooves everyone to make sure they have that number and it's well-distributed throughout so they don't have to waste their time. Because I know how it is to be on hold for that long and then just get transferred and then you have to wait again. So make sure you document that. The veteran one is the one that's the slide previous to that. I don't have it up right now. Hang on real quick. The veteran number is 877-222-8387, and that's found on Slide No. 4. So make sure you call those numbers in the case of a claim denial or you have any questions around a claim so we can get you through there as expeditiously as possible. And that is all we have. Thank you.

MS. CARSON: Okay, thank you. And so, Pam Miller, I'm going to turn it back to you so that you can introduce yourself and your staff that's on the phone and begin your presentation.

MS. MILLER: Yes, ma'am. Thank you. Good morning. This is Pam Miller. I am a director of the contract exam program office, and with me, I have several staff members that would like to take the opportunity to introduce themselves. And then we'll jump right into our presentation.

MS. CRAFT: Good morning. My name is Melanie Craft [assumed spelling] and I am a management analyst on the operations team.

MS. MADDOX: Good morning. My name is Tiffany Maddox. I'm a management analyst on the acquisition team.

MS. HARROD: Good morning. My name is Shanella Harrod [assumed spelling]. I'm a management analyst on the operations team, as well.

MS. MILLER: We thank you for the opportunity to present to you today and we are happy to take questions along the way. Our goal this morning is to provide you with an overview of the contract exam program office, give you a bit of info about our program. And answer any questions, of course, that you might have for myself and the team. At this time, I'll turn it over to --

MS. CARSON: Pam, this is Laurine. When you speak, can you just say next slide so they can know to go to the next slide?

MS. MILLER: Oh, absolutely. So without further ado, I'll turn it over to Melanie to jump into the presentation, and our first slide is the cover, so you're free to go to the next slide, at this point, for Slide 2. Thank you.

MS. CRAFT: Good morning, everyone. This is just an overview of what makes up the program office. We have operations,

acquisitions, quality, and the team that does DBQ and training. Next slide, please. This is just a map of the continental U.S., Hawaii, and Alaska, showing the regions, the four regions, in which we've broken it up. As you can see, we have three vendors and each vendor has an assigned region. Next slide, please. Just a little bit more detail on that. We are working on a contract that started in November of 2018. We did have a fourth vendor. However, their contract ended in November of 2019. We covered the entire U.S. and 33 countries overseas. Next slide, please. This is just an overview. The contract examination program office steps in when VHA does not have the capacity in order to do an examination. The preference is for veterans and service members to get their examinations at VHA. Our system, the examination requests routing assistance, tells the regional offices whether it goes to VHA or to the contract vendors, depending on VHA capacity. Next slide, please. I'm not going to go down this list, but this is our most requested DBQ types. As you can see, the largest number are hearing loss and tinnitus. Next slide, please.

MS. CARSON: So that we don't go too fast, I will read some of those, because we have a lot of audience members that may not be able to see the slide. So it's hearing loss and tinnitus. It's back or the lumbar, thoracic lumbar spine. The knee and the lower leg is a DBQ requested. Mental disorders, PTSD, foot, headaches, peripheral neuropathy, but those are the general - those are the primary DBQs that are requested. And I have - I do want to clarify one thing that might be pressing for Camp Lejeune veterans is this list is not the DBQ types for them, right?

CE: No, ma'am, it is not. It is inclusive of all DBQ types requested through all sources for the vendors.

MS. CARSON: Okay, thank you.

CE: Mm-hmm.

MS. CRAFT: Next slide, please. National mission. For those of you who are unaware, we do have two different programs that allow active-duty service members to begin their VA claims while they're still on active duty. So that when they discharge from active duty, their VA payments start immediately. The first program is IDES, which is for service members who are being discharged due to disability or disease, so they're going before a medical evaluation board. The second program is Benefits Delivery Discharge, and that is for veterans who are just transitioning out but not due to disability. QTC is the only vendor assigned to do that national mission and they cover

Alaska, Hawaii, and the continental U.S. Next slide, please. IDES versus BDD. I already explained some of this. However, with IDES, it is a VA and DOD collaborative. So the examinations that VA does for the IDES disability is also used by the medical board as DOD is transitioning that service member out. With BDD, those are strictly for VA claims, and therefore, DOD does not use those examinations for any purpose. IDES is run in conjunction with DOD and they have have [inaudible]. BDD is, again, just a VA program. Next slide, please. As I said earlier, we cover 33 countries in the world and that is VES only. That contract, as you can see, for those of you who can see the slide, we did 7,873 exams in fiscal year '17, 14,448 in '18, and 15,957 in '19. The other thing I wanted to point out about this particular contract is that VBA provides the only opportunity in foreign locations for veterans to receive contract exams or exams in support of their C&P exams. So we're very proud of our ability to let this contract and service that population of veterans. Next slide, please. This is a list of the international locations and when the countries were added to the contract. As you can see, we are adding additional countries as we identify a need there and can locate providers. Most recently, we added Ecuador, Greece, Singapore, the United Arab Emirates, and Uruguay in June of 2019. Next slide, please. The scheduling process. Okay, initially, it starts with VA sending a request to the vendors. The vendors then reach out to the veterans via telephone within three business days of the exam request receipt date. So that is when they receive it in their systems. Then they send a confirmation letter to the veteran at least five days prior to the appointment. We require postage-paid first class letter. Sometimes they send it by UPS or FedEx. If they're unable to reach the veteran by telephone, then they, again, send a letter via tracked method, again, certified, UPS, FedEx, at least five days prior to the scheduled appointment. The vendors then follow up by telephone or electronic method, so e-mail, 24 to 48 hours prior to the scheduled appointment. The veterans are allowed to schedule the appointment one time. So, you know, if they agree to an appointment time, and then suddenly, they get sick, or a child gets sick, and they can't make that one, they can call the vendors and get that rescheduled. They should contact the regional offices at 1-800-827-1000 if they cannot make the appointments offered by the contractor or if they weren't able to attend the scheduled appointment. That way, we have a record that they weren't able to make it and we won't move forward on the claim.

MR. TEMPLETON: What happens if they've used up that one opportunity to reschedule already and they have to do so again?

MS. CRAFT: The vendors will come back to us and we will reach out to the veteran and see when they are available.

CE: And based on their availability, they'll be rescheduled or the request will be rerouted to a vendor for scheduling.

MS. CRAFT: Next slide, please. Beneficiary travel. Okay, this is for the commons -- the United States, Alaska, Hawaii, continental U.S., and the territories only. The vendors - oh, sorry. I skipped, but I got to the bottom. Vendors schedule at the nearest facility to where the veterans live. So they are required to schedule a non-specialty exam within 50 miles or they have 100 miles radius to schedule a specialty examination. Now veterans can agree to travel further. As I'm sure you're aware, we do have some rural communities and states where, unfortunately, sometimes they live more than 50 miles out of town. So therefore, they can agree to travel further than that 50 or 100 miles. Travel reimbursement is where I started. We only play that - pay that within the United States and the U.S. territories. At this point in time, we do not pay mileage overseas. The current reimbursement rate is 41.5 cents per mile. That check is automatically cut by the vendors when the veteran attends the appointment and it usually takes no longer than three weeks for the veteran to receive the check. Next slide, please. Our quality team is fully staffed. They review the vendors' completed DBQs and provide feedback for consistent errors or things that they can use to improve. They do monthly random sampling. They create the error citation report. There are vendor guidance memos where if we feel we need to clarify previously-provided guidance. We also have quarterly quality reports and we perform vendor site visits. Next slide, please. This is just an example of the training that they did in fiscal year 2019. So there was training in January for ACE examinations. In February, they provided trainings on 1151 claims. February 2019, on the 3M earplugs. Gulf War training was conducted in March of 2019. Musculoskeletal examinations for functional loss, which is really to the court case named Sharp, was completed in April 2019. Mental health error trends was June 2019. DBQs from a clinical perspective, July 2019. And then also in July of 2019, there were multiple audiology trainings. And they continued to implement additional trainings and provide trainings as required to the vendors. They do take the same training as the VHA clinicians.

MR. TEMPLETON: This is Tim Templeton. Regarding your quality checks here, have you guys considered possibly looking at some of the overturned decisions at VBA? Because I know that several

of them have - were done before VES was done, but they still did include some in-house folks at VA that were doing the C&P.

MS. CARSON: Oh, are you referencing the examinations or are you referencing the rating decisions?

MR. TEMPLETON: Actually, both, because and the reason why I'm asking, why they're related here, is that you'll get the C&P examination results back and then we'll get the denial from VA. And then a good number of those will end up being overturned at VA. So you would say, or at least if it were me, I would be looking at that saying, well, something's wrong over here in the C&P process.

MS. CARSON: So one of the things and one of the data do outs I think I've been hearing a lot but we didn't get it for this particular meeting but we do need to get it to you. Has to do with the BVA, Board of Veterans Appeals, remand rates. Because that's where you would see that if a new exam was there, that exam would be an overturned exam. So I need to get some more information. That's a totally different group, not in - BVA is a totally different group, the board. So I need to be able to get that data from them and have a presentation on that information. I think that is what we're going to owe you.

CDR MUTTER: Bernard, do you have a question?

UNIDENTIFIED SPEAKER: Thank you, [inaudible].

MR. HODORE: Yes. I would like to read something from the Women Marine Association. It seems like we're dropping the ball on our women Marines. "It has come to my attention that the Camp Lejeune water contaminated registry and health eligibility is not including reservists that were not called up for active duty. However, there are reservists that did train for their two weeks out of the year, or did their weekends once a month, or both. Which would make them eligible, in one sense, of the contamination with no consecutive 30 days of water contamination. This situation is not allowing these members any VA care as veterans did not serve their country in this capacity. In recent ATSDR CDC meeting, touched briefly upon this subject. However, said that the reservists did not meet the requirements because they were not called into active duty as a reservist during certain period of time between 1953 through 1987. Least we not forget that the base was not cleaned up entirely till 1987."

DR. BREYSSE: Bernard, if you don't mind, is there a question that you're trying to ask?

MR. HODORE: Yes. I wanted to get this on record on why we're not doing this for the women Marines. And the Marine - the Women Marine Association wanted this question handled.

DR. BREYSSE: Okay. So can you articulate maybe in a more shorthand way what the exact question is so we can make sure we get the VA to do it?

MR. HODORE: Well, the exact question is why are these reservists being left out? Why --

MR. ENSMINGER: All right, wait a minute. When the secretary of the VA created the Camp Lejeune presumption program, reserve and National Guard are included in this if they have not continuous 30 days but accumulated 30 days. So if they accumulated 30 days of duty aboard the base, they qualify for the program. Cut and dry.

MS. CARSON: I agree. Thank you.

MR. HODORE: Thank you, Jerry.

MR. ENSMINGER: Yep.

CDR MUTTER: Thank you. Do we have a next slide?

CE: Yes, please next slide. So we should be on Slide 13, which discusses quality. And this slide just provides an overview of the different activities that our quality program takes to ensure that our vendors are providing us with DBQs that are sufficient for making reigning decisions. Next slide, please. This slide outlines the types of training that all vendors were - contract examiners were required to take in FY '19. And the next slide provides information regarding the vendors' performance standard as it related to veteran satisfaction. And for those of you that cannot see the slide, you would note that the FY '18 overall satisfaction score was 93%. And FY '19, or the close of FY '19, I'm sorry. We closed at about 93% for FY '19, as well. That concludes our presentation. Are there any specific questions that we can take?

CDR MUTTER: I see Tim going for his name tent. Go ahead, please.

MR. TEMPLETON: Yeah, this is Tim Templeton. On this last slide, actually, that you have right up here, I'd like to know a little bit more about what the group, the population was that was sampled on this or was it a sampling? Was it a - are these full statistics, in full that you've done? You've got the un-sat performance, so I imagine then this is an o-sat test. And so in the course of the o-sat test, I'm frankly a little bit curious here as to how we got into the 90 to 94% of the expected

standard of performance. I know enough people to knock that number down quite significantly, I suppose, so that's why I want to question where the numbers are coming from. Are these complete numbers or was this a sampling?

CE: Thank you. That's a great question. We're happy to take it. What I can tell you is that VBA contracts with a third party vendor to ascertain customer satisfaction rates. The way that those rates are determined is every vendor - or every veteran is provided with the opportunity to make a determination as to what the outcome of this score is. As part of their appointment package that's sent out by the vendors. So each vendor - each veteran receives a veteran satisfaction card, so to speak, where they have the opportunity to rate the administrative and clinical staff at the appointments that they've attended. And submit that information back to our third-party vendor so that we can ascertain their level of performance in regards to veteran satisfaction. The scores on the slide are just indicators that give you insight into how we determine have been successful in this particular performance element. Based on the percentage or overall score that each vendor receives. So as going back to your point, all veterans have the opportunity to speak to their level of satisfaction with the exams that they receive by our contract exam providers. Tim?

MR. TEMPLETON: So I guess it would come down to how many actually responded. There's probably a large number of them that I would - I'm making an assumption here, of course, that didn't respond. So I mean if you're taking ten of them that got returned out of 1,000 of them, you know, I'm just kind of curious on how you would spread that into a full o-sat.

CE: All cards that are received are validated or considered as part of the final score.

MR. TEMPLETON: So nothing to consider the other ones that are - the large number or a number that are they all returned? I'm guessing that at least some of them are not returned, right?

CE: All veterans are provided with the opportunity to respond, and those that do, you know, are considered part of their overall scores for their evaluation of their performance.

MR. TEMPLETON: Thank you, drive through.

MR. PARTAIN: So you don't have a response rate from the surveys?

CE: I may need you to elaborate on the question. My response is that in FY '18 and '19, we had a 93% satisfaction rate, sir.

MR. ENSMINGER: How many responses did you get back? What's the percentage of participation by the veterans?

CE: I don't have that information immediately available in front of me. What I can tell you is that I believe industry standard for all surveys, whether we're talking about, I mean, a survey -- -- industry standard for a response rate go anywhere from 15 to 25%, or so. That's me being speculative. However that, again, I don't have the specific information as far as what our particular response rate was for any given period. But again, I'd like to remind you that every veteran is provided with a satisfaction card for every appointment that they're scheduled to attend with our contract exam vendors. They also have the opportunity if they don't wish to submit the card via mail directly to the third-party vendor, to provide that information via an online Web link. That's provided to them in their appointment package, as well. And again, we concluded FY '19 at a 93% satisfaction rate.

CDR MUTTER: Okay, so we are at the questions slide. Are there any other questions for the contract examination? Okay, so the next thing on our agenda is the action items. I'm going to suggest we hold action items till a little bit a later in the meeting so we can have Dr. Hastings here. I think it would be helpful. We don't have to revisit things. So if we can just go ahead, and we'll move on to the ATSDR block, and then we'll take a break, and then we'll revisit action items, and go from there. So if we can soil vapor intrusion with Jack Hanley and I'll go pull up your slides.

SOIL VAPOR INTRUSION PUBLIC HEALTH ASSESSMENT UPDATE

MR. HANLEY: Good morning, everyone. I'm Jack Hanley. I'm the acting branch chief of the Central Branch, and I oversee the project of the Camp Lejeune soil vapor intrusion public health assessment. And today, I'm going to - let's see how you do this. I'm going to give you an update and an overview of where we are. First thing I'd like to do is go over some of the key accomplishments. Many of you have been participating in a lot of these activities where we had the work plan. It was peer reviewed. It was presented to the CAP, and the Navy, and that was finalized. The staff, as we've been giving you updates over the years about the computer application and developing that system, importing all the data. That's been completed. And as you know, we've had a number of technical workshops with the CAP and we've had the same updates and workshops with the Navy. We've been able to get some good information and assistance from

you guys. And I think at the last one, we received some input on - you gave us a number of suggestions on mainly helping to be more effective in communicating our results. And then also, that's only - that's in addition to the mapping. I think a lot of this, when we went through our little templates in detail, you know, provided us some good input, so we've incorporated those into the process. The latest thing is now the mapping system. When we showed it to you before, we only had one little area with all the data in it, the environmental data. But now the data is throughout. We have it all throughout the whole base of all the areas we're studying. So it's all in the mapping system. Recently, well, back in November, and I've reported this , too, in our monthly meetings, that the team went out to the Camp Lejeune project. So it was Danielle, and Tonya, and then our contractor. And they spent a lot of time looking at buildings and reviewing building records, especially the buildings that there had not been a completed survey of that we thought needed to be looked at. So those buildings that we didn't have all the information yet or they didn't do - the contractors, the Navy contractors didn't complete the surveys yet, we evaluated those buildings. And looked at all the records, and, you know, construction, and just all the details of that are important to soil vapor intrusion, and occupancy, and those kind of things. So they took a tour. They saw the whole base, as I said, and looked at all the key buildings that were on our list to make sure we have the information we need. And then they gave them a simple, a shorter presentation of the workshop that we gave in D.C. It was a shorter version but we gave them an overview of what we're doing and how we're going through this process of evaluating each building.

MR. PARTAIN: And Jack, you said you guys did a workshop with was it the Department of Navy?

MR. HANLEY: Yes, during that visit.

MR. PARTAIN: Yeah, what was the feedback? I know you did one with us here, but what was their feedback? Any things you can share on that?

MR. HANLEY: Let me ask Danielle. She was there, I was not, and I'll let her answer that.

UNIDENTIFIED SPEAKER: Is it [inaudible]?

UNIDENTIFIED SPEAKER: It works.

MS. LANGMANN: Okay, so the question was what type of input did we --

DR. BREYSSE: Introduce yourself first just to get --

MS. LANGMANN: Oh. Danielle Langmann. I'm the project lead for the Camp Lejeune site, vapor intrusion portion of it. The type of input that we got, we did that TT84 elementary school presentation for them and showed them the templates like we had gone through during the September meeting. And then showed them the interactive mapping application. They - we let them know the types of comments that we got from the CAP. For example, the hazard category, like we have a Category 5 and that's actually our no hazard category. And you guys were like, "Well, that's - we associate that with hurricanes and a Category 5 is the bad." So it's like opposite, and so we told them, you know, we were changing it to Type 1, Type 2, like in terms of so it's not associated with other types of things like hurricanes. They liked the mapping application. They had some comments and questions about what we're going to be displaying like in documents and things like that, on colors. And are we going to provide boundary lines, and buildings, like how much building information we're going to show, occupancy. You know, they want to know which buildings we're going to provide occupancy and the hours that people work because I just want to make sure that that's not something that should be protected. That they don't want people to know about, you know, since this is going to be a public document.

MR. ENSMINGER: Huh.

MS. LANGMANN: Yeah, [inaudible]. And most of the buildings, especially the ones that C2HM, did go out and look at already, the occupancy data is already in their documents, which are out on the Web. But our document is specifically released to the public, so it'll have a different type of audience than a six-volume vapor intrusion document from C2HM in terms of putting out their occupancy. For the other types of changes, they asked questions about the places where the one in the vapor intrusion template where we had underground pathways. So if we're saying that there is a sewer line or natural gas line under the - near the building. They wanted to know more specifics about qualifying that in our text to say that we're not going to really discuss underground pathways like sewer lines and natural gas lines. Unless they're going through contamination and they're going towards the, you know, like towards a building. So just the fact that there's a natural gas lines, you know, we're not going to really push that in our vapor intrusion that that's an important pathway. Unless it's actually going through contamination that's towards a building. They asked for where we provide in the template for vapor intrusion. Besides giving our

conclusion on whether the vapor intrusion potential, is there a potential for vapor intrusion or not in the past, and is there a vapor intrusion potential currently. They want us to put and we had what their action was, whether it was like and for the elementary school, it was a no further action.

MR. PARTAIN: Danielle, let me stop here because I want to ask you a question.

MS. LANGMANN: Mm-hmm.

MR. PARTAIN: When you're talking about the like gas lines, and lines, and stuff like that, as pathways, some of the reports I remember reading, this has been a while back, so my memory's not as good as it used to be. But some of the reports I was seeing in the early-'90s, mid-'90s, discussing removal of the fuel tanks and fuel lines. There was a lot of attention placed on the reports of removing transmission lines and that they served as a pathway for, you know, contaminants to travel up into buildings. So if we're, you know, I understand they're trying to bring a concern about showing or talking about these, but aren't they, by nature, a pathway for vapor intrusion to a building. Because a, you know, water line coming in or gas line coming into a building has an opening into the building that allows vapors to get in. And is also a kind of a super highway for vapors to travel to enter into the building. So I'm kind of confused their concern there.

MS. LANGMANN: Yeah. They just want to make sure that -- -- that it's truly in - that it's truly a pathway potentially to the building or towards moving contamination vapors towards a building.

MR. HANLEY: Danielle, would it be appropriate to say that they - if it's not part of a pathway, they would prefer if we didn't show it on a map, basically. But if we do know it is part of a pathway and it is an issue, we could go ahead and present --

MS. LANGMANN: Well, the pathways for any specific building, like the elementary school. All the pathways, all of the map for TT84 is going to show where all of the current underground lines are that we have for that area. Whether it's discussed in the text in that table template, the VI table template is going to focus on things that were important in our VI evaluation. So you may see it on a map, but it's not going to be discussed in the text. Like we're going to focus that text and those bullets in our evaluation towards things that we considered for, you know, as part of a lines of evidence for VI.

MR. PARTAIN: And what about the transmission - I mean, what about the lines, either water, gas, electrical, that were ripped up and taken out during the '90s because they identified these as transmission points? Has that been accounted for in the work that you all are doing?

MS. LANGMANN: Yes.

MR. PARTAIN: Okay.

MS. LANGMANN: We're looking at - we don't have maps of where things were located. Like I know that one of the buildings that I was just looking on last week or the week before, there were a list of different things from I believe it was the '90s about different lines that were in the area. And it didn't say whether they're there or not. You know, it was like I pulled from this one background reference all of these different things. And so that's actually in the - it's in the template described and it's basically it's unknown if they were there or not, in this case. Because they didn't say whether they got removed, or not removed, or it's just something that a lot of these buildings I feel like there might be some unknowns. And so I don't - we don't know if the - all those lines are still there and exactly where they were located. We don't know if they went through as and if they could potentially be a pathway. So in terms of looking at data from the '90s and past potential exposures, if we know that there were lines in the area, even if we don't know where they are. We'll do, you know, worst case assume that there was the potential and they did help bring contaminants from the ground water and vapors into the soil and along those lines towards the building. So we'd rather be more protective and take a look at it even if we're not exactly sure. And that's some of the conclusions will be better supported than others in terms of lines of evidence. So we have to take into account that we're not exactly sure, but it's better to be protective and assume that there were some underground pathways to the building than to not assume.

MR. HANLEY: The next slide is I think over the year or so, we've talked about this issue of statistical testing. Conducting - we did the third and final statistical testing to look at the simulated historical groundwater reconstruction modeling results and comparing that with the shallow groundwater data. To see if we could use that modeling data and there was a big difference between the model data and the measured data. And like I mentioned, this is the third time we do this. We've kind of refined the process each time. But we determined that we can't use the first model layer of the shallow groundwater that was in

the reconstruction in this assessment because it's just not correlating with the data that's available.

UNIDENTIFIED SPEAKER: Just the shallow?

MR. HANLEY: Hm? Just the shallow, yeah. Just the shallow, because it was a first - in those reconstruction, this was like the first level of screening kind of thing. And so they were focused on the deeper water. And so as they refine their model, they focused on the deeper water, not the shallows. So what we're finding is that first screening that we're trying to see will it correlate, it's not correlating right now. And then we have a number of next steps that we, as always, we include your comments and we respond to your comments. And we're going to - we're working one building at a time, as Danielle mentioned, and we're going to evaluate the soil vapor intrusion line of evidence. Then we look at the public health implications of any exposures that may occur. And then we're also going to look at the effectiveness of the vapor intrusion mitigation systems. And we're doing that in each of the 130 buildings that we identified as the priority buildings. And -- -- anyone has any questions?

MR. ASHEY: Hey, Jack. This is Mike Ashey.

MR. HANLEY: Yeah, Mike.

MR. ASHEY: Hey. How you doing?

MR. HANLEY: Good.

MR. ASHEY: Hey, I want to make sure I understand that what Danielle said. That when she was at the meeting with the technical representatives from the Department of the Navy, that they did not agree that utilities are pathways for both plumes and vapor intrusion?

MS. LANGMANN: This is Danielle Langmann. No, they absolutely agree that utilities are pathways for vapor intrusion. They just want to make sure that, you know, you could have utilities coming in from the west side of a building into the building and you'll see that on the map. And if the contamination is on the east side, then in the vapor intrusion template that we write up which provides our lines of evidence. We're not going to include that line going into the building as a line of vapor intrusion evidence for there being potential vapor intrusion because it's not anywhere near the contamination. It's on the east side that the lines - the utility lines came in on the east side of the building and the contamination is on the west side of the building. So they just wanted to make sure that we weren't saying that, oh, because that would mean every building utility

lines are a line of evidence for vapor intrusion. So they just wanted to make sure that we're making - that we're looking at whether or not those utility lines are in areas of contamination, you know --

UNIDENTIFIED SPEAKER: No? What?

MS. LANGMANN: How far did the contamination go from the well? We have groundwater data for most of the buildings that we're looking at surrounding the entire building. And a lot of times, you have - you could see contamination through the maps, and especially with the interactive application that we have and the filters, you could watch. You could change the date and watch the contamination go up on the levels and go down again. And they have wells surrounding a building and it might only be hitting, you know, one corner of a building.

MR. HANLEY: But you're looking at over 100 feet from the building, right?

MS. LANGMANN: Yes.

MR. PARTAIN: Yeah, are you able to use --

MR. ASHEY: So let me make sure I --

MS. LANGMANN: Hold on. Let Mike finish.

MR. ASHEY: All right. Let me make sure I understand what they're saying. They're saying that if there is a contamination plume on the south side of a building and the utility lines come in on the north side of the building. That you should not consider those utility lines as pathways.

MS. LANGMANN: If the contamination is running north to south. So the groundwater flow would not - if the groundwater flow is not towards where the utility line is. If it's in the - in a different direction. So you wouldn't expect that groundwater flow and that contamination to go anywhere near the utility line.

MR. ASHEY: Well -- -- if it's groundwater flow with respect to a plume, yes. In most cases, that is the case, although there are documented cases where that is not the case, that contamination absolutely behaves differently, depending on the soil. But in this case, we're not talking about a liquid plume. We're talking about vapors and what they're stating is that those vapors are going to act the same way as an underground liquefied petroleum plume that is working its way through the soil. In this case at Camp Lejeune, you have soil which has high transmitivity which - or very porous.

MS. LANGMANN: Right.

MR. ASHEY: And so I don't see how that they can say that.

MS. LANGMANN: No, they're not saying that. They're just asking us to make sure that we look at all the lines of evidence that we place in that one template, that lines of evidence template, that we consider everything. And yes, we'll be considering the geology and the hydrology around the building. Tonya has pulled a lot of information already for a bunch of the different buildings that she's looked at for the Johnson and Ettinger, and you need the information. So she's been looking at the soil borings and that kind of stuff. So to the extent possible, we will have in our templates and in our discussion on buildings, all of that will be included. And if the - the Navy has not asked us not to mention that there's lines there and that there's a potential underground pathway. They absolutely feel that we need to document that. They're just saying make sure that you just don't put in your template, oh, there's a sewer line there. That we look into where is the groundwater contamination. How is it moving? What's happening with the soil? Are there, you know, clay layers in that area that are maybe going to make vapors move in different directions? And so we will be looking at all of what's happening under the surface before we make a determination of whether or not we say that sewer line is or isn't of concern or line of evidence for vapor intrusion.

CDR MUTTER: Mike, do you have any further questions for Danielle before we go around the table and the room for --

MR. ASHEY: Yeah, just a comment. Jack stated that the ground - the shallow water groundwater modeling doesn't match reality and I would argue the same thing here. That just because they say that it shouldn't happen with respect to vapor intrusion and the location of a plume with respect to a utility line intrusion into a foundation of a building. That doesn't mean that it's not going to happen. And so here, again, you have a situation where what they're saying with respect to theoretical modeling may not match reality. So I just caution you on that. You've already discovered that with groundwater modeling, that it doesn't match reality. So that's actually the only comment I wanted to make on this.

CDR MUTTER: Thanks, Mike. I'm going to turn it to --

MR. ASHEY: Thank you.

CDR MUTTER: Thank you. I'm going to turn it to Chris.

MR. ORRIS: Hi. This is Chris Orris, CAP member. So Danielle, I keep hearing the word they when we're discussing this. Can you talk about which agency or agencies you're meaning when you say the word they?

MS. LANGMANN: Okay. They is the technical staff that we've been working with at Camp Lejeune. It includes --

UNIDENTIFIED SPEAKER: Who's we?

MS. LANGMANN: It - I could give you names. I don't know how they're --

UNIDENTIFIED SPEAKER: Company names?

MS. LANGMANN: No, companies, we have Charity Delaney.

MR. ENSMINGER: That's environmental management.

MS. LANGMANN: Scott.

CDR MUTTER: Williams.

MS. LANGMANN: Williams.

MR. ENSMINGER: Scott Williams?

MS. LANGMANN: Scott - what is Scott's last name?

MR. ENSMINGER: Williams.

MS. LANGMANN: Okay, Williams.

MR. ENSMINGER: A little skinny, looked like Opie?

MS. LANGMANN: Kristen Anhorshtel [assumed spelling]. I don't know how to spell her name. And Ansley Boucher [assumed spelling].

MR. ORRIS: So which agencies, though, are these people with?

MS. LANGMANN: They're all Camp Lejeune staff.

MR. ORRIS: So my question in this is who has the ultimate oversight regulatory in regards to vapor intrusion at Camp Lejeune? Is it the Department of the Navy or is it the North Carolina Division of Environmental Quality?

MS. LANGMANN: I'm not sure who has regulatory authority, but for our work, they don't have any authority at all. Like we'll be looking at and they could say, "Well, you shouldn't put this at -" when we go to public comment, they could say, "Well, this -" we might say a pipe, for example, is a potential underground pathway. And they may disagree and say, "No, it's not." The

vapor intrusion lines of evidence that we have in our document are going to be ours and it's not - regulatory has nothing to do with it.

MR. ORRIS: All right, so but for argument, let's say NCDEQ is the ultimate regulatory oversight for Camp Lejeune's water quality. Would that be correct? And if that's correct, or even if it's not, what level of cooperation or involvement does NCDEQ have in any of this process? And if they have none, why do they not have none, and if they do have some, why aren't they at this table?

MR. ENSMINGER: They don't have none. They don't want to get involved.

DR. BREYSSE: So we won't get involved in the regulatory aspects of the cleanup, right, and so that's where, I think, the state is involved. And so we have no regulatory authority, we being ATSDR, in this case. So in fact, we steer clear of that because we have freedom to do stuff in the federal government because we're non-regulatory and we wouldn't want to jeopardize that. And so we very carefully stay away from that.

MR. ORRIS: Thank you, Dr. Breysse. I guess my question is when we come across a site of concern, are we relaying that information to the regulatory authority, namely NCDEQ. So that they can make sure that they're following up with the Department of the Navy to address these situations. I understand that we're looking at a historical water modeling, but are we not forwarding that information to the regulatory oversight?

MR. HANLEY: Oh, we definitely would. We would share what we have with them if we saw something that was an issue. We wouldn't wait until the end of the report. We saw something now, we would work the channels to get that information, and say this is what we've seen, and let them follow up. We wouldn't just wait.

MS. LANGMANN: Right. Whatever recommendations that we make, whatever public health recommendations we make so that people aren't breathing in buildings on a base levels of health concern, we'll be working with. I primarily have just been working with the technical staff at Camp Lejeune who I thought had authority to enact my recommendations that they would be looking at. But when we released the document for public comment, we can work with the Navy and with the CAP. If there's regulatory agencies and names of those people in regulatory agencies to make sure that they get a copy of our document and all of our recommendations. And again, like Jack said, if there's a recommendation that we need to make and we feel needs

to be taken care of now, we won't be waiting for to release the documents. We'll be contacting the agencies, at this point in time, to say, "We really think you need to act on this at this point in time."

MR. ORRIS: I appreciate that. Thank you. And then, of course, my one last follow-up question is has that occurred?

MR. ENSMINGER: Not yet.

MR. HANLEY: No. We haven't come across anything that would raise anything to that level at all.

MR. ORRIS: Thank you both. I appreciate it.

CDR MUTTER: Thanks, Chris. I have Dr. Cantor next.

DR. CANTOR: Yes, thank you. This is very interesting information and my mind is going probably to the next steps of how useful or not useful the information is in the sense of exposure assessment or public health assessment. First of all, I think I'll make the statement. I think Frank will confirm that this is not useful for the epidemiologic study because of all the uncertainties in the modeling, where people were, and exactly where things were historically, and so on. So that being said, though, is it possible for these data to be used in exposure assessment in terms of giving maybe maximum possibility of maximal exposure to individuals. Who might have been spending either living there, and that's another question. How many of these applied to residences and how many working areas? But could it be used to put limits, to put boundaries, on what the exposures might have been. And how they relate to the exposures that we may have a little more confidence about in terms of the drinking water exposures. I have one or two other comments and questions, but if you want to respond to that first.

MR. HANLEY: We will, as Danielle said, and we've explained in the workshops that we've had, once we identify the concentrations that we believe have gotten in there and the range that we think have gotten in the buildings. Then we look at the public health implications of those exposures. And then we'll be able to make a public health conclusion based on that, understanding all the uncertainties that you mentioned.

DR. CANTOR: Yes.

MR. HANLEY: And in that context, we will explain that what we believe is the public health implications of those exposures. Now with related to the groundwater, using that information and

conveying it with the groundwater, I'll let Danielle talk about those issues, and there's some challenges with that.

MS. LANGMANN: Okay, yeah. So there's too much uncertainty within when you look at the uncertainty in the groundwater, and using the model data for the groundwater, and then VI. As Mike indicated, you might get VI in a building and you don't expect it, and you might get - assume that there's VI going to be in a different building and there's nothing. Like it's VI is very, very tricky, so there's a lot of uncertainty. So we're not going to try and combine a risk number that was in the public health assessment for drinking water exposure with a cancerous number for the VI. With that said, when we look at the overall public health implications, we will be able to make statements qualitatively, not quantitatively. About increased risk when you're looking at if you have a one risk from the VI and one risk from - vapor intrusion, and one risk from drinking water, that, you know, that increase, you know. Is that going to increase your potential public health concern for a harmful health effect? And I haven't developed text for that yet. I'm thinking we'll probably use things like, you know, there's - it's very low, low, moderate, but more qualitative terms. And sort of especially looking at past exposures when people were drinking water at much higher concentrations and there was the potential for VI, too. We'll be giving more qualitative, not quantitative.

DR. BREYSSE: So a couple of observations, if I may. So this is, and correct me if I'm wrong, but this is the biggest vapor intrusion investigation in a large scale like this with large visibility has ever conducted. And so we're, in many ways, we're plowing new ground, and I was briefed on this recently and there are thousands of pages of documentation, information that has gone into this estimation. So just the data management, data handling, and data synthesis of this is gigantic and our team is doing a fantastic job. I've been very impressed. But our first, you know, our first public health challenge is to make sure if there are ongoing exposures, we identify them and we stop those. So that's probably the biggest, most important public health goal we have right now. The second goal is to look back in time and see do we think there's some cumulative risk here that we might want to worry about or not. That's a much bigger challenge, as you said. And we probably don't have good tools to do that in a real quantitative way like we might have done with the drinking water for the other studies, but we're not going to ignore it. We're going to do our best to try and estimate what we think the added burden this might add. But our principal goal

here is to stop the exposures from happening if we think they're unacceptable right now.

DR. CANTOR: Okay, thank you. Two more specific questions. One, do you have an estimate of what proportion of the buildings are residences or were residences in the past? So this would be a 24-hour type exposure to some people who might have been living there. Do you have a sense of that?

MR. HANLEY: Danielle, do you have a ballpark figure for that, roughly?

MS. LANGMANN: I can get one for the next meeting. I do know that there are a number of BEQs, the bachelor enlisted quarters, and there's also like married quarters. There's a couple of those in there. So yeah, there are - there definitely are residences where we're assuming the 24 hours of exposure.

DR. CANTOR: Great. And just to be, well, to be specific, was this all TCE that you're modeling, or is it many other things, or is it a Ganish [assumed spelling]? What --

MS. LANGMANN: We're not necessarily modeling like the groundwater did. We're trying to look at the measured concentrations in shallow groundwater, exterior soil gas, sub-slab soil gas --

DR. CANTOR: Of?

MS. LANGMANN: -- and indoor air. Of there's 160 compounds in EPA's guidance that have a potential for vapor intrusion. So our screening process and is looking at all of them.

DR. CANTOR: I see. Okay.

MS. LANGMANN: BTEX, benzene, toluene, ethylene, benzene, and xylene, yes, are included.

CDR MUTTER: Any other questions?

DR. CANTOR: Okay. Not right now, thank you.

CDR MUTTER: All right, Jerry?

MR. ENSMINGER: Yeah. One thing everybody needs to remember, especially on the Hadnot Point industrial area, and a lot of the older H-style barracks that have now been converted, a lot of them, into office spaces. Those things are as old as Methusah, and I'll guaranty you every slab that every building in the industrial area is cracked. It's had holes drilled through it where they mounted equipment and bolted equipment to the deck. So, you know, this shit about worrying about whether a sewer

line comes into the north side or the sound side is a bunch of crap. So, you know, and this is nothing more than the Navy and Marine Corps way of harassing you. That's all it is. I mean they did it with the water model. They didn't want you to pinpoint. They didn't want you to show the maps with the well sites on them. The commandant of the Marine Corps put a damn leaflet out that had the maps located right perfectly identified on them. And but later, when the report was about to come out, oh, you had to take those wells off there. Well, you go to the USGS website, every well on Camp Lejeune is on their website with a 14-digit grid coordinates. So.

CDR MUTTER: Thanks, Jerry. I want to get to Lori, Tim, and then Mike.

MS. FRESHWATER: Is there any consideration being given on the flooding issues that are ongoing and will be ongoing in the years and that has happened already?

MR. ENSMINGER: Global warming.

MS. FRESHWATER: Is Jerry adding to my flooding comment over there?

MS. LANGMANN: Yeah. I know that the flooding and, you know, hurricanes that hit, and shut down buildings, and electrical systems, and obviously vapor intrusion management systems, and all of that stuff. We're aware of it and that we know of, I guess. If there's an area that's particularly prone to flooding, it's something that we conclude - include in the background information about certain areas if it's available online and we can.

MS. FRESHWATER: Well, I mean, the entire - it's silty soil, and as you get closer to the water, obviously that becomes more so and the whole base is prone to flooding. I mean it's North Carolina and I don't remember how much they requested for repairs for one hurricane, you know. It was like a billion or something. So --

UNIDENTIFIED SPEAKER: It's [inaudible].

MS. FRESHWATER: I think it would be really unfortunate not to get that in there. And it goes back to what Jerry is saying. West or east of the building, when you have flooding, it moves soil. That's what it does. I mean I've seen radiation taken from a creek up into people's backyards, not with Camp Lejeune, with another location, so.

MS. LANGMANN: Yeah. I will talk about it with Tonya Burke, who's our subject matter expert for vapor intrusion. And see what types of background documents or how that's been included in vapor intrusion assessments and see if it's something we can consider looking at more closely for this document. I'm not sure if there's anything out there, at this point in time.

MS. FRESHWATER: And it might be just something that, you know, you should have in your back pocket when talking to people who want you to limit where you're looking. Soil doesn't just stay in place, especially not on Camp Lejeune.

CDR MUTTER: Okay. Thank you for that comment. Tim, can I get your comment?

MR. TEMPLETON: Yeah. Two questions real quick. One, and I kind of know the answer but I've got to ask it. Will we ever get access to the ARCGIS system? I got to ask it. You know I do.

MS. LANGMANN: I know it. The --

MR. HANLEY: We will show you in the future. We'll come back once we have more analysis done. They're working really hard to get building to building, but we'll come back and show you. As far as public access, I'm not sure --

MR. TEMPLETON: Okay.

MR. HANLEY: -- if that's even feasible.

MS. LANGMANN: The actual database and the way it's set up and stuff, I think we have discussed in the past, it's ARCGIS online and CDC doesn't actually support it. So but what we discussed in actually a meeting that we had with Dr. Breysse earlier was for other presentations and possibly I'm going to - I actually have a meeting at 1:00 today with staff. So I'm going to find out from our GRASP] group if different things are possible. But when I was going through and you showing, okay, here's, you know, Tarawa Terrace Elementary School, and here's the naphthalene or the benzene concentrations. And you could look at the concentrations go up and down as different things happen in the groundwater. And it's nice to see that maybe in the health assessment document, because ARCGIS, I think other places, when I link online, you can, through other government websites. You can like click on a link, and you could use a slide bar, and it could show you, you know, the locations and concentrations.

MR. TEMPLETON: Right. It has a GUI on there to where you can --

MS. LANGMANN: Yeah, and so it's like you don't have to necessarily - we won't ever release the entire database. But I'm

thinking, and I'm going to talk with folks about developing something that for the chemicals that are of particular interest, and the buildings that are of particular interest. Having something that's kind of interactive that you could click on a point, and see a concentration, and that you could say, okay, you know, 1990, you know. And go through different years when the data's available, and see how concentrations go up and down, to add ARCGIS-type interactive. And it won't be the whole database. It would be smaller little portions that would get developed for different areas. But we're definitely looking into that, because I think that we can describe in my template, engineering me, you know, with my little bullets of how the water's moving and stuff. But I think that visually, it's how I'm doing my analysis is using our interactive map. And so if we can visually get a product to the public so you can see visually what we were looking at, I think that will help tell the story about vapor intrusion for each of these different buildings. So it is something that I'm going to talk to folks about starting today. But hopefully, we'll be able to in future presentations that we do, as well as possibly have some links in our actual public health assessment document. So that the public, that everybody can have some interactive access to the data that we're using and we're seeing.

MR. TEMPLETON: Okay. I was just asking. I am familiar with ArcGIS and I have built databases that also included subsurface engineering for facilities management for a couple of companies in different areas. So that's why I was kind of curious whether I might be able to take a peak and browse the data sets that are there. So anyway, that was the first question. It sounds like no right now. I'll ask it again. I will ask it again. The second question, and this is the $64 trillion question, when do you think it's going to be done?

MR. HANLEY: We have key milestones coming up this year. One is to get the document in our clearance system by November. Once it's in there, we'll have internal clearance. Then it will go to we're looking at --

MR. ENSMINGER: the black hole.

MR. HANLEY: -- next February or so for a - no. It - Jerry, we're going to work through that to get out of that black hole. We - then sometime next year, about February or so, we'll have peer review, and then we're expecting in the summer the public comment period. And then we hope by the end of 2021 to be - have it released final. That's our milestones. We have them laid out and we're working diligently to achieve those.

MR. TEMPLETON: Okay, thank you. I won't hold you to a deadline or anything. I understand all the obstacles.

CDR MUTTER: All right, thanks. Mike Partain?

MR. PARTAIN: Just two quick questions. One on the when it gets to the point for the peer review or is the CAP going to be involved in the peer review like we were with the water modeling stuff that Morris did?

MR. HANLEY: I was not planning on that. I didn't realize you all - I wasn't here, at that time, so we'll have to discuss that and see. I wasn't - did you all participate in the peer review process?

MR. PARTAIN: Yeah. Jerry and I on was it Chapter D that we did? It was part of that we did on the historical parts.

MR. HANLEY: Oh, to look at like historical to make sure it was accurate and get - oh, okay. Because a lot of this is going to be - and it wasn't during a data validation. It was during --

MR. PARTAIN: It was - I don't remember.

MR. HANLEY: It was peer review, then. Okay. Well, I'll look to manage it, and work that out, and see. I just was not familiar with that and I wasn't planning on that. Because we were telling the Navy, they would get access like during public comment, and I just assumed that's when you guys would get it. But we'll work that out.

MR. PARTAIN: Okay, because I mean --

MR. HANLEY: We'll talk to them.

MR. PARTAIN: Yeah, we do have an extra --

DR. BREYSSE: Well, the CAP will be involved. It's just a question of when, right, and how. So that's not uncertain.

MR. PARTAIN: Okay. Now the other part, when Dr. Cantor was talking about the 24-hour exposures, and I believe we talked about it but I don't remember exactly what. There were several housing units that had the - actually, most of them had the either underground or above ground storage fuel tanks. A lot of the housing areas, if not all of them, had the fuel heating oil tanks and a lot of them were leaking. And there's been reports and actual documentation on base of the tanks being removed and issues with fuel down underneath the homes. Are any of those sites being included or looked at as part of your vapor intrusion efforts?

MR. HANLEY: I haven't --

MS. LANGMANN: If there's groundwater data, like you said, that they know that they leaked, so there would be some data that showing that, either soil gas measurements or groundwater data. We included data for the entire base.

MR. PARTAIN: Because we know of one specific - or I, at least, know one specific - sorry - specific family, Michael Bretlidge [assumed spelling]. I can't remember his - Brekleck [assumed spelling] or something like that. They actually went back to find their old house, and when they did, it was fenced off with a pit. And then they found paperwork showing that the area had been excavated. The pit was a hole where the, you know, house used to be, and it was because of their fuel oil tank that had been attached to the house had leaked and gone all underneath the property. And of course, they have some serious medical issues with their family. So that is I know that is documented and it is actually, like I said, fenced off on the base, and I think Michael has some of that documentation. We could probably try to get it from him.

MS. LANGMANN: Yeah, and actually, I would just help knowing the address on the base, because I can then go into our application and look at the specific samples, the years that they were taken, and what the levels were.

MR. PARTAIN: Okay.

MS. LANGMANN: And if they - and if the levels were high enough that they screen into our evaluation, then that would be a building that we're looking at.

MR. PARTAIN: Okay.

MS. LANGMANN: But we can look at it just because there's concern about it, too, so.

MR. PARTAIN: I'll circle back with him and get the address. And I mean specifically in that instance, like I said, there was remediation efforts to the fact that they removed the house, put a fence, and left a hole in the ground, so.

MR. HANLEY: But there's likely to be data there in our system on that, I would think.

MR. PARTAIN: Okay. And I think something like, you know, this needs to be at least find some examples to address and is part of the vapor intrusion. Because it's, you know, this would be an exposure pathway for vapor intrusion. And if I was inferring to

what Dr. Cantor was saying, this may be more of a concern because this was a residence with a 24-hour habitation.

MS. LANGMANN: Yes, and that's actually how our evaluation differs than what the base is currently looking at current future exposures and we are looking at past exposures just because the home isn't there anymore. We're looking at demolished buildings, as well, and all types of buildings. We - I think there were 14,000, over 14,000, structures on the base and we looked at all of the structures that had data within 100 feet of them.

MR. TEMPLETON: During the restoration, they do have some logs that showed what they did. Some of them did not have tests for vapor intrusion or concentration in that particular location. But they did note that they - what they removed there.

CDR MUTTER: Thank you. I think Mike actually on the phone has one last comment before we change over to our health study, Cancer Incidence Study. Mike?

MR. ASHEY: Thank you, Jamie. I know you've all heard me say this before, but I think it serves well at every meeting. Science of remediation is an inexact science, and that means that vapor intrusion is probably inexact inexact science. And as I've said before, the only thing you know for sure about contamination remediation is that you don't know anything for sure. And so there are no certainties here. And what I keep hearing from these people, these so-called technical experts that were hired from the Department of the Navy, is that they're absolute in their convictions. And I don't agree with that and they know better than that. And that's it, Jamie. Thank you.

CDR MUTTER: Thank you. And I think let's take our ten-minute break right now and meet back -- -- 11:15. And just so you know, we do have VA people out in the foyer that can answer claims questions or benefits questions. If you want to see them during this time, that would probably be great. So we'll see you back at 11:15.

[Background Conversations]

CDR MUTTER: Okay. If we can ask everyone to take their seats and let's go ahead and get started with the remainder of our meeting, please. Okay, so I did want to acknowledge that we have Dr. Hastings with us. She made it from the airport in time. Even though she had to sit on the tarmac for hours, we appreciate her finally getting here, so thank you, ma'am. And we did want to correct the record from this morning. Dr. Hastings has been at all of our meetings. She's only called in to one because I

believe she was not feeling well, so we did want to acknowledge that she has been present and active in the CAP meetings, so thank you for that.

DR. HASTINGS: And I do apologize, but as I said --

CDR MUTTER: And Dr. Hastings, there is a handheld mic because we ran out of - yep.

DR. HASTINGS: And I do apologize. Okay. I do apologize. I had planned on being here last night but had a member of my staff, one of my physicians, that decided to go down the Metro steps really quickly. And did the last ten in probably a gravity show, and had to have emergency surgery on both knees, and is going to be rather incapacitated for the next several months, so I do apologize.

CDR MUTTER: All right. So we'll pick back up where we left off, and Dr. Bove, if you wouldn't mind giving us an update on the Cancer Incidence Study.

CANCER INCIDENCE STUDY UPDATE

DR. BOVE: Yeah, real quick. The Cancer Incidence Study is also going to update the mortality study that we published five or six years ago. So the mortality study is going to look at deaths that occurred from 2009 to 2017. The previous study looked at deaths from '79 to 2008. The Cancer Incidence Study will look at - will be comparing Camp Lejeune to Camp Pendleton, like we did with the mortality studies. And the time period for that comparison is 1996 to 2017, so cancers that occurred during that period will be evaluated. When we look at just Camp Lejeune and compare people with different levels of exposure, we'll go back further, as far back as we can with the cancer incidence data. So we're going to be including all 50 state cancer registries. We never thought we would be able to do that. At least two states couldn't participate in a data linkage effort without getting consent from patients and that was going to make it difficult for them to participate. But they're working around that by if they match anyone, they'll get - they'll ask the patient for consent. So we're going to have all 50 states involved plus the VA. We worked out an arrangement. It took a while, but we worked out an arrangement to use the VA registry, as well. We're working with the DOD, at this point, to - they have to give us a sponsor and we're actually working with Scott Williams, a Navy health person, to work out that arrangement. So we're still working with the DOD to get their cancer registry on board. But we have all 50 states plus Puerto Rico, the Pac

Islands. Washington, D.C. has its own registry. So we'll have 55 registries all told. No one's ever done this before and it's difficult because we're trying to keep the data as secure as possible. There's 536,000, over 536,000, Social Security numbers of people that we have. So we're trying to maintain the data as secure as possible. We've had this data for years, but the requirements now are getting more strict to make sure that the data doesn't get hacked or anything of that sort. So the situation is like this. We're waiting to get an agreement with Social Security so that we can match with their data to determine who's alive and who's dead. And then we'll send the data to the National Death Index which has all the deaths in this country located in one place. Unfortunately, there's not a cancer registry like that but there is a National Death Index. And we'll update the mortality study. We'll start the matching process with the cancer registries in May and I'm hoping to get all the data from both the cause of death data and the cancer incidence data by the end of this year. So that's the goal. In the meantime, in the next two weeks, we're having webinars with all the state cancer registries to go over how we're going to do the matching, how we're going to get data to them, how they're going to get it back to us, and how the matching will occur. So we're going to be preparing them for the data linkage that will start in May. And also next month, I think there's going to be a pilot working with four registries just to make sure all this works out, all the logistics works out. So I hope to get all the data by the end of this year. It'll probably take a year, year and a half to analyze it and to develop journal articles and reports from the data, put the results in it. And then so I'm hoping that that happens by the spring of 2022 and then hopefully these things get out before the end of 2022. So that's what we're hoping for. We're planning for it. I'm hoping nothing goes wrong. But again, since this is something that hasn't been done by anybody before, something that may occur, we may have some difficulties with some of the registries but we're planning on it that way. So any questions -- I went over it quickly. Any questions you have about the study? No? Okay.

MS. FRESHWATER: Do you need anything? Is there anything the CAP can do to help you?

DR. BOVE: Yeah, I need a couple to help, statisticians. Let's see, what else could I use? No.

MR. PARTAIN: No issues with funding? I said no issues with funding or any other opposition issues?

DR. BOVE: No, we have funding through the end of fiscal year 2022. It should be done by then.

CDR MUTTER: Alright, no more questions for Dr. Bove?

MR. PARTAIN: Actually one of them just not directly tied to the cancer incidence study but I believe Jerry had brought up at the last CAP meeting that one of the provisions in the 2012 law was a three-year review of the conditions that for Camp Lejeune. And I believe Jerry had brought that up. Has any action been taken on that?

CDR MUTTER: That's actually an action item?

MR. PARTAIN: Oh, it is?

CDR MUTTER: Yes. You want to wait? You can go ahead. We can skip it in.

DR. BOVE: Yeah, I mean there's the 2012 law and then there's the disability compensation presumption issue. So the law is the law. We can't change the law unless, you know, Congress does that. So I've been focusing on what, are there any new studies that have come out on the endpoints that we looked at in the 2017 report that we did to help the VA decide on its presumption list. So we've had some discussions about kidney disease and scleroderma but there hasn't been any new information really about those two, except for the article that Ken discussed at one of the CAP, I guess at the Washington meeting, wasn't it, yeah, where there are kidney biomarkers, differences in kidney biomarkers at very low occupational exposure. So that's interesting but it doesn't directly address the issue of whether end-stage renal disease or chronic kidney disease should be on the list or not. So there hasn't been any new information there but there has been since that report two male breast cancer case control studies and two female breast cancer cohort studies that have come out. So I'm reviewing them and hope to come up to some conclusions as to whether that changes at least our perception or our assessment of the evidence and I'm looking at -- I've been trying to keep up focusing on new studies that have come up on other endpoints too. There're several articles that came out on vinyl chloride and so they may be of interest looking at other endpoints. So right now I'm focusing on breast cancer and looking at that. And then our discussions with the VA and Pat, you can chime in, one thing we are doing with VA researchers is and this has been something that's been developing over time, looking at Parkinson's because that's an interest of those researchers. They've done studies of Parkinson's before looking at twin data and they're very interested in looking at this data. So we've been working with them, you know, and hopefully that'll -- In fact, they just got funding. So that should happen. And we've been bringing up with the VA discussing maybe

possibly other endpoints that could be evaluated using the VA's health data bases to look at some of the other maybe neurologic --

DR. HASTINGS: One we're looking at is scleroderma and looking at that with Frank and then also we've had the discussions. I know registries came up this morning and as they have before and we had a discussion with the CAP looking at taking over the cohort at the time that they would be finishing with some of their work. So we've looked at that, too. But scleroderma, I know, is one that is a very important one.

DR. BREYSSE: Could you see if you could hold that close to your mouth or make sure it's turned on. Okay, you got to hold it really close to your mouth. Yeah.

DR. HASTINGS: Okay. Felony karaoke here. So anyway, scleroderma, yes, very important to look at that more in-depth that we're working on that with Dr. Bove. Dr. Culpepper , one of our epidemiologists, and he have had discussions and Dr. Culpepper is designing a study to look specifically at scleroderma. And we've had several discussions looking at the science and we continue to go through all the work that's been done by ATSDR and relooking at the new stuff.

DR. BREYSSE: So your question, so the original assessment we made of the strength of evidence was done on behalf of the VA, a request from the VA. And we've subsequently received another request to update that assessment and that's what we're working on right now. It's not in the 2012 law but it was really kind of at the behest of the VA.

DR. HASTINGS: And very much appreciate that. Thank you. And, you know, to look at the science, it needs to be done rather routinely. So it's perfect timing.

CDR MUTTER: Lori.

MS. FRESHWATER: I was going to do this at the end but just because you mentioned Parkinson's, I just want to let everyone know that I helped with a book that's coming out in March 17th called "Ending Parkinson's Disease" and there's a chapter on preventing Parkinson's where they detailed the Camp Lejeune story in a section called "Covering Up a Catastrophe." So I didn't do a whole lot but I tried to help steer in the right directions. And so I think it's going to be a really beneficial book. So everybody, you'll want to look out for that. Yes, I will do that.

CDR MUTTER: What's the name of it again?

MS. FRESHWATER: It's "Ending Parkinson's Disease" and it's by Ray Dorsey is one. Oh, I've got the cover here. Ray Dorsey, Todd Sherer, Michael Okun and I can't read the last one, Bastiaan Bloem, I think.

CDR MUTTER: Thank you for the information.

MS. FRESHWATER: So that's Saint Patrick's Day as an easy way to remember.

CDR MUTTER: Thank you. Mike Partain. Okay. Chris.

MR. ORRIS: So, welcome, Dr. Hastings. I'm glad you made it. Sorry you had such difficulty with the flight and everything. I have a couple of questions for you that we were talking about earlier when we were doing the Camp Lejeune Family Member Program. And one of those is being, you know, we keep circling back to congenital heart defects are a sufficient causation found by ATSDR. It's not included in the legislation. We're trying to work in the VA committee to get this modified to add congenital heart defects to this. And in that, in the confirmation process for James Byrne in March and April of last year, there were some QFRs that Senator Tillis submitted to the VA specifically about what the VA's position is on congenital heart defects adding it to the legislation that have gone unanswered. As well, during the toxic exposure examining the VA's presumptive decision making process, there were further QFRs. This meeting happened in October of 2019 and again, Senator Tillis submitted some QFRs about congenital heart defects and what the VA's position is on adding them to the 15 conditions, you know, so on. And again, these questions are going unanswered. And I know in previous discussions you have stated that -- Well, I'm not going to put words in your mouth. But when we were going over The Family Member Program, there was a little circle in here stating that the --

CDR MUTTER: Chris, could you talk into the mike more so people can hear.

MR. ORRIS: Sorry. There's a thing here saying that PDHS is reviewing the science with ATSDR for family member conditions. Is congenital heart defects one of those conditions that you're still examining?

DR. HASTINGS: Absolutely.

CDR MUTTER: Pat, can you use the mike, please?

DR. HASTINGS: Thank you. If we've gotten a QFR, I have not seen it because I will tell you that when I get QFRs, we drop everything because it's from Congress. So --

[Inaudible Comment]

DR. HASTINGS: Okay, they should go to OCLA so that they're accounted for, the Office of Congressional Legislative Affairs, and then I get them directly and we respond to them as soon as we get them. So I don't know what happened there, if they didn't make it, but they have not come to my office. So I have not seen that. In regards to the science, we've met with ATSDR in December to relook and I have my epidemiologists looking through all of the data along with Dr. Vincent, who is our toxicologist. But regarding the QFRs, I apologize, I have not seen those. They have not -- You know, they have not been ignored.

MR. ORRIS: They've gone unanswered.

DR. HASTINGS: I apologize but they would not be unanswered in the office because we respond to those very quickly.

ACTION ITEMS FROM PREVIOUS CAP MEETING

CDR MUTTER: Okay, so let's go ahead and jump to our action items. We'll now go ahead and start with the VA since we have Dr. Hastings here. And if we've already covered this in the previous presentation, if you could just let me know so we can just move over it. So the first action item is the CAP requested information on the 931 Family Members Administratively Ineligible. Please provide a breakdown of that number based on the criteria mentioned in the presentation. I think that was covered. Is that right?

MS. CARSON: It is answered on page nine and 12 of the Family Members Presentation.

CDR MUTTER: Thank you. Okay, so in addition, how many of those administratively eligible but not clinically eligible are with conditions that have sufficient causation as shown by ATSDR? I also think that was covered, right?

MS. CARSON: It was answered on page 12 of the Family Members Presentation.

CDR MUTTER: Thank you. The CAP stated that in regards to benefits -- Oh, go ahead, Tim.

MR. TEMPLETON: There was a little bit of an issue there with the answer that was given on that one and the sufficient causation shown by ATSDR. In fact, we were talking about that, Dr. Hastings, you were talking about that, having a conversation with folks at ATSDR here about that just a little bit ago. And we kind of wanted to see a little bit more about where the guidance that they had originally provided after the 27 drinking water PHA whether why we're not seeing a whole lot being acted on from that. What I heard from Miss Carson here was that she happened to say that you're waiting for more evidence, more medical evidence or something along those lines?

MS. CARSON: No. Let me clarify. I said that when we have to rely on medical science and medical advancements, so we do use that but the Office of Post Deployment Health will review that literature and make a decision.

DR. HASTINGS: We're going through the literature now. We've had the help of ATSDR and we are re-reviewing it, seeing if there's anything new. At this point in time there's not much new in the literature. So we're going through all of the works that's been previously done, seeing if there are any other ways to look at it or to other studies that need to be done. For example, we want to look at scleroderma more closely and we'll look at it with our marine cohorts.

MR. TEMPLETON: Is there anyone that is in charge of you on this study, in this group, or are you in charge of the entire group? Do you make the decisions? Are you the decision-maker for the group?

DR. HASTINGS: Am I the decision-maker for?

MR. TEMPLETON: For the group of folks that are reviewing the data, reviewing the medical information?

DR. HASTINGS: I would say yes, I am the one that would be making the decisions as far as putting them forward to the VA leadership. But I will tell you that I share everything with them. You know, if we have something that shows up as being significant, I make sure the leadership knows.

MR. TEMPLETON: Okay, the reason that I ask is that at the DC CAP meeting we had a little bit of a discussion about the end-stage renal issue. And during that, there was some disagreement and it sounded like that you had produced a document that had two pages on it. And in part of it towards the end in fact, it said that you didn't find any other studies yet the fine gentleman sitting next to me actually did have a presentation that had several

studies concerning that, too. So I guess I'm a little concerned there.

DR. HASTINGS: At the point in time that we did the paper, that wasn't available. We're relooking at all of the different disease entities associated as well as some that are not.

MR. TEMPLETON: I would just -- In light of that, I would just ask that you be especially thorough and I would hope that there would be some deference given to ATSDR and the fine work that they've done for us.

DR. HASTINGS: ATSDR does fine work and we very much appreciate it. Absolutely.

MR. TEMPLETON: Thank you.

CDR MUTTER: Alright, so I'll move on. The next action for the VA, the CAP stated that in regards to benefits, people are being approved by the BVA after being denied by the VA. The CAP would like to know how many and what the major causes of the reversals are starting at 2010 and going forward.

MS. CARSON: So that's one that we will have to save for the next meeting. I have reached out to our Appeals Management Office and our Board of Veterans Appeals and I know there's a lot of acronyms, so BBA and BVA sound like they're the same agency but they are not. So I'm trying to get that information and have a presentation on that information next CAP.

CDR MUTTER: Thank you. Okay, next. Miss Carson recommended the VA do a full presentation on contract examinations of the next in-person CAP meeting and that was completed this morning.

MS. CARSON: Yes.

CDR MUTTER: Thank you. CAP member requested the number of times a child who had been exposed in utero has been denied eligibility based on the 30-day residency requirement for a child in utero. I believe that was answered.

MS. CARSON: That was answered in today's meeting with the Family Care Services and it was zero.

CDR MUTTER: Thank you. CAP member requested to know how many people are being denied due to not meeting administrative criteria such as eligible veteran residency, et cetera. I believe that was also answered.

MS. CARSON: Yes. It was answered in the Family Members Presentation and it was 967.

CDR MUTTER: Thank you. The next action item. How many family members are clinically ineligible because the law is written in such a way that it's not covering a condition that has causation, whether it be sufficient or otherwise. Dr. Hastings stated that this would be hard to specify but would provide the criteria and also the types of conditions that are turned down.

DR. HASTINGS: I believe they -- Did they not do that in the Family Member Presentation today?

MS. CARSON: They did not. They just stated that there was more work being done on that.

DR. HASTINGS: Yes, we're looking at the science but I thought that they were looking at the clinically ineligible and the administratively ineligible.

CDR MUTTER: Can we speak into the microphone?

DR. HASTINGS: Sorry.

MS. CARSON: They provided the administratively ineligible today but not the clinically ineligible.

DR. HASTINGS: Okay, I will go over that with them but clinically ineligible is as it is specified in the law and we are going through looking at all of those that were clinically ineligible just to see just an audit of those.

CDR MUTTER: Okay, should we keep that on the action items for next meeting?

DR. HASTINGS: Sure.

CDR MUTTER: Can we provide those numbers before the next meeting possibly?

DR. HASTINGS: I think so, yes.

CDR MUTTER: Okay. Thank you. The next action item. The VA will consult with their Office of General Counsel to ensure the VA is interpreting the Camp Lejeune Families Act appropriately specifically regarding renal toxicity/renal disease and neurobehavioral effects. In addition, the VA will look at whether they are requiring a nexus for the Family Act and also how they are interpreting the conditions, i.e., acute exposure.

DR. HASTINGS: And that is still with the Office of General Counsel.

CDR MUTTER: Okay, so we'll leave that on as an action item.

MR. PARTAIN: Jamie, hold on a second. On the question on renal toxicity, I know that Tim had brought up the last CAP meeting and the studies that Dr. Cantor and you mentioned that you're reviewing that, do we have a timeframe when that's going to be accomplished? This issue with the renal toxicity has been going on for several years. I want to say probably -- I remember talking about it I think in 20 -- When was Greensboro, 2015, 2016, something like that? It's been an issue. It's ongoing. And there's been science out there and I know we've got some input from Dr. Cantor at the last CAP meeting. Can we expect -- Can we get a timeframe this is going to be resolved or get an answer?

DR. HASTINGS: I don't know about timeframe but Dr. Cantor, Dr. Bove, if you wouldn't mind, we could have a meeting to discuss setting forth a timeline and an agenda for this. Would that be possible? Yes. So we'll report on that at the next CAP meeting.

CDR MUTTER: Okay.

UNIDENTIFIED SPEAKER: I have a question. I apologize. This is Family Member Slide again.

CDR MUTTER: Yes, go ahead.

UNIDENTIFIED SPEAKER: There was a question just prior to this before the renal and it regarded, I believe, clinical ineligibility for family members. And can you reposit the question for me?

CDR MUTTER: Yes. It's how many family members are clinical ineligible because the law is written in such a way that it's not covering a condition that has causation, whether it be sufficient or otherwise.

UNIDENTIFIED SPEAKER: The second part of that question is, I believe someone spoke to that. That's correct. But there is a number that we have for clinical ineligibility on slide nine of our slides. The number is 404. The reasoning as to why is just as the family member may have been denied multiple times for the same condition requested. As to why that condition is being denied, I think we're still working on that scientifically but the numbers are there for us. I just wanted that to be captured.

CDR MUTTER: Okay. Thank you for pointing that out. Okay, the next --

MR. PARTAIN: One thing, something actually came up and I forgot to bring it up with the slides. Thyroid and parathyroid cancers, we've had a lot of them or at least a lot of people reporting back to us and I'm not seeing any type of counts of cancer. As

you know, one of our former CAP members passed away of parathyroid cancer. Do we have any stats on that? I mean, that's -- I know we keep going back to registry but that's one of the things that we need to be looking at but no one's keeping numbers or track of it as far as I'm aware of.

[Inaudible Comment]

MR. PARTAIN: Yes, but I mean for now, I mean, the VA has people treating and people going in. It'd be nice to know where we're at on that.

VHA: I think that might be -- So I spoke to my supervisor about this and it kind of falls back to the 15 major categories and subcategories to fall under that. And we're going to actually thresh that out and list the groupings of subcategories that fall under those main ones in reference to renal toxicity, if you will, and the fact that kidney disease falls under that standard. We will be able to line those out as to what subcategories fall into each one of the those major categories but we believe because of PII and PHI that singling out each number for each one of those subcategories might bring us into a release of information problem. So we'll have to adjust that and work with our policy people on that to make sure we're not doing that either. But in the least you'll have an overall number. Let's say if it fell into renal toxicity and that was a major category, we'll list the subcategories out but we can't just give you numbers, we may not be able to give you numbers for those specific subcategories but you'll have an overall number.

CDR MUTTER: Okay. So I'll move on. Oh, I'm sorry, Lori. I forgot.

MS. FRESHWATER: Dr. Hastings, you said the acute versus chronic issue is still with the General Counsel?

DR. HASTINGS: They're actually looking at all the disease entities and how they are looked at, adjudicated.

MS. FRESHWATER: The action item is that you will consult with the Office of General Counsel to ensure that the VA is interpreting the Families Act and also how they are interpreting conditions, i.e., acute versus --

MS. FRESHWATER: Yes and that is with them right now. I've done --

MS. FRESHWATER: Is it specific to kidney?

DR. HASTINGS: It's specific to all the disease entities.

MS. FRESHWATER: Okay, but the question was the thing that we go back to every single meeting.

DR. HASTINGS: It includes kidney disease.

MS. FRESHWATER: Can I finish? I would like to ask that kidney be taken out and asked separately instead of okay, we'll put it in this big thing, so it's going to take a lot longer to get an answer back because this is specifically about kidney.

DR. HASTINGS: I will ask them to specifically look at that.

MS. FRESHWATER: And can you tell when it went to the General Counsel?

DR. HASTINGS: It was with them in May. I got it back and it's gone back to them several times and I sent it back to them in January.

MS. FRESHWATER: And there's nothing you can share or no progress?

DR. HASTINGS: There is progress but I've gone through several lawyers because they move into different positions.

MS. FRESHWATER: Okay. If you get anything in between meetings, will you send an update --

CDR MUTTER: I will send it to Commander Mutter, absolutely.

MS. FRESHWATER: Okay. And so I would like that to be an action item that the kidney be separated out from the rest because that seems to be the thing where the acute injury seems to be holding up people's progress the most.

CDR MUTTER: Okay.

MS. FRESHWATER: Thank you.

CDR MUTTER: Tim.

MR. TEMPLETON: Real quick. Just a quick comment. What I've ran into in the past in dealing with OGC on this particular issue is that it appears that they're misinterpreting the term, it's a legal term, "notwithstanding," that is in the law, that term is in the law. And it seems like that they're misinterpreting it by the regulations that came from that, that it doesn't match up with that term. It does the opposite. Actually the regulations are doing the opposite. That was just a comment.

CDR MUTTER: Okay. So, alright, so the next. The CAP requested the number of claims filed for renal toxicity. Again, I think that was covered.

MS. CARSON: Actually I have those numbers.

CDR MUTTER: Okay, great. Thanks.

MS. CARSON: Okay, so we looked at not just renal toxicity but we looked at all kidney because sometimes people don't say I want to claim renal toxicity itself. So we have 700. Since 2012, we've had 7028 claims for kidney-related diseases. One specific claim was for nephropathy and it was denied and that was prior to the law being established. We've had 4308 claims that are related to renal codes, renal service connection. And of those, 3316 for kidney cancer were granted and 992 for renal toxicity were granted. We have -- For renal removal, we have 508 grants and 38 denials. And some of these might be that the person claimed a condition and then the diagnosis, though, might've been kidney removal or something like that. So they're not mutually exclusive in these numbers. And for the total number of denials out of the 7028 are 2720. And so the only other thing that I could probably give more clarity about is how many of them were presumptively granted, which I could do at a later time but this is the data that I brought today because you asked for it from 2012.

CDR MUTTER: Okay. Next action item. The CAP requested the numbers for breast cancer are broken down to male and female. I think that --

MS. CARSON: That was on page 13 and it was answered by Family Health.

CDR MUTTER: And Tim, I see your card's up.

MR. TEMPLETON: I wanted to wait until we had gotten through several of the similar questions before I brought this up. One of the things that we've seen in the past and this was the reporting requirement under the 2012 law and there was an expiration on that requirement at the time that a sunset on it but we used to see a lot of different information and that information also covered claims, covered a lot of the claims that fall outside of the 15 in the law and fall outside of the presumptives, too, but we're not seeing those anymore. So I'm curious, I'd like to see them.

MS. CARSON: Just as you said, the reporting requirements of Congress may have sunset. And so as a result, VA is not required to make those publications anymore. There are certain types of

information that we still report to Congress and those reports are available to the public at va.gov.

MR. TEMPLETON: But is there -- So even though it's not required, I'm just requesting. Is there a way that they would be able to at least spit out the information in a similar format? It makes it difficult for us to be able to go back on some of the reports that we were furnished in the past.

MS. CARSON: So on an annual basis, we do an annual budget report that includes prevalent information about certain veterans groups to include Camp Lejeune and it also includes certain claims-related information. That is an annual report that still comes out with that information. That report has not stopped coming out.

MR. TEMPLETON: Okay. Oh, it's an annual report. Okay.

MS. CARSON: It is. It's annual report. And if you go to I want to say -- If you go to va.gov and you look at their budgeting planning and reporting, I don't know the exact link but I'm can give it to Jamie later but it's on there and that report comes out annually. So you may see the 2019 report or you may see the 2018 because 2019 just ended.

MR. TEMPLETON: Yes. Thank you very much. Appreciate it.

CDR MUTTER: Okay, we only have a few more for the VA. The CAP stated that some VA environmental health coordinators, Eastern Kansas and Western Missouri, keep information on a registry for Camp Lejeune using a specific form. Dr. Hastings said she would call to inquire about the process or form.

DR. HASTINGS: And there is not one. I checked with our environmental coordinators and clinicians in Kansas and in Missouri. And none of them were aware of any work being done like that.

CDR MUTTER: Tim.

MR. TEMPLETON: I happened to follow up with the gal that's in that position at the Kansas City VA. She had just been in the position maybe three weeks, I think is what she said. They said that they do have a form that they use; however, they won't use it unless someone is referred to them. Let's say I couldn't go to them and say I would like for you to start tracking me for this. I can't do that. Internally, the physician would have to refer them to environmental health, which I have a feeling that they probably don't know it exist either especially with this person only being in their job for about three weeks. That's

what I found out since the last meeting when we talked about this question.

DR. HASTINGS: Do you have that person's contact information?

MR. TEMPLETON: I'll get it to you.

DR. HASTINGS: Okay, I'll check with them but the people that have been in position for considerable periods of time, as in years, had no knowledge of any of this.

MR. TEMPLETON: I see. Okay. Do they need to like become a part of the whistleblower program, where they're worried about getting walked out of the place or anything over that?

DR. HASTINGS: No, no.

MR. TEMPLETON: Okay, good. Thank you.

DR. HASTINGS: One of them is Elizabeth and I talk to her pretty routinely. She's in Topeka and she was surprised that there was anything that was even in the offing about this.

MR. TEMPLETON: Okay. Thank you.

CDR MUTTER: Okay. Last one for the VA and ATSDR. CAP member asks when ATSDR and VA would review, discuss the current literature regarding health effects for Camp Lejeune. I think we touched on that. So we'll move on. Now we're headed into Navy Marine Corps action items. Go ahead.

MR. PARTAIN: At the last CAP meeting we had brought up -- I'm sorry. At the last CAP meeting, September -- Closer?

CDR MUTTER: Yes.

MR. PARTAIN: Okay. [Inaudible] voice. Anyways, at the last CAP meeting I forgot who asked the question about coding specifically for Camp Lejeune, so if a veteran goes to the VA and the medical code or code designating that this is a Camp Lejeune and you were going to follow on that.

DR. HASTINGS: And I am working on that right now with Community Health and they're trying to do it not only for the Camp Lejeune people that are seen in the clinics but also with pharmacy and they're still working on that. It does take changes in IT systems, et cetera. So I should be able to give you more of an update next time. But they're looking at it from everything from pharmacy to clinic visits.

CDR MUTTER: Okay. So we'll start with the next few action items. The CAP requested the Department of Navy Marine Corps provide

the latest data on all of the contamination plumes to see how far they have moved from the past delineation, i.e., a diagram of where these plumes are located and their movement over time.

MS. FORREST: Camp Lejeune gathers a vast amount of monitoring data each year on installation restoration sites including groundwater plumes. The best single source of information on our active IRP sites is the site management plan which provides a summary of this data including multiple groundwater plume maps showing the most current information. I have a website here that I'll read out where the site management plan can be found. I was also going to say that if the CAP members would like, I could send the link to you and you could distribute it because I know they're not going to write this down. This is going in for the record, for the transcripts, https://www.navfaq.navy.mil/niris/mid atlantic/camp lejeune mcb/m67001 008063.pdf, all the more reason why I'm going to send you an email with the link that you can share to them because I know nobody got that. And just so you know, in the administrative record there are also site management plans for yours previously so if you want compare groundwater plumes, you could look at the previous plans.

CDR MUTTER: Okay, great. The CAP requested the Department of Navy Marine Corps consider providing paid travel for the CAP to the next RAB meeting.

MS. FORREST: Okay, DOD certainly encourages public involvement with all RABs; however, DOD cannot fund travel cost for members of the public who may want to participate in a RAB meeting. From Section 3 of the DOD RAB Rule Handbook, RABs are comprised of individuals from the community who are affected by the installation's environmental restoration activities because they live and/or work in close proximity to the installations. Anyone interested in restoration activities and willing to dedicate their time may participate in RAB meetings although they may not actually be a RAB member. Additionally, from Section 4 of the DOD RAB Rule Handbook, all RAB members must serve without compensation. As recommended in past action item responses, CAP members are encouraged to review the Camp Lejeune RAB webpage to stay informed of progress on Environmental Restoration Program. And if CAP members would like to be involved beyond reviewing the website, it's recommended they work through the community cochair for the RAB.

CDR MUTTER: Lori, did you have a question?

MS. FRESHWATER: I think we talked about doing a possible livestream but I don't think it got on to the action,

CDR MUTTER: I don't know if that was an action item.

MS. FRESHWATER: We talked about skyping or

CDR MUTTER: Livestream or like web --

MS. FRESHWATER: Web meetings so that people could watch the RAB meetings.

CDR MUTTER: We can add that to this transcript as an action item.

MS. FRESHWATER: I can certainly take it back. You know, we try to handle our RABs uniformly throughout DOD. So I don't know if that can be done for one RAB versus the vast number of them that are occurring out there but we can take it back.

CDR MUTTER: Okay, last action item. Miss Freshwater requested the statement regarding construction of temporary or permanent structures on top or near known plumes be sent to her via email before the next in-person CAP meeting. I believe that was accomplished.

MS. FORREST: That's complete.

CDR MUTTER: Awesome. So we are done with the action items. So we'll move in to CAP updates, community concerns. Is there any new business that wasn't on the agenda that the CAP wants to discuss before we get in to community concerns? Mike, did you want to bring up anything, Mike Ashey?

MR. ASHEY: Hey Jamie. Thank you. I and Jerry and Mike Partain have worked on a letter to the United States Senate Committee on Armed Services and I was originally planning on reading the letter but timing it is going to take about five minutes to read. It's about a page and a half. So the short synopsis is, as you all recall, Melissa and I have been going back and forth about the frequency of testing at the wellheads. The Department of Navy believes that twice a year in accordance with federal and state standards is adequate. My response has been that those standards were never meant to address a debacle the size of Camp Lejeune and that monthly testing needs to be done at those wellheads or the potable wellheads to ensure that the next generation of marines and the ones presently serving at the base don't suffer the same consequences that those of us who served there in the past are dealing with. So the conclusion of the letter is that we are asking Senate Armed Services Committee to direct the Department of the Navy to implement monthly testing at all the potable water supply wellhead locations immediately and to publish those test results for public review. As soon as

we mail the letter, I will send you a PDF copy so that it can be put into the record.

CDR MUTTER: Sounds great.

MR. ASHEY: Thank you.

CDR MUTTER: Thank you. Any other CAP member business that we want to get to before we reach out to the community? Dr. Cantor.

DR. CANTOR: I just have going back to our earlier discussion that Frank's presentation, in fact, you mentioned that there were two states where the people want to go back to the individuals to get their permission. Do you know how they're doing this? Is this a letter in which the person has to actively refuse or actively agree to participate?

DR. BOVE: Well, we're actually working that out with West Virginia is one state and Kansas is the other. And we have a call with the Kansas Institutional Review Board which protects human subjects on privacy and confidentiality issues. We're working with them to see how they want to do this. So we don't have it nailed down yet. We do know that they're interested in doing it.

MR. HANLEY: Jamie, I have an update, if you don't mind.

CDR MUTTER: Please, go ahead.

MR. HANLEY: Mike, Danielle said she checked on that address and it is on our list and it is on one of the buildings that we will be, that's one of our buildings of interest and we do have some data on that house.

MR. PARTAIN: Okay, thank you. And as I mentioned during the break, the occupant of the house has a FOIA request with a lot of datapoints. I'll get that from them and get that to y'all so you can doublecheck your data.

MR. HANLEY: Yes, that'll be good. Yes, we're just glad that our screening process did include that building.

MS. FRESHWATER: Is this by chance by the river, because I know -- Is this the house by the river, by chance, over by Marston's Pavilion?

MR. PARTAIN: Yes, I'm not sure which family housing area it is.

MS. FRESHWATER: Because there were a few. I just remember it jogged my memory. I'll send it in an email but there are a few houses right near --

MR. PARTAIN: She's monitoring, so I'll ask her and I'll let you know.

MS. FRESHWATER: Marston's, am I pronouncing that right? Is it Marston's Pavilion?

MR. PARTAIN: I don't remember. I think it may be -- Well, I don't want to speculate. I'll ask her real quick.

DR. HASTINGS: Hi. I know that one of the things that's very important is, you know, making sure that people are aware of Camp Lejeune and still getting the word out to, you know, people that may not be aware. Posters are part of it. They can be electronic posters in the hospitals, in the clinics, et cetera. And mostly they've been very diligent about getting them up. In some places there are problems because we had a very large poster and it was not a standard sized poster. So they had framing rules for cleanliness, et cetera, in the hospitals and in some cases it was difficult to get them up and around when they were the paper copies, not the electronic copies. So anyway, we made them smaller so that they'll be easier to get up and I brought a couple packets of them and I'll put them over on the table. So if anybody wants to take a Camp Lejeune poster, these are the new ones that are available to the hospitals and medical centers and clinics.

CDR MUTTER: Thank you. Chris?

MR. ORRIS: So, Melissa, I very rarely say this but I wanted to give the Department of Defense a compliment. I can't open Facebook without an advertisement for the Camp Lejeune registration website. Every time I look on my social media it's there. I'm glad to see that the Department of the Navy is finally using some of the social media tools. So thank you for that.

CAP UPDATES/COMMUNITY CONCERNS

CDR MUTTER: Okay, so we have about 30 minutes on our agenda for audience community concerns. So we have a microphone set up at the front of the room or if you need me to bring it around, please let me know. Just raise your hand and I'll bring it around. So if we have any questions from the audience, we can go ahead and take them now.

MS. FRESHWATER: I have a concern. I need a ride back to the CDC building so I can get a mug at the museum store if anyone is going back that way. That's where the gift shop is, right?

CDR MUTTER: Yes. None of us work there.

MS. FRESHWATER: Really?

CDR MUTTER: No, we work at the Chamblee Campus.

MS. FRESHWATER: Oh, is there a giftshop there?

CDR MUTTER: No.

MR. ENSMINGER: By the way, I saw Morris Maslia last evening and Morris reported that he's been taking his dad to the VA over here and he said there are posters and stuff all over the place about Camp Lejeune. So that's an improvement.

CDR MUTTER: Okay, wonderful. So ma'am, we'd love to start with you.

MS. ROSE: Fine. My name is Julie Rose. I'm a widow. I'm a sister. This is my brother. I'm a mother of marines. And I have a few questions. I'll try not to be dragging it out. Has there ever been any preventive versus reactive issues addressed with annual testing of marine veterans stationed at Camp Lejeune where they're being tested on an annual basis for any of these diseases rather than waiting until something is wrong and they go to the doctor? I don't expect an answer right here. I just want it on the record. When I was here in December at the meeting or in September, I made note that my husband was a blood donor religiously for years and he died from multiple myeloma, which is a plasma-related cancer. And his blood went out everywhere and now I'm wondering about people who don't know they were exposed to this and we all know there's plenty of those. How many of them died and gave their organs away? I'd also like to bring up one other thing. My brother who served in the Marine Corps also went to work in construction with air conditioning, heating and air, in the '80s and 90's and now they're getting ready to do a whole bunch more construction. Are these contractors being advised of their potential risks? I don't expect an answer now but I would like it before 2020 and I'd like some of these answers.

MS. FRESHWATER: Be more specific as to where you're talking about the construction.

MS. ROSE: On main side I think.

MS. FRESHWATER: So you're just talking about construction in general?

MS. ROSE: Construction, period, with these plumes running line in the ground. These contractors stirring up the dirt because

he's been double exposed. He's a double jeopardy. And I would like to see answers to everything before the next meeting.

MS. FRESHWATER: I can tell you just what I know because I've been involved with people who needed organ transplants that they test the person who is the donor extensively to make sure the organ is healthy. And I self-reported when I was going to be a possible kidney donor for a friend. I self-reported that I had been at Camp Lejeune and they did not disqualify me. So I think that's handled on the end of the organ, just to reassure you.

MS. ROSE: Well, I don't think there's enough science to support the fact that my husband was exposed to this 30 years ago and then when he hit in his late 50s he gets multiple myeloma with changes to his DNA from the exposure a long time ago. I don't believe in my wildest imagine that there's enough science to support the fact that what's laying in his body for 30, 40 years that killed him two years ago is going to manifest itself in a test now on somebody who's not yet been diagnosed. Follow?

MS. FRESHWATER: They take donors who have had drug abuse, you know, there's a lot of different factors that go into it.

MS. ROSE: But this isn't drug abuse.

MS. FRESHWATER: I know. I'm just letting you know that --

MS. ROSE: I just want to put that out there.

MS. FRESHWATER: I appreciate it. I'm just trying to reassure you that they are aware of all of that.

MS. ROSE: One more time, I'd like to get some answers from the VA. I was here in September. People have been coming to these meetings for forever and we're not getting answers. They weren't answered last time. They're not answered this time. I want to see some accountability.

DR. BREYSSE: So you can speak to anyone of the VA representatives after the meeting one on one if there are things that you're not getting answers to.

MS. ROSE: Well, you are getting answers. We aren't.

MR. HUNT: Good afternoon. My name is Wayne Hunt. I'm a United States Marine.

DR. BREYSSE: Can you get a little closer to the microphone.

MR. HUNT: My name is Wayne Hunt. I'm a United States Marine. I was stationed at Camp Lejeune from 1973 up until 1976. Excuse me, '77. I was at ground zero. I worked at -- I was a second

motor transportation out at Camp Geiger and at Courthouse Bay. And I transported the solvents to clean engines that we'd clean from the Amtraks and all the other, the transmission fluids, any kind of thing that needed to go to the dump, I took it there without any protection other than gloves to keep from cutting your hands on the barrels that I rolled off of my five-ton truck. In 1975, the Marine Corps started issuing us quinine pills because every morning, 30 to 40% of the troops were reporting cramps, stomachaches, headaches, and would question going to sickbay. The Marine Corps starting issuing us quinine pills to take every day. For two months I took these quinine pills hoping it was going to resolve the stomach issues and the issues we were having from this water and then they found out we were getting sicker. So they stopped us from taking the quinine pills. Then they ordered us to stop even going to med, going to med calls. Telling us to go on weekends or your time off because so many of us was not being able to report for duty. All of this is documented. All of this was known. And in 1976, I was diagnosed with viral syndrome because they had in '75 water testing showing that there was contaminated water at Camp Lejeune. So the people that was coming in with all kinds of cysts, tumors, and mainly cramps, that's what we were diagnosed with, a viral syndrome in my previous medical records. I didn't come back into the VA medical system until 2014. I filled out in 2011 the letter registration for Camp Lejeune when I received it. I sent it in. Never heard anything back from the Marine Corps or the VA about it. It wasn't until 2014 with the Affordable Care Act that allowed us to come into the medical system. So I've been in the medical system since 2014. As soon as it was authorized I was right there. To today out of all of these experts telling us about what they're studying and even down to the day they saying they got new posters to hang up in the hospital, what we need is not posters. What we need is doctors that know and have the experience about these here killing plumes so that they can work on us and give us medical treatment that we deserve. Y'all failing us!

DR. BREYSSE: Thank you, sir. That's a good point. And I'm sure the VA will take that to heart.

MR. HUNT: Okay, again, cut me off is not going to get to the point where we need doctors. This here hospital here I've been going to for the last five years, they're doing nothing but training Emory doctors there. We can't get a doctor, a primary doctor for more than a year. Every three months we're getting different doctors and they're students. None of these here doctors over in that hospital have any concept of the 82 chemicals that I consumed for five and a half years. Don't want

to talk about it. You guys don't want to talk about it. He's ready to cut me off because we getting to a point that there's all of these here studies that they're going and spending millions and millions of dollars and they not spending money on training doctors to help us with our medical issues.

DR. BREYSSE: Thank you, sir.

MS. CARSON: I just want to ask one question [inaudible].

MR. HUNT: Yes, and they did deny.

MS. CARSON: They denied it?

MR. HUNT: Yes because it's Camp Lejeune. Because you got --

MS. CARSON: It's not looked at on a direct basis [inaudible].

MR. HUNT: Yes again and because it's Camp Lejeune. They deny anything if you say, once you register what I did in 2011 and register for that Camp Lejeune, anything that I was like went straight to Kentucky death row is what we're calling Louisville, Kentucky is death row for us. Once you guys send those files there, they're going straight to appeal. They deny everything for anything and they stack us and rack us until we die.

DR. BREYSSE: Thank you, sir.

DR. HASTINGS: If it could just really quickly address the issue of medical training. I agree physicians, nurse practitioners, PAs need to know more about Camp Lejeune. They need to know about all military environmental exposures. We have something called exposure ed that we tell the physicians about so they can look stuff up on the fly but that's not good enough. We also for the environmental health clinicians and coordinators have a conference and have a number of training opportunities for them. We have a conference every summer which is the environmental health clinician and coordinator conference. We also have trainings that they are required to take because all military environmental exposures are important. We have unique exposures that the rest of the United States population doesn't have. So we take very seriously the education of them. Rotation of physicians, unfortunately or fortunately, VA does a lot of education of physicians in this country and it's one of the things that we give back to the nation. And so when you are seeing someone who is new, who is in training, talk to them about Camp Lejeune. Let them know there's a thing called exposure ed. They can put it on their phone. It's in the VA app store and they can take a look at it. But talk to them about

Camp Lejeune. Let them know about your experience. Educate them also. Thank you.

DR. BREYSSE: Thank you, Patricia. Real quick Lori. I just want to -- Go ahead.

MS. FRESHWATER: I just want to say to everyone when we have community concerns, that does not go into an action item. So if you have a concern that you should talk to the representatives who are here that are available outside because whatever you bring up doesn't go into an action item for the next meeting like it does if one of us do it. I'm just trying to help you get your questions answered.

MR. BOYD: My name is Ronnie Boyd [assumed spelling] and I had an opportunity in September to speak with Dr. Hastings through the teleconference. And her information, you know, was pretty helpful to me but I would like to say that the conditions that I suffered -- I spent 22 years in the Marine Corps and I retired. But the conditions that I experienced were associated with one of the listed diseases. I put in claims, numerous claims, and of course they were all denied with the exception of a finger. And the reason for it was that I had no idea what I had. So just last year, March 2019, I had a bone biopsy and discovered that what I have is MDS. And it's the myelodysplastic syndrome and there are associated diseases that come up. And I was denied those because I also have the shortness of breath from idiopathic pulmonary fibrosis, elevated iron levels, and leukocytosis, and then there's some other things, myositis, whatever. But at any rate, because of what Dr. Hastings had told me, I was able to finally put in a claim and I'm just waiting for results on that now. But also it would be helpful, I think, that if on the name signs that you have in front of you, if you would also identify, you know, where you're from as far as department because you sit here and I see the names but I don't know if you're DOD, VA, or whatever and that would be helpful I think.

MS. CARSON: Okay, sir. So I wanted to say to you I want to know a little, I'll talk to you offline. I want to check up on the status of your claim and give you some information.

MR. BOYD: Yes, ma'am. Thank you.

DR. BREYSSE: Thank you. I want to -- We have a line of people here and we have a limited amount of time and we have the room scheduled for 12:30. We can go beyond that but probably not too much. So if you have a question or comment, if you can be

efficient in asking your question or making your comment. Thank you.

MR. BAILEY: I'm Dan Bailey [assumed spelling] from Florence, Alabama. And I'd like to thank you for what you said about the action thing because I've been coming here asking about endocrinology issues. So now I know where to probably get some answers. This is to the VA. Sometimes I'm economically challenged and you guys turned me over to the IRS for billing practices. You said that eligibility, that I'm not eligible. I have a letter when I filed for the Camp Lejeune saying in March of 2014 that I was eligible and I can start using my benefits right away. I've been going and seeing clinicians and stuff and of course I'm diagnosed and I have to have this medication for a tumor in my head. Like I said, sometimes I'm economically challenged because I'm having to go to all these things because I'm not rated, so I'm not getting paid for my time back and forth. It's coming out of my pocket. Why would you sit there and approve a medication and then all the sudden it's not approved. And I just don't understand when I went down to the eligibility office they had nothing on file that I had any healthcare whatsoever. They didn't even have me listed as a Camp Lejeune veteran even though I have a letter from 2014. This is just recently. This is just last month that I had to go down to the eligibility office and they said we have nothing on file for you.

DR. BREYSSE: Lori, is there something you can do to help this man?

MR. BAILEY: I'm sorry?

MS. CARSON: So those issues are healthcare issues because it's veterans healthcare eligibility and medical billing and that's not in the benefits administration. But I can take it back and try to see what we can do.

DR. BREYSSE: Okay, so we'll ask someone from the VA to meet with you afterwards.

AUDIENCE MEMBER: Hello. I have two. One for the VBA and one -- I have two questions. Well, one comment. I'm looking at something that says military exposures and I know what you said earlier on the registry but this is what I have a question for. Agent Orange, Gulf War, ionizing radiation, depleted uranium, and airborne burn pit registries, they're at the website publichealth.VA.gov. Why isn't there one for the Marine Corps? Why is it just a hard thing to do to get a registry, a health registry for us? Why do we have to continually go through this

every time we come to the CAP? And I've been coming to the CAP for years. Speaking of the CAP, at the CAP you have dependents, male and female and you have male marines. I see no representation of a female veteran who was stationed at Camp Lejeune, whether she was marine or sailor. Why not? Can't no man state what we've gone through as far as miscarriages, infertility, all that other stuff. So those two questions I have and I would like answers. But the registry, we need a registry.

DR. HASTINGS: A registry has limitations with self-reported data and coming in. So we have offered and talked with ATSDR about taking over their cohort studies and following the mortality studies long-term. A registry doesn't have anything to do with benefits. It doesn't confer benefits. The cohort that they have, that they have built, and they have worked with over time will be able to let us look at problems and trends into the future. A registry really would not do that. The registries that we have for Agent Orange, Gulf War, et cetera, are used sort of like to build cohorts for research to function as a phonebook. You sort of have a registry down at Camp Lejeune now which is the phonebook of sending out information.

AUDIENCE MEMBER: But why just at Camp Lejeune, why can't it be nationally? You have marines that are everywhere.

DR. HASTINGS: The registries were put together by Congress. Really they didn't understand what the registries would or wouldn't do and there are significant limitations to them. We do have something new coming in the future. It won't help with the past with Camp Lejeune. It's the individual longitudinal exposure record so we won't have to build registries into the future and we will be able to build cohorts. Cohorts are really what make the difference for being able to look a the science.

AUDIENCE MEMBER: You know, I mean, I have a hard time with that because Agent Orange affected all branches. The Camp Lejeune affected DOD, marines and sailors and maybe a couple of stragglers from the other branches. So why is it so hard to just, I mean, you can go through Congress for other things, why can't you go through Congress to get that straightened out for us?

DR. HASTINGS: The registries that we have now have significant limitations also because they're self-reported data and the people that come in to them are people that often have illness. They're more motivated to come in. So the registries themselves have significant data limitations. We can't really use them for research. We can use them to build a cohort when we do the research but that's really all that we're able to use them for.

They're not like a cancer registry. They're not like a registry for neuromuscular diseases. They function as a phonebook and allow us to build a cohort. And we have talked with ATSDR about taking their cohort over and using that into the future, which is really the way to study the science.

AUDIENCE MEMBER: So how did you get the Agent Orange registry?

DR. HASTINGS: It was legislated by Congress.

AUDIENCE MEMBER: Then why can't you push this through with the legislator?

DR. HASTINGS: If I didn't have -- With Agent Orange, if they asked me if I wanted to have a registry, I probably would say no, I would rather have ILER which goes in to the future. The registry doesn't confer benefits. It really can't be used for research. We can use it to build a cohort for research. And that's what ATSDR has built, a very good cohort.

DR. BREYSSE: I think that's important, right. So people -- Registry means lots of things to different people. But at the heart of it, I think what this community needs is a registry that would allow you to make a cohort to do health studies. Now we've already built a cohort, independent of a registry. And so that's the best and quickest and I think the most scientifically sound vehicle you have to address your health concerns. And it was a big deal for the VA to agree to maintain that cohort when we go forward. So if the registry is, like Dr. Hastings says, a phonebook that you can use to some degree or not, with some success or not, to establish a cohort that you study, we don't need to go through that step because we've already put together records as best we can of people that we think were at Camp Lejeune and we have that. And that's the gold here that needs to be mined and that's what VA has agreed to maintain and continue to mine that gold when we're done looking at our cancer incidence study and the latest mortality update. That's the best thing -- That's what a registry would get you and I have to agree with Dr. Hastings because we're already there, without having gone through establishing this phonebook as the first step.

MR. PARTAIN: And I understand what you're saying about the cohort and I agree. We got a cohort. But here's the point --

MS. FRESHWATER: Mike, can you say what a cohort is because I think some people don't even know what we're talking about.

MR. PARTAIN: In this case the cohort is the marines, and correct me if I'm wrong, the marines who were on the base between 1975 and 1985.

DR. BOVE: Yes, it's anyone who from the marines or the navy who we thought were stationed at Camp Lejeune between '75 and '87 actually.

MR. PARTAIN: So it's this group and then of course the information from this group can be extrapolated to marines prior to 1975, after 1985 who were exposed. But the thing what I wanted to touch base on as far as the community, one of the things we want to see with the registry and I'll use my own diagnosis as a case in point, yes, you have a cohort but what are you going to go look for or look at unless you have some type of community involvement pointing out, hey, we've got this. Male breast cancer was not on the radar for Camp Lejeune until I stepped out, popped out and starting talking about it. The numbers were low but it was a rare disease. And over the course of the past 13 years we've gotten over 115 men with the single commonality of male breast cancer and exposure at Camp Lejeune. And I doubt this would've been looked at or seen because it had been lost in the clutter of the numbers. Getting a health registry where the community has some participation in this and going up and saying, hey, we got male breast cancer, I got parathyroid cancer. It's not scientific to do a study because, you know, like Dr. Hastings pointed out, there is a bias there. But if all the sudden you've got 200 male breast cancer cases or 300 thyroid cases that are being self-reported, it prompts you as scientists to go ask the question to then go back and look at the cohort. That's why I want this registry and the community needs to be involved and it gets them involved to at least give you guys something to look at too.

DR. BOVE: The problem -- We actually -- We did a survey using that cohort and the response rate was --

AUDIENCE MEMBER: Who did you do the survey with?

DR. BOVE: We did the survey, okay -- If you let me finish, I can say it.

MR. PARTAIN: Here's the thing with the survey. We did the survey. Okay? That was back in the early 2000s. Now here's the problem. Back in the early 2000s, the community was unaware, was misinformed about their exposures, and they were not involved.

DR. BOVE: The survey actually was conducted in 2010, 2011, 2012, not the early 2000s. Number one. Number two, we had the Marine Corps actually do a lot of ads for that survey. Okay? This is

the problem with this kind of a registry, which is what Dr. Hastings is trying to point out. We're not trying to sugarcoat this.

AUDIENCE MEMBER: Yes, you are.

DR. BOVE: No, no, no, we're not. I mean, it takes -- These kind of surveys have 20 to 25% participation rate. Okay? They're even having trouble with the Census, for gosh sakes, and the Census you're required to respond to. But a survey is very difficult to do and you get this kind of response and then it's hard to interpret what you have. Okay? In the case of thyroid, we're looking at thyroid cancer in this cancer study. Okay? In the case of male breast cancer, we would've looked at it anyway through this cancer study. Okay? And we've been talking with the VA about looking at other particular diseases that we can't look at very well with mortality data or with cancer incidence data. Okay? And we scour the literature to see what's happening with workers who get exposed to high levels of these same chemicals to see what kinds of diseases are occurring there to give us ideas on what to look at, at Camp Lejeune. So we look at this in a broad fashion. Okay? And I don't think that a health registry would do anything of a sort that we're doing with this cohort that we have already. And really what a health registry is, is a cohort. I mean, if it's done right, it's a cohort and it's followed over time. Well, that's exactly what we're doing. So, you know, we're actually doing a cohort. The question would be: What kinds of diseases can you look at with this cohort, whether you call it a registry or a cohort? Okay? And it's difficult to look at some diseases because you have to do a survey for them. We don't have disease registries for every disease. We have a cancer registry. We have mortality data. And we have health data that we could possibly look at, again with the VA or with other, but there's no national thing and this is a problem with this country. If we were in a Scandinavian country, we could actually look at a whole lot of diseases because there are national registries for them, disease registries, not what we're talking about here but disease registries. Okay? So you're not going to get anything more with a health registry that we're talking about here than we already have with Camp Lejeune, with this cohort that we've been following. You really are not going to get anything more out of it.

MR. TEMPLETON: Dr. Bove, are the individual dataset members in what you already have, are they totally separated from PII or is that link still maintained, still capable?

DR. BOVE: We have to maintain the link. That's how we're going to match with the cancer registries across the country. As I

said, no one's ever done this before, by the way. No one has used a cohort like this and did a data linkage with all the cancer registries. In fact, there's only one other study that tried to use all the cancer registries but they were a religious entity and they had consent from their people. We don't even have consent here. We're doing a data linkage study. And they still didn't get all 50 registries. Okay? So keep that in mind. We are doing what is possible with this cohort.

MR. ORRIS: And Frank, we've had a lot of discussions about this and I know that the cohort you have is a occupational cohort. It's an exposure of occupational -- Well, you do not have the cohort of children exposed in utero. You do not have a cohort of residential exposure. There are different cohorts that we are looking at with this. And so when we talk about the cohorts, yes, absolutely. The work you guys have done is incredible; however, there are other cohorts that can be looked at and the only way that we know to start building that cohort is by a health registry [applause]. And we feel that that needs to be done.

DR. BOVE: Again, we did a survey. The survey involved not just the marines, it involved also all the people that were involved with the earlier birth defects study, ok. Again the participation rate was tiny, 20%. You're not going to do any better with a health registry, you're not. So I'm telling you, look, if I thought a health registry would be useful here, I would be arguing for it, believe me, ok. But I'm just saying we identified all the births that occurred at Camp Lejeune plus additional births that occurred elsewhere, ok. And we did a study of that by the way and looked at birth defects and childhood cancer. We used that same group to do this health survey in 2010, 2012, around that period, ok. We got a participation rate of less than 20%, ok. We can't do anything with that information.

AUDIENCE MEMBER: Ok, some of us never received those surveys. I've been in my house for 20 years. I never received a survey.

MR. PARTAIN: Frank, the difference is

DR. BOVE: that's not going to change with a health registry either, ok. That's not going to change.

AUDIENCE MEMBER: You're saying

DR. BOVE: People move

AUDIENCE MEMBER: there are a lot of us that never received those surveys, so I'd like to know where you sent it.

DR. BOVE: well I'll tell you how we did it, I'll tell you, I'll tell you. We used a locator firm, TransUnion, or one of those firms to get your current address, ok. And that is the best thing you can do, ok. We sent the letters, surveys to those addresses.

AUDIENCE MEMBER: maybe you should have gone IRS because they have information. Ok, listen

DR. BREYSSE: There's lots of people waiting in line and we want to be fair

AUDIENCE MEMBER: I asked another question concerning the CAP. You have male and female genders for dependents on the CAP. But you do not have a veteran woman who has endured the crap that we've endured at Lejeune, i.e., infertility, also miscarriages, stillbirths and stuff. Why is that?

DR. BOVE: We did have one and she passed away several years ago.

AUDIENCE MEMBER: Ok, that's several years ago.

DR. BOVE: Right, well we rely on the CAP to recommend people to the CAP.

AUDIENCE MEMBER: and back to you VBA. Some of the doctors that you all have. They'll tell us [inaudible] that all you want is a paycheck. That's not true. We want to be seen and taken care of.

MR. AMBERGY: My name is Brian Ambergy (assumed spelling). Over the last several months, I have been organizing, doing sit-ins in different states. I have guys from Virginia, Alabama, Georgia, Tennessee. When we're doing this, we're sitting outside the VA's. And we're still finding marines, sailors, and dependents that the VA or anybody else has contacted to let them know what happened to them. Yesterday, we sat outside the VA here. We found 7, 7 people who did not know about Camp Lejeune. Over the last 6 months, I personally have dealt with 43 people that has not been told or contacted. They're out here every day. Now we're talking about

MR. TEMPLETON: Hey Brian. How many of them were going to the VA to be seen.

MR. AMBERGY: All of them. That is Kentucky, Virginia, North Carolina, and Georgia, and Alabama. No documents. Ms. Hastings, I have emailed you. There are several people back here that's with me that has emailed you. We all get the same robo email back, about the signs. I had to go to my congressman and he called the VA in Lexington and force them to put the signs up.

DR. HASTINGS: In regards to the signs in Lexington, I don't have the picture with me now, but I talked to Debbie Belcher who is the Environmental Health Coordinator there and I have her give me a proof of life picture. The posters were up and she held a newspaper under it with the date so I knew they were there. Cause you had told me they were not there. And I will let you know that I do contact the Environmental Health Coordinators. I say, here's the letter from the Secretary. He would like these up, electronic or paper. I have talked to the Division Director's, many of them have rules about how they have to be displayed with you know, in a frame or whatever. They do that for us, so we are working to get that up. We are working to get the word out and it really isn't a robo email back, but I do want to get back with you and let you know we're working on it. But I did have Debbie take that picture for proof of life to say, on this date, here's the poster and yes it is up.

MR. AMBERGY: Another issue I'm having is with one of the people in Kentucky is when they do go to talk them about signing up and getting their medical benefits for Camp Lejeune, their telling them they make too much money and all you're out for is a check and you need to leave. That's what's happening in Louisville, KY.

DR. HASTINGS: I know you're not in it for a paycheck. I'm here to try and address questions and I want to help. I want to be a part of the solution. What happened decades ago was wrong and VA really wants to help fix this and we want to help you. In regards to the making too much money, in regards to what the rules are for the eligibility of being seen, I don't know what all those are, but in regards to Camp Lejeune, you are able to be seen in VHA for the eligibility. So I am not sure what you are talking about in regards to

MR. AMBERGY: When you go in, the form you fill out

DR. HASTINGS: but for some of the things that might not be related, you might have a copay, yeah.

MR. AMBERGY: No, no, not that. When they go in to fill out the paper saying they were at Camp Lejeune, everyone of us had to fil it out. Their telling them they can't fill it out because they make too much money because of their income. It's happening nationwide. You can go on our Facebook group. We are 15,000 strong.

DR. HASTINGS: What I'll do is ask Health Eligibility to give me a read on what they are doing because my understanding is you were at Camp Lejeune, you may be seen for the Camp Lejeune

issues without a copay. Let me talk with Health Eligibility and I will send that back to CDR Mutter so she can get it back to the group.

MR. AMBERGY: Who trains the doctors? Who trains the doctors? I mean, you go to every VA, they don't know what the hell we talking about, excuse my language, but they don't.

DR. HASTINGS: You know in medical school, they don't teach about military environmental exposures and

MR. AMBERGY: They are working there, they ought to know.

DR. HASTINGS: Can I finish.

MS. FRESHWATER: They also don't know about, when you go to a pediatrician, the doctor is not aware of a lot of environmental issues, so that's across the board in the medical profession. Because I'm a civilian

MR. AMBERGY: [inaudible]

MS. FRESHWATER: I understand, I was too. I'm just

MR. AMBERGY: [inadaudible]

MR. AMBERGY: I'm now going through to be seen for neurological behaviors. I'm going to see a neurologist. And I said can water contamination cause this and he said there's a great possibility. I said you ever here about Camp Lejeune. He said what's that. That's what we get in the VA hospitals and clinics. They need the doctors, the nurses and the people working there to be better informed about what's going on with us.

DR. BREYSSE: That's a point well taken sir.

MR. AMBERGY: Because they don't know. They don't know nothing. And I got lucky, a doctor I did have, he transferred to Louisville, KY. I got a new PA come in, a friend of hers was at Lejeune and that's how I am finally getting treatment. If it wasn't for that, cuz the other doctor did not put one thing in my file about Camp Lejeune. Not one, as many times as I talked to him about it.

DR. BREYSSE: I think we need to give other people a chance as well, but thank you, your points well taken.

MR. LAYMAN: Hi, Mike Layman [assumed spelling]. So I have a question, if we did have a registry, would my sister be excluded from that registry like she was excluded from the studies? There was a study, I think, birth records from '68 were computerized, is that right?

DR. BOVE: From ’68 to ’85, yeah.

MR. LAYMAN: Well my sister was born in ’67, you wouldn’t have even looked at the data.

DR. BOVE: Right

MR. LAYMAN: Ok. Somebody that was exposed or a doctor or even the study group here to know what to study. What’s the number 1, number 2 issues. What are new issues that are popping up that may be a concern. I just found out that I have hip dysplasia, I have some nerve problems. Bunch of people on our group have had spinal problems, have had neck problems for years. Try to look at a computer and I am in agonizing pain and doctor’s just can’t understand why I’m complaining so much. Now I’m trying to fight and get my low back and hip good enough so I can go back to work doing what I love, being an electrician. So.

DR. BOVE: To answer your question, what we found in the group that we did look at would be relevant to your sister. So, in other words, we looked at over 12,000 births, ok, and what we saw there is relevant to births before that as well so that’s

MR. LAYMAN: How many cases of lupus?

DR. BOVE: We didn’t look at lupus in this group. We looked at birth defects and birth weight. In the survey, in the survey, lupus was on the survey questionnaire, ok.

MR. LAYMAN: Ok, but my sister would have been able to fill that out herself if the survey was also given to my sister.

DR. BOVE: Right, but it was sent out to tens of thousands of people, ok.

MR. LAYMAN: But not me or my sister.

DR. BOVE: But we…Well we don’t know why you didn’t get one because I said we sent it out to this entire cohort plus all the families that were involved in the birth defects study. We sent it out to all of them. We got addresses for hundreds of thousands of people we’re talking about here and sent it out, ok. And we got a response of about 70,000 which sounds like a lot, but it was like 20% of the people that we had good addresses for. So the response rate was low and the response rate is always going to be low with these kinds of surveys. That’s why there difficult to do and oftentimes not that useful. It’s unfortunate, but that’s the case, ok. I’m just trying to be honest with you. From a research point of view, if you want to learn, if you want to use this stuff for science, if you want to use this research in order to push a case for the VA to look at

a particular disease, you have to do credible science. That's what I am talking about.

MS. FRESHWATER: … to be taken seriously.

DR. BOVE: If it did, I would be pushing for it, believe me, ok. But it's not going to help you get additional diseases on any list. It's not. It's just not going to be credible enough to provide that kind of evidence. The studies that we do and other people do with real cohorts, with good data, that's how your going to get diseases put on this lists. That's what was done initially and that's how you can do it in the future as well.

MR. LAYMAN: The study I read said that they sent it out to mothers not kids so I think you just stated before that it was sent out to everybody, so I don't know if agree with that with what I read.

MR. ORRIS: Well this is something, I can speak to this myself because this happened to me. So I was born at Lejeune in '74 with an undiagnosed cardiac defect. Now, Frank and I have talked about the science back then, they did not test for many defects the way that they do now. That's just the way it is. We're going to see a lot of conditions underreported. It's one of the reasons I do ask for a registry so we can get kind of an idea because of the lack of testing that was done. Let me tell you how the survey worked, so the survey was not sent to dependents. They were sent to the sponsor, the parent. From the scientific standpoint, ATSDR is not going to talk to me. They are going to talk to my parent, my dad or my mom. That's where the survey went to. And it's one of those things where unfortunately, I understand what Frank is saying about the basis of science, but the basing the science on 1970's reporting methods as well. Which is something that is an issue as well because birth defects are going to be underreported in the '70's and early '80's because there weren't many tests with that.

DR. BOVE: Birth defects will also be underreported for your situation. The birth defects registries in this country only go up to one year of life for the most part. Ok, if you weren't diagnosed by then, you were missed, period. Period, ok. Any study done on birth defects would miss you, ok. But that doesn't mean, but it doesn't miss, it's not the bad testing, it's how these registries are set up. They do capture cardiac defects, heart defects, up to one year of life and some of them actually do it up to 2-3 years of life, they follow them to that extent, some of them. But most of them one year of life. Studies are done using those registries, we've learned a lot about cardiac defects and exposures to chemicals, including TCE, from those

registries. So, it's not a question of testing, it's a question of this is what the do, this is how they are set up, ok. What's relevant, what we find with those registries and those studies is relevant to you, ok. Even though you're not in the study. Keep that in mind. You do not have to be in a study, anything we find in our Camp Lejeune studies, the mortality study, the cancer incidence study, in our previous studies is relevant to all of you. All of you who were exposed. You do not have to be in the study to have it relevant to you, ok. I just want to make that clear because sometimes people feel if they are not in the study, somehow their not being, their situation is not being addressed. Well, it may not be addressed because the study isn't studying that.

MR. LAYMAN: It might change the number if more people had you know like my sister has autoimmune disease that may not have been covered.

DR. BOVE: Well again, the survey we asked these things and they are difficult to study and as we talked about before, scleroderma for example, is related to TCE. In my opinion it's good evidence, ok. We're going to be trying to look at it through the VA's data, ok. But other studies have been done of scleroderma and workers exposed to trichloroethylene, that's relevant, ok, so that's why I said we look at all the literature, you know. Any worker, any study that has looked at trichloroethylene exposure among workers is relevant to what happened at Camp Lejeune even though these people were never at Camp Lejeune. They were workers somewhere maybe in another country, but that's still relevant. The exposure

MR. LAYMAN: It is very hard for us to find and my doctor doesn't even have time to listen to me because I have neurobehavior effects which is very confusing on how you wrote it there. My doctor said I didn't have it because he didn't understand the term and its not defined well on your paperwork.

MS. FRESHWATER: We need to we two more people and we're going to run out of time. You should talk to the representatives though after about the specifics of your case, ok.

[inaudible]

MR. HOSTRAINER: I'm Dwight Hostrainer [assumed spelling]. My dad was in the Marine Corps for 20 years. I was at Camp Lejeune from about 4 months to somewhere in the neighborhood of 4 years old. Knox trailer park. Cancer's been battling me for 20 years and we're on the downhill side. I'm doing some things now starting next week that probably most people would consider a little

experimental, mixing some medications together through the advice of some top medical experts in the field who study mypaliphery [assumed spelling] neoplasm, such as polyselemiavera [assumed spelling]. Because my stuff is out of control, beyond that, a couple of questions I have. When you guys gather here, I think this is probably for the VA, but you have people who are out here helping veterans with their claims and sign up and stuff like that. I'm asking for you guys to put some people there for family members.

MS. CARSON: That's a good point and I will take that back for that particular office, the health eligibility service need to be here.

MR. HOSTRAINER: It's difficult at best to wade through this system.

MS. CARSON: [inaudible] in this state and there are a lot of questions asked about family services on the phone so we will try to work with the larger VA to make sure we have that representation.

MR. HOSTRAINER: I appreciate that and just a few moments ago you talked something about a diagnostic code or something for veterans, I believe you mentioned, ok

UNIDENTIFIED SPEAKER: I did.

MR. HOSTRAINER: I want to make sure I am understanding that correctly. Are you going to have a code 1205 and that's Camp Lejeune. Is that what that's about? Are there certain criteria you have to meet for that?

MS. CARSON: no sir, it is the claim for the condition, not the exposure [inaudible] and the Camp Lejeune Act is what has the list of those disabilities. So the criteria is in the ratings schedule.

MR. HOSTRAINER: I understand that so I guess what I'm looking for is I don't go to the VA, I'm not a veteran. I've been treated and have been for years, for 20 years. Is there some type of diagnostic code that could be developed that says Camp Lejeune toxic water, you know. And then that data is there with the insurance companies who people are tapped into and then all the stuff that is underneath that, you can take a look at and there is all of your information that you need to gather. Seems pretty simple to me, I don't know. I'm just a simple person so. Might be too easy.

MS. CARSON: No, so I am going to split those two out. So diagnostic codes that are in the 38 CFR part 4, which is the VA rating schedule for disabilities, that is a subset of criteria, evaluative criteria for making disability determinations. But it does --

MR. HOSTRAINER:: See --

MS. CARSON: Wait one second. But there's also the VA healthcare system, and there's other medical billing and coding that --

MR. HOSTRAINER: Right, that's what [inaudible].

MS. CARSON: -- corresponds to that. There is an effort by VA to do the electronic health records system which is an enterprise-wide ingest of all the information about diseases, medical service connection, etc. And all of us are working to marry our data up so that you don't have to go to different places in order to pull that piece together.

MR. HOSTRAINER:: Right.

MS. CARSON: And I also believe that there's lots of efforts to partner with private sector so that those codes, those billing codes and etc. would then correspond.

MR. HOSTRAINER:: I think that's what I'm talking about, the billing code. I think that would make this whole process much easier for everybody.

MS. CARSON: Yes, but it's an extensive, it's an extensive undertaking --

MR. HOSTRAINER:: I get that.

MS. CARSON: -- in a system that has to -- that still has to stay on for all the veterans that are currently on the rolls and be updated and modernized. And so there's information about the electronic health records modernization effort, and that's where you're going to see that change. Right now I don't know the exact year that that's planned for. But I know there is a objective in the secretary's priorities for that.

MR. HOSTRAINER: And I also hear everybody, you know, talking about a lot of issues trying to gather statistics and stuff like that. And as I watch the news with flu and coronavirus, there's got to be somebody in this building or in the CDC they seem to be able to gather stats pretty quickly with a diagnostic code of flu or coronavirus or whatever is. Because I see them every morning on the news, a representative from CDC telling us. I don't get why we can't utilize that group of people who go out

and collect that information and get it put forward for the family members and the service members, you know, who have been impacted by Camp Lejeune toxic water. It just -- we have the capability of doing this, okay? Then the last thing is as I sat here and listened to all of this and I hear the people with the registry and I hear the answers, the responses, I think really for -- I don't want to speak for anybody else. For me I'm just asking for you folks to cut through the red tape, okay? And let us get the healthcare, and I'm saying healthcare, I'm not talking about an insurance card. I'm on Medicare. I can't afford to buy a supplemental policy. So all of a sudden I'm responsible for 20 percent of my bills. I can't afford the 20 percent either, okay? So I'm making decisions, do I make my house payment this month, my electric bill this month, or do I go buy my medicine, okay? So I'm just asking for you folks cut through the red tape and get us the help that we need, okay? I'm not even asking you for any money. I'm just asking for you guys just do this. This has gone on way too long. I heard Mike say I think it's been 13 years that he's been on this CAP. This is way too long for something this big. Some of you have made your careers out of Camp Lejeune toxic water. I'm just saying that -- beyond all the noise this is what we're talking about. Cut through the red tape for us. This can be done. This can be done. Thank you.

DR. BREYSSE: Thank you.

MR. SCHWARTZ: My name is John Schwartz [phonetic] and I'm a United States Marine. I was stationed at Camp Lejeune from 77 to 82.

DR. BREYSSE: And who's your buddy?

MR. SCHWARTZ: And this is my service dog Eve. And I have to take her with me because I never know when I'm going to have an attack. I don't have cancer, but I have these attacks in my chest and my stomach where I lay on the floor for hours in pain. I just cuss and I cry and I pray that the pain will go away or God will take me home so that I'm not in pain anymore. I can go from the sink to throw up to the toilet to crap. I mean I'm just in so much pain. And I never know when it's going to happen. I mean all these talks are about cancer. What about the other diseases that we have? I have aplastic anemia, zero percent compensated connected. I have neural behavior disorders. They tell me to show them scientific proof. You've already got all your scientific proof. Why do I have to go out and find scientific proof that it's from Camp Lejeune? My doctor told me to tell you guys to show me that it isn't connected to Camp Lejeune. I mean why should I have to give you scientific proof that my neural behavior order is from Camp Lejeune? And then the

Murfreesboro VA they have no posters up. They've had no posters up for two years. I gave them posters and they still didn't put them up. I've had four doctors in three years at the VA at Murfreesboro. Every time I mention Camp Lejeune water they transfer me to a different doctor. And that's all I got to say.

MS. GRIMES: My name is Brenda Grimes. And I attended the CAP meeting in D.C. And at the end Ms. Carson gave out information to different people and gave them her card. I did not get a robo call back, I got a quick response when I emailed her. She set me on the path to the right direction. So hopefully it will stay off from death row in Louisville, but I think that I'm on the right path there. My question - - I got a couple of questions. One, I don't know if Ms. Miller is still on the phone or not. But she mentioned the different quality trainings that they were receiving and the examiners were. And so my question is I didn't recognize any on Camp Lejeune on the PowerPoint.

MS. CARSON: So one of the things I'll take back for the record because she did have to jump off and I text with her. But I will take that back for you. You wanted to have a list of the trainings that they give to the contractors on Camp Lejeune.

AUDIENCE MEMBER: I would because --

MS. CARSON: Yes, I can do that.

MS. GRIMES: -- I received [inaudible] from my examiner. And, first of all, I did get a survey and I did not take it back, return it because on there it was asking me things about what time your appointment, were you seen, what's the facility, this or that. I never went. They just simple examined my medical records. So I didn't see a physician to answer any of those survey questions. And so I don't know if that has happened to other Camp Lejeune members because I think that number was significantly high for us as a representative.

MS. CARSON: Okay, yup, so I'll take that back as well. So I think what you're telling me just so I can take it back accurately you're saying that even though there was a review of your file for like a medical opinion which wouldn't require you to be seen but for them to review your records, you still got a survey asking you how was your visit. And so you're thinking that the number is high because there are people who are getting that and they respond to it, but they really weren't physically seen.

MS. GRIMES: Correct. And that the CDC has a list of things that caused my particular diagnosis, and those -- the medical

examiner said it was because I was black. But that's not on the --

MS. CARSON: Oh, wow.

MS. GRIMES: That's not a reason for that. And that according to the CDC it's not. And that I'm a woman, well, only 12 percent have my condition nationwide and over 40. And so that was my question. And then my last question is about in 2018 Mike asked about the approval rate for the nonpresumptive diseases on the list, and the VHA came back and gave one. And one of those being renal toxicity, it had what -- five of those had 90 percent disapproval ratings. But compared to what you told us earlier about the renal in the 7,000 that were applied and only 2,000, that makes it about a 62 percent rate. So how is VBA able to approve 62 percent, and the VHA is only 10 percent?

MS. CARSON: So those are two different stacked laws. So there's the Camp Lejeune Act of 2012, and there's the VA presumptive Camp Lejeune list that came from March 14, 2017. So those are eight conditions that we have determined are service related, and they are independent of the 15 conditions where you can go and have access, healthcare. So those statistics that VHA is providing you are for healthcare. And those statistics do not require that you have a claim, like a benefits claim as well.

MS. GRIMES: But theirs were low -- they had a higher disapproval rate according to the chart that was presented.

MS. CARSON: Correct, that's regarding eligibility for healthcare. That's what they presented to you. And I don't know if Family Services is still on the phone. I presented to you the number of service connected veterans based on the eight presumptive conditions at the -- so March 14, 2017 is when that law went into place that allowed us to concede that exposure for eight presumptive disabilities. And all those persons who were previously denied and who filed a new claim were granted if they had one of those eight conditions. That's why ours is higher. But I would have to have Family Services speak to what they have. But those are two separate things, that's healthcare access and this is benefits money.

MS. GRIMES: Okay, so let me get this correct. What you're telling me is that not of the eight but of the nonpresumptive, you're able to approve it?

MS. CARSON: I'm able to approve cases for eight presumptive disabilities effect March 14, 2017 for service connection which allows you to get disability compensation benefits, yes.

MS. GRIMES: Okay, and my question was about the nonpresumptive like renal toxicity.

MS. CARSON: So when it's a nonpresumptive disability we also look at that case for a -- as to whether or not it has a direct correlation between the records in the military and the person's current disability diagnosis. And there are times where we could directly service connect somebody on a direct basis, not -- the presumption is not the only way you get service connection for veterans.

MS. GRIMES: Okay, and so on the VHA side you were able to disapprove it because you -- on the chart it said you disapproved it at like 86 percent was disapproved for renal toxicity, VHA, not you, VHA.

DR. HASTINGS: In the family member program with renal toxicity most of the cases that are disapproved are for end stage renal disease which is related to other conditions such as hypertension and diabetes and not directly related to Camp Lejeune.

MS. GRIMES: Okay, thank you.

MS. FRESHWATER: But that's under contention right now. We are -- that's one of the things we're working on on how to read the law. With this I'm not sure how you can decide that it's because of diabetes as opposed to the chemical.

MS. GRIMES: Okay, thank you.

MR. CRAWFORD: Curtis Crawford. I just have a couple of questions. First why are we not recognizing the autoimmunity in this? There's so many autoimmune diseases out there. Is that the big reason that you're afraid to open up the autoimmune category because it covers over 100 different diseases? Because Sjogren's Syndrome is a disease that most white American males should not have unless they have hereditary factors. And I'm sure Dr. Blossom is curious as to why you're overlooking it as well. With the science that we have available to it, it does point TCE straight to autoimmune diseases. And we're not recognizing enough of these diseases. Scleroderma --

DR. BREYSSE: That's part of our reassessment that we're doing right now.

MR. CRAWFORD: I was just wondering is that part of the reassessment?

DR. BREYSSE: Yeah.

MR. CRAWFORD: Are we going to be looking into Lupus, Sjogren's Syndrome and those diseases?

DR. BREYSSE: Yeah.

MR. CRAWFORD: And that's the reason why us veterans are kind of adamant about the health registry is because a lot of us have been found in the past eight years and that weren't even included in this study. And it would help us have a different cohort in the long process. You know, the ability to get that commonality with some of us can get us those other cohorts so that we can progress this a little bit further. But it's good to know that you are looking at the autoimmunity in this, and I thank you for that.

WRAP UP ADJOURN

DR. BREYSSE: Sure, all right, I think -- and I see a lot of people needing to catch planes and trains and an afternoon appointments. So we'll adjourn the meeting, and thank you all very much.