THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

convenes the

FORTIETH MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE PANEL (CAP) MEETING

April 27, 2018

The verbatim transcript of the Meeting of the Camp Lejeune Community Assistance Panel held at the DoubleTree by Hilton Hotel, 500 Mansfield Avenue, Pittsburgh, Pennsylvania, on April 27, 2018.

STEVEN RAY GREEN AND ASSOCIATES
NATIONALLY CERTIFIED COURT REPORTING
404/733-6070

C O N T E N T S

April 27, 2018

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

(alphabetically)

ASHEY, MIKE, CAP MEMBER
BEATTY, GAYLE, VA
BLOSSOM, DR. SARAH, CAP TECHNICAL ADVISOR
BOVE, DR. FRANK, ATSDR
BREYSSE, DR. PATRICK, NCEH/ATSDR
CANTOR, DR. KEN, CAP TECHNICAL ADVISOR
CARSON, LAURINE, VA
DINESMAN, DR. ALAN, VA
ENSMINGER, JERRY, CAP MEMBER
FORREST, MELISSA, NAVY/MARINE CORPS
FRESHWATER, LORI, CAP MEMBER
GILLIG, RICHARD, ATSDR
HASTINGS, DR. PATRICIA, VA
HODORE, BERNARD, CAP MEMBER
IVES, SCOTT, VBA
MCNEIL, JOHN, CAP MEMBER
MUTTER, CDR JAMIE, ATSDR
ORRIS, CHRISTOPHER, CAP MEMBER
PARTAIN, MIKE, CAP MEMBER
STRATFORD, DONNA, VBA

P R O C E E D I N G S

(5:00 p.m.)

WELCOME, INTRODUCTIONS, ANNOUNCEMENTS

DR. BREYSSE: So why don't we get started. On behalf of ATSDR/CDC I'd like to welcome everybody to the Camp Lejeune CAP meeting for this April 27, 2018. As you know, the CAP meeting is this evening, and there's a companion meeting tomorrow, where there'll be a public meeting that we've scheduled for tomorrow. So I just want to again thank everybody for coming, and we'll take a minute to go around and introduce ourselves and then we'll have some announcements. So why don't we start down at the end and we'll work our way around.

MR. IVES: Sure. Scott Ives with Veterans Benefits Administration, and I'm a contracting officer representative with the compensation service.

MR. ORRIS: Christopher Orris, I was born at Camp Lejeune, congenital heart defect, CAP member.

MR. ASHEY: Mike Ashey, served at Camp Lejeune, CAP member.

MR. HODORE: Bernard Hodore, CAP member.

MR. MCNEIL: John McNeil, Marine, served at

Camp Lejeune, CAP member.

MS. FRESHWATER: Lori Freshwater, CAP member.

MR. ENSMINGER: Jerry Ensminger, CAP member.

MR. PARTAIN: Mike Partain, CAP member.

CDR MUTTER: Jamie Mutter, ATSDR, CAP coordinator.

DR. BREYSSE: Patrick Breysse, I'm the director of ATSDR.

DR. BOVE: Frank Bove, ATSDR.

DR. BLOSSOM: Sarah Blossom, scientific advisor to the CAP.

MR. GILLIG: Rick Gillig, ATSDR.

DR. HASTINGS: Pat Hastings, VA.

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

MS. CARSON: Laurine Carson, VA.

MS. BEATTY: Gayle Beatty, VA.

DR. DINESMAN: Alan Dinesman, VA.

MS. FORREST: Melissa Forrest -- I can't say my name. Melissa Forrest, Department of the Navy.

DR. BREYSSE: Okay, so Jamie, you’re up?

CDR MUTTER: Yes, thank you. So just as a reminder, everyone, please turn off your phone and put it on silent so there's no interruptions. If you need to use the rest rooms, go out these doors,

down the stairs, and they're to the left. Emergency exits are straight out these doors. Right across the hall are the doors to the outside.

And just so everyone knows, if you got an agenda there is a place for audience comments at the very end. We have limited time for audience comments tonight but we have a whole meeting tomorrow dedicated to the public, so if we don't get to you today we have a complete meeting for you tomorrow to have comments and questions.

And just so you know, tomorrow the VA is holding a Camp Lejeune health and disability claim clinic from 9:00 to 2:00 p.m., just down this hallway, in the very first room. Representatives will be available to answer questions, review your disability claims and assist with healthcare registration.

And just so our table knows, the mics are going to be on the entire time. You don't have to push to turn on and off, just so be aware of that, and thank you very much.

DR. BREYSSE: And if I can add to that, remember, so the transcription can be done efficiently, use the microphone and try to remember to say your name before you start talking.

So the agenda, I'll just walk through that real quickly. So there will be an update from the VA, followed by action items from the previous CAP meeting. There'll be a short break, and then a discussion of the public health assessment updates, which includes the soil vapor intrusion efforts, health study updates, the health survey, cancer incidence study. Then we'll hear from the CAP and get updates on community concerns, as usual. And then we'll wrap up and adjourn around eight o'clock. So any questions about the agenda?

Great, so why don’t we just jump right in then, and we'll turn the floor over to the VA, and we'll get some updates from the Veterans Affairs.

U.S. DEPARTMENT OF VETERANS AFFAIRS UPDATES

MS. CARSON: Good evening. First and foremost, CAP members, I wanted to say thank you for allowing us to be here today. My name is Laurine Carson, and I am the acting senior advisor to the director of compensation service at VBA. And today I am here to basically follow up on an agenda item that you all asked us to follow up on.

I brought with me Scott Ives, who is over at the front of the table. Scott is on our medical

disability examination staff in compensation service, and there was questions, I think Mr. Ashey asked me, about the contract examinations. And so I brought him with me today, as promised, to talk a little bit about that program within VBA, and how it relates to Camp Lejeune veterans. So he will be here and he'll be doing the briefing today.

CDR MUTTER: We'll be pulling up your slides momentarily.

DR. BREYSSE: Did somebody want to say something about the brochure that the VA provided with everybody at the table?

MS. CARSON: We'll have Donna Stratford, our public affairs officer, say something.

MS. STRATFORD: Everyone has a copy, hopefully, of the Camp Lejeune brochure, and that has an overview of both our health and disability benefits that are available. And we did work with CAP members to help develop that, and make sure all the information was covered that they felt was important, and --

DR. BREYSSE: Can you lean closer to the microphone, please?

MS. STRATFORD: And so if anyone needs a copy, they didn't pick one up at the table, please let me

know, and I'll go get some and bring them around.

DR. BREYSSE: And your name again?

MS. STRATFORD: Donna Stratford from Veterans' Benefits Administration.

DR. BREYSSE: So we got the slides up?

MS. CARSON: Yes, we do. So Scott, I'll have you start.

MR. IVES: Yes, ma'am. All right. So to begin with, way back in 1996 Congress enacted a public law that authorized the VA to contract for medical examinations from non-VA sources. When this public law was initially done it was limited in scope but it has expanded since then to where now it is a nation-wide activity.

In April 2017 VBA modified their exam contracts to assist VA regional office Louisville, Kentucky with a large number of Camp Lejeune contaminated water claims that required a medical opinion. At that time all of the opinion requests were going to VHA. Unfortunately the capacity was not there at that time to keep up and have a, quote/unquote, positive delta, and by that I mean that there was more cases coming in than they were able to actually do and provide back in a timely fashion.

In August 2017 VBA central office along with

the Louisville regional office and VHA conducted a training session with contract examination vendors. And then in September 2017 the first Camp Lejeune contaminated water subject matter expert opinion requests were submitted to the contract vendors. All right, everybody good?

Next up, as of April 25th the contract examiners have completed 1,781 Camp Lejeune contaminated water subject matter expert opinions. The average days that it takes for a vendor to complete one of our Camp Lejeune contaminated water opinions is 14.1. And to-date VBA medical officers have conducted special focused reviews of Camp Lejeune contaminated water subject matter expert opinions that have been completed by each vendor. There are four vendors who are currently doing these, and a special focus review has been done on each one.

MS. CARSON: And just so I may -- this is Laurine Carson -- I wanted to say a special focus review is a quality check on whether or not they followed the guidelines to complete the examination. So they had one of those reviews.

MS. FRESHWATER: Hi, this is Lori Freshwater. I just want to make sure, can we get a copy of these -- a digital copy of this presentation?

MS. CARSON: Yes.

MS. FRESHWATER: Okay. Thank you.

MR. IVES: So the providers who are completing the CLCW SME opinions must be a medical doctor who is board certified in occupational medicine. The providers must complete all VHA DMA training. The vendors have a timeliness standard of 20 days from the date the request is submitted to the vendor to the day the completed results are submitted to VA, and vendors have a quality standard of 92 percent.

MS. CARSON: And this is Laurine Carson again. Scott, if you may, can you please explain what DMA is.

MR. IVES: Oh, I would actually defer to Alan on that.

DR. DINESMAN: DMA is the office of disability and medical assessment, and that is the department in VHA that performs compensation and pension examinations.

MR. ENSMINGER: So what did you say about the 92 percent? What?

MR. IVES: That is the quality standard.

MR. ENSMINGER: Who's judging this quality?

MR. IVES: We have a separate quality team that does that.

MR. ENSMINGER: How do you -- I don't get it. How, how do you --

MR. IVES: Okay. I'll see if I can explain it. So every time an examination is done by one of our vendors we take a statistically balanced sample of all of them that are done, and there is a quality checklist that they go through, which in essence, says here is -- are you familiar with disability benefits questionnaires? DBQs?

MR. ENSMINGER: Yeah.

MR. IVES: They take that DBQ that was returned by the vendor, they go through and make sure that the request that VBA submitted to the vendor and what the disability benefits questionnaire, that was submitted back to us from the vendor, answered everything that's on the DBQ and any other question that was asked by VBA.

MR. ENSMINGER: Okay.

MR. IVES: So that is if they did not answer a particular section, for instance, on the DBQ, that would be an error.

MR. ENSMINGER: Do you have a copy of this quality standards checklist that you're grading these people on?

MS. CARSON: So in order to get -- I know there

was another question about whether or not you can have copies of the training materials that VHA has and whether or not you can have this quality checklist. You would need to submit a Freedom of Information Request to the department, and you can get a copy of that information.

MR. PARTAIN: Yeah, we already have a lawsuit.

MS. CARSON: You do have one?

MR. ENSMINGER: A lawsuit.

MR. PARTAIN: A lawsuit.

MR. ENSMINGER: Because they won't fulfill a FOIA request.

MS. CARSON: Okay. I'll take it back, for the record, then, and I will try my best to see if I can get you some information.

MR. ENSMINGER: And, and also I'd like to see the training materials that were used to train these vendors.

MS. CARSON: Okay.

MR. PARTAIN: Now, let me ask, is it my understanding that the VA has gone away from using in-house or internal personnel? Are you guys just using outside vendors?

MR. IVES: No. That actually is not correct. This was used to supplement the VHA providers that

were able to do this. As I said, there was a capacity issue in regards to making sure that we were able to complete CLCW SME opinions, so this was to supplement the VHA in-house DMA folks that were able to do this.

MS. CARSON: So -- this is Laurine Carson again. So Mike, last time, as I explained to you, VA, as an agency, VHA and VBA, have always had contractor assistance in its claims process and in its exam process, and that is to supplement our in-house examiners.

As of, I want to say almost going on two years now, VBA became, for CMP exam purposes, all CMP exams, we became the office to administer the VA contract for CMP examinations, and that's the staff that Scott is on. It's a newly stood-up staff.

In that group I think that they are doing approximately -- don't -- Scott, I'm just -- I'm looking at you to see if I'm correct -- but it's about 40 percent of all CMP exams are done by that group across all of the CMP examinations.

MR. PARTAIN: Let me ask you, what -- you know, we have the term SME, subject matter expert. Also I see in a lot of documents IME, independent medical examination, or whatever. But what's the

relationship between the two terms, SME and IME?

MS. CARSON: So, and I'll ask Dr. Dinesman if he knows, but the independent medical examinations that I'm most familiar with are generally related to a BVA, board of veterans appeals, directed exam for an independent examiner, completely unrelated to VBA or VHA, to do that type of an examination, or from the entity who performed the exam, they want another exam by somebody that is not from that affiliation. So it can be that, if it's a private exam, they ask us for a different exam, then the VA person can do it. If it’s a VA examiner asking for someone outside of the VA system to do it, our contractors are considered within the VA system.

DR. DINESMAN: Yeah, the term independent medical examiner is -- you literally just take it for what it says. It is somebody who has not generally seen this person or treated them. So all compensation and pension exams are IMEs, or what is also known as IMOs, independent medical opinions. There's also a term that's frequently used in the workmen's comp arena of a insurance exam, which may be somewhat confused with it. But an independent medical exam is just exactly that, it's an independent exam.

A subject matter expert, although that term is kind of, I guess, poorly used --

MR. ENSMINGER: Hey, you guys started it.

DR. DINESMAN: Right. No, I'm going to agree with that. That's why I'm saying the term is kind of poorly used. A subject matter expert is somebody who has a requisite amount of knowledge about the information. In fact I would consider you, Jerry, probably a subject matter expert.

MR. ENSMINGER: Depends on what you're talking about.

DR. DINESMAN: Well, but that is -- so it is somebody who's had the appropriate training. So for our CMP clinicians we have a process of certification, and then there are individual trainings that go on for a variety of topics. We have training for Gulf War exams. We have trainings for a variety of different components. For the group that have been known as our SMEs, they are folks who have had the requisite training to be able to do these examinations.

MR. ENSMINGER: Yeah, but from what I'm seeing, you've got a higher standard for your contract people, who are all board certified in occupational medicine, than you do for your own internal

so-called subject matter experts, because most of them are family practitioners. They don't -- they aren't certified, board certified, in occupational medicine.

DR. DINESMAN: So for the term -- to be a subject matter or person trained, you don't have to be an OM for this.

MR. ENSMINGER: Yeah, I know, but you're getting crap evaluations.

DR. DINESMAN: There may be some that you disagree with, but I think they're high quality. The, the --

MR. ENSMINGER: Well, wait a minute. Wait a minute. Wait a minute. I have seen subject matter experts -- so-called subject matter expert opinions that were written that said that that examiner had done a comprehensive study of the meta-analysis of well-conducted -- two decades' worth of well-conducted scientific studies, for several decades' worth of studies, and could find no evidence that TCE causes any type of cancer, let alone renal cell carcinoma or kidney cancer. He wrote two opinions, both denied. The claims were denied, and this was prior to the presumption status coming in. What rock was this guy living under? He

was a subject matter expert.

DR. DINESMAN: We'd have to look at the individual exam to see --

MR. ENSMINGER: I'll get them to you.

DR. DINESMAN: I would like to look at them.

MR. ENSMINGER: And I want to know if this guy is still a subject matter expert.

DR. DINESMAN: We would be happy to look at them. Understand, you're talking about one or two out of thousands, and so I think that is --

MR. PARTAIN: Are there thousands of SMEs?

DR. DINESMAN: No, thousands of exams.

MR. PARTAIN: Well, it's more than one or two, so.

DR. DINESMAN: Still, when you look at it statistically, and even if you look at -- by the way, the quality standard, as you'll hear, is a ratability standard. It is not a medical quality, not a clinical quality, standard. And in fact that is something we are working on right now. That is a ratability standard. So if you need to look at that --

MR. PARTAIN: Dr. Dinesman, on the IME-SME question that I had, so when you're -- when we're seeing IME, or independent medical exam, or

whatever, is the SME report considered an IME report or --

DR. DINESMAN: All compensation and pension exams are IMEs.

MR. PARTAIN: No, I'm just trying -- I mean, what the -- 'cause I see IME mentioned in documents. I'm trying to understand what is the difference. Is an SME producing an IME, an independent medical review, or whatever, for the decision for the veteran? I mean, what exactly -- I mean, what I'm trying to figure out is this is a substantial break from past -- sorry, train of thought, but it's essential break in procedure in the past and as far as introducing the SME process into the Camp Lejeune claims. And I'm trying to get a handle in understanding, you know, why is it there.

DR. DINESMAN: So first off, and thank you; that's a good question. All the exams are IMEs, all right. That is an independent medical exam. That's just saying you're going in for an independent examination. This is not a break in any way of normal VA procedure or VHA procedure. We've had a need and a requirement for specialized training for certain types of exams.

You're looking for -- one that comes to mind is

for former prisoners of war. There is a limit on who can do those, based on the people that have had the appropriate training courses. That's been around for -- I mean, how long have we had former prisoners of war? A long time. We've had specialized testing -- or training, excuse me. Not testing but training -- necessary for all different types of examinations, so this really is not a break.

And that's why I kind of want to emphasize that -- and I'll take that -- I didn't come up with that term, but I'll just say that the use of the term SME, I think, was a misnomer. It was just a way of these people kind of designating the fact that they'd had training to look at these, and I would prefer to get rid of the term SME because again it's a standard technique and a standard procedure that we've used in VA for a long time.

MR. ENSMINGER: Well, let me ask you this --

DR. BREYSSE: Jerry, can I -- can I interrupt for one minute? So we'll let you finish this train of thought, but then I want to remind people to put their name tents up if they want to get in the queue, and we have a bunch of people waiting to have an opportunity as well. And I don't know how much

more slides we have but it's 5:30. We have another half hour for the VA updates, so I just want to keep track of the time.

MR. ENSMINGER: Let me ask you this. Of all the environmental exposure incidents that the VA is covering, such as Camp Lejeune, Agent Orange, Gulf War, burn pits, how many of them have an SME program like Camp Lejeune?

DR. DINESMAN: They all have special training programs.

MR. ENSMINGER: How many of them have SME evaluators' opinions for their claims and aren't covered under -- okay, Agent Orange. You have a presumptive program for Agent Orange. How many non-presumptive claims for Agent Orange get an SME opinion? None.

DR. DINESMAN: I don't think that's correct, sir. If you -- I think the, the difference is that, if you look at Agent Orange and if you look at Gulf War, the numbers are so much greater than -- those are mandatory training for all CMP. So all are trained to do so.

This was a more focused group, or focused population, and therefore it's not something that every single CMP examiner has undergone the

training, and that's why we have a limited group. So it's, it's the same, same type of training, though. It's still focused.

MR. MCNEIL: Real quick, 'cause this sort of goes to the numbers that we were just talking about today. John McNeil from the CAP. What -- is there a difference between the vendor rate of review of these cases and the VA rate of resolution of these cases? Like you talk about 14 or -- the timeliness standard is 20 days. What's the VA's resolution rate versus the contractor resolution rate?

DR. DINESMAN: So these are not resolution dates. That is the date which the examiner has completed the report. Remember, the, the examiner just completes a report. That is medical evidence, just like expert testimony. It is then up to VBA to rate it. VBA can look at it and they can say, we agree with this opinion or we disagree with this opinion. And we -- and we see both. We've seen people that the opinion has been one way and something else has been granted. There's nothing that says that what the examiner opines necessarily means what will be granted or not.

But this 14.1 days is probably pretty close to what our examiners on the VHA side, who, as far as

getting the exams completed from the date that it is requested, and that's what that number is, from the date it's requested from the Veterans' Benefits Administration, to the clinic. It's 14.1 days. For the vendors, I haven't gone back and looked at what ours is for, for Camp Lejeune in particular. I know as a total we're around 20 -- 20, 22 days. So for Camp Lejeune I imagine we're going to be well within that.

MR. MCNEIL: 'Cause the numbers, from what I saw in those slides, and heard, about 1,700 of these have been resolved in seven months by four contractors. That comes out to having a review and resolve rate of three a day per contractor, if they worked 20 days a month, which it would seem to me -- I'm not a doctor and I don't have a full-time job as a doctor doing something else, and then reviewing the records -- but it would seem to me that, to be able to review -- you know, I mean that's basically completing three of these cases all day every day every month, which I can't imagine that this is their primary or only employment, and three a day just seems a whole lot to be able to resolve from their very first time they got sick to whether or not this relates to the Camp Lejeune

water.

DR. DINESMAN: I cannot speak to how the vendors do or what they do because that is up to VBA. I can only speak about what the VA, or VHA, examiners do.

MR. MCNEIL: But if your guys rate -- I mean, if you guys are working as hard as the contractors, is it possible to take up three files every day, every day of every month, and know scientifically that this doesn't relate or does relate to Camp Lejeune?

DR. DINESMAN: I think you have a good question but I cannot comment regarding it because I don't really --

MR. IVES: I can actually comment on that one. Allow me to expand upon that. When I say that there's four vendors that doesn't mean that there's just four board certified medical doctors that are doing these. Each vendor has multiple board certified medical doctors that are doing this.

MR. MCNEIL: Okay, so that makes a little more sense.

MR. IVES: Yeah. So it's not just four doctors that are doing these full-time.

MR. ENSMINGER: Well, then how many are there?

MR. IVES: It varies by vendor.

MR. ENSMINGER: I mean, you got a total?

MR. IVES: That's not something that we actually -- let me back that and explain it better. We tell our vendors, this is the capacity, the total number of requests, that you can expect to see. We allow them to subcontract with the medical doctors based on what they feel is going to be the correct capacity for them. As is noted, sometimes they may have a doctor who's doing it full-time, which would allow them to do more, as opposed to, has a doctor that has their own practice and only does maybe one or two of these a week.

DR. BREYSSE: Chris?

MR. MCNEIL: So the VA doesn't know whether they've got one person working full-time or a hundred subcontractors?

MR. IVES: As far as -- we can always go and ask them. We get a list of all --

MR. MCNEIL: Have you guys ever asked them?

MR. IVES: We get a list of all the physicians that are working for them.

MR. ENSMINGER: Are you vetting them?

MR. IVES: Yes. We make sure that they are all credentialed and licensed.

DR. BREYSSE: Yeah, Chris -- I mean, we need to give Chris a chance.

MR. ORRIS: This is Chris Orris. A couple of questions here. I'm looking this over, and, you know, coming from an auditing background, first of all, I see that you're talking about the special focus review, and then you start giving statistics based on a PWS, which is a performance work statement. What is the difference between the special focus review and the PWS, and why is it that you give us a score of 92 percent of PWS and yet I don't see any score for the special focus review? And I'd also like to know what is exactly the special focus review?

MR. IVES: Okay. So let me divide that up into two different parts. The special focus review for each vendor was done after they had completed a number of these exams.

MR. ORRIS: And what is the percentage of pass as opposed to fail for the special focus reviews?

MR. IVES: I would have to go back into that and get that information.

MR. ORRIS: Obviously you must know that it's not good because it's not written here.

MR. IVES: I would disagree with that, but...

MS. CARSON: This is Laurine Carson. A special focus review is a review of the ratability of the claim based on VBA guidelines, what -- the requirements for them to look at the disability evaluation itself and whether or not they followed those -- the, the laws, the 38 CFR guidelines. So it's ratability, the ability to make a decision based off the review follows those guidelines.

MR. PARTAIN: 'Cause the devil's always in the details. How about a contract and a scope of work for what the vendors are doing for you all?

MR. IVES: And so allow me to, to follow up on it.

DR. BREYSSE: I want to remind people to use their tents to respect everybody's opportunity to speak.

MR. IVES: So allow me to follow up on that. We could certainly provide what the score was for the special focus review. The purpose of the special focus review was, because this was new for our vendors, it was something they had not previously been doing, we wanted to make sure that special focus review for them so that we could say, here is where we found a problem; here is where we didn't find a problem. The reason we put the

92 percent in there is because that is what is written into the PWS. It's their expected quality standard.

MR. ORRIS: Sure, and I understand that. Now, by saying that, you know, the special focus review was trying to identify what your strengths and your weaknesses were in regards to this, correct? What I want to know is what were those weaknesses and how did they affect individual claims in the process? And whether or not you have certain SMEs who are scoring at a very subpar level, and if so, what are you doing to provide them better training so that they're providing the community with the proper care and support that they need or whether you're moving them on to something else like maybe cleaning windows in the parking lot or something, instead of handling these cases?

MR. IVES: One, I would say that these individuals, the medical doctors who are doing these, are not actually providing care. These are more of the forensic type of examinations as opposed to care examination.

MR. ORRIS: Yeah, yeah, but they're providing or they're either giving or disagreeing with providing benefits to people who need care.

MR. IVES: They're providing a subject matter expert medical opinion, but at the -- after that is provided it is still in VBA's to adjudicate the claim.

MR. ORRIS: Yeah, but the devil's in the details. I want to see what the scores were, what the individual breakdown was for each of these SMEs. I'm sure you have that. And I don't want to hear Freedom of Information Act.

MS. CARSON: If the stuff is -- that's within VBA's system, I can't just say, here -- here's all of this information. There is a process, and the process is through the Freedom of Information Act.

MR. ORRIS: But you can tell me a 92 percent score, but I have a sneaking suspicion that this other score is way less than 92 percent, and I just cannot believe that you just can't stand out and say this is what our body of work is, and own up to it.

MS. CARSON: And so, Jamie, I would ask that you provide me with a concise question that is being asked so that we can actually go back and provide what information we can, to the best we can.

DR. BREYSSE: So Chris, if you can articulate that for us, we'll make sure --

MR. ORRIS: Okay, what --

DR. BREYSSE: -- it gets in the request for the next meeting.

MR. ORRIS: The exact request is, is I want to know what the special focus review pass-fail percentage was overall for Camp Lejeune.

MS. CARSON: Okay. Thank you.

DR. BREYSSE: Lori? Welcome back, by the way.

MS. FRESHWATER: Thank you very much. It's good to be back with everyone. I'm wondering, as far as the occupational doctors go, what is the rationale for only having occupational doctors? Because I mean, are you saying you would exclude any others? And why go with that field? Because they don't necessarily have any training in environmental toxins and what that does. A lot of times their resume will say environment, the word environment, and people assume that they have some sort of special training or knowledge, but they don't. That's very rare that they have any, any clue what these chemicals do to a person's health.

DR. BREYSSE: Would you mind if I take a stab at that, Lori? So I know 'cause in my previous job we ran a residency program in occupational and environmental medicine. And so they indeed get training in environmental toxins and stuff. And the

residency is specifically called occupational and environmental, so they're not just solely focused on the work place.

MS. FRESHWATER: Well, when I looked into the SME program before, there were some of the occupational doctors that did not have the environmental component. Maybe that's changed. I guess I would just ask if that's --

MS. CARSON: When did you look into it? Because these doctors were not addressed in these claims until the enactment of the new law, so.

MS. FRESHWATER: Well, like for instance, Dr. Deborah Healey (sic), I believe I'm getting the name right. Heaney. She's still there. I don't remember her exact qualifications, but she also runs a business on the side. So I still contend that there's a conflict of interest there, but I won't get into that. But --

MS. CARSON: You're saying she's one of the VBA contractors or is she a VHA employee?

MS. FRESHWATER: No. She's an employee.

MR. ENSMINGER: She's a VA employee.

MS. CARSON: Okay.

MS. FRESHWATER: But that's when, when she -- when the SME program was first began, so

maybe it's changed since then, so if I could just get an update on -- no, I'm talking about the qualifications -- to make sure that the occupational doctors also have the environmental component to their...

DR. BREYSSE: Can I pause here for a minute? 'Cause we're not done with the one presentation. We have a whole 'nother presentation, I believe. How many slides do you have left?

MR. IVES: That's it.

DR. BREYSSE: Okay, that one's done. So we're going to weigh the options here of having further discussion of this versus hearing what else they have to present. So you guys both have more comments or questions further?

MR. ENSMINGER: Yeah, I do.

DR. BREYSSE: I think Mike was up before you, Jerry.

MR. ENSMINGER: Yeah, he was. Yeah, he was.

MR. PARTAIN: I just want to go back 'cause I got my hand slapped when I had my card up. Like I said, the devil's in the details. I'd like to see the contract. I know FOIA, and I've heard that, and once again, we have a FOIA lawsuit on this. But, you know, transparency is what needs to be seen

here, and the contract for the vendors here, and also the scope of work, how are they doing their jobs, what materials are being provided to them? So that needs to be transparent.

DR. BREYSSE: Can you give that to us in writing, and make sure that's in the things to follow up with the VA, please?

MR. PARTAIN: Yes. And, you know, just cutting to the chase with the argument is my final point. You know, this whole point of contention with the SMEs is objectivity. You know, if we're going to do an independent review or an independent evaluation on these veterans' claims to try to determine whether or not they're related to the exposures at Lejeune, once again, transparency. Number two, independent.

Prior to the contractors we had VBA employees making decisions. They're employees. They're not independent reviewers. They're going to do what they're told because they're working for the VA. Now, these are now contract employees, and we have no idea what they're being told, what training material they're being presented or --

MR. ENSMINGER: Who the hell they are.

MR. PARTAIN: -- who the hell they are, to

begin with too, what companies these are, what associations these companies have with different entities. Do they represent workmen's comp for -- you know, like Deborah Heaney -- workmen's comp environmental types? That needs to be in the public.

MS. FRESHWATER: She's actually involved in court cases recently where she is working for industry.

MS. CARSON: Right, but she's not one of the contractors.

MR. PARTAIN: No, but -- we don't know.

MS. CARSON: She's one of the VHA.

MS. FRESHWATER: Right.

MR. PARTAIN: We don't know who these contractors are is my point.

MS. CARSON: Okay.

MS. FRESHWATER: They could be like her or worse.

MR. PARTAIN: You gotta raise your card. Just like Deborah Heaney, we didn't know who she was until she surfaced, and we found out that she had an independent business where she was providing consulting work for the government and industry against toxic tort cases involving workers comp. To

me that's a conflict of interest.

MS. CARSON: Thank you for bringing that to my attention. I will definitely take that back to the deputy director of the medical disability exams, for her to find out and to provide more information on that.

MS. FRESHWATER: I can send you some stuff I have.

MS. CARSON: Yes, I'll give you my card afterwards.

DR. BREYSSE: Jerry, you get the last word for this session before we go on to the next presentation.

MR. ENSMINGER: Yeah. You know, this whole process stinks. I mean, before, all a veteran had to do was fill out a claim and get a nexus letter from their attending physician or their specialist. Nowadays these opinions are being written by people that have never even seen these people. They have never examined them. All they're doing is looking at pieces of paper and making their opinions on these people. That's wrong. They are actually going in back and questioning the nexus letters that have been -- that these veterans have had submitted by their oncologists. That's wrong. This is so

sterile and so impersonal, it's not right.

If you're going to write an opinion and deny somebody their right to life, really, then, by God, you should be seeing these people instead of just sitting back somewhere in an office and looking at pieces of paper and making an opinion that is going to affect the rest of these people's lives. It's not right.

MS. FRESHWATER: Going against their oncologists.

MR. ENSMINGER: Yeah. So that's the last word I have.

DR. BREYSSE: So is there another presentation?

DR. HASTINGS: Yes.

DR. BREYSSE: For the VA?

DR. HASTINGS: We have the family member program. There were some questions in regards to that the last time, so they have an update to that as well as the numbers that were requested in regards to funding.

DR. BREYSSE: Great.

MR. ASHEY: Ms. Carson?

MS. CARSON: Hi.

MR. ASHEY: Hey. Did this presentation, was that to answer my question?

MS. CARSON: That was to try to answer your question and tell you a little bit more about the contract exam staff.

MR. ASHEY: Okay. So the only statement that was really made, that vendors have a quality standard of 92 percent. The question I asked was: How are these contractors graded? If they have approximately -- I think what the number was, about, well, a little less than 1,700. So of that, how are -- I mean, are they being graded based on how many they approve or how many they deny? That's the question I asked last time.

MS. CARSON: So that's -- Scott, can you answer that question?

MR. IVES: Yes. And no, they are not being graded on whether they provide a positive or a negative opinion. That is not what they're graded on.

MR. ASHEY: Okay. So then they're graded on the paperwork that they do, and that they check all the boxes and review everything. Again, as Jerry said, that's a very impersonal process. I mean, they're not even examining these people. They're just looking at paperwork, right? Am I understanding that correctly?

MS. CARSON: For the medical opinions?

MR. ASHEY: Yeah.

MS. CARSON: Unless there's a need they generally do not see the person, but for all other exams they do see the veterans.

MR. ENSMINGER: Would you personally accept a medical opinion from somebody making an evaluation on your life? No, you wouldn't. Hell, I wouldn't.

DR. BREYSSE: So the next presentation is by whom?

MS. BEATTY: Gayle Beatty.

DR. BREYSSE: Gayle, thank you.

MS. BEATTY: Good evening, everybody. I am a program management officer in the office of community care in Denver. I'm over --

DR. BREYSSE: Speak a little closer to the microphone, please.

MS. BEATTY: I'm over the Camp Lejeune family member program. I've been over it for the last five months. The Honoring America's Veterans and Caring for Camp Lejeune's Families Act of 2012 was enacted August 6, 2012. Section 102 requires VA to provide healthcare to veterans who served on active duty at Camp Lejeune and reimbursement of medical care to eligible family members for one or more of 15

specified illnesses or conditions that are listed.

To be eligible for VA healthcare 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 healthcare. Veterans do not need a service-connected disability to be eligible as a Camp Lejeune veteran for VA healthcare.

VA healthcare related to any one of the 15 qualifying health conditions is at no cost to the veteran, including copayments. Camp Lejeune veterans are involved in VA healthcare in Priority 6, unless they qualify for a higher priority group. VA began providing care to Camp Lejeune veterans on the date the law was enacted which was August 6, 2012.

As of March 31, 2018 VA has provided healthcare to 52,688 Camp Lejeune veterans, 3,211 of which were treated specifically for one or more of the 15 specified Camp Lejeune-related medical conditions. So any Camp Lejeune veterans interested in enrolling, we've got a phone number here. We also have copies of the slide show, afterwards, if you'd like.

MS. FRESHWATER: So that looks higher from -- again, I'm trying to catch back up. I've been on leave from the CAP for a while. But does anyone know what to compare that to, say, a year ago?

MR. ENSMINGER: You got any historical data?

MS. BEATTY: I don't have it on me now.

MR. ENSMINGER: Okay.

MS. BEATTY: But I will know for next time, if that's what you'd like.

MS. FRESHWATER: Thank you.

MS. BEATTY: So the table below displays the number of veterans who have been treated for each specific Camp Lejeune medical condition. As you can see, the renal toxicity is the -- has 769, which is the most common bladder cancer.

MR. ENSMINGER: Go back up to that, please. You have a copy of this, hard copies of this?

CDR MUTTER: It's in your --

MR. ENSMINGER: It is in the folder?

CDR MUTTER: Yeah.

MS. BEATTY: If you want extras, I've got a few extras too.

MS. FRESHWATER: So there's -- there's no listing for auto-immune, except for scleroderma; is

that right?

MR. ENSMINGER: Renal toxicity, 769? Oh, gee, go figure. That's not one of the presumptives. It was one that was dropped off. Okay, thank you.

MS. BEATTY: So the 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 providers and the VA reimburses, as payer of last resort, out-of-pocket medical costs associated with the 15 conditions. Family members may request reimbursement for covered expenses incurred up to two years prior to the date of the application.

As of March 31, 2018 we had 1,839 family members that are administratively eligible, 537 family members that are clinically eligible for one or more of the 15 covered conditions. VA has provided reimbursement to 372 family members for claims related to treatment of one or more of the 15 conditions. We've got the phone number and the link.

To receive reimbursement for medical expenses the 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 time frame, have resided, to include in utero, on Camp Lejeune for at least 30 days between August 31, 1953 and December 31, 1987, and have one of the -- one or more of the 15 qualifying health conditions. And again, that's for clinical, to get reimbursed for your claims.

MR. ORRIS: Thank you for providing all this information, Ms. Beatty. I appreciate that. I have a couple of questions for you. Something that I've pointed out, I'm one of the administratively eligible Camp Lejeune. I was born there at the base. However, my condition, even though the scientists have given sufficient causation for that illness to be included in the Camp Lejeune bibliography, it's not covered under this healthcare act.

My question is: There's a large discrepancy from the administratively eligible Camp Lejeune family members and those who are actually medically eligible. How many of those who are administratively eligible have an illness or condition that has sufficient causation, scientifically, and are just not able to receive any care or reimbursement for those conditions, based on the statutory requirements?

MS. BEATTY: Because of the 15 conditions? They have something other than the 15 conditions?

MR. ORRIS: ATSDR has released a public health assessment that includes many conditions that are not included in this act. How many of those family members who have been approved administratively are not receiving care just because of this Act?

MS. BEATTY: I could not tell you that.

DR. HASTINGS: And part of that -- hi, this is Pat Hastings; I work in post-deployment health -- and part of that is because this is legislated. And I think you do some very important work here, the science. We're very happy to work with you on those things because those are important questions. But part of it is legislative, and, you know, we hope that, with working together, we can change some of these things.

MR. ORRIS: I agree with that, and one of the first things to being able to work together is to find out how many of the administratively eligible family members are not receiving care because their condition is not included in the Act?

MS. FRESHWATER: Well, how do you prove a negative, though, Chris, is what I'm trying to figure out on your question.

MR. ORRIS: Lori, please raise your, your thing. I'm sorry, I didn't hear your response.

DR. HASTINGS: I was going to say it's probably the majority of those, because they would have a condition that was sufficiently concerning to them. So what I would say is we can look at those each individually. My supposition, and this is only a supposition, would be that it probably is the majority of them that have something that is concerning to them. I'm not sure what the science says but we could look at that.

MR. ORRIS: Maybe for -- bring it back for the next meeting.

DR. HASTINGS: Absolutely, and Jamie, if you could take that under advisement.

MR. ORRIS: And then I want to say thank you for providing the dollar amounts for the family members for reimbursement as well as the payments to the family members. One thing that I always ask for and do not see again in this is the cost to run your program as opposed to the benefits that are paid out. I see historically we've paid out 1.9 million in total for the family member program but I don't see how much that program has cost since inception, which is something that I normally ask for.

MS. BEATTY: And Mr. Orris, I watched the live stream from last meeting, and I know that you were a little bit upset about the numbers that we had provided. I contacted Brady White. I work with him in Denver. And I said, okay, what was it that you gave him, because I want to replicate that, and he could not give it to me. He said -- he says, when I got the program I received about a thousand documents and not a real in-depth review about the program. I was involved in the beginning, and I had to back out. I've got four other programs that I am over, that I take care of as well. So I was not as crisp as I should have been right in the beginning. But anyway, I needed more information. He could not give it to me.

DR. HASTINGS: Can I ask a question, and this is of you, Gayle. I think what might answer your question is how many staff people do they have?

MR. ORRIS: No, I want to know the bottom dollar budget amount that this program costs every single year as opposed to what it pays out.

DR. HASTINGS: Right. And I think most of the cost right now is simply staff.

MR. ORRIS: Okay.

DR. HASTINGS: So we could absolutely give you

that.

MR. ORRIS: Okay. Thank you, I appreciate that. Because in looking at the numbers, just to put this into comparison, taking this from a personal perspective, just four surgeries that I have had equal more than the total you've paid out year-to-date, for all of the family members. So I can really -- I, I want to highlight that, that, while these numbers seem big, from a medical standpoint these are very, very small amounts for providing care and compensation to the family members who were also exposed.

DR. HASTINGS: And can I ask one more question? You're talking specifically about the family member program.

MR. ORRIS: Correct, specifically about the family member --

DR. HASTINGS: Okay.

MR. ORRIS: -- program.

DR. HASTINGS: Yeah. The cost is really the personnel, and we can get you that.

MR. ORRIS: Okay, thank you. And then one other thing I'm looking at here. I see you broke down by fiscal year for '15 through '18. The administratively eligible as opposed to the

clinically eligible. Is that a cumulative total?

MS. BEATTY: No, that's each year.

MR. ORRIS: That is each year. Okay.

DR. BREYSSE: Okay. So what I'm going to ask, again, to be fair, if you raise your card, limit you to one question, and then come back. If you have multiple questions, again, I think it ties up the queue a bit. Lori?

MS. BEATTY: I just wanted to finish with Mr. Orris real quick, just for a second. What I was wanting to show with that is that hopefully we've kind of reached the saturation point, and it's starting to go down each year, which is a positive. I just wanted to show that.

MR. ORRIS: Yeah. I appreciate that. Thank you.

MS. FRESHWATER: Hi. Lori Freshwater. I was also a family member. I was on base from around '79 to almost '84. So I got the really full dose of the water. I also went to Tarawa Terrace to school, so.

I have auto-immune issues. So this is my first meeting actually having Dr. Blossom here, and I really want to thank you for being here and doing the work you do. My issues are auto-immune, and

they get worse each year. I don't have -- I have not been diagnosed with lupus, even though I have many lupus symptoms. I haven't been diagnosed with this or that, but we all know what auto-immune does, and each year my quality of life -- I'm more limited in what I can do.

So what I want to know is I understand what a -- a can of worms doesn't cover it, metaphorically or cliché-wise. It would open with auto-immune. But I think we need to start addressing it because the science is more and more, every year, inflammation, immune, curing cancer. You know, I've been on this for years, all the connections, and I think we could actually do some good together on this.

So what can I do, what steps can I take to open up the conversation about having family members being looked at for auto-immune and how do we -- and then I understand it legislatively, the haul we would have to go through, but what could we do to be more prepared as family members when we go to Congress and say we really need you to add, you know, lupus, or, or whatever it is that the science might be showing, by the time we get there in 30 years or whatever? I just want to start, you know.

DR. BREYSSE: So is that -- was that a question?

DR. HASTINGS: I think it -- I mean, I think she's telling us that more needs to be done, and that's part of this process. We're very happy, with the VA, to be invited to this because it's important for us. I mean, we, we exist to take care of veterans and in this case the family members.

The legislation is not perfect but it was historic. This was amazing legislation to get through and, you know, thanks very much to the gentleman across the table and many of you that are here. It's not done yet though, and we are very happy to work with ATSDR to look at the science and to make objective decisions about where the science is leading us. I think -- and, you know, this is -- ATSDR would lead the charge but I think it is to have specific disease processes that are scientifically valid, that can be documented and validated. And to go to the halls of Congress and say the science shows this and it is a preponderance of the evidence.

MR. ENSMINGER: Well, I believe that there's supposed to be a review every three years, or is that just for the presumptive program?

DR. BREYSSE: I'm not aware of a mandate to re-review stuff every three years.

MR. ENSMINGER: It's either in the law or in the presumptive rule.

DR. HASTINGS: Yeah, I'm not aware of that, but, you know, to, to take this --

DR. BREYSSE: If there is something just let us know.

MR. ENSMINGER: And Senator Burr has an amendment to the 2012 law. I don't know where the hell it is right now but I'll ask him. I'll be up there next week so I'll ask him where it is, because we're supposed to get all these health conditions straightened out. I mean, there are some on that list that are currently on there need to come off and there's some that aren't on there that need to go on it, like Chris's --

DR. BREYSSE: Yeah, so we're --

MR. ENSMINGER: -- you know, the congenital heart defect.

DR. BREYSSE: Let me just get -- put Lori's question probably to bed. Then we have a decision to make 'cause we're at the end of this time. So I want to remind people, we produce the review document that I think Chris is referring to, where

we evaluated what we thought the strength of evidence was between the exposures of chemicals at Camp Lejeune and different disease endpoints, at the request of the VA.

MR. ENSMINGER: That was not for the 2012 law. That was for the presumptives.

DR. BREYSSE: So the Secretary of the VA asked us to do that, and we produced that on their behalf. So if the VA would like us to assist them in assessing the strength of evidence about the relationship between chemicals and the other disorders, we'd be happy to do that, but I think we'd need a -- to work on that, we need a request to do such a thing, as we received when we did that last one.

DR. HASTINGS: And what I will do is, if I can talk to you next week, we can see where we need to go with this plan.

DR. BREYSSE: Sure.

MS. FRESHWATER: 'Cause I know -- I'm sorry, just real quick, you have in there that children exposed to the chemicals are -- I don't want to phrase it wrong, but there's -- auto-immune is listed in the research; is that right?

DR. BOVE: Well, again, I think -- I'm not sure

which auto-immune disease you're talking about on the health assessment, but it's scleroderma that's the key auto-immune disease related to trichloro-ethylene, and so -- and we --

MS. FRESHWATER: I'll find it. 'Cause when I was doing some reporting recently I came across it. I'll find the exact language.

MR. ORRIS: So one final quick question, and I want to say --

DR. BREYSSE: I'm going to have to ask the people who -- I'm going to have to call on people before they speak, if you don't mind, 'cause Mike, again, had his up first. So when you're done speaking if you could put your thing down, so I can keep track of that. And we'll just do -- we'll do Mike, Mike and Chris, and then we'll move on to the next session.

MR. PARTAIN: This will be a little bit longer 'cause it's -- I'm sorry, my voice is going out. This is concerning one of the non-presumptive categories, and we've been talking about this for quite some time. I came across a document recently and kind of -- a question based off of it. This document came out of the Office of Disability and Medical Assessment. I'm not sure who wrote it. If

any of y'all would know I'd like to hear it. But it was written September of 2015. It's a white paper concerning kidney and renal conditions based on an IOM report that we've been talking about for the better part of three years. I pretty much mention this IOM report almost every meeting.

We continue to get veterans after veterans -- I had one two nights ago, email me who had renal condition and denied. And I keep asking the same question. We have an IOM report where the recommendation was made to give the benefit of the doubt to the veterans.

And I'm going to read the section from this white paper. This was written by the VA in regards to the IOM report. As stated in the IOM report, among the contaminants at Camp Lejeune trichloro-ethylene and perchloroethylene, or PERC, were most likely to be responsible for acute kidney injury and potentially subsequent chronic renal disease. In general, human and animal studies demonstrate that high-dose exposure are required for -- are required for acute renal effects to be observed and that such effects are variable among species.

Now, note the high-dose exposures are required. That's something I continually see in the

paperwork with the SMEs. Nothing about long-term low doses. It's always high doses.

MR. ENSMINGER: Or mixtures.

MR. PARTAIN: Or mixtures, okay. The IOM report noted: There is no evidence for an increased incidence of chronic kidney disease in those who resided at Camp Lejeune during the time of the contaminated drinking water, unquote. This finding was primarily attributed to the fact that the documented levels of PCE and TCE in the drinking water at Camp Lejeune were much lower than those in human and animal studies reviewed, and the duration of exposure would likely have been much shorter for Camp Lejeune residents. Okay?

Now, the IOM report and one of the recommendations towards the end of the report, which is not mentioned in this white paper at all, reads: Therefore the committee, IOM committee, recommends that VA consider modifying their guidance and algorithm K, as suggested in revised algorithm K, to indicate that patients presenting with defined reductions of GFR -- and I cannot say this word -- proteinuria, and who had abnormal renal function tests or a urinalysis of unknown etiology while residing at Camp Lejeune should be accepted to the

program. The committee also recommends that VA consider accepting into the Camp Lejeune program patients with chronic kidney disease but without evidence of kidney damage during or around the time of residence at Camp Lejeune if there are no more other likely causes of their kidney disease.

This language appears nowhere on this white paper. And, you know, one of the veterans that contacted us recently, we're looking at his denial, which was on a template. I guess it's a checklist that you guys have to fill out when you write these reports now. The SME is Deborah Heaney, and she's saying that the veteran, while he, he was at Camp Lejeune for three and a half years but he worked in the automotive industry. He was exposed there and had been -- they ended up denying his claim for renal toxicity.

DR. BREYSSE: So your, your point is?

MR. PARTAIN: Yeah, my point is --

DR. BREYSSE: You would like renal toxicity to be reconsidered as a condition?

MR. PARTAIN: Yeah, we keep asking it, and we keep getting a stone wall. And now that I'm looking at this white paper that was written three years -- or what, three years ago now. I mean, it

goes back to what we've been talking about the SME program. You can't cherry-pick, and that's what it appears to us when we see this stuff that it's been --

MR. ENSMINGER: Because that's what is happening.

MR. PARTAIN: -- and anyway, so I'd like to know who wrote this paper.

DR. BREYSSE: So if you can come forward after the VA --

DR. DINESMAN: If you can send it. I'm not familiar with the white paper so if you can send that. Also would like to, just as an aside, you emphasized what was in the IOM report, and I do remember when I just started on the -- coming to the CAP meetings, being told that we should never use the IOM.

MR. PARTAIN: No, that's the NRC report. This is something you guys -- you guys commissioned the IOM to review your clinical guidance, and they came back with something that the VA did not like. And the report just disappeared. This is the first time I've seen it discussed in the VA, in the documents. And by the way, the, the point of contact in the document was redacted, so.

DR. DINESMAN: Yeah, if you can send that, 'cause --

MR. PARTAIN: Oh, I'll be glad to.

DR. BREYSSE: Mike?

MR. ASHEY: Is the family member eligibility issue -- and I know you're not going to be able to answer this question but I'd like to know -- on the VA's lobbying team's agenda to Congress?

DR. HASTINGS: That I'll have to defer to the family member program. So Gayle?

MS. BEATTY: I'm sorry, I could not tell you that.

DR. BREYSSE: But I can tell you, as a federal employee, we don't lobby.

MR. ASHEY: No, but -- no, no.

DR. BREYSSE: We're very careful not to look like we lobby.

MR. ASHEY: That's not -- that's not what I'm asking. I'm not asking for individuals, but your VA Secretary, when you get another VA Secretary at some point, or past VA Secretaries, there is usually a lobbying team that supports him and lobbies individual members of Congress for issues that are important. You do it for budget, you do it for staff, you do it for facilities, you do it for

improvements.

And my question is: Is this family member eligibility issue one of the action items for the lobby team or the Secretary?

DR. HASTINGS: And I can tell you I don't work with the lobby team. I can find out if there is an interest, if the lobby team has that. I don't -- to tell you the truth, I have not heard of the lobby team before, but I'll find out if we have one.

MR. ASHEY: Well, either that or the Secretary, but I guarantee you it can't be the Secretary alone. They probably have a legislative lobbying group.

DR. HASTINGS: No, they do have an office that looks at legislative affairs, but I have never heard of us going over and lobbying. But I'll, I'll find out if there is a lobbying team.

MR. ASHEY: Well, maybe I'm using the wrong word. Instead of lobbying maybe it's who is it that pushes your budget? Who is it that asks for money? Who is it that asks for increases in staff or individual legislation? Who does that? And the question is: Is this issue one of their action items, to get this disparity straightened out, so that people like Chris get their issues covered.

DR. HASTINGS: And we're very happy to work

with ATSDR and this group, but it is a legislative fix that has to happen, and some of that has to come from you, you know, as members of the CAP team, and the, the public at large. But we're very willing to work with you and look at the science with ATSDR, and that's an important component of this. I'm not aware of lobbying and legislating for this, but I'll find out if we have an effort in that area.

MR. ASHEY: You've got to have a set of priorities before Congress.

MS. CARSON: This is Laurine Carson from the VBA, and we do have groups on both VHA and VBA side, and we do present a certain number of legislative proposals.

MR. ASHEY: Right. That's what I'm talking about.

MS. CARSON: So yes, that's my staff. Yes, we do do that. We come forward with various issues. What I would like to ask you to help me do is what should that legislative proposal be? We are not in that season yet but we will be coming up on that season around June-July. We need ideas for what should be a legislative proposal. I am willing to -- if you want to get with me, I'll give you my card, and I can take that back to my group as an

idea for a legislative proposal to be presented up through our chain.

MR. ASHEY: Well, I don't want to volunteer Chris but he -- I, I think he would be more than willing to sit down with you --

MS. CARSON: That's fine.

MR. ASHEY: -- and help write --

MS. CARSON: Let's talk about --

MR. ASHEY: -- legislation.

MS. CARSON: Let's talk about what it is you're talking about. My staff is skilled at it. VHA also has a staff that's skilled at the exact same thing. We have a parallel staff that writes legislative proposals. It's the policy staffs that write it, it generally goes up, Secretary's agenda, President's agenda, sometimes like that too. But I know what you're talking about, and yes, we -- just maybe help us frame up that issue for the legislative proposal, because, in order for us to add anything to the things that VA considers at Camp Lejeune, we do need legislation.

MR. ASHEY: Thank you, Ms. Carson.

MR. ORRIS: I have, I have one final question, and this one's directed to our Department of the Navy representative, Mrs. Melissa Forrest.

Listening to the VA and the ATSDR talking about the family member program, I would like to know how the Department of the Navy feels that their exposed family members and children are being treated, and whether you agree or disagree that they're being treated well right now, and if you do disagree -- or if you feel that there's more that needs to be done, what will the Department of the Navy do to take care of their exposed spouses and children?

MS. FORREST: Chris, I feel like you've asked this question before. Just to reiterate what my function is here, I listen to questions, I listen to concerns, and I take them back so that we can support ATSDR's efforts in doing their studies. That question is outside the realm of my function here as a representative of the Navy.

MR. ORRIS: I agree, and I understand that but I would like you to take that back, and I would like to hear from the Department of the Navy whether they feel that their family members, their exposed family members and children, are being well taken care of with the current legislation, 'cause I don't -- I believe that the last thing the Department of the Navy ever said was that they feel that this issue was being well taken care of with the legislation

that is current. And we're hearing from two different agencies in the government where they're saying that there's some disparity again, and something that needs to be done. And I'd like to know if the Department of the Navy, if you can take that back to them, and find out if they want to get on board with everybody else in fixing what seems to be an issue.

MS. FORREST: I will take that back, but like I said, it's outside of my particular function.

MR. ORRIS: Thank you.

DR. BREYSSE: Jerry's sign was up first, so I think I have to respect that. Jerry, you want to let Lori go first? It's up to you.

MR. ENSMINGER: No. Where's Dr. Erickson?

DR. HASTINGS: He is in San Diego. Actually he's probably on a plane right now. He was there for the millennium cohort study, which is like a Framingham study, which will follow veterans for about 50 to 60 years.

MR. ENSMINGER: Okay. I've sent him a decision that was made by Dr. Deborah Heaney a couple weeks ago, and not only is she using some questionable study that she cites in her opinions, she is also using the old NRC report water data.

DR. HASTINGS: And, and if I could --

MR. ENSMINGER: And she's -- she is actually stating in her opinions that this individual was stationed at this part of Camp Lejeune and, well, they weren't stationed over here --

DR. HASTINGS: I know, I know --

MR. ENSMINGER: That's not supposed to happen.

DR. HASTINGS: And I know that Dr. Erickson will look at those things, but I will also say that that does fall under DMA so I would also include Dr. Dinesman, but I absolutely know he, he would look at that because he is very conscientious, as you know. If you want to send it to me also I'm happy to look at it, and I can give you my card. And I'm patricia.hastings5, and I don't know why I'm five 'cause there's no one through four.

MR. ENSMINGER: Just give me your card.

DR. HASTINGS: Absolutely.

MR. ENSMINGER: Did Erickson give this to you?

DR. DINESMAN: Not from a couple weeks ago but I've seen one. But please do. Do get with me. I'd be happy to discuss some --

MR. PARTAIN: I've got it right here.

DR. DINESMAN: Please do that. But also as we talk about opinions, and I was teasing when I say,

you know, you're an expert. You've obviously been able to go through this and form an opinion as an expert, in saying that you thought that this was incorrect. One of the things that I'd like to kind of point out about opinions is everybody has one.

MS. FRESHWATER: Not when you're talking about medicine. I'm sorry --

DR. DINESMAN: No, no, no, absolutely.

MS. FRESHWATER: No, you're not going to go down that road now with medicine.

MR. PARTAIN: And by the way, Dr. Dinesman, we're not experts.

MS. FRESHWATER: And we don't claim to be.

DR. DINESMAN: No, no, but in the world of medicine --

MS. FRESHWATER: Right, but you're trying to equate something that is a false equivalency, and, and I'm sorry, I don't even want that in the record. With the atmosphere we have.

DR. DINESMAN: Just one thing to keep in mind, even in the medical world, there are multiple opinions, and I have seen other legal issues in the world of medicine. And you will have -- you'll have experts for both sides, and they're both experts, and they're both going to give you a totally

opposite opinion, and it doesn't mean one is right or one is wrong.

MS. FRESHWATER: It pretty much does, usually, I think.

DR. DINESMAN: Well, again, that's the legal system.

MS. FRESHWATER: One, one's opinion could mean someone lives and one's opinion could mean someone doesn't, right?

DR. DINESMAN: Well, and so -- and so here's -- well, so here is -- and I'll -- and I'll take what you say, 'cause this is not -- for the person doing the opinion, they're going to -- just like an expert, they're going to give you their opinion. The person who then decides is VBA, all right?

MR. ENSMINGER: Yeah, but the one I just brought up -- we're getting off the track here -- the one I just brought up was stuff that she's using in her opinions that are against the rules, okay? Where the person was stationed aboard Camp Lejeune doesn't matter worth a damn, and the VA Secretary said that.

DR. DINESMAN: Well, please send that to me.

MR. ENSMINGER: I will.

DR. DINESMAN: I'm happy to look at that.

DR. BREYSSE: So let's just make sure we follow up --

MS. FRESHWATER: She's been doing it for a long time, and I'm sorry for being a little impatient but this particular person has been doing this exact same thing for years, and it's really hard to take that it's still happening.

DR. BREYSSE: So Lori, you're -- the reason you raised your card, that was it?

MS. FRESHWATER: No. I, I found what I was talking about. I had misspoken. It is immune disorders, not auto-immune, so this is the PHA. And it says people -- I just want to make sure it's in the record. People who used water from the Hadnot Point water treatment plant -- it's underneath that, sorry. Children and adults exposed to TCE during 1972 to 1985 could be at risk for immune system disorders. So that's in the PSA -- PHA. That's my PSA.

DR. BREYSSE: So we need to move on to the action items from the previous CAP meeting, and I'll turn to Commander Mutter.

ACTION ITEMS FROM PREVIOUS CAP MEETING

CDR MUTTER: All right, thank you. So let's start off; we have a few with the VA, and I think we might have covered most of these, so I'll just go ahead and read them. The CAP members asked if the materials being presented during the SME training course are publicly available.

MS. CARSON: So there's -- this is Laurine Carson, and there is the current FOIA and Yale litigation going on. I will go back and check and see if that's the only way that we can provide that information. Right now I do think that is but I will go check one more time.

CDR MUTTER: Okay, thank you, ma'am. A CAP member asked if the VA could explain how the SME contract is being graded. I think that has been covered. Wonderful.

Total expenditures for Camp Lejeune chart information more -- in a more understandable format to match previous presentations. I know we were going to get to that, revisit that. Thank you.

ATSDR: ATSDR will follow up to ensure the CAP received the list of environmental health clinicians and coordinators at every hospital in the VA. I re-sent that earlier this week in an email, so let me know if you did not get it.

The rest of the action items are for the DoD. The first one: A CAP member asked why DoD claims that contamination ended in 1987, what the DoD plans to do to update their website, their literature, to inform past and current residents of some of the risks and dangers of being born on that base.

MS. FORREST: This is Melissa Forrest with the Department of the Navy. DoD has not made a claim that soil and/or groundwater contamination ended in 1987. Soil and groundwater contamination at Camp Lejeune continued to be addressed under the defense environmental restoration program and Camp Lejeune installation restoration partnering team, which is made up of representatives from the Environmental Protection Agency, the State of North Carolina, the Navy and the Marine Corps.

The 1987 date being cited is ATSDR's modeled estimate for when drinking water contamination ended at Camp Lejeune. The state has subsequently been incorporated into Marine Corps outreach as well as the 2012 Department of Veteran Affairs Camp Lejeune healthcare legislation. As discussed at the last CAP, additional information on the progress made on the Camp Lejeune environmental restoration program is available through the Restoration Advisory Board,

or RAB. The Camp Lejeune RAB meets quarterly in Jacksonville, North Carolina. More information can be found on the Camp Lejeune website under environmental management division. The address is http://go.usa.gov/x3f7m.

MR. ORRIS: So, and I hate to do a summation with this, but basically what you're saying is that your website states that the drinking water contamination ended in '87 but you do not state that other contamination has been ongoing on that same website; is that correct?

MS. FORREST: I don't think it addresses, 'cause we have a lot of different environmental contamination issues on Camp Lejeune. Like I said, we have a whole program dedicated to that. Anyone interested, please participate in the RAB.

MR. ORRIS: Wouldn't it be fair to the veterans and their family members who were on that base between '87 and whatever date you're claiming that the rest of the contamination to PCE, TCE, vinyl chloride, wouldn't it be fair to tell them that those chemicals were still present and they might have been exposed just in a different pathway?

MS. FORREST: You know, there might be a link on that website to the Restoration Advisory Board

website. I could take that back as a request, if we could, and somehow advertise the fact that other environmental contamination is addressed under the RAB, and here's a link to that website. I can take that back as a request, if you'd like me to.

MR. ORRIS: Thank you, because I think a lot of the community feels that the Department of the Navy's stance is is that the PCE and TCE and vinyl chloride contamination did end in '86 or '87, and some of these people who are experiencing health issues or concerns similar to the actual drinking water contamination should be eligible for some kind of care and compensation as well. And I think the first step in doing that would be as, as you just said, the Department of the Navy updating their website to make it clear that, maybe you turned off the tap water, but that doesn't mean that the contamination to those three specific chemicals ended on that date.

MS. FORREST: I can take that back.

CDR MUTTER: Thank you. Dr. Hastings, did you have something?

DR. HASTINGS: I just was going to talk a little bit about the environmental health coordinators and clinicians, that you had asked for

the list of. They do not do the, the Camp Lejeune exams. They, they might in some capacity, if they're a care provider. But the clinical coordinators are to help the veterans to navigate the system and get to the right person, whether it be their care provider, to comp and pen or to talk to one of the environmental clinicians. So they are not the ones that are doing the, the determinations. They're not contractors and they're not doing the determinations of benefits for Camp Lejeune. So I just wanted to specify that.

They're very helpful. We have one coordinator at every single hospital, and they can help the, the veteran navigate the system, and that's what their primary goal is.

CDR MUTTER: Thank you. Okay, so let's move on. The next action item is a CAP member asked why it took years to correct the soil vapor intrusion problem when the Navy knew the levels were above the accelerated response levels.

MS. FORREST: And before I read the response, just to clarify for, for people who maybe weren't here last time, this is in reference to Building HP57.

MR. ORRIS: Correct.

MS. FORREST: And it was the Region 9 -- EPA Region 9 accelerated response levels.

MR. ORRIS: Yes.

MS. FORREST: Yeah, and I just wanted to clarify that because it sounds kind of like a vague, open-ended question. All right, so the response is: It did not take years for the Marine Corps to respond. The EPA Region 9 guidance was not issued until July 2014. Corrective action, a/k/a, capping the sewer pipe, was completed in November 2014, a few weeks after the October 2014 results were received.

Please note, previous guidance from the EPA Region 4, which oversees North Carolina, was to use an action level of 6.3 micrograms per meters cubed, using a hazard quotient of 3, which has never been exceeded at this facility, including the April 2010 sampling event, with non-detect, and the April 2013 event, with a maximum of 4.4 micrograms per meters cubed, indoor air results.

This guidance was provided in 2012 upon request by the Marine Corps. The response time in 2014 was within the parameters detailed in the EPA Region 9 TCE guidance, which was utilized by the Camp Lejeune personnel for decision-making.

MR. ORRIS: Now, 'cause this is in response to my question. And in all fairness, the levels you are talking about previously were an industrial level and not a residential. You were testing for industrial levels at that barracks at that time, and didn't change to a residential until 2014; isn't that correct?

MS. FORREST: I can't say that that's correct for sure because I think the evaluations looked at it as residential because it's a barracks.

MR. ORRIS: Your internal memos were categorizing that as an industrial building until -- from 2010 to 2012. CHM2(sic) Hill --

MS. FORREST: I would have to go back and confirm that.

MR. ORRIS: They refer to HP57 as an industrial building and not a barracks.

MS. FORREST: Okay. It could still be referred to as an industrial building, but when they do the risk assessment and they do the, the exposure assessment they can still use exposure time frames that are residential. So just because it says it's categorized as an industrial building does not mean it was evaluated with an industrial exposure.

MR. ORRIS: But you have completely cut off any

exposure at that building to pregnant female Marines?

MS. FORREST: The sewer pipe was capped. We continue to do sampling, and everything seems to be fine.

MR. ORRIS: Okay, because when Congressman Jones requested more information in regards to this, the Marine Corps responded that nine pregnancies of eight female Marines were potentially exposed at that barracks, with one adverse pregnancy result. And in asking whether they had been -- if you had followed up on those nine pregnancies, to make sure that these were not vapor intrusion-exposure problems, have you done anything with that?

MS. FORREST: I, I don't know the response to that at this point.

MR. ORRIS: Wouldn't it be in the Department of the Navy's best interests to take care of their personnel and make sure that these nine pregnancies --

MS. FORREST: I'm not saying that it hasn't been done; I'm just saying that I don't know the response.

MR. ORRIS: Can you -- can we do that as a follow-up, and find out whether or not that is

something that has been addressed with those -- with those personnel? I know you can't give out the specific -- because of HIPAA, but you can certainly follow up internally.

CDR MUTTER: Thank you. So let's move on. We have three more action items, then we'll take a very short break. A CAP member asked if there are presently charcoal filtration systems on the drinking water well heads.

MS. FORREST: No. There are no charcoal filtration systems on potable water supply wells. All water from potable water supply wells is sent to treatment plants for pretreatment prior to distribution. So it's not at the individual well heads.

MR. ASHEY: Well, your point about, what, maybe 15-20,000 gallons an hour out of those -- each one of those wells to supply the base, that's my assumption because it's a pretty big base, neither liquid or dry carbon filtration systems could handle that. So you said that it's handled at the water treatment facility. Are they using air strippers on the inlet side in order to ensure that any contaminants that might possibly be in that water is being stripped out? Which is a pretty inexpensive

way to do it.

MS. FORREST: I know we have a very advanced treatment system, and it's similar to what's done for other public water supply wells, but I don't have the details on the equipment. I wish you had been a CAP member when we did our tour -- when was that? -- a year or so ago, because we did go by the water treatment plants.

MR. ASHEY: Right.

MS. FORREST: And they were able to ask all these questions.

MR. ENSMINGER: There is no filtration process at any of the water treatment plants, to speak of.

MS. FORREST: But it is tested before -- it is tested to ensure that the water --

MR. ENSMINGER: Well, no. How often though?

MS. FORREST: It's in compliance with federal and state --

MR. ENSMINGER: Yeah, well, that's what they said when the water was contaminated.

MS. FORREST: That's all I can -- all I can tell you is we have, you know, testing requirements, and we have all the records, and we meet the records, and the drinking water --

MR. ENSMINGER: Yeah, I know.

MS. FORREST: -- on Camp Lejeune is treated and tested.

MR. ASHEY: Surely the geologists that work for CH2M Hill, I believe that's your primary contractor there --

MS. FORREST: We have multiple contractors.

MR. ASHEY: Well, the reports I've read have been from CH2M Hill. Sure -- or any of those contractors, their geologists know that the soil there is highly permeable and that resetting those wells is a temporary fix, that the hydraulic gradient created by those wells are going to pull those plumes that are still in the ground towards those wells eventually. And even if those wells are screened below a clay lens -- I think, Jerry, you had mentioned that there's a huge clay lens there -- there's always cracks in those clay lenses.

MR. ENSMINGER: No. No, it is incomplete clay lenses. I mean, the -- like over Building 22, the dry cleaning plant, over at Area 2 on Main Side, that contamination -- that area had a non-continuous clay layer. And as the contaminants ran down toward the old MP building it went under that building. And then just after it went under that building the clay layer, the confining layer, depleted, and the

stuff sort of dropped out the bottom. I mean went hundreds of feet down.

MR. ASHEY: My point is, Melissa, that what -- you know, we had a serious problem at Camp Lejeune, and a lot of people, a lot of veterans and their families have been affected by that. So what is the Marine Corps and the Department of the Navy doing to ensure that those wells are pulling clean water and that, if those plumes get pulled towards those wells, that the laboratory analyticals and the testing of that water is being done routinely, and that, as a precaution, you would think that there would be, at a minimum, probably air stripping towers that are used on the inlet side of the water treatment facilities. You know, you would put chlorine in there and other stuff but you're not going to get that petroleum or TCE or chlorinated solvents out without an air stripper.

And so that's my question: What, what is the military doing, what is the Department of Defense doing to ensure that the next generation of Marines does not suffer the consequences that past generations of Marines have suffered at Camp Lejeune? That's my question.

CDR MUTTER: Mike, let me read the remaining

questions. I think they are built into what you were saying as well.

MR. ASHEY: Right. It's all tied in together.

CDR MUTTER: Yeah. So I'm just going to read --

MS. FORREST: Because we do do some voluntary testings.

CDR MUTTER: Okay. How often is the water from well heads tested, along with: Are those analyticals from those tests posted anywhere, and if so, where?

MS. FORREST: So I'll read both of those responses together. So all potable water supply wells are currently tested for a variety of contaminants semiannually, including but not limited to VOCs, SVOCs, metals and explosive constituents. This testing is a voluntary Marine Corps initiative and not required by the EPA safe drinking water act or State law. So we are testing the well heads twice a year.

Voluntary potable water supply well sampling results, the detections only -- if it's not detected, it's not reported -- have been reported publicly since 2011, with metals added in 2012. Non-detect results are not reported. These results

can be found online, either in the annual water quality reports, from 2011 to 2014, or in a separate report, 2015 and later. So you can find it with our water quality reports.

So we, we are doing -- I am not a geologist, a hydrogeologist, or an expert in water treatment, but I can tell you that we have an advanced water treatment system, and we do testing. What I've been -- what I have been told exceeds what's required for a distribution system. So we do test that water on a regular basis.

You know, we don't want anything -- we don't want people to be exposed to, you know, contamination that we can prevent. We test according to federal and state regulations, I mean. The TCE example, what happened in the 1980s, you know, it wasn't regulated at the time, so.

MR. ENSMINGER: Nah.

MS. FRESHWATER: No, Melissa, don't do that.

MS. FORREST: I'm just saying, but to say that we're not testing now, the, the water is tested on a regular basis.

MR. ENSMINGER: Okay, but don't go -- don't go to it wasn't regulated back then.

MS. FRESHWATER: We're protect -- being

protective on this. I just have a really quick --

MR. ASHEY: So I can continue talking.

MS. FORREST: Oh, I haven't finished reading the websites where you can find all these reports. Hold on, I'm not done yet.

MR. ASHEY: Okay, go ahead.

MS. FORREST: Okay, annual water quality reports can be found at -- I'm going to leave off http://stuff -- www.lejeune.marines.mil/offices-staff/environmental-mgmt/annual-reports.

MR. ENSMINGER: Geez.

MS. FORREST: Yeah. Now, so that will be in the transcripts. Okay. And I could also -- if you want to come at the break I can give this to you, if you're really interested.

MR. ASHEY: I was hoping maybe you would invite us all back to the base so I can walk around the water treatment facilities --

MS. FORREST: I, I, I so wish you had been there.

MR. ASHEY: -- and see it for myself.

MS. FORREST: I so wish you had been there when we had the tour.

MR. ASHEY: Well, I --

MS. FORREST: Yeah, you missed it by what --

MR. ASHEY: -- I didn't know Mike and Jerry until after that.

MS. FORREST: I think you might have missed it by one meeting. Yeah. Okay, voluntary sampling results for 2015 and later can be found using the links on the above mentioned website. Under annual reports look for voluntary monitoring detected contaminants and water supply wells metals detection. Or you can use the direct links below. Here's another nice long one: www.lejeune.marines.mil/offices-staff/environmental-management/annual-reports/voluntary-monitoring-detected-contaminants.

MR. ASHEY: Have you got all that, Jerry?

MS. FORREST: -- .aspx.

MR. PARTAIN: Why doesn't the Marine Corps just update the usmc.mil site on the Lejeune page with all this, rather than go through this litany?

MS. FORREST: I, I am not -- I can't tell you exactly why different reports are in different areas.

MR. ENSMINGER: I think the best question is: Are the plumes being monitored? So are they being pulled toward operating --

MS. FORREST: The plumes are being monitored, and that, that is where I keep talking about

participation in the Restoration Advisory Board. That is your best resource to go.

MR. ASHEY: Well, this -- this is not -- yeah, but it's not a restoration issue. I understand what you're saying, put that portion is. But my question is about prevention. My question is about what are you doing to protect base personnel, state personnel that work on the base, military personnel that work on the base. Not like Marines but Navy, Army, all branches of the service work on that base.

MS. FORREST: Well, I think that flows into what we were talking about, though, the connection with the Restoration Advisory Board with the environment clean-up program, is that that is the program that is monitoring those plumes, because they are still included in that program. And so that information is what feeds over to, you know, the side of the house that does the treatment plant and the production of the finished water. So those two are working together. I mean, it's not that --

MR. ASHEY: Well, you -- I get that. And, and thank you for providing all that information. But I also know that plumes, underground plumes, in highly permeable soil are unpredictable. And I know you're not a geologist but I will tell you that any

geologist who doesn't say that, who is familiar with contamination, probably ought not to be working in the contamination industry.

So the -- I, I guess where I'm going with this, you know, I think it would be prudent for those facilities to have -- and my guess is they probably have some type of air stripping system, either a tray air stripping system or some kind of stack air stripping system, that's in place as a precautionary measure, just to make sure that, if they miss something, or within the four- to six-month period, you know, you could have a plume that can, that can hit one of the -- one of the depressed areas within the groundwater and just start pulling contaminations. And it can go on for months and nobody would know it.

DR. BREYSSE: So Mike, can we get the -- the request is can you describe a specific water treatment --

MS. FORREST: Say, is that the request that I'm hearing: Would you like a general description of our water treatment plant --

MR. ASHEY: Well --

MS. FORREST: -- process equipment?

MR. ASHEY: Just for removal. Volatile

removal.

MS. FORREST: For, for volatile removal?

MR. ASHEY: I just want to know is there an air stripping system at the -- 'cause you have more than one water treatment plant, right?

MS. FORREST: I, I think that there is but I just can't answer for sure. I can't remember. I can't remember. There's not something -- let me take it back and get --

MR. ENSMINGER: There's an air stripping plant that's over along Piney Green Road but that is for the plume that's under Lot 203. So but that's site-specific; it's not for drinking water. That's a pump-and-treat plant.

DR. BREYSSE: Okay. Good, so Lori, one quick question and then we'll take a break.

MS. FRESHWATER: I just -- I, I might have missed this. Going back to one person was asking about the barracks that had the vapor intrusion incident. Is that being tested with OSHA standards, or?

MS. FORREST: No. They're comparing -- for the TCE they're now comparing it to that EPA Region 9 rapid response guidance that's out there.

MS. FRESHWATER: Was it at one point were they

using OSHA standards?

MS. FORREST: It wasn't OSHA. It was still the State of North Carolina screening levels. It was still looking at -- the standard, they were using residential exposure scenarios so they were not looking at the number of hours that you would be exposed in an industrial. They were looking at it as residential. But I -- in part of my response I explained how the screening value used to be 6.3 micrograms per meters cubed, but it's lower now because it's in line with the EPA Region 9 rapid response.

MS. FRESHWATER: But no, that's where that happens in --

MS. FORREST: Yes.

MS. FRESHWATER: All right, thank you.

MR. ASHEY: I just have one more comment, please, and then I'll be done. You mentioned that you're following EPA standards and guidelines and probably the guidelines of the State EPA. The problem with that is those guidelines were never designed to address an issue like Camp Lejeune. I don't think anybody ever contemplated such a massive contamination issue as what showed up on this military base with exposure of tens of thousands of

people.

And in Florida we don't have protocols designed to deal with a problem that big, and probably most of the states don't either, because no one could imagine such a massive problem having occurred over a long period of time and no one not knowing it; although the people that worked at that water treatment plant knew there was a problem; I guarantee that, because as soon as that underground -- as soon as that water was exposed to ambient air all that stuff started to volatilize out. There's no way they could've not known there was a problem, and yet nobody ever said anything.

MR. ENSMINGER: They know it now. They're all dead.

MR. ASHEY: Yeah, they know it now. So it's just a precaution that following EPA guidelines -- 'cause I helped write some of those guidelines back in 2000, 2002, 2003, 2004, when we were looking at -- we were in EPA District 5, and we were looking at those things. No one ever contemplated something like this. It never occurred to anybody.

And quite frankly the day I retired from state government I got a notice about Camp Lejeune, and I thought it was a joke because I was running the

largest petroleum clean-up program in the United States. I thought my staff put together this document and sent it to me just as a joke. I was horrified at the numbers. I know what those numbers mean. Three thousand ppb in drinking water is like drinking gasoline.

So no one ever contemplated this. And EPA standards, they still, for these massive contamination plumes on military bases, you guys got to be doing something different. You know, semi-annual testing is for stable plumes. You don't know if that plume is going to stay stable. And I realize, Melissa, this is not you, but somebody needs to take a look at what the protocols need to be on a base where you have a problem like this. Semi-annual testing is not enough.

DR. BREYSSE: Okay. John, do you --

MR. MCNEIL: That was sort of where I was. If it only takes 30 days to inflict 15 conditions on people, why is the DoD testing once every six months?

MS. FORREST: That, that was specific to that voluntary well head testing. That is not treated water coming out of our treatment plants that we're distributing to people for drinking water. That was

where Mike had asked a specific question, if we had filtration on the well heads, and that is what's only done semi-annually. There is much more --

MR. MCNEIL: Okay, I'm not --

MS. FORREST: -- frequent testing done on the, the treated water.

DR. BREYSSE: All right. So could we take a ten-minute break? So I have -- let's be back here at 6:55.

(Break 6:47 till 7:00 p.m.)

DR. BREYSSE: I want to start off with an announcement. Tomorrow a company’s going to be here who wants to film the public meeting, which of course they’re free to do. Public access and local affiliates of Cortland, NY. I just want to let people know that there will be a camera in the room tomorrow filming us. We'll make that announcement again in the morning but I just thought I'd let us know up front. Since it's a public meeting they have a right to be here for that.

So I'd like to now turn to Rick Gillig to talk about the soil vapor intrusion aspect of the public health assessments.

PUBLIC HEALTH ASSESSMENT UPDATES

MR. GILLIG: So again, my name is Rick Gillig, for the record. As far as the vapor intrusion work plan, I've talked about that the last couple of CAP meetings, we have addressed the peer review comments. It is now in preclearance. I've just received a copy of it yesterday. We plan on putting it in the official clearance process by the end of next week.

We've worked with an SME on addressing all the comments. My expectation is that it will go through the clearance process fairly quickly; I'm hoping in a matter of two or three weeks.

In the meantime we are doing work on all the data we have, working with a couple of computer programmers. They've been looking at the data sets. They're writing the programs so that we can analyze the data. So we're not just waiting until we have the work plan cleared before we start analyzing the data.

Again, as we've talked over a number of meetings, the data we're looking at, we're looking at environmental sample results, that was pulled from our document library that we've discussed in previous meetings. We've got additional environmental sampling data sets from Navy

contractors. Those were spreadsheets that have a lot of the environmental sampling results as well as what we've pulled from documents. We have groundwater modeling results. That was done under Morris's project. That model was done by the Georgia Institute of Technology. They looked at surficial levels of contaminants from several areas of the base. We've also collected additional information on the 14,000-plus structures at Camp Lejeune. Chances are we'll continue to collect information on these buildings.

So again, we've done the data analysis. We expect to have the draft report ready for peer review, that's the health assessment, in early 2019. And Jerry, it's a lot of information to go through.

MR. ENSMINGER: Oh, I know. I know. Damn, I mean, we've been working on this project since '91. 1991.

MR. GILLIG: Well, the vapor intrusion we started in --

MR. ENSMINGER: Yeah.

MR. GILLIG: -- 2012.

MR. ENSMINGER: I know. We're getting there.

DR. BREYSSE: Mike?

MR. ASHEY: Rick, you mentioned that you got V-

I sampling data sets from Navy contractors.

MR. GILLIG: It was environmental --

MR. ASHEY: Yeah. CH2M Hill and other --

MR. GILLIG: And contractors.

MR. ASHEY: -- contractors. Do you know if -- this is the issue I brought up before, and I'm sorry I keep harping on it -- this data set for biosparge and air sparge, were you able to discern anything from the data sample sets you got from CH2M Hill on that issue?

MR. GILLIG: Not this time.

MR. ASHEY: Okay. I mean, from, from --

MR. GILLIG: We know where the systems are. So on a map we can map those systems basically, where they are. So when we look at that data we'll take that into consideration.

MR. ASHEY: But the data sets that you got from them, you can't discern from those data sets, bio sparge from air sparge; it's just a set of data sets for sampling.

MR. GILLIG: Correct.

MR. ASHEY: Okay. That's what I was afraid of.

DR. BREYSSE: Anything else, Rick? Ken?

DR. CANTOR: Yeah. So could you expand a little bit on the output of this effort in terms of

exposure assessment? Is that the ultimate aim, to put some maximum/minimum parameters on what exposure could've been, might've been during certain periods of time?

MR. GILLIG: Yeah. One of the limitations with doing this project is that we will be modeling modeled data in many cases, and the level of uncertainty would be very large. Our first effort will be to identify buildings to look at further. With 14,000 buildings we want to do an algorithm to narrow that list to the ones that we feel are most likely to be impacted by vapor intrusion. And then we'll do a building-by-building analysis based on the environmental data that we have.

Of course there are indoor sources in many of these buildings. It's going to be a challenge. And coming out with specific exposure doses to the people that occupied those buildings may be impossible. But we will know which buildings had the greatest likelihood. And of course the people that occupied those buildings, if they're residential or if they worked in those buildings, for a number of the other building uses, we'll know that they were exposed to additional, or likely exposed to additional, contamination that was the

result of vapor intrusion.

DR. BREYSSE: Good. Another question? Mike? Sorry.

MR. PARTAIN: I'm dead to you, I guess. Two quick questions. One, Rick and Dr. Breysse, when y'all are doing the data analysis and calculations and stuff, if something comes up to where there is potential exposure that may be ongoing that was not seen, is there a plan in place to get that out or to address that?

And then two, and this is directed towards Rick, on the data sets, as far as the data that you all have collected in the documents and stuff, are you seeing anything with the USTs from the family housing areas? I know Jerry and I have talked to a couple of families, one in particular, where houses -- where their old house was surrounded by a fence and a void, 'cause apparently the UST was leaking, and they came and dug everything up. Have you seen anything like that in the documents? 'Cause I know that wasn't --

MR. ENSMINGER: No, the house is gone.

MR. PARTAIN: There's a void where the house was. But Morris didn't capture that in the water model because these were, you know, individual

houses and stuff. Have you guys seen anything about UST removals and potential contaminants in the family housing areas?

MR. GILLIG: That's hard to answer until we do our analysis, Mike. I know a lot of the sampling they did for those fuel tanks at the homes, often they did it with crude equipment. And they basically were testing for organic vapors. I mean, that's PID data. So I don't know if they did much more sampling than that or not. It's, it's hard to say; we'll look into that.

MR. PARTAIN: Would it show up in like soil samples for the extraction tanks extractions? I don't know if they did it -- like, you know, with the Hadnot Point fuel farm, when they did the tank extraction there was a report, soil samples, and that's what Morris generated the water model from, some of the data from. I don't know if that same thing was done, you know, with a 50- or hundred-gallon tank for use in a home, but I know it's a problem because we've been contacted by families that have brought that up.

MR. GILLIG: Well, if they did environmental sampling and it was in the reports, then we'd be able to look at thousands of reports, we would have

that data in our data set. I'm just not certain.

DR. BREYSSE: And what was the first part of your question?

MR. PARTAIN: Just if -- when you're doing the data runs, if it becomes apparent or, you know, that there is a problem or an ongoing problem that may have been missed, how is that going to be addressed?

MR. GILLIG: Well, I assume that we will address it if we identify something of concern, probably via a letter from ATSDR to the base, basically saying we found this issue.

MR. PARTAIN: Can I be copied on that letter, if that happens? Hopefully it doesn't but, you know, for the public to know too.

MR. GILLIG: Sure. I don't think that would be a problem. I'm looking to Pat for a nod.

DR. BREYSSE: I don't think it'd be a problem. We'd certainly share with you that we found a concern, and we've alerted the base about it.

All right, and I'd like to shift now to the health studies update. Dr. Bove?

HEALTH STUDIES UPDATES

DR. BOVE: I'm going to start with the cancer incidence study first. That's the study that's

ongoing where we're working with as many state cancer registries, the VA registry, the DoD registry and also the registries in Puerto Rico and the territories.

So right now we have 43 confirmed registries, 39 states. We're working hard to get four states in particular on board: Missouri, Texas, New Mexico and Florida. They're important states for us. Indiana, we're going to submit near when we want them to give us data 'cause that's not what they asked us to do. Illinois hasn't done any studies for many years because they lack the staff, and so we're going to see what we can do with Illinois. It's an important state. We're going to try to -- when we get a contractor on board, and I'll talk about that in a second, we'll see if the contractor can't do the matching for the state, and that would work for them, so.

There are two states that can't do it, Kansas and West Virginia, because of state law, but I don't expect those two states to be that important in the mix of things. The other outstanding states are North Dakota, South Dakota and Maine. We'll pursue them but we want to get the other four I just mentioned first. We want to get Missouri, Texas,

New Mexico and Florida.

So we reviewed proposals from contractors. We've selected a contractor. There is still some preliminary -- some, some additional work that needs to get done to, to finalize that. We're also going to be meeting with the Navy to go over the amount the contractor thinks -- propose -- for the cost, it's reasonable, and I think that there won't be any problems there but we'll see. But there shouldn't be any. Hopefully we'll have a contractor on board, I'm hoping, by the end of May, but again, I can't promise anything. It's something I don't deal with, so I don't know how our office, our grants and contracts office, works, so it may take longer.

But I'm hoping that they're on board by the end of the month, and then they'll start working immediately to -- the first step would be of course me giving them the data they need, and then they doing a search to find out if the people are alive or dead, to find out the vital status basically, and then sending that to the national death index.

So we'll be updating the mortality studies as part of this effort. So there's really going to be four -- at least four studies out of this: Two mortality, two cancer incidence studies. There's

going to be a lot of reports coming out of this, as we go. So that's the status right now of the cancer incidence study.

Now, we released -- we finally were able to release what we're calling the morbidity study. It's the health survey-morbidity study, and it's on our website. There's a fact sheet that we'll be handing out to the public tomorrow that come to the meeting. So there's a lot of findings in this study, and I'm not going to go through all of them; it would take all day. But you have all the information. I'll go over some of the issues with this study and also what we think it does say.

Just so you know, and I think you all know, that this was an Act of Congress, the National Defense Authorization Act of 2008, that mandated this survey to be done, and requested ATSDR develop the questionnaire, and we did so and we carried the study out actually.

And so we had it initially about a little over 310,000 people that we identified as -- that we had information on. That included all the DMDC, defense manpower data center, personnel records from '75 to '85. And also for Marines and for workers we had it from '72 to '85. And we used that information plus

those who participated in our 1999-2002 survey that was our basis for our birth defect study. So we -- the contractor tried to get addresses for all these people. About 20 percent we were unable to get addresses. And so we dropped down to 247,000 that were -- that complete addresses that were mailed.

The participation rate wasn't great, but in general, surveys that are mailed do not have good participation rates. That's true of the millennium cohort; it's true of the census, when they mail it. They have to go door to door to really get the participation, I mean, even though it's required to fill these out. So it's not unusual that this happened. But it did mean that we had small numbers of some of the diseases to evaluate. And when you have small numbers of diseases to evaluate, you have a lot of uncertainty. You have what's called wide confidence intervals, and it gets hard to interpret the findings. So I'll go into that a little bit more.

CDR MUTTER: Can you advance the slide, please? Just the next one.

DR. BOVE: Well, anyway, so the number that actually completed the survey was a little over

76,000. The participation rate was about a little under 30 percent. In particular in the Marines, the participation rate was around 28 to 30 percent. For the workers it was a little bit higher. But it still meant that -- this is the number that we actually were able to analyze. This includes people who filled out the HIPAA forms -- people who reported a disease, in order to confirm it we asked them to fill out a HIPAA form and so that we could go get their medical records and confirm their reports. So this is the final number of people we were able to evaluate, who participated and also participated in the HIPAA part, where we verified the diseases.

So as you can see there's not that many civilian workers that we had to analyze. 2,466 workers is not a lot to -- for a sample, especially with these rare diseases. We had more from the Marines. So many of the endpoints we had more cases to evaluate so that we had less uncertainty for some of those estimates.

DR. CANTOR: Can I interrupt with a question about --

DR. BOVE: Yeah, and then you can interrupt me any time.

DR. CANTOR: Okay, so the numbers say that the response rate from Camp Pendleton was much worse than from Lejeune. Is that --

DR. BOVE: Not much worse.

DR. CANTOR: -- a proper interpretation?

DR. BOVE: No.

DR. CANTOR: It's not a proper interpretation.

DR. BOVE: No. It was --

DR. CANTOR: 'Cause you had 56,000 Camp Lejeune and 9,600 --

DR. BOVE: Oh, okay. So some of the -- it's not -- okay. So what happened, actually the participation rate was pretty similar. It was 30 percent for Camp Lejeune Marines and 28 percent for Camp Pendleton. We included those Marines who started before '75 but were at the base any time between '75 and '85. For those people who started before '75 we don't have complete information on their military record. So some of those we thought were at Pendleton, turns out they also were at Lejeune. We didn't know that until we did the survey. So they shifted. So some of the Camp Pendleton people that we had surveyed actually were at Lejeune. So and you can see that from the table. I think it's table 1, where some of them, about

2,000 or so, shift. So that cuts down on the Pendleton people.

So the survey went through and it requested information on diseases, on occupational exposures, the usual questions that a questionnaire asks. And in order to evaluate, first we compared Camp Lejeune to Camp Pendleton, and that comparison's problematic, and I'll go into that in a minute, why that's problematic. But we did that comparison. We also did what's called a nested case control sample, and we did that for the Marines because we needed to use various databases to figure out where they lived. Some of the answers we got from Marines was, either it wasn't clear where they lived or they didn't know. And we had to go back and use the family housing records and also whatever we could get from the DMDC information to help us figure out where they lived.

So we didn't want to do that for 56,000. We just didn't have the staff to do that. So we did a sample instead. And so the sample was all the cases of reported diseases that were confirmed, in both Pendleton and Lejeune, and that's the case series. And then we took a sample of all the Marines, both Pendleton and Lejeune, figured that if we have them

all in a pot, we just took a sample. And that would be the controls. Okay? So that's how we did that analysis.

And with that analysis we looked at cumulative exposure to the -- at their residence. And we don't have information on training or anything of the sort but we do have information on residence. So we used that in the analysis.

So that's basically what we did. And I think that, as I said, there are a lot of findings and there are a lot of limitations. So maybe I should start with the limitations and then go over the findings.

The first problem, as I mentioned, there's a low response rate. What that means is that we have small numbers of confirmed cases to evaluate. And when we have small numbers we have wide confidence intervals and a lot of uncertainty.

Now, some epidemiologists, when they see a wide confidence interval, like some of the ones you'll see in the tables in the report, would discount the finding altogether. We don't do that, but we do have to acknowledge there's a lot of uncertainty nonetheless. So when you see a very wide confidence interval that means that there's a lot of

uncertainty. It doesn't mean the finding should be ignored; it just -- but it's important to keep that in mind.

But a bigger problem and a much more serious problem with the survey was selection bias, and that happens especially with the comparisons between Camp Lejeune and Camp Pendleton. The Camp Lejeune -- at the time of the survey there was a lot of media reports around male breast cancer, for example. So there was a lot of information out there. And you can see that in the actual male breast cancer finding where there were no male breast cancers from Camp Pendleton at all. And that tells you that there must have been some; they just did not participate. But the male breast cancers at Camp Lejeune were more likely to participate, and that's probably true for almost all the diseases, that the Camp Lejeune Marines and workers were more prone to participate if they had a disease versus Camp Pendleton. So the comparisons, any comparison between Camp Pendleton and Camp Lejeune is problematic in this survey for that reason.

So one way we tried to deal with this problem is to focus on the analyses where we just looked at Camp Lejeune, and we looked at cumulative exposure

to the residence -- residential exposure to the drinking water because we figured that that was not as likely to have a selection bias problem. People wouldn't know what their cumulative exposure was. And so that wouldn't have affected the participation. So even if they were diseased and participated more, there wouldn't be a connection with their exposure status, so there wouldn't be a selection bias problem. So we thought that that was the analyses least likely to have the problem, and that's the one we focused on. So if you see the -- if you go through the executive summary or in the report in general, that's why we focused on the internal -- what we're calling the internal analysis, the analysis just looking at Camp Lejeune and looking at their residential cumulative exposure to the drinking water.

We have problems in general with exposure assessment, and that's true for all the studies. It's true for environmental epi, or occupational epi for that matter. We always have problems with estimating exposures. There are errors there. Oftentimes it makes it hard for us to detect an effect when there really is one there. It also makes it hard to see a nice, smooth exposure

response curve. The curves can go -- all kinds of shapes we can get when we have that kind of error in estimating exposure, and it occurred in this study as well. And again, as the slide says, wide confidence intervals.

So let me back up, Ken, yeah. So we decided to focus our attention on those findings where we had an odds ratio, or a risk ratio, whatever you want to call it, of greater -- of equal to or greater than 1.5, so that's a 50 percent higher excess in the high exposure group versus the low exposure group. And we also -- for the internal comparison, right. Again, I'm focusing only on the internal comparison because of the problems I just mentioned about selection bias.

So we also wanted to emphasize not only that, but if we evaluated it in the ATSDR assessment, which has been talked about, where we -- the VA had asked us to assess various diseases for the evidence for TCE and PCE for the presumption. So we used that report. So if we saw an odds ratio of greater than 1.5 or equal to 1.5 for a particular disease in the internal analysis and the assessment indicated there was at least as likely as not or higher evidence, that's the ones we emphasized.

If we didn't assess the disease in that assessment then we looked to the mortality study for the finding. So it's kind of complicated. And a lot of this was given back and forth within the Agency, trying to figure out the best way to interpret these results and present them. So I guess if someone else did it they might do it somewhat differently, but again, we didn't want to ignore findings, even if there was a lot of uncertainty, and we wanted to use some other way of presenting the results and emphasizing results that we thought might be the most important.

So based on that, we saw an increased risk of kidney cancer, which we would expect, bladder cancer and PCE, which we'd expect, kidney disease, and Parkinson's disease just in the civilian workers. And the civilian workers were much older than the Marines in this study, and in our mortality study too, and Parkinson's disease is a disease of older people. So we think that the civilian information, the civilian part of the study on Parkinson's is important. We also saw Parkinson's disease mortality in the civilian study that we published back in 2014. And again, there's literature evidence on Parkinson's disease. That's why it's in

the presumptive list.

So these are the key findings we thought we wanted to emphasize. But again, there are a lot of findings in this study. And, you know, you might find -- you may decide that another finding's important. And again, keep in mind that a lot of findings, there are those wide confidence intervals so that does mean that there's some uncertainty in that risk estimate, and that makes it a weaker estimate. But again, as I said, some epidemiologists would ignore those findings; we don't.

So I'm going to stop there 'cause it's getting late, and I want to hear some questions. If you have some questions about what we did, about the findings, or whatever. So Lori.

MS. FRESHWATER: I wanted to go back to the cancer incidence study and the four states. Is there anything in common that is -- it's different issues with each state?

DR. BOVE: No, and this is why these studies are hard to do. There's only one other study that I'm aware of that have tried and used most of the state cancer registries, the Seventh Day Adventist study, where they got consent. We don't have

consent. This is a data linkage, so this is the first time this is being done, a data linkage effort. And it's extremely difficult to get each state on board. Each state has a different process.

We're trying -- there's an effort to try to streamline that for future studies. And we've been active in helping that effort along but it's not there yet, and it won't be there for this study, and so we've had to go to each state and work through their process. And Florida in particular has been difficult. They have a lot of hoops -- sorry, Mike. But they have a lot of hoops. And Texas also seems to be difficult, more difficult than some of the other states. So but we are confident that we'll get them on board; it's just taking a while.

MS. FRESHWATER: So there's nothing really that we can do?

DR. BOVE: Not yet, no. I want to see how the contractor deals with them as well 'cause I think the contractor will have more leverage to -- and we're expecting that, but I can't say who the contractor is, so. But I have a feeling that -- not a feeling, but I'm pretty sure that they can help us get these states on board.

MS. FRESHWATER: And do you think that -- I'm

trying to phrase this carefully -- do you think that, if we -- when we succeed in getting most of these states, or all of these states, on board, do you think this might be a good leap forward in the effort to get a national registry?

DR. BOVE: I hope so. I mean, that was part of my motivation for wanting to do this study. But that's going to take legislation, of course.

MS. FRESHWATER: So we'll be able to help with that when that comes --

DR. BOVE: Yeah. Yeah, it's very important. As I said, there is an effort by the North American -- I always have problem with this -- North American Association of Central Cancer Registries. That's the -- basically the trade group for all the registries, if you will. They're involved with coming up with this streamlined process, at least to have one place where you can get all of the IRB, state IRBs, dealt with, one form that all the states will accept. These are important steps. It's still far away from a national registry but they're working on that.

As I said, we actually gave them Camp Lejeune data to start that process so we're very much involved to trying to push this that way.

MS. FRESHWATER: Well, let us know if there's anything we can do, 'cause I do know the importance of it.

MR. PARTAIN: Frank --

DR. BREYSSE: Well, wait, wait.

DR. BOVE: Wait. Chris, you have yours up.

MR. ORRIS: First off, thank you very much, Frank, for all the work that you have done. Thank you to everybody at ATSDR for all the work that you have done on this. A couple of just really quick questions. I know you included spouses and children into the Marine cohort. Did you see anything popping out in the data that you received, either from the children or from their spouses, that was significant at all, just, just in that broken-out segment of the population?

DR. BOVE: Yeah, what we did there was, because we had no referent group, we didn't have Camp Pendleton spouses, so we looked at spouses and children separately, and we just did frequencies, basically.

I looked over the -- one of the questions on the questionnaire was a birth defect question. And I've looked through the birth defect descriptions that people gave, and there was nothing remarkable

there. No, I really didn't see anything remarkable.

MR. ORRIS: Okay. And really I was just wondering because I know you just lumped all the cohorts in together.

DR. BOVE: No, no, no. We didn't do that. The Marines are separate, civilian workers, and then we looked at spouses and dependents separately, just to do frequencies.

MR. ORRIS: Okay, okay.

DR. BOVE: And we did the same thing with registrars. The mailing list that the Marine Corps has, I think it was like 110,000, we sent letters to -- I mean surveys to -- the participation rate wasn't great there either, and that was just, again, we just did frequencies there. Sorry.

MR. ORRIS: And then just the last question on that. Was the participation rate about the same, the 31 percent, for the participants of the original ATSDR study?

DR. BOVE: You mean the survey?

MR. ORRIS: The survey.

DR. BOVE: The survey in 1999-2002 was a telephone survey. So the participation rate was much higher. The problem is a mailed survey, where you -- you know, that really is a difficult thing to

do these days. Actually a telephone survey would be too, but back then it wasn't.

MR. ORRIS: I mean, just, just to clarify, the participation rate for the Marines was roughly 31 percent for the mailed survey. Was that roughly the same participation rate for the spouses and their children as well?

DR. BOVE: Let me see if I have that. I have to look that up in the report. It was probably in the 20-30 percent range, yeah.

MR. ORRIS: Right around the same range.

DR. BOVE: Yeah.

MR. ORRIS: Okay. Thank you for everything you did with this.

DR. BLOSSOM: Very good work. I just have a quick question. Since individually auto-immune diseases and immune-mediated inflammatory diseases, such as skin, are quite rare individually, did you ever consider in your analysis kind of lumping them all together, just all auto-immune? Okay.

DR. BOVE: Sorry. No, we didn't do that. I think that, you know, the fact that there was such a low participation rate kind of flummoxed us to some extent, I have to be honest. I think that that's -- and, and you know, we could not rule out

at all selection bias, especially with comparisons between Lejeune and Pendleton. And again, the cancer incidence study will not have any of these problems. Neither did the mortality study have the selection bias problems. It's just this survey that did.

DR. BREYSSE: All right. Hearing no further questions, we can move now to the remaining time, a little bit less than half an hour, for CAP updates and any community concerns that people in the audience might want to share. I know the CAP had a lot of updates as we had our general discussion.

CAP UPDATES AND COMMUNITY CONCERNS

DR. BREYSSE: I'll start with the CAP. Hearing nothing from the CAP.

MR. ENSMINGER: What?

DR. BREYSSE: The CAP updates, Jerry. This is like the teacher, you're passing notes. Want to show everybody what's on your phone now?

So it's the time for any CAP updates or CAP concerns that we haven't addressed already.

MS. FRESHWATER: My daughter needs a summer internship. She wants to go into medicine. She's thinking about cardiology. So anybody. She's a

sophomore, dean's list. Keep that in mind, everybody.

DR. BREYSSE: So we can also -- hearing none from the CAP, is there anybody in the audience who would like to --

MR. PARTAIN: One thing.

DR. BREYSSE: You have to raise your card, Mike. Remember, you're a visitor.

MR. PARTAIN: For the community concerns, before we go to the audience, there was one thing I wanted to point out, I did put on the Facebook page, the Camp Lejeune toxic water survivors. By the way, we're close to -- since the last meeting I think we had 6,000, and we're approaching 9,000 members on that page.

Someone did point out, and no disrespect to Melissa, but I'll read from them. His name is Bob. He says: My big question is why would they send some lady who has no clue -- once again, no disrespect -- as to what she was talking about? If they had someone who actually knew how the plants worked and designed, you know, basically pointing to something that we continually point out for the past several years now. Why isn't the Navy and the Marine Corps here?

I understand what you do, Melissa, but as evidenced today during our discussion, you know, the Navy and the Marine Corps need to come back to the table. This is getting ridiculous as far as you guys not being here. So you can bring that back to them and let them know that the community outside the CAP is asking why you guys aren't here. Other than --

MS. FRESHWATER: -- official request.

MR. PARTAIN: Yes, I'll repeat that. Please be here.

MS. FRESHWATER: We want to put it in an official request.

MS. FORREST: Well, we've put in an official request --

MS. FRESHWATER: Do it again.

MS. FORREST: I will put it again. I am here as a representative. Like I said, my role is to facilitate any gaps for the ATSDR studies.

MS. FRESHWATER: And we always want you here, Melissa, because we adore you, but we want them to come, and so please ask them again.

MR. PARTAIN: And that was an unsolicited comment. I just put on we're having the meeting and put the link for the my link. So people notice.

DR. BREYSSE: So is there anybody in the audience who would like to say something? If you have a question or comment just step up to the microphone, please.

MR. PARTAIN: One thing to keep in mind too, we do have -- yeah, make sure you keep it succinct to make a point.

MR. KOHL: Yes, my name is Larry Kohl; I'm a Marine. I'm not going to go into my history and my family, from fighting for this nation since the Revolutionary War. But something was mentioned here tonight so I thought I should talk about your vendor doctors. September the 28th I had 20 percent of my left kidney removed because of cancer. I picked my own doctor. I paid for my own doctor. I did not go to the VA for one reason. First of all, I wanted to live. The second was they gave me a Dear John back when I was 65 years old. They said because I work I made too much money, and that's disgusting.

I had an examination February the 12th. Took 10-15 minutes. He says, where's your records? I said, my surgeon sent them to the VA. You have everything. He said, you got pain? I said, sure, I got pain. I'm 77 years old. He said, where's it at? I said, back here. What kidney? I said, my

left kidney. Said, you got any pains any place else? I said, sure, right here. Let me see your scars. I pulled up my shirt and I showed him these scars. That's from robotic surgery. And this is -- I'm going to end this now. He put his hand over here on this one, and he says, boy, they really cut you there. And I said, yes, sir, they did. But I failed to tell him they did that in 1968. That was my appendix. I'd be very careful who you get to make the decision of the benefits. Are they going to pay the benefits for my wife and my children for what they went through, worried about this old guy? I'm tough as nails but they're not. There're young ladies. Be careful 'cause they don't know what the hell they're doing. That's a fact. That's not an opinion, sir.

DR. BREYSSE: Thank you for your service, sir.

MS. METZLER: Hi, my name is Patti Metzler. I'm here to represent my father, David Metzler. He was a Marine at Camp Lejeune, and he developed neural behavioral disorders. I came to the meeting that was down in Jacksonville, and one of the statistics said that only two percent of the neural behavioral cases had been awarded service-connection at that time. And it became my quest to win.

I'm a nurse practitioner. I spent the last five years, from the start of my father's -- when he first applied for this stuff 'til this past January he was awarded six different neural behavioral diagnosis service-connection for. Now I'm waiting for the VA rating.

Now, in five years' time my father passed away before I could get to this point, which is part of my problem that I want to address with the VA, because it took that long for me to get to the first denial, the second denial and the final appeal. And I finally got a judge to look at my research, that I did on my own, to agree that this was correct. And there was no help from the VA because his SME tried to blame his exposure to chemicals on his work at General Motors, okay?

As a medical professional, a certified and registered nurse practitioner in the State of Ohio, I would never give a medical opinion on anybody that I did not examine. It's my medical opinion that that process is unethical, and you're doing a huge disservice to a lot of these veterans. And many, many, many people are getting denied because of that.

Now, the second piece that I am concerned about

is how long this whole thing is taking. Okay, January, we're celebrating. We got the service-connection award, and my mother is 76 years old. Okay, we're going to expedite this case for her to get your rating. It could be another three to six months. You know, I don't get why this takes so long.

And maybe none of you on the board have any answers for me but I wanted to be able to stand up here and tell you that it took my medical background and tremendous blood, sweat and tears, and hours of research to present a 15-page document to this judge, and finally got her to agree with me. And she slammed it. She said, hands down, everything, six different things, all of it service-connected.

I brought with me -- it's probably going to be more relevant tomorrow, because there may be some people here -- but if you applied for anything neural behavioral, I made up a flyer, all of his diagnoses and all of the research articles that I used to present my case for my father. I put my email address on the back here, and I will hand this out to anybody and everybody that I can give it to, to help them through this process too, because it's just wrong. It's wrong how long it's taking.

And I know that the neural behavioral was on the bottom rung, the 2 percent, but my dad served too. He served. And he suffered for many, many, many years because he developed a neural muscular disorder that he had chronic pain, muscular dystrophy, lost his hearing, had sensory neural hearing loss, and I honestly don't know how I would've been able to handle the anger if we hadn't won this case, because it would've felt to me like his service and his suffering was for nothing. Now maybe it'll help somebody else. If he can open that door and his case was the one that opened the door for other people, hallelujah and thank you, God. I hope that it works. And I'm going to keep spreading the word as much as I can. Thank you. [applause]

AUDIENCE MEMBER: Yeah, I'd like to mention something. Currently I'm in the VA system now and I'm -- thank you for this panel 'cause I'm learning a lot about the drinking water issue. I was stationed at Camp Lejeune for three years. I even complained about the taste and the smell of the water during that time. But as the rest of us here all know, as Marines, when you're told to shut up and drink it, you drink it, and that's it. And you consume it.

Well, I have nerve condition issues that obviously I'm seeing now that's probably related to the drinking water issue. But going to the VA issue, so you all know, it's just not that easy to go through a system, because my experience in the VA, even after I've had a judge, the VA judge, order me to go for another exam through the VA, which I just recently went through, the judge ordered the doctor to spend at least an hour with me going over the issues I've had for my military injuries and other things that we're trying to add, the doctor -- I was in his office and back in my car in 16 minutes, after he was ordered to spend an hour with me. He didn't go through a lot of the stuff. My wife said -- was sitting in there. My wife had a question and he told her, shut up and sit down. She is not to speak while this exam is going on.

AUDIENCE MEMBER'S WIFE: We have the doctor's name; he's here in Pittsburgh.

AUDIENCE MEMBER: Yeah. And she wasn't allowed to speak at all unless she was spoken to.

MR. ENSMINGER: Did you knock his ass out?

AUDIENCE MEMBER: This -- and the sad thing is, is he's a veteran himself, an Army ranger doctor.

MS. FRESHWATER: That's the problem.

AUDIENCE MEMBER: Well, and so the whole thing is, as I'm going down through, then I find out that with my liver, 75 percent of my liver is fat. Went to the civilian doctors. They all contributed. The only thing I got that is the drinking water from Camp Lejeune, 'cause I don't drink; I don't smoke; I don't have bad habits. I don't eat fatty foods.

And the thing is, when I go to the VA they don't know anything about it. But they're more than happy every year to take seven tubes of blood out of me every, every year that I go in. And when I asked a question, they said they're monitoring me and they're following something. But they can't answer what, until one day a doctor told me in there that they're monitoring a genetic issue. Well, what genetic? Well, nobody wants to say nothing. And this is the experience I'm having with the VA. We've been going through it now for what?

AUDIENCE MEMBER'S WIFE: Fourteen years on a 16-minute exam.

AUDIENCE MEMBER: Fourteen years on a 16-minute exam. And I got to lay my hope that you guys going to get my liver and everything else straightened around to the VA, that I can't even, at this stage right now, going to my local VA office, that didn't

even know about this meeting because they're not informed -- the VA service officers in our county in Ohio don't even know about these meetings. My Legion didn't know about this until I brought it up. My 10th district commander said, we didn't know about this whole thing going on with the drinking water issue. At that level. Now, I'm not saying that the national legion doesn't know about this, but this has got to get out to other people because the Legion, 1.1 million people, we, we specialize in lobbying Congress to get things passed. But when the district commanders don't know about this we can't get anything accomplished.

But I hope, since the VA representatives here -- 16 minutes. How do you do that when you order to be with me for one hour and find out what's going on. And it's 16 minutes, and then tell my wife to shut up and sit down. When we get the paperwork, he said he was with us for 55 minutes. Thank you.

MS. CARSON: This is Laurine Carson, and I am really sorry for your experience. On the benefits side, if you -- I'd like to talk to you and just find out more information so I can take that back to the appropriate persons. I do believe we'll have some VHA Pittsburgh people here tomorrow.

AUDIENCE MEMBER: Thank you, and I'll be here tomorrow.

MS. CARSON: Okay.

MR. BANKHEAD: My name is Bob Bankhead, and I'm a retired United States Marine. I heard several things here today, and a lot of them are going to deal directly with Congress, and have a bearing on what Congress does and how they act.

I'm a member of every veterans' service organization there is: VFW, American Veterans, American Legion and DAV. Each of those organizations have a legislative director at their conventions on the national level. At their conventions they pass resolutions. These resolutions are directives to that legislative director to tell them to go -- when they go before Congress, to knock on these doors and say, this is what my organization wants. If we don't write a resolution and send to these organizations, we're probably wasting our time. Thank you.

DR. BREYSSE: Thank you, sir.

MS. STEVENS: My name is Sharon Stevens. I'm from upstate New York. My husband was in Vietnam from '65 to '66. When he came back he was at Camp Lejeune. And he never registered with the VA,

didn't want anything to do with anything with the military when he got out.

And about four years ago he started to have severe neurological problems. I'm a gerontologist. I have a background in public health. I ran an aging service agency. So I have a little bit of a medical background. I've done a lot of research, finally put in an application. I wrote a book too that I submitted with the application. Make a long story short, his illnesses, I won't go into the whole list, but he has the autonomic system disorder, severe neurological effects, so on and so forth.

I'm wondering if there's any research, I haven't found any, on the impact of Agent Orange and the chemicals at Camp Lejeune. Is there a compounding effect with the chemicals? Is there a synchronicity? Has there been any kind of look at that? No, okay. 'Cause I think that's what a lot of the Vietnam veterans who were at Camp Lejeune are dealing with.

It's very weird stuff that's happening. He's been through the ringer, and he wants to put a gun to his head now, and I don't know what to do other than what I'm doing. But it's very sad that this

hasn't been researched, and I'm appalled because I was an advocate for seniors for 30 years, and I was pretty good at what I did. Dealing with this system, it's unbelievable to me. It's unconscionable that people have to go through what they have to go through. And granted some people get treated appropriately. I know that everybody's trying and so on, but I cannot believe what I see online in the support groups, and what I hear. It's just inconceivable to me. Thank you.

DR. BREYSSE: Unfortunately, I don't think, you know, the science is there to help make a connection between, you know, Agent Orange and some of the solvents at Camp Lejeune. It's an important question; you're absolutely right. And it wouldn't surprise me if there was some combined toxicities, but that's just beyond what we have any evidence for at this time.

So we have just a few minutes left, and I see Mike has his tag up.

MR. PARTAIN: Another question from the community through the internet. A veteran who was denied for bladder cancer before the presumptive service connection was made filed a NOD in December of 2016 and has not heard anything. Actually he

admitted that he heard something March 22nd, but still has not had a decision. These veterans that have got the presumptives, that have been sitting around denied or if they are filing appeals, is there any reason why this is taking over a year?

And the second part, that I'm going to ask off of that, is do you guys have or do you intend to establish a registry for these Camp Lejeune veterans that go in so we can start keeping track as far as a formal registry with the conditions of who's applying or who's registering and the conditions that they're registering for?

MS. CARSON: So with regards to the notice of disagreement that's in the appeals process, are you saying that that veteran has one of the eight presumptives --

MR. PARTAIN: He has bladder cancer.

MR. ENSMINGER: Yeah.

MR. PARTAIN: He has bladder cancer.

MS. CARSON: I'm just asking the question because I didn't hear you say that. But yeah, I would want to get that information so that I can talk to the appeals maintenance center and see what we can do to get that. That should not be still sitting in an appeal state.

MR. PARTAIN: Well, I'll text him in a few minutes and see if I can get his name and phone number to give to you.

MS. CARSON: Yep. And you have my information too.

MR. PARTAIN: Yeah, okay.

MS. CARSON: From last time. And then with regards to the registries, those are generally healthcare registries so I would have to ask the VHA folks to respond to that.

DR. HASTINGS: And as you know, a registry does not confer benefits. A registry is basically a mailing list, and also can be used to build cohorts. We are studying with ATSDR the issues that surround Camp Lejeune and healthcare, and we do use the Navy's registry, the Navy's list. So the Navy has the registry.

MR. PARTAIN: Yeah, you got dependents, and it's a totally different type of registry. You know, what I'm asking is are you guys -- there should be a registry for the VA for people calling in like the gentleman I was talking about that has bladder cancer, who has applied, been denied, or not --

DR. HASTINGS: The, the list, you know, of

people that have applied for claims -- I mean, it's a combination between Laurine's office, VBA, and VHA. We use the list that the Navy maintains for Camp Lejeune, and we research it. We look at the research that --

MR. PARTAIN: Yeah, but all that is is a mailing list.

DR. HASTINGS: Right.

MR. PARTAIN: You know, what I'm looking and asking for is, you know, like you've done with other --

MR. ENSMINGER: Environmental.

MR. PARTAIN: -- environmental exposure stuff, is you -- you know, you keep track of -- like for example, during the meeting you presented to us a table with the numbers of the different conditions that you have there. Well, there should be --

DR. HASTINGS: And that's with the family member program and also with VBA.

MR. PARTAIN: Okay.

DR. HASTINGS: It's not -- the Agent Orange and the Gulf War and the airborne hazards registries are, are self-identified registries. They can come in for an exam if they would like to. Camp Lejeune does not require registry. You certainly

can -- they can come in and have an exam with a care provider at the VA.

MR. PARTAIN: But we're asking you is -- well, I'll just make a request: Why can't we -- or can we have a registry with the VA for the Camp Lejeune veterans that are going in reporting -- you know, to keep track of what's being reported, who's reporting, and we have that information; can we establish that with the VA?

DR. HASTINGS: I'll have to -- I will take that under advisement. I'll take it for the record. The purpose of the registries that we have now, the six registries, would be very different than what you're asking, so let me get back to you with that.

MR. PARTAIN: Thank you.

DR. BREYSSE: All right. So I want to be respectful of people's time. I have pretty much eight o'clock straight up. Is there anything burning on the table? If not we can adjourn, and we'll see everybody at what time in the morning? 9:00 a.m., nine to one o'clock tomorrow morning. Same room. Thank you all.

(Whereupon the meeting was adjourned at 8:00 p.m.)

CERTIFICATE OF COURT REPORTER

STATE OF GEORGIA

COUNTY OF FULTON

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of April 27, 2018; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither relation nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 26th day of May, 2018.

Steven Ray Green, CCR

STEVEN RAY GREEN, CCR, CVR-CM, PNSC

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CERTIFICATE NUMBER: A-2102