

*REPORT OF THE ADVISORY
COMMITTEE ON MINORITY
VETERANS*



Annual Report

July 1, 2006

ADVISORY COMMITTEE ON MINORITY VETERANS (ACMV)

EXECUTIVE SUMMARY

The Committee visited the Greater Los Angeles Health Care System (GLHCS) April 3-7, 2006. We selected this area due to the diversity of the population and to assess the outreach and services provided to minority veterans who seek help at the many Department of Veterans Affairs (DVA) facilities located in the area. Specifically, we looked at adequacy of outreach, volume of veterans reached, frequency of events held to promote outreach and diversity of staff. The Committee also visited the Los Angeles National Cemetery and the VA Regional office. Throughout the report, the Committee makes reference to DVA as the entity for policy, management and execution. Within that context, we recognize that the Department has three major administrations, the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA).

The Committee was struck by the unusually high homeless rate within the Greater Los Angeles area and we were pleased with the extensive programs that have been put in place and seemingly are having an impact in the area. We recognize that this is not just an issue for the GLHCS however they are addressing it very aggressively.

During the course of our visit we identified ten recommendations we would like you to consider addressing. They are not listed by importance rather, each is equally important as the rest.

Committee Recommendations in brief:

1. Comprehensive Outreach Program

The Secretary mandates that an outreach program be established by all Veterans Affairs Administrations and appropriate staff offices to reach out and support all veterans. As a minimum, the program must incorporate the following goals/activities:

- a. Inclusion of and coordination with local, federal and state veterans' serving organizations in VA facilities' outreach activities.
- b. Establishment of periodic Veteran Town Hall meetings;
- c. Allow facilities to advertise veteran benefits and healthcare services and consult Marketing experts;
- d. Expand and improve the use of internet based access to VA benefits and healthcare, with particular attention given to cultural and linguistic diversity;

e. Establish Minority Outreach Coordinators that are full time as appropriate.

f. Further recommend that these be additional billets that are fully resourced for those facilities;

g. Mandate enhanced outreach communication and coordination between VHA, VBA, and NCA;

h. Identify federal grants for states to conduct grassroots outreach programs.

2. Marketing

DVA should clarify and disseminate its policies pertaining to the issue of marketing. The Committee observed that field facilities perceive outreach and marketing to veterans is still prohibited based on a marketing policy established by VHA in 2002. The Committee views this perception as a serious impediment to minority veterans' knowledge of their VA benefits and VA healthcare entitlements and suggests that VHA clarify its position on the matter to the field.

3. Research Programs

DVA design, develop and fund research agendas focusing on minority veteran issues. The goal is to inform minority veterans and those entities serving the minority community of potential barriers to access so that appropriate measures may be taken to eliminate the barriers.

4. Coordination Care Home Telehealth (CCHT)

DVA aggressively implement the CCHT program in rural communities where veterans, and especially minority veterans, are at greatest risk of not being able to receive appropriate and timely VA healthcare (i.e., South Texas, Alaska, Montana, Samoa, etc.)

5. Vet. Centers

The Committee needs a better understanding of how Vet Centers function and interact with DVA. We have requested a briefing.

6. Land Use Policies

Greater local flexibility to make business decisions would result in more funds for ancillary programs such as those that address outreach to minority veterans and homeless veteran populations.

7. Staff Diversity

Staff diversity at the Los Angeles VA facilities was not representative of the Minority Veteran population especially with regard to the higher pay grades and for African Americans, Hispanics and American Indians. This appears to be a systemic issue throughout DVA.

8. Impact of Local Economy on Budget

Facilities' annual budgets should include adjustments for the cost of living in the local economy. Proper resourcing of employee payrolls, incentive pay and retention pay need to reflect the economic realities of the facility location. (i.e. the cost of housing in Los Angeles makes recruitment of lower pay grade employees almost impossible and impacts minority hiring because they tend to be in the lower pay grades.)

9. Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans

DVA hire Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) minority veterans into the agency to ensure departmental sensitivity to a new generation of minority veterans seeking services from DVA.

10. Seamless Transition.

With regard to the seamless transition of returning OIF/OEF minority veterans entering the VA system, the Committee recommends that:

- a. DVA establish processes, at the cabinet level, that ensure the Department of Defense (DOD) and DVA work together on integrating OIF/OEF minority veterans into the VA healthcare and benefits system;
- b. DOD/DVA coordinates their programs informing all minority veterans of their VA benefits;
- c. DVA pursue the collection of DOD data identifying the upcoming release/discharge of minority service members within 90 days of their release to assist DVA with outreach to the service member;
- d. DVA vigorously pursues DOD's collaboration, support, and agreement in sharing minority service member health and service record information.

The Committee looks forward to assisting in advancing the quality of the services minority veterans currently receive. The findings and recommendations are explained in much more detail in the body of the report. It is our hope that the report is read in its entirety.

INTRODUCTION

The Advisory Committee on Minority Veterans' (ACMV) responsibilities includes advising the Secretary and Congress on the administration of VA benefits and services to and for minority veterans. The Committee conducts site visits, holds town hall meetings and meets with and VA officials to ensure accurate and meaningful recommendations are set forth each year in the annual report that will ensure better services for minority veterans.

The Committee met in Arlington, Virginia December 6 – 8, 2005. VA senior officials from Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and National Cemetery Administration (NCA) briefed the Committee on important issues and programs currently ongoing within the organization. In addition, the Committee heard from the Veterans Disability Commission and the Office of Small and Disadvantaged Business Utilization. The Committee gleaned important information from these briefings that helped prepare them for future site visits. Appendix (A) of this report contains the follow-on questions the Committee had for several of the presenters. It also provides the responses from VA to those follow-on questions.

From April 2 – 8, 2006, the Committee conducted a site visit to the Greater Los Angeles Health Care System (GLAHCS), Veterans Affairs (VA) Long Beach Health Care System, Los Angeles Ambulatory Care Center, the Los Angeles Regional Office and the Los Angeles National Cemetery. While one of the primary purposes was to look at outreach efforts extended to minority veterans in light of cultural sensitivity and frequency, the Committee was exposed to issues that affect all veterans. Appendices (B) and (C) are the respective agendas for the Committee's Washington DC meeting and Los Angeles site visit.

The Committee's visit to the Los Angeles Ambulatory Care Center left an indelible mark on the members, because of the staggering number of homeless veterans. It was reported that the veterans' homeless population was approximately twenty-three percent (21,400) of the total 90,000 homeless population in Los Angeles. Although several programs had been established to minimize the plight of all homeless veterans, the Committee was concerned that those programs might not be of sufficient magnitude to effectuate noticeable and effective changes in the minority veteran homeless community. We believe that similar situations may affect the homeless veteran population throughout the Continental United States and its Territories.

We believe that much remains to be accomplished for all veterans and, particularly, minority veterans. We applaud the efforts and the programs to support, identify, and care for soldiers, sailors and airmen, who have served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) theaters of operations. The early identification of Post Traumatic Stress Disorder (PTSD) will certainly help in the observation and treatment of all veterans who served in

those areas. Yet, we are concerned that the same services might not be readily available to minority veterans who have served in the Vietnam Conflict.

Further, the Committee understands that while the focus is on minority veterans' issues, it is important to take note of all veterans' issues as they present themselves in the course of the Committee's work. It is with this in mind that we present our twelfth annual report.

Throughout the report, the Committee makes reference to the Department of Veterans Affairs (DVA) as the entity for policy, management, execution. The Committee recognizes the DVA has three major administrations:

- Veterans Health Administration (VHA)
- Veterans Benefits Administration (VBA)
- National Cemetery Administration (NCA)

The Committee's recommendations are delineated in Appendix (D). Committee members' biographies are in Appendix (E).

PART I. GENERAL OBSERVATIONS

Monday, April 3, 2006

Greater Los Angeles Health Care System (GLAHCS)

The Committee gathered the following from the Executive Brief:

1. A special outreach program has been developed for currently returning OIF/OEF veterans to provide a timely, seamless transition experience from Department of Defense (DOD) to the Department of Veterans Affairs (DVA). However, there did not appear to be adequate resources (personnel and dollars) for effective outreach to existing veterans given the size of the population being served. Outreach to Native Americans, in particular, was found to be minimal.
 - a. There was no Native American outreach coordinator assigned. The Committee noted that direction had been provided recently to establish a Minority Veterans Outreach program, but the program was not yet staffed. It appeared that primary responsibility rested on one collateral duty person, who had been assisted on a part-time basis for the past six months.
 - b. The homeless grant and per diem program was funded separately by the DVA. However, Congressional authority for the program is soon to expire. The Committee strongly urges its re-authorization.
2. The Los Angeles area has the largest homeless population (approximately 90,000) in the nation. It was estimated that approximately twenty-three percent, or 21,400 of the homeless population, were veterans. The committee recognized the impact of poor public transportation system; high cost of living that presented a challenge for recruitment of healthcare professionals; and an aging infrastructure.
3. Staff diversity appeared to be representative of the community; however, African Americans, Hispanics, and Native Americans were under-represented in the higher grade levels. This observation appears to be systemic throughout the Department. In its December meeting, the Committee made the same observations at the DVA and asked for processes to correct that issue.
4. The Committee noted that a special program – Coordination Care Home Telehealth (CCHT) – had been implemented within the GLAHCS. This special initiative was designed to provide continuous monitoring, frequent communication, early detection & intervention of patients at a cost of

\$1,000 per patient. DVA and the Veterans Health Administration (VHA) should include the program at all its facilities.

5. GLA appeared to be under-funded. Patient population seemed to be the “only” criteria for funding. In itself, patient growth may be an inadequate measure of the costs of operating the facilities, which are by nature complex. The Committee was also advised that the majority of the VA \$2.5 billion supplemental has not reached the field; it appeared that 60% of the supplemental was being retained at DVA/VHA, in Washington. The Committee observes that DVA should establish processes to ensure that resourcing of facilities consider their location, such as high cost of living areas, and their ability to maximize staff recruitment and retention in those areas. Finally, DVA/VHA should ensure that funds are distributed to facilities based upon requirements and needs; should obtain additional resources for VAROs, specifically for appellate work; and ensure that resourcing models consider the relationship between staffing and workload.
6. A related funding issue was the low percentage of income (2%) derived from the oil well on the property that is allocated to the GLA budget. The Committee understood that this percentage was allocated by VA as the owner of the property and the adequacy of the distribution should be reviewed.
7. DVA centralization of the IT functions in Washington, DC, had effectively caused a self-imposed buying freeze for medical equipment for fear of violating IT buying restrictions. Furthermore, this policy was seen as detrimental to a much decentralized IT system.

There is a need to review the adverse impact that current IT policy is having on facilities and organizations, specifically where it concerns needed equipment purchases. For example, the Committee was advised that needed medical equipment could not be purchased, because of restrictions imposed by the current IT policy. The Committee was concerned that the impact of such a policy would affect the care given not only to Minority population, but also to all beneficiaries. The policy needs to be reviewed and modified as necessary.

8. The CARES process, which was intended to determine and maximize efficient land use, had not yielded a plan to generate adequate revenues. A better and speedier land use plan is needed, along with the latitude to begin taking some actions in the near term. The Committee was advised that the property could not be used for the benefit of veterans, such as for expansion of housing for staff, and other uses of vacant land. There seemed to be a need to take advantage of this property, which has an

estimated value of \$6 billion. The Committee observed that the inability of GLAHCS to exercise its land use options in a timely manner indirectly impacted the availability of VA healthcare services for veterans.

9. The Committee noted several standout GLAHCS programs to include: Seamless Transition Outreach and Retention (STOR) program; Coordination Care Home Telehealth (CCHT); New Directions (recipient of Homeless Grant and Per Diem Program); as well as general outreach to the homeless veteran population; which it considered to be models for DVA.

Tuesday, April 4, 2006

Los Angeles VA Regional Office (VARO)

1. The transformation of the Los Angeles Regional Office, from one of skepticism towards veterans and a high rate of denial of benefits to one of customer focus and customer satisfaction with claim approval percentages compatible with the rest of the nation, was noteworthy. The change of direction provided by new leadership has resulted in a highly-motivated, well-focused work force that enjoys high morale, coupled with the approval of the veterans that they serve. The Committee commends all personnel associated with that transformation. It is a model which should be replicated throughout DVA.
2. The Committee toured the entire facility and was struck with the level of pictorials, and other memorabilia that graced all floors and offices within the Regional Office. Discussion with Veterans, who were visiting the facilities, showed extreme satisfaction with the surroundings. Of note, were the Veterans' praise for the courtesy and care exhibited by all with whom contacts were made. The Committee congratulates all personnel at the Regional Office.
3. The Committee noted that the LA VARO had a significant backlog in their appellate reviews. It was reported that 4,000 appeals were pending, which represented approximately 23% of workload; yet only 8% of the VARO staffing was designated to work on those appeals. The Committee was concerned that DVA's resource allocation model did not account for this additional workload.
4. The Committee met with the following California Veteran Service Organization officers:

Dan Ortiz, National Service Supervisor, Veterans of Foreign Wars
Bill McClure, Director, California Department of Veterans Affairs
Jack Kerwin, California Department of Veterans Affairs

James Hung, California Department of Veterans Affairs
Dan Contreras, Junior Vice-Commander (Los Angeles), Disabled
American Veterans
Earl Ivey, National Service Officer, National Blinded Veterans
Association
Susan Alvarado, Paralyzed Veterans Association

Of note were the following points addressed by the officers:

- a. Medical facilities in the L.A. area were not adequately prepared to provide services to women veterans.
- b. Veterans complained about the difficulty of obtaining transportation to and from facilities, particularly for the blind and other disabled veterans.
- c. The greater L.A. area had all the significant factors that impacted on the delivery of services, and many veterans were unaware of the benefits because of the cultural diversity within the community. Many of the communities were isolated linguistically. This required targeted outreach which needs additional assets. This also identified a need for increased funding for outreach. The Committee noted the existence of an excellent program to reach the Korean community, relying on newspapers and television media which could serve as a model for other DVA agencies targeting specific veteran populations.
- d. California Department of Veterans Affairs can be most effective at implementing and supporting grassroots outreach programs. Concurrently, the various associations of Veterans Service Organizations should be incorporated in all programs. The Committee supports the recommendations of providing, and/or facilitating access to, federal grants to the states for grassroots outreach programs. The Committee also supports a much closer association between all DVA agencies and Veterans Organizations. In fact, the Committee was struck by the lack of coordination, information, and support between DVA organizations and the associations of Veterans Organizations. The Committee suggests that a more coordinated and concentrated effort be established, and that monthly meetings between those elements be conducted.

LA Ambulatory Care Center

1. The ambulatory facilities were relatively new. The staff was extremely dedicated. Its outreach programs for homeless and incarcerated veterans were exemplary and innovative. These programs have resulted in

significant decreases in recidivism and should be used as models for other similar areas. Yet, the Committee was concerned because of the absence of detailed racial and ethnic profiles for the categories of veterans served. Also, as the Committee noted here as well as at other locations, the absence of information on Native American veterans was quite disconcerting. DVA needs to remedy the lack of ethnic information as soon as possible. This Committee has been in existence for several years and has noted this issue on many occasions. Leadership must be exercised to bring all DVA agencies in line and to direct the compilation of ethnic data for all population, which falls under the aegis of the Advisory Committee on Minority Veterans. Efforts should be made to obtain ethnic data from all federal agencies, such as DOD and those agencies dealing with Native Americans.

2. The Committee was informed that the majority of incarcerated veterans were not prone to violence, except domestic violence. This suggested that the staff was “safe” in pursuing contacts with those veterans. Yet, this also suggests that DVA staff providing care to this category of violent offender needs to recognize that domestic violence is as equally serious as other inter-personal violence.

Veterans’ Town Hall Meeting

1. Approximately twenty-two (22) Veterans attended the town hall meeting, which was unremarkable in content.
2. The disappointing attendance raised the question of the adequacy of communications among and interaction between the GLAHCS and the Veterans Organizations in the Los Angeles area. The Committee also noted the conspicuous absence of all senior DVA staff representatives, within the Los Angeles area, and of the Veterans Service organizations. This suggested that interaction and communication among all agencies interested in Veterans’ support and service were conspicuously non-existent.
3. A Female non-veteran relayed the concern that Filipino citizens who served during WWII are not granted veteran status and requested that this be rectified. The Committee researched the background on the issue and found the following:
 - a. In 1941, under President Roosevelt, the Commonwealth Army of the Philippines was called into service for the United States. Many Filipinos who served at that time were killed or wounded in combat. Those who did serve were supposed to receive full veterans’ benefits by reason of their active service with the U.S. armed forces. In 1946, Congress enacted the Rescission Act of 1946,

which deemed that the service performed by these Filipino veterans would not be recognized as “active service” for the purpose of any U.S. law conferring “rights, privileges, or benefits.” This included the denial of veterans’ access to health care and pension benefits and limited their death compensation to half of their American counterparts. Approximately 30,000 of 200,000 Filipino WWII veterans are still alive, of whom 7,000 live in the United States.

- b. H.R. 4574, the Filipino Veterans Equity Act of 2006, and a similar Senate Bill, S-146 would deem certain military service performed by Filipino veterans’ active military service for purposes of eligibility for veterans’ benefits and services through the VA, and repeal certain provisions that disqualify such service. It was the enactment of these proposed bills that the Committee was asked to support.
- c. The Committee believes that these minority veterans’ service should be afforded “active service” for purposes of benefits under the VA, and therefore, the Committee supports enactment of the legislation.

Wednesday, April 5, 2006

Los Angeles National Cemetery (LANC)

- 1. The Committee visited the L.A. National Cemetery and was impressed with the dedication and initiative of the small staff to honor veterans and provide support to their families. \$25.5 million were programmed for improvements. The cemetery is now closed for casketed burials for lack of room and needs additional land for expansion. Negotiations were underway with the director of the GLAHCS for the use of twenty acres of land that would provide 80,000 niches for the columbarium, which would last approximately 12 years.
- 2. The Committee was concerned about the position classification and promotion potential for Ms. Jones. Ms. Jones has held the Grade of GS-05 for the past ten (10) years. Also of note was that Ms. Jones has been the Assistant Director for LANC for the past ten (10) years, as a GS-05.
- 3. The Committee was informed that the family of Bob Hope has offered \$500,000 for the historically correct restoration of the chapel on the grounds. A draft memorandum of understanding has been two years in the making and is at the VA General Counsel’s office. That memorandum needs to be expedited.

Research Representatives, GLAHCS

1. The Committee was briefed on the experiences of a returning war veteran who served as an Army engineer in Iraq. The individual's experiences illustrated an unintended gap in providing needed healthcare services in the transition between DOD and VA. The veteran in question returned from Iraq in November 2003 and was on terminal leave from January 2004 through March 2004. He sought help from the VA healthcare system with two weeks remaining in his terminal leave period and was turned away because he was considered to be in DOD's care program. The veteran returned for treatment at the end of the terminal leave period and it took six weeks to begin treatment for PTSD and other physical ailments. The experiences of this veteran were shared by other veterans who testified before the Committee and highlighted policy matters that must be resolved in order to achieve the intended seamless transition for returning war veterans.

2. **“Improving Healthcare for Minority Veterans,” Dr. Harada, PhD**
 - a. The Committee received a brief of an ongoing study, “Racial/Ethnic Variations in Veterans Healthcare Access and Quality” which identified the principal reasons for non-use of VA Healthcare facilities by men and women veterans. Interestingly, the reasons were different for men and women. For men, the principal reason for non-use of VA facilities was a perception of poor interpersonal communication between the veteran and the attending medical staff. The negative perception was interpreted as poor quality care and resulted in dissatisfaction with the VA. For female veterans, only 8% used VA facilities, with the principal reason for non-use being lack of knowledge about eligibility criteria and available benefits. This also resulted in a perception of low quality care. The studies indicated that the use or non-use of VA facilities was less race dependent than in the private sector.

 - b. The studies did not address the participation of Native American veterans in the VA healthcare system.

3. The Committee was also briefed on VA & Indian Health Services, “Access for American Indian & Alaska Native Indians.” The study was limited in its scope by a representation of only 44% of Native American veterans. This ongoing study disclosed that 28% of the represented veterans use VA healthcare facilities when no Indian Health Service (IHS) hospital or clinic was available; 47% of Native American veterans used only IHS facilities when an IHS hospital was available; and 25% were dual users, accessing VA facilities for diagnostics and specialty care and using IHS mainly for primary care and chronic diseases. These statistics highlighted the need

to find more effective ways of making Native Americans aware of the VA benefits that they are not using. There was a significant need to promote accessibility to VA facilities and services. Throughout the visit, the Committee was informed that “marketing VA services were prohibited and, as a result, there were impediments in advising eligible beneficiaries of the services available. DVA should consider defining “marketing” for the purposes of informing its eligible population of their entitlements. The Committee was concerned that the narrow interpretation of “marketing” was being used for purposes which did not seem to be supportive of the VA mission.

Thursday, April 6, 2006

Long Beach Health Care System, Veterans Integrated Support Network (VISN) 22

1. The Committee was briefed on overall operations of VISN 22 with particular emphasis on minority affairs. Each facility had a minority coordinator; however, it was determined that Minority Coordination were collateral duty assignments. The Director indicated “tremendous effort” for Native American outreach; however, success was not forthcoming.
2. There were no Native Americans on the VISN director’s immediate staff. Further, there was incomplete or no data on race, ethnic group distribution of the patient load. It was reported that 40% of the veterans do not self-report race or ethnic information making the measurement of progress in servicing minority veterans difficult to achieve.
3. Recommendations and suggestions were provided the Network Director on means and processes for improvement. The Director’s response is appended to this report. The Committee believes that the planned action, when taken, will go a long way to enhancing outreach to minority groups and to measuring progress in their treatment.

Long Beach Healthcare System (LBHCS)

1. The Director of the Long Beach HCS highlighted four new mental health programs for PTSD, dual-diagnosed individuals, sexual trauma, and a drop-in center for severely mental-ill veterans.
2. Of significance was Long Beach’s strong outreach program for incarcerated veterans. The program’s approach centered on developing with the Veterans a working relationship, which would help them cope (or integrate) with society after their release; working with the public defenders and the homeless court to get released veterans transferred into the VA system for treatment. There were no metrics to measure the

level of achievement with the program; but all personnel associated with or involved in the program expressed confidence that the desired results were being achieved.

3. In the area of minority outreach, the Committee noted that there were no African American representatives on the Minority Council. Many activities were listed under the heading of outreach, but there were no metrics to measure success, and racial/ethnic data were incomplete. There were no Town hall meetings with veterans; but periodic forums were held with different groups to provide information about the services available. The prevalent belief among the director's staff was that VA was precluded from advertising its services. This belief significantly restricted outreach efforts. Although the Committee was informed that the prohibition against outreach has been rescinded, there was a need to define "marketing" as suggested during our visit at GLAHCS. The Committee noted the apparent absence of coordinated effort with state or county agencies and with service organizations to leverage outreach efforts to minority groups. As previously suggested, all activities should maintain close coordination and cooperation with state and county agencies, and with service organizations to maximize efforts to reach eligible beneficiaries.

Villages of Cabrillo

The Committee visited the Villages of Cabrillo and found a unique collaboration between for- profit and non-profit organizations.

1. The Villages of Cabrillo is located on former U.S. Navy land in Long Beach. This unique organization services approximately 1800 veterans per year. Its main focus is to outreach homeless veterans through treatment, training, assistance in securing jobs, and independent living. A twenty person contingent from the VA collaborates in the Cabrillo operation in providing a full range of interventions. This type of arrangement was noteworthy and should be considered for emulation in other large urban areas throughout the country. Assistance in providing funding to the Villages of Cabrillo should be an issue for DVA. Eleven (11) Veterans, in different stages of intervention and treatment at Cabrillo, discussed the program with the Committee. All, without exception, expressed their total and unequivocal praise for the staff and the programs offered at the Villages of Cabrillo.
2. The Committee was impressed by the participation and involvement of Native Americans in the program. Yet, as suggested previously, there was a need to reach out to Native Americans.
3. During the tour of the Villages, the Committee noted its exceptionally fine condition. All personnel exhibited great pride in the Village.

Veterans' Town Hall Meeting

The Committee concluded its activities by holding the second Town Hall Meeting with Veterans. The meeting was advertised on a billboard, located at the entrance of the installation. Coordination and communication with Veterans Organizations seemed to have been minimal. Eleven persons, other than staff, attended the meeting.

1. A non-veteran – A Navajo Indian serving the Native American community made a passionate plea to develop greater cultural sensitivity among healthcare workers within the VA system, so that Native American veterans would find it more attractive to visit VA facilities for treatment. The Committee endorsed such a recommendation and recommends that DVA considers establishing cultural sensitivity training for all its personnel, located in and around areas with high density of Minority Veterans. The Committee recognizes that such a program may be taxing in terms of cost; yet, the benefits derived would outweigh cost.
2. The daughter of a veteran, who was a former green beret and resided in New Mexico, pointed out that there were no VA medical facilities in and around the rural area where her father lives. Local outpatient clinics did not have all the facilities and services his medical condition required. She made a passionate plea for more VA facilities and/or clinics in rural areas in New Mexico. During previous visits and in discussions with Veterans from other parts of the country, there were similar cases and pleas for VA facilities in rural areas.

Friday, April 7, 2006

Committee meeting with DVA Directors and selected staff

1. DVA personnel participating in the meeting, for a final discussion of issues were:

Mr. Ken Clark, Director, VISN 22
Mr. Charles Dorman, FACHE, Director GLAHCS
Dr. Lisa Altman, MD, GLAHCS
Mr. Ronald Norby, Director LBHCS
Ms. Lily Fetzer, Acting Director, VARO, Los Angeles
Mr. Wiley Buffington, VARO, Los Angeles
Ms. Michelle Kwan, VARO, Los Angeles
Mr. William Livingston, Director, Rosecrans National Cemetery

All personnel praised the openness and productivity in the discussions, and for the opportunity to exchange ideas and clarifications.

2. The Committee commended the leadership for the high quality of programs examined, and for the professionalism and enthusiasm exhibited by personnel. Issues were summarized and discussed with the executive team.
3. The executive team accepted the Committee's views and recommendations, and agreed that all issues should be incorporated as priority items, requiring actions. The Committee and the executive team agreed that the visit had been worthwhile, and that it was an important first step to forging a productive working relationship between the two organizations, as a way of improving services to minority veterans.

PART II SPECIAL RECOGNITION

The Committee recognizes the following individuals and enterprises for their superb performance and activities:

Wiley Buffington, Public Contact Coach/MPVC for Los Angeles Regional Office

William Livingston, Acting Director, Los Angeles National Cemetery

Sheri Moore, Volunteer Archivist for Los Angeles Regional Office

New Directions, Inc., (Homeless Services)

U.S. Vets Initiative, Inc. (Homeless Services)

PART III RECOMMENDATIONS

The Committee recommends the following:

1. Outreach Program

The Secretary mandates that an outreach program be established by all Veterans Affairs Administrations and appropriate staff offices to reach out and support all veterans. As a minimum, the program must incorporate the following goals/activities:

- a. Inclusion of and coordination with local, federal and state veteran serving organizations in VA facilities' outreach activities. These entities should include, as a minimum, state and county Veterans Affairs Agencies, Veteran Service Organizations (VSOs), veteran serving organizations (i.e. minority veterans' organizations that have not been granted VSO status), agencies and organizations that serve the minority community in the local area, faith-based organizations that serve veterans, etc.;
- b. Establishment of periodic Veteran Town Hall meetings with veterans and their families to determine needs and issues; meetings/processes must ensure that minority veterans and communities are targeted in culturally appropriate venues;
- c. Allow facilities to advertise veteran benefits and healthcare services and consult Marketing experts to help VA facilities conduct effective communication of VA offerings with particular attention to marketing to minority communities;
- d. Expand and improve the use of internet based access to VA benefits and healthcare, with particular attention given to cultural and linguistic diversity;
- e. Establish Minority Outreach Coordinators that are full time, where warranted. Further recommend that these be additional billets that are fully resourced for those facilities, rather than requiring facility directors to give up other billets to fill those positions;
- f. Mandate enhanced outreach communication and coordination between VHA, VBA, NCA and appropriate staff offices;
- g. Identify federal grants for states to conduct grassroots outreach programs.

2. Marketing

A current ban on marketing established by an Assistant Secretary of VHA was brought to the attention of the Committee several times during its site visit. This policy is currently interpreted by the field as a ban on all outreach programs especially to minority veteran populations. The Committee views the application of this policy as a serious impediment to minority veterans' knowledge of their VA

benefits and VA healthcare entitlements. The repeal or redefining of the DVA policy prohibiting marketing needs to be immediately disseminated to all DVA field facilities. The Committee was led to believe that the memorandum establishing the ban on marketing had been formally rescinded. If this is correct, it is vital that all facilities be advised that outreach to minority veteran populations is encouraged and expected. The Committee desires a brief on the efforts taken by DVA leadership addressing this contentious issue at its next Washington DC Committee meeting.

3. Research Programs

DVA design, develop and fund research agendas focusing on minority veteran issues to include but not limited to:

- a. Identification of racial-ethnic health disparities;
- b. Identification of barriers that prevent minority veterans from accessing and using their veteran benefits and healthcare services;
- c. Identification of what culturally appropriate practices would support greater participation in VA benefits and services by minority veterans;

VA must endeavor to coordinate and disseminate the results of such research to audiences both within DVA (practicing healthcare givers, VBA and NCA employees) as well as providing briefings of findings to VSOs, minority community leaders, state and county veteran's officers, etc. The goal is to inform minority veterans and those entities serving the minority community of potential barriers to access so that appropriate measures may be taken to eliminate the barriers.

4. Coordination Care Home Telehealth (CCHT)

VA aggressively implements the CCHT program in rural communities where veterans, and especially minority veterans, are at greatest risk of not being able to receive appropriate and timely VA healthcare (i.e., South Texas, Alaska, Montana, Samoa, etc.) The Committee noted in particular the Coordination Care Home Telehealth (CCHT) program in Los Angeles that would have broad implications for minority veteran health if aggressively utilized throughout the country.

5. Veteran Centers

A comprehensive briefing on Rehabilitation Counseling Services be given the Committee at its next Committee meeting in Washington DC. The purpose is to fully explain the functions of the Veterans Centers and their interaction with DVA's health facilities, concerning minority veterans.

6. Land Use Policies

VA should conduct a review of land use policies within the agency, to allow VA facility Directors greater latitude in generating revenue to execute their mission. Greater local flexibility to make business decisions would result in more funds for ancillary programs such as those that address outreach to minority veterans and homeless veteran populations. Because of the impact of CARES on this issue, the Committee requests an update on CARES at its next Washington DC meeting.

7. Staff Diversity

Staff diversity at the Los Angeles VA facilities was not representative of the Minority Veteran population especially with regard to the higher pay grades and for African Americans, Hispanics and American Indians. This appears to be a systemic issue throughout the Department of Veterans Affairs (DVA). The Committee recommends that DVA:

- a. Develop a targeted recruitment plan for minority hiring at all levels of the department across the country;
- b. DVA design, implement and fully resource cultural sensitivity training programs for all DVA employees and make it mandatory;
- c. DVA direct the compilation of ethnic/racial data of its employee population and the veteran population in all its data gathering processes;
- d. Provide a brief at the Committee's next Washington DC meeting on the progress made concerning this issue.

8. Impact of Local Economy on Budget

In formulating its budget for facilities, there must be consideration of the local economy and its impact. Facilities' annual budgets should include adjustments for the cost of living in the local economy. Proper resourcing of employee payrolls, incentive pay and retention pay need to reflect the economic realities of the facility location. (i.e. the cost of housing in Los Angeles makes recruitment of lower pay grade employees almost impossible and impacts minority hiring because they tend to be in the lower pay grades.)

As a minimum the Committee recommends:

- a. DVA establish processes to insure that resourcing of facility budgets consider their location, cost of living, and recruitment/retention cost requirements;
- b. Ensure that funds are distributed to facilities based upon requirements and needs;

- c. With respect to Regional Offices, provide additional staff and funding for appellate work to ensure VARO budgets are based on staff to workload ratios.

9. Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans

DVA hire Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) minority veterans into the agency to ensure departmental sensitivity to a new generation of minority veterans seeking services from DVA. The Committee recommends DVA review its pilot recruitment program “Coming Home to Work” to ensure it adequately targets OIF/OEF minority veterans for employment throughout the Department.

10. Seamless Transition

With regard to the seamless transition of returning OIF/OEF minority veterans entering the VA system, the Committee recommends that:

- a. DVA establish processes, at the cabinet level, that ensure DOD and DVA work together on integrating OIF/OEF minority veterans into the VA healthcare and benefits system;
- b. DOD/DVA coordinate their programs informing all minority veterans of their VA benefits;
- c. DVA pursue the collection of DOD data identifying the upcoming release/discharge of minority service members within 90 days of their release to assist DVA with outreach to the service member;
- d. DVA vigorously pursue DOD’s collaboration, support, and agreement in sharing minority service member health and service record information.

The following relates to the Direct Home Loan Program which was briefed to the Committee at its December 6-8, 2005 Washington DC meeting.

11. Native American Veteran Direct Loan Program

Under the authorizing legislation of the Native American Veteran Direct Loan Program, VA is to receive \$.05 (sic) million each year for administration and outreach activities, including travel to meet with tribes and individuals.

- a. What plans are currently in place by VBA to utilize these funds to increase outreach efforts to Native communities?

Also in the program’s authorizing legislation, it states that VA, among other things, is to attend housing conferences, and provide information to veterans, tribal governments and organization (sic). Other program requirements

state that VA should annually assess and report to the Congress on the effectiveness of its outreach activities and annually report on the pool of eligible Native American veterans.

- b. Are the current figures reflecting the activity of the program over the last thirteen years being reported to Congress annually?

The Committee requests a follow-up briefing from VBA to address the concerns delineated above.

Appendix A: Responses to Committee Follow-on Question from its December 2005 Washington DC Meeting

Veterans Health Administration (VHA)

Question 1: Why isn't veterans' high utilization rates in certain areas used as a factor in determining appropriate budgeting and resources? (e.g., Puerto Rico)

Response:

Utilization rates are used as a factor in determining appropriate budget and resource. The amount of funding a network receives is based on the number and type of patients served. The network then determines how to allocate budget and resources to its facilities.

Question 2: Why can't VHA consider contracting health care services from IHS to provide care for veterans living in rural and remote areas (e.g., Alaska) and provide reimbursement for patient travel to/from health care facilities?

Response:

Under the Economy Act, Federal agencies have authority to purchase goods or services from other Federal agencies, subject to limitations prescribed in law and regulation. Those limitations include the stipulation that the arrangement be in the best interest of the United States government, that the services can not be acquired more easily or more economically in the private sector, that the agency supplying the services can readily meet the request and that the agreement does not conflict with other agency authorities.

Under the Memorandum of Understanding (MOU) signed between the Department of Veterans Affairs (VA) and the Department of Health and Human Services, VHA and the Indian Health Service (IHS) agreed to work together to "Improve beneficiary's access to quality health care and services." Toward this end, VHA and IHS field staff have been encouraged to explore all available options under their authorities for delivery of services that meet the local needs and requirements of both agencies. In a number of locations, IHS and the tribes have agreed to provide space where VHA can deliver services to beneficiaries. (It is important to note that tribal leaders exercise the legal authority to determine who can have access to health services on tribal lands, whether delivered by IHS or the tribe, and must pro-actively approve use of facilities by non-tribal members.) At this time, only the Choctaw Nation Tribal Health Authority has determined that providing services to all veterans through a VHA-contracted community-based outpatient clinic is in the interest of the tribe, although a number of other tribes are considering similar arrangements.

Question 3: What specific programs is VHA fielding to ensure diversity on their staff?

Response:

VHA's 2006-2010 Workforce Succession Strategic Plan provides information on training programs that were implemented at the field and national level to provide opportunities for all employees. These programs assist with the development of leadership skills or skills in various major occupations that are difficult to recruit or retain. Field facilities have various training programs (i.e. leadership effectiveness accountability development (LEAD), Upward Mobility Programs, and National Nursing Educational Initiative), that addresses the development of employees at all levels. The Executive Career Field Candidate Development Program and the Technical Career Field program are two national programs that address components of leadership and technical skills needs. Officials are sensitive to diversity concerns during the recruitment and selection processes.

The *Executive Career Field Candidate Development Program (ECFCDP)* was established in 2002 and provides developmental opportunities for high-potential employees, preparing them to apply for Executive vacancies. ECFCDP is a two-year program which consists of a personal development planning (PDP) and mentor and preceptor components as well as a wide variety of educational and experiential learning opportunities. Candidates attend an assessment center and learning goals are tailored to meet the identified needs of the individual.

In the Executive Career Field Program minorities are selected at a higher rate (24.68%) than their presence in the applicant pool (22.70%). The workforce distribution of the applicant and candidate pools is continuously monitored in an effort to improve the workforce distribution at the executive levels as compared to the relevant civilian labor force.

The *Technical Career Field* internship program was created to develop employees in fields where full-time training in VHA procedures and regulations is required, such as Prosthetics Representative, Human Resource Specialist, Budget Analyst, etc. Two-year internships are centrally funded. Recruitment is focused on local colleges and universities. Each intern is placed at a VHA facility and trained by a Preceptor experienced in the target position. Preceptors receive training, interns convene for an annual conference with their peers, and the program is evaluated at the national level. The program is designed to flex with changing workforce needs. On an annual basis, the target positions and number of intern slots are determined based on current and projected workforce needs and program evaluation data.

Technical Career Field has a national percentile of 22.37% of minority representation. The workforce distribution of the applicant and candidate pools is

continuously monitored in an effort to improve the workforce distribution in the careers that are a part of this program.

Provide breakdown of minority representation on staff?

In FY 2005, VHA's total workforce consisted of 212,000 employees; minority employees totaled 81,018 (38%). The breakdown of the minority representation consisted of the following:

- Hispanics 14,441 (7%)
- Black/African American 49,769 (23%)
- Asian 14,986 (7%)
- American Indian/Alaskan Native 1,822 (1%).

Question 4: What evaluation processes does VHA have in place to hold people accountable for their actions and to ensure consistent performance vis-à-vis service and care for minority veterans?

- **Are bonuses/promotions attached to increase of outreach /cultural appropriate care of minority veterans?**
- **Tie leader's performance criteria to diversity of staff?**

Response:

In the FY 2005 VISN Director's performance standards, Measure 22: Diversity and EEO Management included elements of diversity which were met by all VISN Directors. These elements included:

- Development of a workforce diversity analysis
- Identification of specific strategies and measurable goals
- Maintenance of an active Diversity Advisory Committee or similar structure in the Network (or each facility)
- Maintenance of formal recruitment relations, such as cooperative education or intern programs, with at least two minority-serving institutions (e.g. Historically Black Colleges and Universities, Hispanic Serving Institutions, and Native American Tribal Colleges, as geographically located)
- Provide at least three, clearly defined on-going programs offering wide developmental opportunities available to the workforce (e.g. Upward Mobility, SCEP/STEP, NNEI, etc).

In the current performance standards for FY 2006, VISN Directors will be accountable for the following performance standards regarding diversity and Equal Employment Opportunity (EEO) management.

Work Force Planning

VA Enabling Goal: Deliver world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance

VHA Strategy: Promote diversity, excellence, and satisfaction in the workforce and to foster a culture which encourages innovation

Measure 22: Work Force Planning and Program Implementation

By the end of FY 2006, Network Directors and VHA Central Office Program Officials will assure that workforce plans and programs for their organization meet the following criteria:

1) STRATEGIC WORKFORCE PLANNING: The strategic plan contains a component addressing workforce development, including a succession plan that identifies projected workforce needs and underrepresented employee groups by occupation, as well as goals and objectives to guide diversity management, employee satisfaction, education and High Performance Development Model plans. (Specific instructions will be sent to Networks).

2) LEADERSHIP AND EMPLOYEE DEVELOPMENT

a) VISNs will implement facility level Leadership Effectiveness and Development (LEAD) programs that, at a minimum, meet established core criteria.

b) VISNs will ensure that all VISN and facility LEAD participants are entered in the leadership database and are actively using the online Performance Development Plans (PDP).

c) VISNs will demonstrate a clear strategy for implementing national supervisor training for all supervisors.

3) DIVERSITY MANAGEMENT

a) **Diversity Education:** VISNs will ensure that all employees are trained on the value of a diverse workforce by implementing diversity training appropriate to the grade levels and roles and responsibilities of the employees in the organization.

b) **Diversity Acceptance:** VISNs will develop goals for improvement and implement the resulting action plan for diversity based on analysis of relevant 2004 All Employee Survey (AES) (e.g., Diversity Acceptance).

- i) VISNs will demonstrate any level of improvement in the area(s) measured by the 2006 All Employee Survey.
- ii) VISNs will demonstrate significant improvement in the area(s) as measured by the 2006 All Employee Survey. Significant improvement will be defined as an increase of a .5 standard deviation.

c) **Diversity in Succession Planning:** VISNs will take action to ensure that qualified and high potential applicants in all succession and workforce development initiatives reflect the local workforce.

4) **EMPLOYEE SATISFACTION**

VISNs will review, revise, and continue to implement action plans developed from the analysis of **specific** topics from the 2004 AES results.

- a) VISNs will demonstrate any level of improvement in these specific topic areas as measured by the 2006 AES Survey.
- b) VISNs will demonstrate a significant improvement in these topics as measured by the 2006 AES. Significant improvement will be defined as an increase of a .5 standard deviation.

5) **EEO MANAGEMENT**

VISNS will demonstrate the use and success of an Alternative Dispute Resolution (ADR) program by the reporting the percent of complaints that have gone to mediation and the percent of cases that have been settled using ADR.

Question 5: Please provide a written update on CARES implementation process and future actions.

Response:

Capital Asset Realignment for Enhanced Services (CARES) is a comprehensive, system-wide approach to, and ongoing process for, identifying the demand for VA care and projecting into the future the appropriate function, size and location for VA facilities. CARES planning is not simply a one-time evaluation of VA's capital infrastructure and the ideal placement of VA facilities, but was undertaken to provide a set of tools and the process to allow VA to continually plan for future resources needed to provide quality health care to veterans.

The Veterans Health Administration's (VHA) Strategic Vision has been outlined in the Departmental FY 2006 budget submission to Congress. This vision has been widely distributed to Congress, veterans' service organizations, throughout VHA

and the Department. In the document are some highlights of VA's commitment to health care planning for all veterans and notably for special populations of veterans, as required by Public Law 107-135. VHA updated VHA Directive 2003-064 in October 2003 that describes the strategic planning process for this administration. This directive outlines a comprehensive planning continuum that effectively integrates the various tasks, activities, and reporting requirements associated with budget, capital asset, information technology, human resources/workforce development, performance and strategic planning within VHA.

An additional component of the strategic planning process for the FY 2006-2010 planning horizon is the merging of CARES into VHA's strategic planning process. The Secretary's May 2004 CARES Decision provides a blueprint for VA's future to effectively guide the Department forward. CARES is the creation of a set of tools and a process for annual capital and strategic planning to enable VA to keep its eyes fixed on the future as it plans for the resources it will need to provide quality health care to veterans.

Current CARES initiatives, including expansion of Community-Based Outpatient Clinics (CBOCs), identified in the CARES Decision Document have been implemented. VA hopes to be able to proceed with review and implementation of selected CBOCs through a national approval process. The process will require VA medical centers and Network offices to develop sound business plans for new CBOCs based on national criteria and standards. In FY 2005, some Veterans Integrated Service Networks (VISNs) began implementation of some initiatives, including new CBOCs. This and other new initiatives must be scrutinized within the context of the recently released FY 2006 budget. VISNs are currently re-evaluating their needs for CBOCs and prioritizing their needs using the Secretary's CARES Decision Document as a guide.

The CBOC business plan review process as outlined in VHA Handbook 1006.1 has been initiated by the Office of the Deputy Under Secretary for Health for Operations and Management. Business plans for CBOCs that VISNs plan to proceed with in FY 2006 will be reviewed against national CBOC planning criteria during the second quarter of this fiscal year.

VA currently has over 712 CBOCs and operates or contracts for care at 100 outpatient clinics located in areas considered to be rural or highly rural areas. Nationally, from 2000 to 2003, VHA added 67 CBOCs, which increased by 1 percent the number of veterans (approximately 70,000 veterans) who live within a primary standard of 30-minute drive time.

The 2004 CARES Decision Document also called for additional studies in 18 VA locations to refine the analyses developed in the CARES planning and decision-making process. The study results are to be integrated into a site-specific business plan format that provides VA decision makers and stakeholders with

clear options for the type, size, location, and reuse potential of VA health care resources under study. These plans will provide VA with an independent business analysis from which implementation decisions will be made. The planning horizon for implementation is 2013, but any options must be projected as viable, using demand data through 2023. The conduct of these analyses, recommendations and conclusions will receive a great deal of scrutiny both in and out of the Department. These decisions need to be sensitive to stakeholder concerns within and outside the government. The decisions will be incorporated into VHA's Strategic Planning process.

To ensure that broad range of options were considered before a detailed analysis was done and that stakeholders were able to comment before any options were selected for detailed analysis, VA required that PricewaterhouseCoopers (PwC), the VA contractor, present what they considered a series of credible options. These were based upon a very high level macro analysis. To do in-depth analyses of all potential options in all of the seventeen study sites would be very costly. The study design incorporates screening criteria of access, quality and cost measure as the initial a high level of assessment. PwC used their panel of experts to determine which of the options they initially explored would be likely to at least maintain or improve the current access and quality of services. Those options, as well as options that PwC had screened out as not meeting these criteria, were presented at the second series of Local Advisory Panel (LAP) public meetings which occurred in the summer and fall of 2005. The LAPs made recommendations to the Secretary on options they believed deserved further study and these along with PwC's proposed options, are included in the study's Stage 1 process. VA officials are presently being briefed on the Stage I options. The Secretary will decide which options will be considered for further analysis in the study's Stage II process.

Each acceptable Business Plan Option (BPO) will meet or exceed the following screening criteria:

- Maintain or improve overall health care quality
- Maintain or improve veterans' access to care
- Result in a cost-effective configuration of VA physical and operational resources
- Result in a modernized, safe and secure health care delivery environment
- Maximize the re-use/redevelopment potential of VA-owned sites

To begin the final stage of the study, the LAPs will be informed in a third series of LAP meetings to be held in early 2006 of the Secretary's decision on BPOs that will be further analyzed. The LAP members will have an opportunity to provide PwC with additional comments about specific options the Secretary has selected for additional study. PwC will complete an independent analysis and recommend one of the remaining options for implementation. The LAPs may either agree or disagree with the recommendation. If they disagree, PwC is required to bring

forward the LAP's recommended option and PwC's assessment with their full evaluation in a final report to be submitted to the Secretary. All the recommendations that PwC makes will be fully supported by appropriate data and analysis. The Secretary will make the final decision on which business plan option should be implemented. The current study schedule enables VA to make the decision within the June 1, 2006, timeline regarding new hospital facilities. All final decisions will be incorporated into VHA's strategic planning process.

VA's Web site www.va.gov/CARES is dedicated to veterans, elected officials and any other interested parties, and gives them the opportunity to provide electronic feedback and comments. They can refer to the web site for the most current information on any of the 18 sites and upcoming LAP meeting times and locations.

The goal of CARES is to enhance outpatient and inpatient care, as well as special programs such as spinal cord injury, blind rehabilitation and seriously mentally ill and long-term care. Once CARES is completed, VA will have a national plan for directing resources where they are most needed; preserving VA's missions and special services; and, at the same time, continuing to provide high quality care to veterans. The initiatives and plans identified will be validated and reassessed continually to ensure they reflect current VA policies and priorities.

Question 6: The Committee is concerned that genetic testing for pre-disposition to certain diseases may be used as a criterion to establish "pre-existing medical conditions." What policy safeguards can be put in place to ensure that does not happen to the detriment of minority veterans?

Response:

The objective of VHA's Genomic Medicine Program (GMP) is to improve veterans' health by delivering better medical care rather than to disenfranchise any group of individuals selectively. A Genomic Medicine Program Advisory Committee (GMPAC) will discuss important issues and will be sure to consider concerns such as expressed by the Advisory Committee on Minority Veterans.

Question 7: The Committee would like to see VA implement a Tribal Veteran Representative Program (TVR) model, nationwide and develop similar programs of support for other minority groups.

Response:

With leadership from VHA, VA is finalizing program materials to support a national TVR Program. TVRs participating in VA's TVR program will be identified/endorsed by the tribe as the sanctioned Tribal Representative who will assist veteran tribal members/veterans and their families in obtaining eligible VA

benefits and services. The Tribal Veteran Representative program is intended to augment the Tribal Veterans Service Officers or County Veterans Service Officers programs that are in the community and establish links between the veteran, Veterans Service officers, VA and the Tribal Health or Indian Health Service. Implementation of the TVR program will be a local decision. Veterans Integrated Service Network (VISN) staff will reach out to the tribes and implement programs in response to local Tribal interest. Based on the success of the TVR programs implemented in VHA's VISN 19 and VISN 23, VA staff from across the Department, with the assistance from the VA Learning University/Employee Education System, developed national materials that will provide a consistent set of up-to-date training and reference information for VA outreach staff to use in training TVRs. The TVRs will use the program materials provided by VA when assisting American Indian/Alaska Native veterans in their Tribe and community. Outreach assistance on or near tribal lands was identified as a need since other sources of outreach information and assistance were not routinely reaching tribal veterans.

At this time, VHA is unaware of any plans to develop similar programs for additional minority veteran groups. With the possible exception of Native Hawaiians on Hawaiian homelands, no parallel authority exists in other minority communities that are equivalent to tribal governments.

Question 8: What programs has VHA implemented to achieve its legislated mandate of awarding 3 percent of contracts to Service Disabled Veteran (SDV) businesses? The Committee is concerned about the lack of progress on this issue and whether minority veterans are included in the Department's SDV contract goals.

Response:

VHA has established a network of Small Business Liaisons who are responsible for ensuring that the Small Business program in each network is active and results-oriented. The Prosthetics and Clinical Logistics Office (P&CLO) holds monthly teleconferences with these Liaisons to provide training, communication of Department priorities, and an opportunity to discuss best practices and difficult issues. Each VHA Network has developed a protocol for access to key decision makers that includes:

- A list of key network staff who may be contacted about business opportunities
- Scheduled outreach events
- A communication plan
- A training plan
- Guidelines for market research

In addition, P&CLO has met with representatives of veterans groups to obtain their views on how best to meet the Department goals for contracting with veteran-owned businesses. As a result of one such meeting in January 2006, two vendor fairs are being planned in the Gulf region in March to provide information and networking opportunities to veteran-owned businesses who wish to contract for the hurricane clean-up effort.

Finally, P&CLO is tracking and reporting results to senior management on a monthly basis.

**Veteran's Benefits Administration (VBA)
Home Loan Guaranty
Native American Direct Home Loan Program**

Question 1: What increased outreach efforts does VBA have planned to increase participation in the Direct Home Loan Guaranty program and what timelines are in place to measure increased loans to American Indian veterans?

Response:

In response to the first question, loan Guaranty Service looks forward to coordinating outreach with the Minority Veterans Center. It has long been a goal of our office to work with the Minority Veterans Center to provide consistent, timely, and accurate information to Native American veterans. While we do provide our own outreach to this audience, we expect greater success in reaching eligible veterans if we are able to coordinate outreach efforts with [the Center for Minority Veterans].

The second part of the question has no definitive answer. The decision to purchase a home is a very personal one, and there are many factors at play. For this reason, we have never viewed the success or failure of this program as being based on achieving certain specific numbers of loans to specific tribes. Every veteran's circumstances are different, as is every tribe's reason or reasons for participating or not participating in this program. As you are aware, the law requires that, before we may provide a loan to a native American veteran, his or her tribe must enter into a Memorandum of Understanding (MOU) with VA setting out the rights and responsibilities of both the tribe and the Department with regard to property access and foreclosure procedures, in the event the veteran is unable to meet his or her monthly mortgage obligation. We cannot make a tribe participate, nor can we make a veteran choose a VA direct loan to finance his or her home purchase, if he or she decides to buy a home.

Committee Comments to Response:

Under the authorizing legislation of the Native American Veteran Direct Loan Program, VA is to receive \$.05 (sic) million each year for administration and outreach activities, including travel to meet with tribes and individuals.

- a. What plans are currently in place by VBA to utilize these funds to increase outreach efforts to Native communities?

Also in the program's authorizing legislation, it states that VA, among other things, is to attend housing conferences, and provide information to veterans, tribal governments and organization (sic). Other program requirements state that VA should annually assess and report to the Congress on the effectiveness of its outreach activities and annually report on the pool of eligible Native American veterans.

- b. Are the current figures reflecting the activity of the program over the last thirteen years being reported to Congress annually?

The Committee requests a follow-up briefing from VBA to address the concerns delineated above.

Department of Veterans Affairs Deputy Assistant Secretary for Policy (008A)

Question 1: Provide the Committee with the law or regulation and VA's interpretation of the law or regulation that precludes the Department of Veterans Affairs from collecting race and ethnicity data from veterans.

Response:

There is no VA regulation *per se* we can point to which precludes VA from systematically collecting race/ethnicity data from veterans on its administrative forms. As discussed in December, various VA organizations do collect race and ethnicity as part of their on-going processes based on specific needs using the OMB race and ethnic categories. For health purposes, race and ethnic data are collected because race and ethnicity are seen as risk factors in the health of veterans. On housing loan forms, race and ethnicity are asked as a matter of law pertaining to all federal housing—viz., to monitor discrimination in housing. Race and ethnicity data is not collected as part of the C&P claims filing process to insure that benefits are not contingent on race and ethnicity. Race and ethnicity data is also collected as part of survey research studies such as the National Survey of Veterans.

The Office of Policy has recently completed a review of VA's collection of this type data. Such data does exist in various data bases that would facilitate matching of records to provide a yearly report on the utilization of VA benefits by race and ethnic category. Our plan is to begin compilation of this report at the end of FY 2006.

**Department of Veterans Affairs
Assistant Secretary for Human Resources and Administration**

Question 1: When will the Community Prosperity Partnership (CPP) be used for outreach for all minority groups?

Response:

The CPP is a pilot project for the Hispanic communities in four pilot sites. The pilot seeks to establish a model framework to expand outreach efforts to Hispanic veterans during 2006. VA will assess the results of all CPP pilot sites and will share information on effective practices when it is available. Once CPP is proven effective, the CPP model will be implemented for all minority groups.

Appendix B: Washington DC Meeting Agenda

AGENDA

Advisory Committee on Minority Veterans
December 6 – 8, 2005
Crowne Plaza Hotel
1480 Crystal Drive
Arlington, Virginia

Tuesday, December 6, 2005

- 8:30 a.m. Dr. Jonathan Perlin, Under Secretary for Health
- 9:15 a.m. Committee Discussion
- 10:15 a.m. Break
- 10:30 a.m. Committee Discussion
- 12:00 p.m. Lunch
- 12:45 p.m. Committee reconvenes
- 1:00 p.m. Mr. Kevin Crowley, National Guard Bureau
- 1:30 p.m. Committee Discussion
- 2:00 p.m. Session Adjourns for the day

Wednesday, December 7, 2005

- 9:00 a.m. Honorable Gordon Mansfield, Deputy Secretary Veterans Affairs
- 10:00 a.m. Break
- 10:15 a.m. Dr. Barbara Fleming, VHA Office of Quality and Performance
- 10:45 a.m. Break
- 11:00 a.m. Ms. Geraldine Breakfield, Associate Deputy Undersecretary for Management, Veterans Benefits Administration
- 12:00 p.m. Lunch

- 12:45 p.m. Committee reconvenes
- 1:00 p.m. Mr. Richard Wannemacher, Deputy Undersecretary for Memorial Affairs
- 2:00 p.m. Mr. John Brown, Director, Seamless Transition Office
- 2:45 p.m. Break
- 3:00 p.m. Mr. Keith Pedigo, Home Loan Guaranty
- 3:30 p.m. Mr. Mike McLendon, Deputy Assistant Secretary for Policy
- 4:00 p.m. Mr. R.Allen Pittman, Assistant Secretary, Human Resources and Administration
- 5:00 p.m. Committee Discussions
- 6:00 p.m. Committee adjourns for the day

Thursday, December 8, 2005

- 9:00 a.m. Mr. Raymond Wilburn, Veterans Disability Benefits Commission
- 9:45 a.m. Break
- 10:00 a.m. Mr. Scott Denniston, Office of Small and Disadvantaged Business Utilization
- 11:00 a.m. Dr. Frances Murphy, DUSH for Health Policy Coordination
- 12:00 p.m. Committee open session officially adjourns

Appendix C: Los Angeles, CA Site Visit Agenda

**Public Agenda
Advisory Committee on Minority Veterans
3 – 6 April 2006
Los Angeles, CA**

Monday, 3 April (Greater Los Angeles Healthcare System)

- 8:00 a.m. GLAHS VAMC Executive Brief
- 10:00 a.m. Break
- 10:15 a.m. GLAHS VAMC Outreach Services Brief
- 11:45 a.m. Transport to New Directions Luncheon/Brief
- 12:00 p.m. Lunch
- 1:30 p.m. Mental Health Outpatient Treatment Center Brief/Tour
- 3:30 p.m. Committee adjourns for the day

Tuesday, 4 April (Greater Los Angeles)

- 8:30 a.m. Los Angeles VA Regional Office Brief
- 10:00 a.m. VARO Tour
- 11:00 a.m. VSO State Commander Discussion
- 12:30 p.m. Enroute LA Ambulatory Care
- 1:30 p.m. Los Angeles Ambulatory Care Executive Brief/Tour
- Ms. Jo Etta Brown-Higgins
 - Dr. Wolf
 - Vivian Hines – Homeless Women Veterans Coordinator
 - Angel Rosario – Social Work Service
 - Dr. Jenny – Filipino Community Liaison
- 4:00 p.m. Dinner/Admin Break

6:00 – 8:00 p.m. Town Hall Meeting

8:00 p.m. Committee adjourns for the day

Wednesday, 5 April (Greater Los Angeles)

10:00 a.m. Los Angeles Cemetery Brief/tour

- Video
- Mr. Livingston
- Ms. Brown
- Tour of Cemetery

12:00 p.m. Lunch Break

1:30 p.m. Dr. Nancy Harada – Health Disparities Brief

3:00 p.m. Committee Adjourns for the day

Thursday, 6 April (Long Beach)

10:00 a.m. VISN 22 Meeting

10:30 p.m. VA Long Beach HCS Executive Briefing

12:30 p.m. Lunch Break

2:30 p.m. Villages at Cabrillo tour/brief

4:30 p.m. Dinner

6:30 – 8:30 p.m. Town Hall Meeting

Advisory Committee Adjourns

Appendix D: Committee Biographies

2006 ACMV Member Biographical Sketches

Nelson N. Angapak, Sr.

Alaskan Native

Mr. Nelson Angapak is an Alaskan Native who served in the U. S. Army and was honorably discharged on 10 June 1971 as an Army Specialist Five. Mr. Angapak has more than 25 years of Alaska Native Land Claims Settlement Act (ANCSA) land and natural resources management experience. In his current role as Executive Vice President of the Alaska Federation of Natives (AFN), he lobbies Congress on ANCSA amendments, monitors land and natural resources legislation in Congress and state legislatures, coordinates AFN Land and Legislative Committees, and is in charge of AFN in absence of the President.

Mr. Angapak holds a Masters Degree in Urban Studies from Antioch College/West, 1976-1978 and a Bachelors Degree in Mathematics and History, Fort Lewis College, 1965-1970. He also holds a degree in Theology, Golden Gate Theological Seminary, 2002. He is fluent in Yupik, and has served on the Boards of the Calista Native Corporation, Alaska National Bank of the North, Tuntutuliak Land, Ltd, Linfield College, and First Native Baptist Church, Alaska Baptist Family Services. He has been an advocate for Alaska Native veterans' issues for over 30 years. Mr. Angapak currently resides in Anchorage, Alaska.

Samuel Calderon

Hispanic American

Sam Calderon is a retired Colonel from the United States Army Reserve. He began his military career in the Army in 1967, reaching the rank of Staff Sergeant. Appointed as a Warrant Officer in the U.S. Army Reserve in 1978 as a Supply Technician, he served with the Arizona National Guard until his commission as a First Lieutenant in 1982. Colonel Calderon held a variety of commands and staff assignments.

Colonel Calderon began his federal career in 1973 with the Bureau of Reclamation and a year later transferred to the U.S. Army where he served on a variety of assignments in Europe and the Pentagon. While in Europe, he managed the VII Corps annual budget of \$1.2 billion supporting 73,000 soldiers and 16,500 civilians. He was hand picked by the VII Corps Commander to manage a \$270 million budget supplemental for the deployment of U.S. forces from Germany to Southwest Asia to participate in Desert Storm. Upon completion of this assignment, Colonel Calderon moved to the Pentagon to oversee the 1993 Base Realignment and Closure recommendations for logistics, maintenance, and ammunition facilities for the Department of the Army. In January 2001 he was promoted to the Senior Executive Service as the Deputy Director for Budget in the Department of Commerce from which he has retired in July 2003. Colonel Calderon currently resides in Bucaramanga, Columbia.

John D. Jefferson

African American

Mr. Jefferson currently serves as the African-American Outreach Coordinator for the Farm Service Agency at USDA. His work experience includes serving in the Bush Administration at the Department of Education (2001-2002), as well as working for the American Legion's Washington, DC office as an Assistant Director and Lobbyist with the National Legislative Commission (1995-2001). Mr. Jefferson is a Vietnam Era Veteran who served in the U.S. Army (1970-72). He was stationed in Berlin; Germany from 1971-72, and currently resides in Silver Spring, Maryland.

Major General James H. Mukoyama, Jr., **

Japanese-American

Major General Mukoyama is retired from the Army Reserve after more than thirty years of dedicated service in both the active Army and Army Reserve. He culminated his career as the Deputy Commanding General of the U.S. Army Training and Doctrine Command at Fort Monroe, Virginia. During his five years on active duty, General Mukoyama served as a platoon leader in the Republic of Korea and as an infantry company commander in the 9th Division in Vietnam.

In September of 1970, General Mukoyama left active duty and joined the Army Reserve. General Mukoyama was the youngest general officer in the entire U.S. Army when he was promoted at age 42 to Brigadier General in 1987, and subsequently the youngest Major General when he received his second star three years later. In 1989, General Mukoyama became the first Asian American in the history of the United States to command an Army division. His 70th Training Division, located in Michigan and Indiana, was the first Army Reserve Training Division ever to be mobilized at Fort Benning, Georgia, when it was called upon to participate in Operation DESERT STORM in January 1991.

General Mukoyama is the executive vice president and chief operating officer of Regal Discount Securities in Chicago. He holds a B.A. in English from the University of Illinois and a M.A. in the Teaching of Social Studies from the University of Illinois. He is active in numerous veteran and community organizations. General Mukoyama lives in Glenview, Illinois.

Carson Ross *

African American

Mr. Ross is a U.S. Army Combat Infantry, Vietnam Veteran. He currently serves as Chairman of the Missouri Veterans Commission appointed by Governor Bob Holden in 2002 and re-appointed by Governor Matt Blunt in 2005. Mr. Ross served four terms on the Blue Springs City Council including Mayor Pro-Tem and completed seven terms in the Missouri House of Representatives in 2002. He was elected Republican Whip in the Missouri House of Representatives from 1991 to 1992. His numerous awards include the Department of Missouri Veterans of Foreign Wars of the United States Legislator of the Year Award (2000), the American Legion Legislator of the Year Award (2000), and the National Guard Association's Charles Dick Medal of Merit Award (1998.) He was elected vice-chairman of the Missouri Legislative Black Caucus in 1998. Mr. Ross is also President of Graves and Ross Investment Company doing business as Smoking Hill Bar-B-

Que and retired from Hallmark Cards with 39 years of service on June 30, 2005. Mr. Ross has experience in municipal, legislative, and community service, including being appointed to the Missouri Air Conservation Commission by Missouri Governor John Ashcroft in 1986. He earned his Bachelor of Science Degree in Business Administration from Rockhurst University, Kansas City, Missouri. Mr. Ross currently resides in Blue Springs, Missouri.

Major General Harvey D. Williams

African American

Major General Williams held several key staff positions during his career in the U.S. Army to include Deputy Inspector General; Chief of Staff Military District of Washington; Department of Defense Military Liaison to Arms Control Disarmament Agency, Washington DC; and Chief-Security Division, Assistant Chief of Staff for Intelligence, Department of the Army. Since his retirement from the military, MG Williams has held the position of Executive Vice President or Chief Operating Officer of four companies providing services to the Federal and Commercial Sectors. He has also been the President of a Non Profit Corporation that developed programs improving access to technology and career information for minority and disadvantaged communities. MG Williams resides in Germantown, Maryland.

Colonel Reginald Malebranche

Haitian American

Col. Malebranche held several major staff positions during his military career to include Inspector General, US Army Health Services Command; Commander, 5th Medical Battalion, 5th Infantry Division (Mech.); and Commander and Operations Officer, Silas B. Hays Army Hospital. Col. Malebranche has over thirty-five years of expertise in Policy, Planning and Program Management. He has extensive experience in leadership, business development, project/program management, resources management and organization design, in the private as well as the federal sectors. Col. Malebranche resides in Alexandria, Virginia.

Lawrence A. Bastian, Sr.

Crucian, US Virgin Islands

Mr. Bastian, a native Crucian, was born and raised in the town of Fredriksted, St. Croix, United States Virgin Islands. In 1958, he enlisted in the U.S. Army at Fort Dix, New Jersey and trained as an Air Defense Artillery Missile man. During his tour of duty in the service, he was stationed in Alaska, the Far East (Korea and Okinawa) and the Continental United States (Ft. Dix, New Jersey, Ft. Bliss, Texas, Ft. Stewart, Georgia) until his honorable discharge from the service in July 1974 with the rank of First Sergeant (E-8).

Upon his departure from active duty Mr. Bastian served his native St. Croix as an Administrative Officer in the Office of the Hospital Administrator at Charles Harwood Hospital, Department of Health, and later at the new St. Croix Hospital. In January of 1995, he was transferred to the Office of the Governor of the United States Virgin Islands and assigned as the director of the Office of Veterans Affairs. In this capacity he provided services to all the veterans of the Territory

and coordinated veterans programs with the National and Regional Veterans offices, Veterans Administration Medical Center, Veterans Center and community based outpatient clinics in Puerto Rico and the Virgin Islands. He was also responsible for coordination with the Office of the Secretary of Veterans Affairs in Washington, DC, and the National Association of Directors of Veterans affairs of which he was a member and served on committees as assigned.

Mr. Bastian is the District Commander of the American Legion District No. 10 of the Department of Puerto Rico and the U.S. Virgin Islands. He resides in Christiansted, St. Croix, U.S. Virgin Islands.

Vice Admiral Diego E. Hernández, USN (Retired)

Puerto Rican

VADM Hernández is a native of San Juan, Puerto Rico. He attended Illinois Institute of Technology with a Navy ROTC scholarship. Upon graduation he was commissioned an Ensign and underwent flight training. He was designated a Naval Aviator in August 1956.

VADM Hernández served at sea in a variety of assignments in carrier based fighter squadrons and flew two combat tours in Vietnam. He also served as Aide and Flag Lieutenant to Commander, Carrier Division 14. At sea, he was commander of a fighter squadron, a carrier air wing, and a fleet oiler. VADM Hernández commanded the aircraft carrier USS John F. Kennedy, a carrier group and was Commander, Third Fleet. His last assignment on active duty was as Deputy Commander in Chief U.S. Space Command, dual hatted as Vice Commander, North American Aerospace Defense Command.

VADM Hernández was presented a Lifetime Achievement Award by the National Puerto Rican Coalition in 1987 and was named the distinguished graduate of his class by Illinois Institute of Technology in 1988. Since leaving active duty VADM Hernández has been active as a management consultant to private and public companies, and serves on several boards. He resides in Miami, Florida.

Frank A. Cordero

American Indian, Squamish Nation

Mr. Cordero is a Vietnam Combat Veteran with over eight years of active duty in the United States Marine Corps and was honorably discharged with the rank of Sergeant (E5).

He has had a second career as a general and operations manager in the seafood industry and has participated on numerous boards. As a member of the Lummi Indian Business Council, he was the council's liaison to the Seattle Regional Office of Veterans Affairs. Other executive positions held by Mr. Cordero include: member of the Board of Directors, Whatcom County Chapter of the American Red Cross; Executive Vice President of the Northwest Indian Veterans Association; Co-chair of the Veterans Committee of the Affiliated Tribes of Northwest Indians; and Co-chair of the Joint American Indian Veterans Advisory Committee for the Seattle Veterans Affairs Medical Center.

Additionally, Mr. Cordero has been a member of the Local Selective Service Board since 1993. He sits on the steering committee for the Regional Minority Affairs Board of the Veterans Affairs Regional Office, Seattle. He is an advisor to the Washington State Governor's Veterans Advisory committee and is the current Chairman of the board for the Advocates for American Indian Veterans organization. In the Lummi tribal Court system, he sits as the Chairman of the Alternative Justice panel for first time juvenile offenders. Additionally, he is one of the founding fathers of and a current facilitator in the annual Camp Chaparral program which provides Department of Veterans Affairs Health care providers with intensive cultural and outreach education on American Indian Veterans. He has been a member of the American Legion for over 30 years and is the current Service Officer for Post #33. He is also a tribal veteran representative which focuses on serving American Indian veterans. Mr. Cordero resides in Bellingham, Washington.

Cathleen C. Wiblemo

Caucasian

Ms. Wiblemo has been with The American Legion National Headquarters since November 1999. She is currently the Deputy Director for Health Care. Prior to serving in her current position, she was the Assistant Director for Resource Development and before that she served as an Appeals Representative with the Special Claims Unit.

Ms. Wiblemo is a graduate of Black Hills State University in South Dakota, where she received her B.S. degree in History. She was the recipient of an ROTC scholarship and the George C. Marshall award. Upon graduation in December 1984, she was commissioned a 2nd Lieutenant in the United States Army. During her 10 years in the military she served in various positions both in country and overseas. In August 1999 she received her Masters of Health Administration from Chapman University. Ms. Wiblemo is a member of Post 18 in Mitchell, South Dakota. Originally from Mitchell, South Dakota, she currently resides in Annandale, Virginia.

Kerwin E. Miller

African American

Mr. Miller serves as the first Director of the new District of Columbia Office of Veterans Affairs, a position he has held since November 2001 when he was appointed by Mayor Anthony A. Williams. Mr. Miller was responsible for establishing the new office within the Executive Office of the Mayor. As the Director, he oversees the management and daily operation of the office which provides advocacy support and benefits assistance and information to veterans, their dependents, and their survivors concerning federal and District laws and regulations affecting veterans' benefits and claims.

Mr. Miller is a retired Commander in the U.S. Naval Reserve, who completed twenty-eight years of honorable active duty and reserve naval service. He earned a Bachelor's of Science Degree in Political Science from the U.S. Naval Academy in 1975. He graduated Cum Laude from the Howard University School of Law in Washington, D.C. and received a Juris Doctor Degree in 1985. He went on to earn a Masters of Law Degree from the George Washington University National Law Center in 1989.

Mr. Miller is a member of the Washington, D.C., New Jersey and Pennsylvania Bars and the Bar Association of the District of Columbia. He is also admitted to practice before the United States Court of Appeals for Veterans Claims.

Mr. Miller is a life member of the United States Naval Academy Alumni Association and a member of the Kappa Alpha Psi, International Family. He is an active member of the National Association of Black Veterans and the American Legion. Mr. Miller resides in Ward Five in northeast Washington, D.C.

Brigadier General Julia J. Cleckley, USA (Retired)

African American

BG (Ret) Cleckley served in numerous positions during her military career including Reserve Officer Training Corps (ROTC) Professor of Military Science at Hampton University, Hampton, VA and as the Army National Guard Advisor at Fort Eustis, VA. In 1987, she was assigned to the National Guard Bureau, Military Personnel Management Branch and went on to manage over 44,000 federally recognized officer promotions for the Army National Guard. She also served on the Department of the Army Staff at the Pentagon. BG (Ret) Cleckley served as the Special Assistant to the Director, Army National Guard from July 2002 thru September 2004. As Special Assistant for Human Resource Readiness, she assisted the Director with human resources programs and policies that affected over 350,000 Army National Guard citizen Soldiers.

BG (Ret) Cleckley is currently Director of Armed Forces Education with University Alliance. She resides in the Washington, D.C. area.

Lieutenant Colonel Joe C. Nuñez, USAF, (Ret)

Mexican American

Lt. Colonel (Ret) Nuñez is an Air Force veteran with 21 years of active duty service. His duty assignments included tours in Japan, Thailand and Puerto Rico. He was also assigned to the Office of the Secretary of the Air Force in the Pentagon where he performed the duties of Congressional Liaison Officer. Lt. Colonel (Ret) Nuñez's education credentials include a MAE degree from InterAmerican University of Puerto Rico and a B.A. from the University of Northern Colorado. He is also an honor graduate of the Japanese Language Institute, Yale University.

Lt. Colonel (Ret) Nuñez was appointed to his current position as Regional Director Region VIII, U.S. Department of Health and Humans Services on December 31, 2001. From January 1999 until December 2001 he served in the Colorado House of Representatives where he was the Vice Chairman of the Military and Veterans Affairs Committee. Additionally he served as member of the Appropriations, Education, and Transportation Committees. He resides in Littleton, Colorado with his family.

* Denotes Chairman

** Denotes Vice Chairman