REPORT OF THE ADVISORY COMMITTEE ON MINORITY VETERANS

Annual Report

July 1, 2007

ADVISORY COMMITTEE ON MINORITY VETERANS (ACMV)

ANNUAL REPORT

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EXECUTIVE SUMMARY

October 23-27, 2006

Anchorage, Alaska Site Visit

The Advisory Committee for Minority Veterans (ACMV) visited the Greater Anchorage, Alaska VA Health Care System, Anchorage VBA Regional Office, Anchorage National Cemetery Administration, Alaska Native Medical Center, and Coordinated Care Consortium/Joint Venture at Elmendorf Air Force Base during October 23-27, 2006. Alaska was selected because of its diverse minority veteran population, remote location, and the challenges veterans encounter when they attempt to secure benefits and services from the Department of Veterans Affairs. The Advisory Committee for Minority Veterans was interested in assessing the delivery of all VA services and benefits to a varied minority population with no specific concentration in and around large communication networks. The Alaska Native beneficiary population could be characterized as mostly rural and located in villages throughout the state.

Anchorage, Alaska's largest city and only official metropolitan area, has a population of about 260,300 or 42% of the total state population. The Fairbanks North Star Borough is the next most populous at 66,180. The third largest city in size is Juneau, with 30,711 residents. Juneau is the only state capital in the United States with no road access from other major metropolitan cities in Alaska and must be accessed by air or sea. The land mass of Alaska is vast and has a geographic peninsula with about 33,900 miles of shoreline; more than all of the contiguous states combined. Communities in Alaska are rarely accessible by road. There is one main highway in the state, running essentially from Homer on the Kenai Peninsula south of Anchorage through Anchorage, north to Fairbanks, and then east to Canada. Seventy-five percent (75%) of Alaska communities are not connected by road to a community with a hospital. This necessitates the development of creative and often expensive travel alternatives that greatly impact access and costs for health care as well as all other services.

Alaska's sheer size is incredible and unique. Alaska is a world apart from its "siblings" in the lower 48 states and their challenges/issues take on an entirely different perspective. What may appear to be a minor problem or issue in the lower 48 states is maximized in Alaska which becomes a major challenge.

The challenges for the VA in providing services to the veterans' population (11.48% or 72,000 of Alaska's population) are influenced, affected, and/or hampered by the uniqueness of several factors: demographics, geography, transportation, infrastructure, high cost of living, and the existence or non-existence of parallel healthcare systems in the state.

The unalterable realities of the large veteran and rural population, lack of surface transportation, high cost of air transportation, and travel time required to access central medical facilities define the unique challenges that must be overcome if a VA healthcare system is to provide services to veterans living in both rural and non-rural Alaska.

Because of these difficult challenges, a majority of the Alaska Native veterans utilize the services offered through the Alaska Native Medical Center and some Alaska Native veterans living in urban areas use the VA health care system. There are no statistics available locally to document the extent to which dual eligible recipients use one system preferentially over the other or access both. The unique difficulties identified above fall heavily on the non-Native Alaska veteran rural population since a well-developed health care system is in place to serve only the American Indian and Alaska Natives in Alaska.

Throughout the report, the Committee makes reference to VA as the entity for policy, management, and execution. Within that context, the Committee recognized that the Department has three major administrations: Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA).

Committee identified nine (9) recommendations:

1. VA establish the feasibility of implementing a cooperative agreement with the Alaska Native Tribal Health Consortium (ANTHC); Alaska Tribal Health System; Alaska Area Indian Health Service (IHS); Alaska Native Medical Center (ANMC); and Southcentral Foundation (SCF) to provide all services which fall within the purview of VHA. This would include the following actions:

    a. VA reimburse those entities, through ANTHC, for all services rendered to Alaska Native veterans enrolled with VHA.

    b. VA conduct a feasibility study to examine whether the ANTHC can provide same services that can be offered to the general veteran population (non Alaska Natives) which may be located in close proximity to rural areas and villages throughout the State of Alaska.

    c. VA develops, coordinates, and submits all legislative initiatives for enactment of cooperative agreements, and/or elimination/modifications of statutes, which might impede the establishment and/or consummation of those agreements.

    d. VA recognize the influence and importance of Alaska Native Elders and that VA coordinates with and secures the approval of these Elders before finalizing and implementing cooperative agreements.

2. Secretary and Deputy Secretary encourage VA leadership officials to utilize all available means (i.e. Internships, Mentoring Programs, Executive Career Field Training Programs, Leadership VA, SES Candidate Development Program) to promote the career development of VA employees. The ultimate goal will be to increase the number of VA minority group employees in leadership positions throughout the Department.

3. VA outreach programs are extended and/or modified to include all means and processes to advise minority veterans of their entitlements and the Office of National Outreach Program Coordination provides the Committee a report reflecting actions initiated to date.

4. VA ensures that translation services are available in VA facilities through either the services of employee translators or contract services. This will ensure “Patients’ Rights and Responsibilities” functions normally assigned to VHA are being addressed.

5. The current appointment processes and procedures contained in VHA Directive 2006-055, VHA Outpatient Scheduling Processes and Procedures, be adhered to by the Alaska VAMC and other VHA facilities to ensure that veterans are not penalized unfairly, and that veterans’ needs for health care services are fully met. This could be monitored during reviews under the current SOARS process.

6. VA, under the VA’s State Cemetery Grants Program, facilitate discussions with the government officials of the state of Alaska and Alaska Native tribal leaders to explore the possibility of establishing additional veterans’ cemeteries on either state or tribal lands.

7. Replicate the Joint Venture initiative VA has with the Elmendorf Air Force Base hospital in Fairbanks Alaska with the U. S. Army.

8. VA develops and implements a Tribal Veterans Representative (TVR) program in Alaska.

9. The Alaska VA Regional Office should partner with the Indian Health Services (IHS) to provide outreach to Alaska Natives.

April 16-19, 2007

Washington, DC Meeting

The Advisory Committee on Minority Veterans (ACMV) convened at the Department of Veterans Affairs (VA) Central Office in Washington DC for their administrative annual meeting on April 16 –19, 2007.

The Committee was indeed privileged to hear reports presented by Honorable R. James Nicholson, Secretary of the Department of Veterans Affairs, and other VA senior leadership personnel representing the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA). The Committee was particularly pleased with a most informative and insightful presentation from a panel of District of Columbia National Guard members of a Military Police Battalion who have recently returned from an Operation Iraqi Freedom Deployment. The presentation highlighted the unit's first-hand experiences and reaction to their tour of duty in Iraq and provided the Committee with honest and candid observations, which bolstered the Committee's pride in our military service members who have served, continue to serve, and sacrifice on behalf of our Global War on Terrorism.

The Committee was touched by a most spirited presentation given by an energetic African-American female Army soldier who had her leg amputated, as a result of an improvised explosive device, while serving in Iraq. She was undergoing rehabilitation medical treatment at the Walter Reed Army Medical Center. Joined by her mother, she described in detail her recovery challenges and successes while receiving what she considered excellent treatment at Walter Reed. Her responses to the questions greatly impressed the Committee who were all touched by her pride in her military service, her strong will and determination to recover from her medical condition, and to succeed in her pursuit of her life goals and objectives.

Committee identified four (4) recommendations:

1. VA expeditiously complies with the VA Acting General Counsel Opinion, Subject: WEBCIMS 372917-Collection of Veterans Ethnic and Racial Demographic Data, dated March 2, 2007.

2. Center for Minority Veterans (CMV) provides information on their budget, employee resources, and accomplishment of their performance measures to the Committee during the next Washington, DC meeting.

3. CMV consider the necessity for sponsoring a Minority Veterans National Conference or Summit to provide outreach and veterans' benefits and

assistance information to minority veteran conference attendees and address concerns and issues adversely affecting minority veterans.

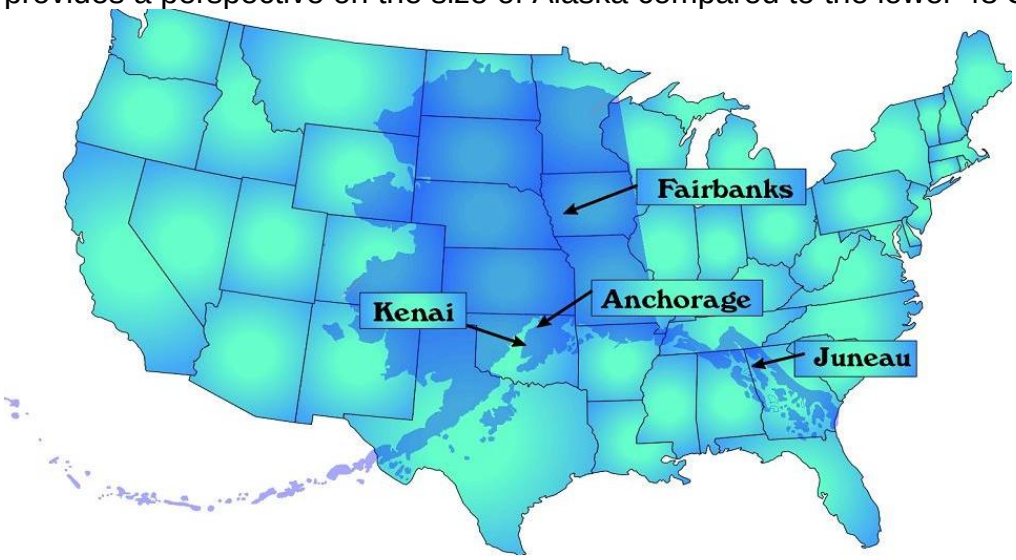
4. VA analyze its reported VA workforce minority employee statistics to ensure that they are consistent with the Office of Personnel Management (OPM) reporting of workforce minority employee statistics and ensure the accuracy and sustainability of conclusions concerning representation of VA minority workforce.

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 VA officials to ensure accurate and meaningful recommendations are set forth each year in the annual report to ensure better services for minority veterans.

From October 24 – 26, 2006 the Committee conducted a site visit to the Greater Anchorage, Alaska VA Health Care System, Anchorage VBA Regional Office, Anchorage National Cemetery Administration, Alaska Native Medical Center, and Coordinated Care Consortium/Joint Venture at Elmendorf Air Force Base. Since 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 affected all veterans.

The Committee's visit to the Greater Anchorage, Alaska VA Health Care System left an indelible mark on the members because of the sheer size of the state of Alaska and the major issues on accessibility faced by all veterans. The uniqueness of the state suggests that innovative management processes and partnerships would be the main stay to support the veteran population in Alaska. Understanding the problems and issues faced by VA in supporting the beneficiary population requires an extensive look at Alaska. The following map provides a perspective on the size of Alaska compared to the lower 48 States.



Alaska is the largest state in the union, with 586,412 square miles of territory. It is more than 2 ½ times the size of Texas; the next largest state. Overlaid on a map of the lower 48 contiguous states, Alaska stretches from the Atlantic to the Pacific and from Mexico to Canada. Its north-south dimension is 1,420 miles and east-west is 2,400 miles. Alaska is the 49th state joining the United States in 1959. Its population totaled 626,932 in the 2000 Census.

Anchorage, the largest city and only official metropolitan area, has a population of about 260,300, or 42% of the total.

The Fairbanks North Star Borough is the next most populous at 66,180. The third largest city in size is Juneau, with 30,711 residents. Juneau is the only state capital in the United States with no road access and must be accessed by air or sea.

The land mass of Alaska is vast and is a geographic peninsula with about 33,900 miles of shoreline; more than all of the contiguous states combined. Communities in Alaska are rarely accessible by road. There are three main highways in the state running essentially from Homer on the Kenai Peninsula south of Anchorage through Anchorage, north to Fairbanks, and then east to Canada. The highway north from Palmer is less traveled and less maintained.

There are vast areas of the state with no road connections at all. Seventy-five percent (75%) of Alaska's communities are not connected to a community with a hospital with roads. This necessitates the development of creative and often expensive travel alternatives that greatly impact access and costs for health care, as well as, all other services.

Alaska's sheer size is incredible and unique. Alaska is a world apart from its "siblings" in the Continental United States (CONUS), and its challenges/issues take on an entirely different perspective. What may appear to be a minor problem or issue in the CONUS or in the lower 48 states is maximized in Alaska and becomes a major problem.

Challenge:

The challenge for the VA in providing services to the veterans' population in Alaska is influenced by uniqueness of several factors in the state: demographics, geography, transportation, infrastructure, high cost of living, and the non-existence of parallel health care systems in remote areas of the state.

Eleven and a half percent (11.48% or 72,000) of Alaska's population are veterans. Of those veterans, twelve percent (12%) come from the Second World War (WW II) and the Korean Conflict. The greatest numbers of veterans (63%) emanate from the Vietnam Conflict (38%) and Desert Shield/Desert Storm (25%). These percentages will change substantially over the next two years given that so many soldiers from Alaska have recently deployed to Iraq and Afghanistan.

It is estimated that 80% of the veteran population resides within the greater Anchorage and Fairbanks areas; the only portions of Alaska interconnected by roads. The rest of the veteran population is spread out throughout the rural areas of Alaska and are not reachable except by aircraft or

by boats. Approximately half of the populations residing in the rural areas are Alaska Natives.

The 52,000 veterans residing in the urban areas connected by road are served by medical facilities at Anchorage, Kenai, and Fairbanks. The rest of the veteran population must fly to the Anchorage or Fairbanks area for the availability of any medical service within the VA system. There are some Alaska Native clinical facilities in the rural areas that are more readily accessible than VA facilities to the 8% of veterans who are Alaska Natives.

There is no Level I Trauma Center in the entire state and the only Level II Trauma Center was recently certified at the VA Medical Center in Anchorage. Many specialty services must be accessed in the lower 48 states. Patients requiring those specialty services must be transported to the lower 48 states. Even if there were a reasonable number of health care providers located in one community, in a borough or census area, residents of other communities within that area would have to travel hundreds of miles to reach the providers via air or water.

Health Professional shortage in Alaska:

Most of Alaska is designated with some form of Health Professional Shortage Areas (HPSA) status. Statewide, 370,088 or approximately 59% of the state's residents are classified as underserved**.** This percentage may be understated because 23 of 27 Boroughs/Census Areas are either:

Whole or part Medically Underserved Area/Population (MUA/P) or
Governor-designated Medically Underserved Population (MUP)

Alaska's Physicians:

Forty-Nine (49%) of all physicians in Alaska are primary care physicians (2002 data.) Compare that with the U.S. average which is twenty-eight percent (28 %.)

Alaska is forty-eighth in "doctors to residents" ratio. Sixty-five percent (65%) of the physicians are located in Anchorage.

There are shortages in many of or even in all specialties.

Twenty-five percent (25%) Alaskans or forty-six percent (46%) of Alaska Natives live in communities of less than 1000 people.

Approximately 579 Community Health Aides, servicing some 200 villages, provide nearly ½ million encounters each year.

Air Transportation:

The cost of air transportation from outlying villages to existing VA medical facilities in Fairbanks or Anchorage averages $900.00 round trip for the most part. In effect, access to the centralized health services is severely limited and unavailable; particularly when the low levels of income of the rural residents is taken into account. Although the VA reimburses the cost of transportation and lodging for eligible veterans who must travel to access medical services, there are eligibility criteria for veterans – 30 to 50% service-connected and a maximum income of $9,400.00 for non-service connected.

The unalterable realities of the large veteran and rural population is the lack of surface transportation, the high cost of air transportation, and the time required to travel to access the central medical facilities define the unique challenges that must be overcome if a VA healthcare system is to provide services to veterans living in both rural and non-rural Alaska.

The high cost of living in Alaska coupled with high unemployment rates in the outlying villages create conditions of subsistence living for many of the Alaska Native veterans in these areas. Their need to take advantage of the fishing season in the spring time and the hunting season in the fall constrains their availability to fly into the urban areas for consultations and treatment. For the same reason, the provision of traveling medical services to the villages is somewhat impractical because the veterans are not available.

Because of these difficulties, a majority of the Alaska Native veterans utilizes the services of the Alaska Native healthcare system although some Alaska Natives use the VA healthcare system in the urban areas. There are no statistics available locally to document the extent to which dual eligible recipients use one system preferentially over the other or access both.

The unique difficulties identified above fall heavily on the non-Native Alaska veteran rural population because the well-developed Alaska Native healthcare system currently in place can only be utilized by American Indian and Alaska Natives.

PART I. OBSERVATIONS & DISCUSSIONS

Tuesday, October 24, 2006

Greater Anchorage VA Health Care System (GAVAHCS)

The Director, Alaska VA Health Care System, Anchorage, Alaska, presented a very comprehensive brief on Alaska, the VA healthcare system, the challenges faced by all – beneficiaries and providers – in its ability to identify benefits to receive and provide care to all beneficiaries.

Current Staffing is approximately 410 employees. The focus is on hiring Alaska Natives. The Committee noted that there were very few Alaska Natives, Asians or Pacific Islanders on the staff. The following chart illustrates the diversity and Alaskan workforce.

The following illustrates the Diversity and Employment Demographics-Employees Focus Demographics of Alaska VHA Workforce (Does not reflect senior staff demographics):

The Alaska VHA has 410 FTEE of which 30% are minorities.

- African American/Black	16.5%	(RCLF 7.13%)
- American Indian/Alaska Native	4.87%	(RCLF 8.97%)
- Asian American/Pacific Islander	4.39%	(RCLF 3.68%)
- Hispanic	2.68%	(RCLF 3.91%)
- White	71.4%	(RCLF 75.1%)
- Women	55.41%	(RCLF 63.2%)
- Reportable Disabilities	16.77%	
- Targeted Disabilities	2.36%	
Veterans	42.7%	
- Men	73.8%	
- Women	26.1%	

*Relevant Civilian Labor Force (RCLF) 2000 – Alaska VA %'s a/o September 2006

Issues impacting on access and delivery of care to eligible veterans:

1. Travel distances in Alaska impact accessibility and often requires one or more modes of transportation:

   a. Travel by air, which is very costly.
   b. Travel by car is limited; there are only three major road networks.
   c. Travel by boat limits access to VA facilities.

d. Travel by dog sled limits access to the same facilities.

Access to care is further complicated by the facts that most Alaska Veterans must travel to Anchorage for specialty care. The VA initially paid travel benefits, which were curtailed, and reinstated on October 1, 2006.

2. Recruitment/employment of health care personnel.

The VA continues to be burdened by its limited capabilities to attract, recruit, and retain health care personnel. There are no medical schools within the local areas of Anchorage and Fairbanks. There is one nursing school. The Greater Anchorage VA Health Care System was allocated $3 Million to recruit more personnel but VA fell short of its goal because of the cost of living and the climate in Alaska.

3. In evaluating health resources for the system in Alaska, one needs to consider the following:

a. Veteran population is the highest per capita of any state in the nation. Approximately 11.48% of the population is veterans.

b. Female veterans have grown to about 7%.

c. The majority of the veterans are concentrated around Anchorage. Kenai is 160 miles from Anchorage with Fairbanks being 350 miles. The Committee noted that when employees traveled to the lower 48 states for vacation, they stayed a minimum of two weeks before returning home to Alaska. These lengthy stays creates staffing shortages for VA.

d. The veteran population is younger.

e. Alaska has the fastest growing population over 65.

f. The 52,000 veterans residing in the urban areas connected by road, are served by medical facilities in Anchorage, Kenai, and Fairbanks. The rest of the veteran population must fly to the Anchorage or Fairbanks area for the availability of any medical services within the VA system. There are some American Native clinical facilities in the rural areas that are more readily accessible than VA facilities to the 8% of veterans who are Alaska Natives.

g. There is no Level I Trauma Center in the entire state and the only Level II Trauma Center was recently certified at the VA Medical Center in Anchorage. Many specialty services must be accessed in the lower 48 states. Patients requiring specialty services must be

transported to the lower 48 states. It is worthy to note that 23 of the 27 boroughs and census areas have been identified/designated Medically Underserved Area/Population (MUA/P) or governor-designated Medically Underserved Population (MUP). Statewide, there is a total underserved population of 370,088. Even if there were a reasonable number of health care providers located in a community, in a borough or census area, residents of other communities within that area would have to travel hundreds of miles to reach the providers via air or water.

h. Specialty care is limited within the Greater Anchorage VA Health Care System. This requires flying Veterans to Seattle (1,500 miles away) or to other states having the appropriate specialties, for definitive care. The cost for air transportation (approximately 900 trips a year), lodging, etc. is borne by the VA. Veterans located in and around the Juneau area utilize the VA Health Care System in Seattle, Washington, because of its close proximity to the Capital of Alaska.

i. The Medicare rate in Alaska is much higher, at least 30%, than in the lower 48 states. Local physicians within the Anchorage area, have in the past, refused to care for Medicare patients/veterans within the community. This situation continues to exist despite the fact that the Greater Anchorage VA Health Care System had been given the authority to establish a "special medical care plus rate."

j. The Greater Anchorage VA Health Care System offers limited Mental Health services at Fairbanks and Anchorage. VA HCS also uses state and local facilities to assist/augment/supplement in the delivery of mental health services.

4. The Committee noted, with particular interest and attention, some of the steps which have been implemented in Alaska to improve the health care system. The Committee takes this opportunity to highlight and comment, as required, on those steps:

a. Reimbursement of care:

(1) The Greater Anchorage VA Health Care System developed a market based rate to keep pace with Medicare and to reimburse providers for their services.

(2) VA staff holds monthly vendor meetings with physicians and other providers to insure that payments are made on time. The Committee noted that there were insufficient specialty physicians in the community. The impact on VA can be quite

expensive since most patients must travel to the lower 48 states for specialty care. Furthermore, it appeared that care under the TRICARE system was limited because there was no excess capacity within the community. The Greater Anchorage VA Health Care System was in the process of getting the same TRICARE rate applied to Alaska.

b. The Greater Anchorage VA Health Care System, in coordination with the VISN, is currently assessing its long term care needs.

c. Joint Venture Elmendorf AFB:

(1) This initiative with Elmendorf Air Force Base should be replicated in Fairbanks with the U.S. Army Medical facility. Concurrently, VA should endeavor to forge similar processes with Department of Defense (DOD). The Committee recognizes that VA and the U.S. Air Force have joint ventures in other states and those relationships are working extremely well and have been a model of cooperation and resource sharing, as envisioned by the Congress in 1982. Although the issue of interfacing both VA and DOD medical records continues to be predominant, it did not seem to negatively impact on the cooperation between and utilization of personnel assigned to the two different departments; VA and DOD. The Committee recognizes that there was no integration on medical records. In fact two automated systems were set up; one for the Air Force active duty personnel and one for veterans. That issue was addressed by the Assistant Secretary of Defense Health Affairs. The cooperation and coordination between Air Force and VA personnel were noteworthy.

(2) The number of VA personnel at the military facility was close to 70 FTE and VA expected that number to grow significantly. The benefits of the relationship could be found in the area of orthopedics, where orthopedic surgeries could be performed at the Elmendorf medical facility, rather than traveling to Seattle, Washington for the same procedures.

(3) Lastly, there were plans for a new facility at Elmendorf Air Force Base dedicated specifically for use by the Greater Anchorage VA Health Care System. The new VA health care facility will be built on Air Force property and both buildings, Elmendorf AFB and VA will be linked at the new site.

(4) The relationship with Elmendorf had other significant benefits for veterans. For example, prescriptions were provided under

TRICARE at no cost to the VA beneficiary. There was no co-payment.

d. Partnerships:

(1) The Committee noted with great enthusiasm that partnering with other health care agencies appeared to be a great system to maximize health care delivery to the beneficiary population in Alaska. The Committee also noted, in particular, the levels of partnership with other agencies, such as, the Alaska Federal Health Care Partnership (AFHCP).

(2) The AFHCP's operations extended to all major communities, within the state of Alaska, with a beneficiary population of about 283,000.

(3) The Committee also noted the interaction and interdependency between the VA and the Indian Health Service (IHS). In fact, several initiatives have been consummated to bring necessary services to beneficiaries. The following VA/IHS Initiatives at the executive level bears to be highlighted:

(a) MOU has been signed with VISN 20, Portland area IHS Office, and Alaska Area Indian Health Service (IHS).

(b) Alaska Federal Health Care Partnership.

(c) Tested connectivity with Manilaq Association for screening for veterans industrial/Homeless Veterans Services.

(d) VA facility Alaska Native Outreach Committee consisting of VHA, VBA, and Vet Center.

Veterans Benefits Administration

The Director, Anchorage/Ft. Harrison/Salt Lake City Regional Office, briefed the Committee on the Veterans Benefits Administration, their challenges, and efforts to maximize beneficiaries' access. The state of Alaska does not follow the traditional county alignment that is prevalent in the lower 48 states. Alaska follows an organization akin to a business. Alaska is divided into corporations or regions that impacts on effective program coordination and management. The management of VBA has evolved significantly over the past three years. A 2003 survey, commissioned by the Under Secretary for Benefits showed several VBA agencies and 9 VAMROC's managed by VHA managers.

1. Outlined some issues which impact on the successes of VBA's efforts. For example:

   a. VSO's haven't established strong service officers in the field to outreach to veterans regarding their benefits.

   b. Partnership opportunities lack initiatives to partner with the Native or minority organizations.

   c. The following initiative, develop and Implement a Tribal Veterans Representative (TVR) Program in Alaska for 2007, is both an issue and a future activity. It falls under the former because ANMC's representatives have declined to participate in the TVR training program.

   d. Increase utilization of the internet. Rural areas in Alaska "lack" internet connectivity. Further, the internet can be a great asset in recruiting personnel. Yet, it does require communication with Veterans' groups, in particular those representing Alaska Natives regarding job announcements. Experience has shown that the starting salary is significantly lower than what is offered by Tribal organizations. There is a need to insure that VR&E coordinator's initiative include all ethnic groups and Vocational Rehabilitation Counselors ensure that veterans enrolled within the program are fully aware of vacancies within the VA.

2. There is a need to develop and implement the Tribal Veterans Representative (TVR) Program in Alaska for 2007.

Fort Richardson National Cemetery

The Director, Fort Richardson National Cemetery discussed their budget of $750,000.00 for Fiscal Year 2006. Staffing included the Director and two other employees. During a four year hiatus, 1998-2003, there was a thirty percent (30%) increase in burials at the National Cemetery. The Director attributed that increase to the cost of private burials within the State of Alaska.

1. Burials at the National Cemetery do present some challenges. The Cemetery is located on the Army Installation – Fort Richardson. For security reasons, the Military Police must be given twenty-four (24) hours notice of a burial to grant access to all participants, at the main gate of the Installation. All participants, except for Retired and Active Military personnel, are "confined" to the burial ground during and after the ceremony, and must vacate the premises. The Fort Richardson complex has approximately 200 burials per year; whereas Sitka, which consists of 6 acres, has a caseload of 35 burials per year.

2. There seems to be inconsistencies in Military Honors within each of the services; Army, Navy (including the Marines), and the Air Force. Every branch of service (DOD) is not consistent and uniform in their support of military honors.

Telehealth System

The Care Coordination Home Telehealth (CCHT) Program Manager informed the Committee that the system was implemented on October 31, 2005 and received its first enrollees on January 31, 2006. Currently, 66 veterans are enrolled in the system but there are no Alaska Natives enrolled.

$38 million dollars have been allocated for telehealth, whose capability consists only of 55 lines. Data is translated from LAN line; cellular communication is much too expensive to use. A live demonstration did show the utility of the system but it also showed its liabilities in terms of cost, staffing, and limitations.

VA Domiciliary

The Chief, Homeless Veterans Service, briefed the Committee on the Homeless Program. The Committee visited the domiciliary residential facilities which were being renovated. The Committee met with some of the residents, who recounted their personal stories, and explained how the program has benefited them in their quest for rehabilitation. All were very complimentary of the staff and of the program.

Elmendorf Air Force Base

Commander of the Medical Treatment Facility, Elmendorf AFB provided the Committee with an overview of the State of Alaska. As noted in previous presentations, the state is “extremely rural” and must adjust to severe weather conditions. Elmendorf Air Force Base is the states largest Air Force installation.

1. Elmendorf Medical Treatment Facility and VHA:

The facility and VHA operates on a joint venture modality. The treatment facility was dedicated and opened in May 1999 and occupies 433,922 square feet. Of the total cost of $191,000,000.00, VA contributed $11,000,000.00. The facility consists of 110 fully staffed beds. The staffing between the two agencies, Air Force and VHA, is fully integrated in the management and operation processes.

2. VA Clinic under the CARES program:

A new VA clinic was approved for construction on the grounds of the installation just outside the Muldoon Gate of Elmendorf Air Force Base with the Department of the Air Force granting land use permit for the construction of the clinic. Construction of the clinic is projected for completion in FY 2009 with additional space totaling 180,243 gross square footage (GSF) versus the current Air Force clinic space of 112,000 GSF.

3. Identified two major priorities:

a. Timely access to quality healthcare for active duty, guard, reserve, families, retirees, and deserving patriots.

b. Expansion of collaboration with the Alaska VA and Alaska Federal Health Care Partners (AFHCP) which includes: DOD, US Coast Guard, Alaska VA Healthcare System & Regional Office, Alaska Indian Health Service, Alaska Native Tribal Health Consortium, and Alaska Native Medical Center.

4. Following the Commander's presentation, the Committee toured the Elmendorf DOD/VA Joint Venture facility. VHA staff was fully integrated with the Air staff at all agreed upon levels. In other areas, VHA staff was charged with full management and operation of clinic and/or service. Yet, despite what appeared to be an excellent model for joint venture, the Committee noted the operation and management of two separate records systems. In clinics, there were two automated systems; one for active duty military and the other for Veterans. (Note: The subject of medical records integration between DOD and VA has been and is the subject of congressional initiatives. The Assistant Secretary of Defense, Health Affairs indicated that full integration may not be possible until the years 2010 to 2012.)

PART II. OBSERVATIONS & DISCUSSIONS

Wednesday, October 25, 2006

Undoubtedly, today was the most productive day. Productive from the standpoint that the Committee was able to assess the delivery of care to Native Alaskans and was able to extract a promise that could open care to non-Alaska Native veterans located in the outer regions of the state.

The day began with the Native Tribal Leadership panel that included the CEO, Alaska Tribal Health System and the Alaska Native Tribal Health Consortium (ANTHC); Director, Alaska Area Indian Health Service (IHS); Active CEO, Alaska Native Medical Center (ANMC); and the Southcentral Foundation (SCF).

Alaska Native Tribal Health Consortium (ANTHC)

The CEO provided an overview of ANTHC which includes the Alaska Tribal Health System. ANTHC was established in late 1997. Their charter is to manage all statewide IHS programs, including the Alaska Area Native Health Service, Indian Health Service, and the Alaska Native Medical Center. ANTHC is based in Anchorage and is the largest tribal self-governance entity in the U.S. with over 1700 employees.

The Alaska Tribal Health System consists of 12 “unaffiliated” tribes, which manage and provide their own community-based health programs and 14 regional health organizations which are non-profit. Their charter is authorized and governed by tribal government resolutions under boards of directors composed of Alaska Natives.

1. Alaska Tribal Health System Levels of Care:

    a. Village-based services: 550 Community Health Aide/Practitioners working in 180 village clinics.

    b. Sub-regional services (some regions): Mid-level practitioners serving several villages.

    c. Regional services: Referral hospital or physician health center.

    d. Statewide services: Alaska Native Medical Center.

    e. Contract Health Services: For private sector referrals.

Alaska Tribal Health System operates in concert with Native Health

Corporations under contract with IHS. Their referral pattern blankets the entire state of Alaska. Despite their successes and abilities to deliver care to a dispersed population, ANTHC faces many challenges:

2. Health System Challenges:

    a. Congressional support to maintain and augment core health services funding.

    b. Replacement of aging/inadequate hospitals and health centers (i.e. Barrow and Nome).

    c. Maintaining operating efficiencies in a decentralized health system.

    d. Supply and retention of health professionals.

Alaska Native Tribal Health Consortium (ANTHC) must endeavor to meet all challenges in delivering care to its dispersed beneficiary population.

3. IHS does not cover all Native health care; funding levels restrict certain services:

    a. Adult dental care.

    b. Skilled nursing care.

    c. Rehabilitation and substance abuse treatment.

    d. High-cost complex medical treatment.

    e. High costs of medical technology and pharmaceuticals.

4. To meet those challenges, ANTHC:

    a. Requires congressional support to maintain and augment core health services funding.

    b. Must plan for replacement of aging/inadequate hospitals and health Centers (i.e. Barrow and Nome).

    c. Must be innovative in maintaining operating efficiencies in a decentralized health system.

    d. Must find means to minimize the supply and retention of health professionals.

e. Must contend with high population growth in the Native community (3.8% a year).

f. Must assess the impacts of regulation and compliance.

g. Must endeavor to stay at the forefront of information/technology requirements.

h. Must find means to deal with substantially higher costs of providing services in isolated rural communities.

ANTHC developed several initiatives to maximize its services to Alaska Natives and to be a major force in the delivery of care. Their focus on the use of technology, among others, is designed to ensure access to the remotest areas of the state.

5. Major Alaska Native Health Program Initiatives:

a. Development of elderly health services and more long-term care alternatives.

b. Domestic violence and child abuse prevention.

c. Medical evacuation system improvements.

d. Enhancement of Alaska Native health research.

e. Sustained telehealth network/electronic health record deployment.

f. Developing Alaska Native health care administrators and clinical providers.

g. Replacement and renovation of village primary care facilities, health centers, and two hospitals.

h. Optimizing third party reimbursements.

i. Partnering with other health systems and institutions (i.e. Denali Commission, University, HHS, State, foundations, private sector).

The ACMV noted the similarities between ANTHC and VA in the challenges faced by each entity and the initiatives which each organization would resort and implement; to provide the best and most effective care to their constituents. The Committee recognized the limitations that each agency faces or may face as it embarks on developing solutions for maximum coverage and entitlements. Yet, the Committee supports the desirability of partnering with

ANTHC; including IHS and other Native consortium to provide and extend coverage to all veterans throughout the state of Alaska. The Committee was of the opinion that all avenues and impediments, including legislative, should be explored and changed as necessary to maximize delivery of care and entitlements to all veterans in Alaska.

Alaska Area Native Health Service and Indian Health Service (AANHS-IHS)

Director, Indian Health Service, addressed related activities pertaining to the IHS in Alaska, their enactment and legislative historical perspective. Their mission and goal is to raise the physical, mental, social, and traditional health of American Indians and Alaska Natives to the highest level. Their beginning found themselves in the Snyder Act, Indian Health Care Improvement Act, Treaties and Case Laws (note: Tribes are considered "Domestic Sovereign Nations), and Indian Self Determination & Education Assistance Act (Government to Government Relationship with 231 federally recognized tribes). Their mission is to make Tribal Self-Determination work for all.

Tribal Self-Determination: The Experience

- Tribes and Tribal organizations have assumed Programs, Functions, Services, and Activities (PFSA's) since mid-1970s.
- Authority to Reprogram and Redesign.
- Conducts their own health needs assessments.
- Tribes have broadened the scope and depth of service offerings beyond which a federal agency can provide.

IHS concentrates on functions that cannot be performed by tribes. IHS manages the 6 regional hospitals located in the communities of Barrow, Bethel, Dillingham, Kotzebue, Nome, and Sitka**;** the 28 tribal health centers and other health facilities. Additionally, IHS oversees and manages 40 contractual arrangements and agreements to provide health service to approximately 125,000 Native Alaskans. IHS complexity is striking when one considers their profile, sphere of operations, and all the activities they interact with and supervises.

Alaska Area Profile

- Area Office IHS is located in Anchorage with a staff of 37 (22 are federal residual and the remaining are transitional federal, buy-back, IAA, or PSC positions).
- Alaska Native Tribal Health Consortium (tribally managed by all tribes in Alaska) is responsible for statewide services and ANMC; in conjunction with Southcentral Foundation, the local Anchor tribal healthcare organization for purposes of P.L. 930-638.

- Other federal agencies, such as the Arctic Investigations Laboratory of the Centers for Disease Control (CDC) and the Alaska Federal Health Care Partnership (AFHCP) members, work closely with IHS and tribes to improve the health status of Alaska Natives.
- Alaska Area IHS works with 40 different contractual arrangements with tribal organizations to provide comprehensive health services to 125,000 Alaska Natives.
- There are 18 Title I contracts, 26 grants, and one Title V compact with 22 funding agreements.
- Alaska tribes administer 99% of IHS funds earmarked for Alaska.
- There are 6 regional hospitals located in communities of Barrow, Bethel, Dillingham, Kotzebue, Nome and Sitka.
- 28 tribal health centers/other health facilities.
- 176 community health aide clinics throughout the State.
- The Alaska Native Medical Center (ANMC) in Anchorage serves as the Area's referral center and gatekeeper for specialty care.

ANMC's referral pattern is astonishing. They provide coverage for the entire state. Their superimposition on the Continental United States (CONUS) is really designed to give the reader a perspective on the system, its reach, pattern, and the distances it must negotiate.

Alaska Native Medical Center

The ANMC is the third part of the triad of the Alaska Tribal Health System and Alaska Native Tribal Health Consortium. The Interim Hospital Administrator presented a comprehensive and informative briefing on the Medical Center. ANMC is owned and operated by the people it serves. The Alaska Natives, Alaska Native Tribal Health Consortium, and Southcentral Foundation have joined efforts to provide excellent quality care and customer service. They work together to achieve wellness by providing the highest quality health services for all Alaska Natives.

Southcentral Foundation (SCF)

The Vice President, Primary Care, Southcentral Foundation, gave a comprehensive presentation on SCF's 22 year history on staffing (approximately 1,300), mission, functions, ownership, management of 20 privately owned medical primary care systems, and clientele. SCF provides services to a clientele of 45,000 Alaska Natives to include 10,000 in over 50 remote villages.

SCF's experience, philosophy and tenets were striking. They find roots with the Elders, their experiences, and their wisdom. Their system is based on Native values:

1. SCF Experience:

a. Complex systems theory; provide us ways to describe our experience.
b. Native values and principles driven.

c. The wisdom of elders and Native ways of knowing.

d. Customer Control; service industry model.

e. Asset based thinking.

2. The SCF Story at ANMC:

a. Complete system redesign on Native values.

b. Decrease in emergency room and urgent care over 40%.

c. Decrease specialty care by about 50%.

d. Decrease in primary care visits by 20%.

e. Decrease in admissions and days by 20%.

f. Improved health outcomes; patient and staff satisfaction indicators.

The Vice President provided the ACMV with a concept; on the surface might appear to be totally new but historically may have been the modality in other parts of the Continent. This was a very refreshing concept which tended to put less credence on the technological world and much more on the family and cultural environment.

3. Real Issues:

a. Understanding power and control – where decisions are REALLY made – in the home, work, and community.

b. Understand all we can really hope for is to influence behavior.

c. Done by walking alongside in trusting relationship – no barriers, teaching, coaching, encouraging.

4. The Ladder of Patient Activation:

a. Self Efficacy
- Level of Patient Needs – I need to care for myself. Please walk with me.
- Health System Responses – Foster a continuous relationship that

promotes partnering and independence.

b. Behavior
- Level of Patient Needs – I need to change my behavior. Please partner with me/us to change.
- Health System Responses – Be a coach, advisor, partner.

c. Knowledge
- Level of Patient Needs – I need education. Please help me/us (family) understand.
- Health System Responses – Instruct patients.

d. Defect
- Level of Patient Needs – I need repair. Please fix me.
- Health System Responses – Provide a mechanical fix.

In response to a question posed by the Committee regarding the impact of PTSD on Alaska Natives, the Vice President responded that Alaska Natives needed more emotional and traditional counseling, full utilization and integration of the tribal doctor in the treatment process and more importantly, a "family warrior wellness healing approach to depression and violence." He suggested that grant money be allocated to non-VA programs in Alaska for mental health programs. Reimbursement of cost for care provided Alaska Native Veterans was severely lacking and difficult to obtain.

Alaska Federal Health Care Access Network (AFHCAN)

The Director, Alaska Federal Health Care Access Network (AFHCAN) concluded the session with a comprehensive presentation on the Network; access to care and impediments, and the benefits, limitations, and future of telemedicine (tribal telemedicine). Our Committee found AFHCAN has the same technology issues as VA.

Anchorage Vet Center

The Team Leader**,** Anchorage Vet Center, escorted the Committee on a tour of the facility during which he gave a briefing on the staffing (a multidisciplinary team consisting of a team leader, office manager, and three counselors) and on the history of the Center.

The American Indian Readjustment Counselor discussed his functions, responsibilities, and achievements, which include:

1. Conducting aggressive outreach to veterans and their families at remote villages throughout Alaska by traveling along with the National Guard during military exercises.

2. In 2004, he established a Veterans Traditional Talking Circle for all veterans. Attendance has been strong and the program has been quite successful.

The Committee examined the Vet Center's mission, area of responsibility and chain of command. In their mission statement, the Vet Center indicated that "Our Vet Center mission works hard at providing a continuum of quality care that adds value." Their outreach program is targeted to a specific area of the state only. It is an extremely large area and requires travel by all modes of transportation. As noted earlier in this report, travel in Alaska can be quite challenging and costly.

The Committee was concerned about other veterans who are not located in the targeted outreach area. These veterans located in other rural areas (i.e. villages, etc.) have the same entitlements to benefits, services, and care as all others in close proximity to Anchorage. The need and requirement to advise all veterans of their entitlements cannot be ignored or forgotten because of distances or inability to access. Alaska needs a concerted and innovative effort to ensure that all veterans are provided the same level of services that each and all veterans deserve.

The Vet Centers may have done a masterful job at advising and helping veterans but entrusting individuals with no training or license to practice, with providing services that require training and licensing, may bring different results to the organization than the expected or anticipated needs.

Veteran Service Organization (VSO)

The Committee met with a panel of VSO's in Alaska. The panel included**:** Alaska State Veterans Coordinator; State Commander, Veterans of Foreign Wars; Senior Vice Commander, Veterans of Foreign Wars; Department Service Officer; American Legion; State Commander, Military Order of the Purple Heart; Department Service Officer, Disabled American Vets; Commander, AMVETS Department of Alaska; and Service Officer, VFW.

After a brief introduction, each panel member gave his perspective on health care delivery in Alaska for the minority population (i.e. Alaska Natives, etc.) The following issues were discussed:

1. Access to VA is a major issue. Lack of roads, weather, and seasonal subsistence living made it nearly impossible for VSO's to outreach to veterans. In addition, 35 U.S. Postal Officers are assisting by providing feedback to VSO's from veterans in these rural areas because of the lack of VSO's in the state.

2. Veteran organizations are experiencing financial difficulties, thus, increasing the hardships for VSO's to travel to remote areas.

3. OIF/OEF returnees are also a major concern. PTSD is very high in villages and remote areas. Providing counseling and other healthcare benefits to these veterans is very challenging particularly since veterans in these areas experience hardships due to fuel, water, and job shortages.

4. There are difficulties scheduling appointments for veterans in these remote areas because of lack of choices for travel, weather conditions, and seasonal subsistence living. As a result, many veterans miss critical appointments.

5. A TVR (Tribal Veteran Representative) is needed to help with the language and cultural barriers when Alaska Native veterans are dealing with the VA. There was supposed to be some training through VHA but no training to date.

6. Getting legislation passed for funding from the state is a major challenge.

Following the VSO's remarks, the Committee agreed that health care delivery is a critical issue and queried the panel for more information and concerns as provided below:

1. Vocational Rehabilitation

2. Lack of a full operational veterans' hospital in Alaska in order to treat cancer

3. Specialty care is not available, even in civilian hospitals.

    a. Doctors in rural areas can only diagnose and then the patients are sent to the lower 48 states for treatment.

    b. The physician making the diagnosis is unable to collect any fees.

4. Concerns regarding TRICARE

VA staff members were given the opportunity to comment on the VSO Panel's responses. VA staff noted:

1. TRICARE was not an issue for veterans.

2. There were no contract providers in the Fairbanks area.

3. Purchase care and fee basis was originally not available for some services at VA because VA did not have providers. However, purchase care was later brought into the VA system once the services became available.

4. There is a VA clinic located on Ft. Wainwright in Fairbanks, Alaska.

5. All missed appointments due to weather:

   a. Are annotated in veteran's records as missed appointments.

   b. To re-schedule another appointment, the veterans were required to go through the Director.

   c. Veterans with three no shows were automatically dropped from the system.

   d. VA has made a lot of improvements with missed appointments.

PART III. TOWN HALL MEETING

Wednesday, October 25, 2006

Juneau Conference Room, Downtown Marriott Hotel, Anchorage, AK

The ACMV held a Town Hall meeting with Veterans, from 6:30 p.m. to 8:30 p.m. with approximately one hundred-twenty-five (125) veterans and invited guests to include Senator Betty Davis, Ms. Celeste Hodge, Mayor's Office and Mr. Jerry Beale, Director, Military and Veterans Affairs.

The VA was represented by:

Mr. Max Lewis, Director, VISN 20
Mr. Alex Spector, Director, VHA
Ms. Virginia Walker, Director, NCA
Mr. Doug Wadsworth, Director, VBA
Mr. Chris Schiebel, Service Center Manger, VBA

Veterans Issues

A myriad of issues, comments and questions were raised and discussed at the town hall, ranging from legislative actions to individual concerns. The areas of concerns discussed are listed below:

1. Native allotment (legislative actions)

2. VA services in rural Alaska

3. Rehabilitation training

4. Vocational rehabilitation

5. Eligibility and status of VA claims

6. Mental health issues

7. Assistance in obtaining medical records to apply for benefits

8. State veteran's cemetery in Fairfax

VA representatives and committee members responded to all issues and concerns.

PART IV. EXIT INTERVIEW WITH DVA LEADERSHIP

Thursday, October 26, 2006

Skagway Valdez Conference Room, Downtown Marriott Hotel, Anchorage, AK

The purpose of the meeting with DVA Leadership was to allow the VA staff to present issues, comments, and recommendations from a staff perspective.

VA's Comments

- The use of telemedicine in rural areas, such as in the State of Alaska, is limited due to the lack of specialists required for the conduct and evaluation of patient condition. Where telemedicine can be appropriately used, VHA has made and continues to make great strides in its utilization, and its benefits.

- VHA is unable to deploy psychiatrists to rural areas and villages within the State of Alaska. VHA continues to experience a critical shortage of psychiatrists and supporting staff. To compensate the shortage, VHA is leaning towards utilizing the Public Health system, rather than trying to recruit sufficient specialists to work in Alaska. The cost for recruitment and benefits could not be borne by VHA.

- Staff acknowledged there was a general absence of cooperation between the VSO's and the Veterans. It recommended holding "a supermarket of benefits fair" between the VSO's, VA, and the Veterans to inform all of benefits entitled to.

- Cultural burial rights and ceremonies are held, however, the rules and regulations of the military installation must be adhered to. There are national standards and policies in reference to ceremonies conducted for veterans. Gravesite services are not permitted because of safety reasons (committal service).

- There is a lack of Alaska Natives employed at the VA Regional Office. Applications come in from urban areas only. VARO will recommend utilizing the VOC Rehab graduates. There is a lack of personnel to run the program. In our recruitment efforts, we include incentive bonuses to relocate to Alaska, and we provide opportunity to get announced vacancies. We could utilize all forums to host interns/work study programs. Lastly, we will recommend that Alaska Regional Office go to IHS to provide outreach to all Alaska Natives.

- Alaska Native Tribal Health Care (ANTHC) is not a federal system. The Alaska Native veterans normally utilize the Alaska Native Medical Center.

Remarks of the Advisory Committee on Minority Veterans

The Committee commented on the practice of hiring minorities, emphasizing the absence of Alaska Natives, Asians or Pacific Islanders on the senior VA staff. This appeared to be a systemic problem throughout the VA. The hiring of minorities must become a priority within and throughout VA.

The Committee requested a follow-up in reference to the issues below:

1. Partnership opportunities with villages and corporations regarding mental health and outreach training in offering of services

2. Outreach committee activities

3. Demographics of minority employees and their positions. Hiring of minorities must be a priority. There are no Alaska Natives, Asians, or Pacific Islanders on the staff. (Note: VA staff provided the data-no further action is required.)

PART V. RECOMMENDATIONS

The Committee recommends the following:

RECOMMENDATION 1: VA establish the feasibility of implementing a cooperative agreement with the Alaska Native Tribal Health Consortium (ANTHC); Alaska Tribal Health System; Alaska Area Native Health Service; Indian Health Service (IHS); Alaska Native Medical Center (ANMC); Southcentral Foundation (SCF) to provide all services which fall within the purview of VBA and VHA. This would include the following actions:

- VA reimburse those entities, through ANTHC, for all services rendered to Alaska Native veterans.

- VA conduct a feasibility study to examine whether the ANTHC can provide same services that can be offered to the general veteran population (non Alaska Natives) which may be located in close proximity to rural areas and villages throughout the state of Alaska.

- VA develops, coordinates, and submits all legislative initiatives for enactment of cooperative agreements, and/or elimination/modifications of statutes, which might impede the establishment and/or consummation of those agreements.

- VA recognize the influence and importance of Alaska Native Elders and that VA coordinates with and secures the approval of these Elders before finalizing and implementing cooperative agreements.

DISCUSSION: The Committee noted during the Alaska site visit, that in many cases in rural Alaska, the healthcare facility nearest to where veterans resided were those operated by the Alaska Healthcare System. A review of the VISN 20 Strategic Plan reflects minor mention of actual initiatives between VA and the Alaska Healthcare System. If Memorandum of Understandings (MOUs), support agreements, and sharing agreements are expanded, it could alleviate some of the access issues for non-Alaska Natives veterans allowing them to receive care in Alaskan Health Care System facilities and Alaska Natives that are not veterans to receive care in VA facilities on a sharing basis.

RECOMMENDATION 2: Secretary and Deputy Secretary encourage VA leadership officials to utilize all available means (i.e. Internships, Mentoring Programs, Executive Career Field Training Programs, Leadership VA, SES Candidate Development Program) to promote the career development of VA minority and female employees. The ultimate goal will be to increase the number of VA minority group employees in leadership positions throughout the Department.

DISCUSSION: During the Committee's site visit to Los Angles in 2006, it was noted that the VAMC leadership positions were not occupied by minority staff in numbers that would seem representative of the community being served. The same situation was noted in the Committee's site visit to Alaska in the latter part of 2006 and has been noted in previous Committee site visits. Aggregate numbers presented during the 2007 Washington, DC meeting of the Committee appeared to indicate that Hispanic females and white females are the only groups needing focus due to their small numbers. However, the Committee has consistently been concerned with a small number of minorities in Director, Deputy Director, Associate Director, Assistant Director, Chief of Staff, Chief Medical Officer, and Nurse Executive positions. Focus needs to be paid on the number of minorities presently in the SES, GS 13 to GS 15, Title 38 equivalent leadership positions, and the systems in place to ensure that individuals in the pipeline are being prepared to assume leadership roles in numbers that will parallel the veteran population in the future. Staff recruitment training, mentoring and career development programs require constant diligence.

For example, the current MD 715 Report for VHA/Canteen, Table A11: Internal Selections for Senior Level Positions (GS 13-15), reflects that white females comprise 40% of the selectees for GS 13/14, 29% of the GS 15, and 50% of the SES. Conversely, black males comprised 3.58% of the GS 13/14, 2.91% of the GS 15, and 0% of the SES internal selections. When looking a the future pipeline for leaders in VHA on Table A 4-1, white females were 40.15% of the GS 7, 40.62% of the GS 9, 4.53% of the GS 11 and 39% of the GS 12 positions. Conversely, black males were 8.97% of the GS 7, 7.37% of the GS 9, 2.86% of the GS 11, and 4.43% of the GS 12 positions in VHA. In overall numbers white females may be underrepresented. However, white females are currently in the GS 13-15 positions and GS 7/9/11/12 developmental positions in fairly high numbers.

RECOMMENDATION 3: VA's outreach programs are extended and/or modified to include all means and processes to advise minority veterans of their entitlements and the Office of National Outreach Program Coordination provides the Committee a report reflecting actions initiated to date.

DISCUSSION: After the Committee's site visits to Los Angeles and Long Beach in 2006, a need for enhanced outreach efforts was identified as it was in the Committee's site visit to Alaska in the latter part of 2006. The VA's responses to the Committee's inquiries related to outreach indicated the following:

- ***VA concurs, endorses, and supports the overall purpose and key elements of the recommendation. Although most VA programs already have an outreach component, the need for a Department level coordination function became apparent in recent years. In response, the Office of National Outreach Program Coordination was***

established in the Office of Public and Intergovernmental Affairs (OPIA) in late 2005. This organization works closely with VA Administrations and staff offices to coordinate and monitor major Departmental outreach efforts meant to ensure that veterans and their families have timely access to information regarding VA benefits and services. This office also is responsible for the development and implementation of national VA policies related to outreach.

- ***To address the specific outreach recommendations contained in this report, the Office of National Outreach together with the Center for Minority Veterans (CMV) will monitor outreach to minority veterans. CMV will analyze the results of those efforts and recommend changes where appropriate. Through this collaboration VA will ensure: (1) coordination with internal and external stakeholders and veteran service organizations, and (2) utilization of culturally appropriate venues and technologies for effective communication.***

- ***Minority Veterans Program Coordinators (MVPC) are assigned to most VHA, VBA and NCA facilities nationwide and are another means by which VA will address the outreach recommendations. This is a collateral duty for the majority who serve as MVPCs. However, VA facility directors have the authority to expand this role as needed to better serve minority veterans in their respective areas. In addition, each Administration has a designated MVPC Liaison in VA Central Office. The MVPC Liaisons work closely with the CMV to coordinate outreach efforts targeted to minority veterans and respond to inquiries from minority veterans.***

RECOMMENDATION 4: VA ensures that translation services are available in VA facilities through either the services of employee translators or contract services. This will ensure that "Patients' Rights and Responsibilities" functions normally assigned to VHA are being addressed.

DISCUSSION: Alaska has many dialects and each tribal entity may speak a different dialect. Communication with Alaska Natives and other minority veterans not fluent in English was extremely difficult. The Committee noticed that during the town hall meeting, a large number of veterans could not converse in the English language and required a friend or a family member's help to translate. The Committee assumed that this situation may occur when the veteran visited VA facilities or when VA staff addressed the veterans. The end results are missed appointments, misunderstanding of diagnosis, etc.

RECOMMENDATION 5: The current appointment processes and procedures contained in VHA Directive 2006-055, VHA Outpatient Scheduling Processes and Procedures, be adhered to by the Alaska VAMC and other VHA facilities to ensure that veterans are not penalized unfairly, and that veterans' needs for health care services are fully met. This could be monitored during reviews under the current SOARS process.

DISCUSSION: Based on comments received from veterans during the Alaska site visit, the Committee is concerned with the practice of closing appointment schedules (automated or not) and/or the practice of not answering calls for appointments after a given time and its impact on minority veterans in Alaska and the lower 48 states. Alaska veterans reported the following practices:

- All missed appointments, due to weather conditions, are noted in the veteran's records as "a missed appointment."
- Veterans with three no shows were automatically dropped from the system.
- To re-schedule another appointment, the veteran is required to submit a request through the Director.

RECOMMENDATION 6: VA, under the VA's State Cemetery Grants Program, facilitate discussions with the government officials of the state of Alaska and Alaska Native tribal leaders to explore the possibility of establishing additional veterans' cemeteries on either state or tribal lands.

DISCUSSION: Distances and travel costs are burdens on all Alaska Natives who have contributed their share of warriors in defense of our principles. Alaska Natives have also contributed their share to the fallen warriors. Most have found their final resting place at the National Cemeteries in Anchorage or Fairbanks on land donated by the State of Alaska. Alaska Natives are also self-governed and in that context; are "members of a nation." Current VA State Cemetery Grants guidelines place initial and long-term financial burdens on tribal governments.

RECOMMENDATION 7: VA expeditiously complies with the VA Acting General Counsel Opinion, Subject: WEBCIMS 372917-Collection of Veterans Ethnic and Racial Demographic Data, dated March 2, 2007.

DISCUSSION: The General Counsel Opinion states the following in paragraph 3: 38 U.S.C., Section 544(c) requires that the annual reports of the Advisory Committee on Minority Veterans include "an assessment of the needs of veterans who are minority group members with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs sponsored by the

Department." In order for the Committee to capture and report this information, VHA, VBA, and NCA must collect this information. In addition, one of the primary purposes of the Center for Minority Veterans is to "conduct and sponsor appropriate social and demographic research on the needs of veterans who are minorities and the extent to which programs authorized under this meet the needs of those veterans, without regard to any law concerning the collection of information from the public." 38 U.S.C., Section 317(d)(5). The Center for Minority Veterans' ability to "conduct and sponsor" research as needed to determine minority veterans needs and the efficacy of VA programs in meeting them also requires the participation of the three program administrations.

RECOMMENDATION 8: The Center for Minority Veterans (CMV) provides information on their budget, employee resources, and accomplishment of their performance measures to the Committee during the next Washington, DC meeting.

DISCUSSION: The Committee requested this information in order to determine the tangible support that is being provided by the Department to the Center for Minority Veterans.

RECOMMENDATION 9: CMV consider the necessity for sponsoring a Minority Veterans National Conference or Summit to provide outreach and veterans' benefits and assistance information to minority veteran conference attendees and address concerns and issues adversely affecting minority veterans.

DISCUSSION: The Committee as asked the CMV to consider the merits of conducting a Minority Veterans National Conference or Summit after noting that a similar meeting is conducted by the Center for Women Veterans.

RECOMMENDATION 10: VA analyze their reported VA workforce minority employee statistics to ensure that they are consistent with the Office of Personnel Management (OPM) reporting of workforce minority employee statistics and ensure the accuracy and sustainability of conclusions concerning senior staff representation of VA minority workforce.

DISCUSSION: The Committee has continued to note an absence of minorities in leadership positions during site visits to VA facilities. Briefings that have been provided have not alleviated concerns that additional attention needs to be given to the recruitment and career development of potential senior minority staff.

RECOMMENDATION 11: Replicate the ongoing initiative VA has with the Elmendorf Air Force Base hospital in Fairbanks Alaska with the U. S. Army.

DISCUSSION: The joint venture between the VA and U. S. Air Force provides benefits for both organizations and their patient populations. This could be use as a best practice example. The Committee recommends that the VA and U. S. Army determine if a similar collaboration at the Fairbanks Alaska U. S. Army facility would have potential for similar benefits.

RECOMMENDATION 12: VA develops and implements a Tribal Veterans Representative (TVR) program in Alaska.

DISCUSSION: Due to the expanse of the state, the lack of ample VSO support, and the unique needs of the Alaska Native veteran population; a viable TVR program has the potential of assisting greatly with outreach to Alaska Native veterans and non-Alaska Native veterans living in rural and remote areas of Alaska.

RECOMMENDATION 13: The Alaska VA Regional Office should partner with the Indian Health Services (IHS) to provide outreach to Alaska Natives.

DISCUSSION: With its current infrastructure in Alaska, the IHS is a viable resource to provide outreach activities to Alaska Native veterans.

APPENDIX A: Anchorage, AK Site Visit Agenda

AGENDA
Department of Veterans Affairs (VA)
Advisory Committee on Minority Veterans
October 23-27, 2006
Anchorage, AK

Monday-October 23, 2006	Travel Day
Tuesday-October 24, 2006	**Activities**
7:00 a.m. – 7:30 a.m.	**Depart** Anchorage Marriott Downtown Mode of Transportation: **Bus service**
8:00 a.m. – 11:00 a.m.	VA Leadership Panel VA Clinic, 2925 DeBarr Road (Ste 3614) Mr. Alex Spector, Director, VHA Mr. Douglas Wadsworth, Director, VBA Ms. Virginia Walker, Director, NCA
10:00 a.m. – 10:15 a.m.	Break
10:15 a.m. – 11:00 a.m.	VA Leadership Panel Presentation con't
11:00 a.m. – 12:00 p.m.	Telehealth Demonstration (Ste 3614) Ms. Dede Stallings, RN
12:00 p.m. – 1:00 p.m.	Lunch (catered)
1:00 p.m. – 1:15 p.m.	**Depart/Break VA Clinic**
1: 30 p.m. – 2:30 p.m.	VA Domicillary, 3001 C Street Chief, Dr. James Fitterling
2:30 p.m. – 2:45 p.m.	**Depart/Break VA Domiciliary**
3:00 p.m. – 4:30 p.m.	Elmendorf DoD/VA Joint Venture Hospital, Air Force Base 5955 Zeamer Avenue P.OC. Mr. Adam Kurzejeski, VA Coordinator
4:30 p.m. – 4:45 p.m.	**Depart/Break Elmendorf**

5:00 p.m. – 6:30 p.m.	Kodiak Conference Room Marriott Anchorage Downtown 820 West 7th Avenue

Wednesday-October 25, 2006	**Activities**
7:00 a.m. – 7:30 a.m.	**Depar**t Anchorage Marriott Downtown Mode of Transportation: **Bus service**
8:00 a.m. – 12:00 p.m.	Native Tribal Leadership Panel 4315 Diplomacy Drive (ANMC Rm. 1&2) Mr. Paul Sherry, CEO, Alaska Native Tribal Health Consortium Mr. Chris Mandregan, Director, Alaska Area Indian Health Service (IHS) Ms. Susan Childers, Active CEO Alaska Native Medical Center Dr. Eby, South Central Foundation
9:15 a.m. – 9:30 a.m.	Break
9:30 a.m. – 11:00 a.m.	Native Tribal Leadership Panel con'd.
11:00 a.m. – 12:00 p.m.	Tribal Telemedicine Demonstration Dr. A. Stewart Ferguson, Director
12:00 p.m. – 1:30 p.m.	Lunch (catered)
1:30 p.m. – 1:45 p.m.	**Depart Alaska Native Medical Center**
2:00 p.m. – 3:00 p.m.	Anchorage Vet Center 4201 Tudor Centre Drive (Ste 115) Mr. Robert Irwin, Team Leader
3:00 p.m. – 3:15 p.m.	**Depart/Break Vet Center**
3:30 p.m. – 4:30 p.m.	Veteran Service Organization Panel Northway Mall 3101 Penland Pkwy Ste A-12
4:30 p.m. – 5:00 p.m.	**Depart Northway Mall**
5:00 p.m. – 6:15 p.m.	Dinner (on own)

Wednesday-October 25, 2006	**Activities**
6:30 p.m. – 8:30 p.m.	ACMV Town Hall Meeting Anchorage Marriott Downtown Hotel Juneau/Haines Conference Rooms 820 West 7th Avenue
8:30 p.m.	**PUBLIC SESSION ENDS**

Thursday-October 26, 2007

Administrative Meeting occurs at the
Anchorage Marriott Downtown Hotel
Skagway Valdez Conference Room
820 West 7th Avenue

8:00 a.m. – 9:00 a.m.	VA Leadership Exit Briefing
9:00 a.m. – 9:30 a.m.	Break
9:30 a.m. –12:00 p.m.	Committee Report
12:00 p.m. – 1:30 p.m.	Lunch
1:30 p.m. – 3:00 p.m.	Committee Report
3:00 p.m. – 3:30 p.m.	Break
3:30 p.m. – 4:30 p.m.	Committee Report
4:30 p.m. – 5:00 p.m.	Administrative Paperwork

Friday, October 27, 2006 Travel Day

APPENDIX B: Washington, DC Meeting Agenda

AGENDA
Advisory Committee on Minority Veterans
VACO, 810 Vermont Ave, NW, Wash DC 20420
April 16 – 19, 2007

Sunday, April 15, 2007 (Travel Day)

Monday, April 16, 2007- Room 230 VACO

07:45 a.m.	Coffee
08:00 a.m.	Open Meeting: Carson Ross, Chair Opening remarks/Introductions/Review Agenda
09:00 a.m.	VHA Overview/Update (marketing, staff diversity, cultural sensitivity) Dr. Michael Kussman Acting Under Secretary for Health
09:45 a.m.	Break
10:00 a.m.	Readjustment Counseling (vet centers, GWOT, mental health) Mr. Charles Flora Assistant Chief Officer
11:00 a.m.	CARES Overview/Update (Land use & revenue issues) Allen Berkowitz, Associate Director Office of the ADUSH for Policy and Planning
12:00 p.m.	Lunch (on your own)
1:00 p.m.	Center for Minority Veterans Update
1:30 p.m.	VBA Overview/Update Brad Mayes Director, Compensation and Pension
2:30 p.m.	Loan Guarantee Service (American Indian Direct Home Loan Program) R. Keith Pedigo, Director

3:30 p.m. Wrap-up

4:00 p.m. Adjourn

Tuesday, April 17, 2007- Room 230 VACO

08:00 a.m. Coffee

08:30 a.m. Open Meeting: Carson Ross, Chair

09:30 a.m. Move to Omar Bradley Conference Room – 10th Floor

10:00 a.m. Remarks: The Honorable R. James Nicholson
Secretary of Veterans Affairs

Presentation of Certificates of Appointment
Ms. Julia J. Cleckley Mr. Harvey D. Williams
Mr. James T. McLawhorn, Jr. Ms. Debra L. Wilson
Mr. Joe C. Nunez

Group photograph

10:45 a.m. Resume meeting in Room 230

11:00 a.m. NCA Overview/Update
William F. Tuerk, Under Secretary for Memorial Affairs

12:00 p.m. Lunch (on your own)

1:00 p.m. Staff Diversity/CPP/Recruitment/Retention
Paul Hutter, Executive in Charge Human Resources & Administration

Susan C. McHugh, DAS for Diversity Management & EEO

2:00 p.m. National Veterans Employment Program
Greg Alleyne

2:30 p.m. Break

2:45 p.m. VA Strategic Plan Overview
Curt Marshall

3:30 p.m. Telehealth Overview/Update
Dr. Adam W. Darkins

4:30 p.m. Adjourn

Wednesday, April 18, 2007- Room 230 VACO

07:30 a.m.	Coffee
07:45 a.m.	Open Meeting: Carson Ross, Chair
08:00 a.m.	Ethics Brief Susan Bond
08:45 a.m.	Center for Women Veterans Overview Dr. Irene Trowell-Harris Director
09:30 a.m.	Seamless Transition Overview/Update John Brown
10:15 a.m.	Break
10:30 a.m.	Fisher House/Center for the Intrepid Overview Earl Newsome Deputy Director, Center for Minority Veterans
11:00 a.m.	Research & Development Overview/Update Joseph Francis, MD Deputy Chief, Research & Development Officer
12:00 p.m.	Lunch (on your own)
1:00 p.m.	Homeless Program Overview/Update Mr. Pete Dougherty
2:00 p.m.	DC National Guard (MP Battalion) LTC Aaron Dean, Troop Commander
3:00 p.m.	Break
3:30 p.m.	Panel – OIF/OEF Soldiers Jim Mayer Walter Reed Army Medical Center
4:30 p.m.	Adjourn

Thursday, April 19, 2007- Room 530 VACO

08:30 a.m.	Coffee
09:00 a.m.	Open Meeting: Carson Ross, Chair
09:30 a.m.	Work on the 2007 Report of the Advisory Committee on Minority Veterans
10:30 a.m.	Break
10:45 a.m.	Work on the 2007 Report of the Advisory Committee on Minority Veterans
11:30 a.m.	Lunch (sponsored by VFW) Mr. Bradshaw Mr. Wallace
1:00 p.m.	Work on the 2007 Report of the Advisory Committee on Minority Veterans
2:00 p.m.	Committee Discussion Dates of next meeting/Site Visit
2:30 p.m.	Break
2:45 p.m.	Administrative Paperwork (Travel Voucher, Honorariums)
3:30 p.m.	Adjourn

Friday, April 20, 2007 (Travel Day)

APPENDIX C: Committee Biographies

2007 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, 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.

Ms. Debra L. (American Horse) Wilson

Lakota Sioux

Ms. Wilson is a Lakota Sioux; her family name is American Horse. She is a former Marine who was honorably discharged in August 1982 at the rank of Staff Sergeant, E-6. Her family has a long tradition of service to the country. Her father, brothers, sister, nephew and husband all served in the United States Marine Corps.

Ms. Wilson's duty stations included Headquarters Women Marine Company, Arlington, Virginia. She was assigned to the Dress Blue Detail at the White House, Commandant's House, Pentagon and Iwo Jima Memorial. She was then assigned to Camp Zukeran 3rd Marine Division, 2nd Battalion, Okinawa, Japan. While stationed to the 3rd Marine Division, Ms. Wilson attended Administrative Chief School. She was subsequently assigned to Recruiter School in San Diego, California. Of interest, she was the only woman in the class. Her subsequent duty station was as a recruiter 1st Marine Corps District, Buffalo New York. Ms. Wilson served under the command of then Major Peter Pace, now Chairman of the Joint Chiefs of Staff. Ms. Wilson's awards include: Marine of the Quarter, two Good Conduct Medals and a Meritorious Unit Commendation.

Ms. Wilson worked in a variety of assignments at the Department of Veterans Affairs. She has been a Vocational Rehabilitation and Education Coach; Veteran's Claims Examiner; Public Affairs Officer and a management analyst in Equal Employment Opportunity for the Director of the VA Regional Office in Muskogee, Oklahoma. In that capacity she served as the program manager for the regional office's special emphasis programs to include: Minority Veterans Program Coordinator, Women Veterans Coordinator; Oklahoma State Veterans Program, Veteran Service Officers Liaison, EEO Program Manager, and Native American Program Coordinator. Ms. Wilson was also a program analyst in the Center for Minority Veterans and served as the American Indian Veteran Liaison for the Center.

Ms. Wilson currently works for the Cherokee Nation Gaming Commission in Tahlequah, Oklahoma as their compliance officer. She continues to outreach to Cherokee Veterans throughout Cherokee nation by assisting them with their claims, providing information on their benefits and helping them to interact with the Department of Veterans Affairs. Ms. Wilson resides in Tahlequah, Oklahoma.

James T. McLawhorn, Jr.

African American

Mr. McLawhorn has developed innovative programs to improve the quality of life for thousands of disadvantaged persons in the Midlands of South Carolina. He also serves as a catalyst to improve race relations and diversity in the community. He spearheaded the establishment of the South Carolina Race Relations Commission. He has provided more than twenty years of leadership in social policy planning and human service development.

Mr. McLawhorn was a Housing and Transportation Planner and an Assistant Director for Employment and Training for the city of Charlotte, North Carolina. He also taught social planning as an Adjunct Instructor at the University of North Carolina. Mr. McLawhorn is presently the President and Chief Executive Officer of the Columbia Urban League in Columbia, South Carolina. He has held this position since 1979.

Mr. McLawhorn has been extensively recognized for his social activism. Awards received include: United Black Fund Chairman's Award, 2005; Wil Lou Gray Award for Youth Leadership, 2003; Trailblazer Award, Alpha Kappa Alpha South Atlantic Region, 2000; National Urban League President of the Decade, 1999; National Urban League Whitney M. Young, Jr. Leadership Award in Race Relations, 1996. Mr. McLawhorn resides in Columbia, South Carolina.

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-Tern 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. Bastion 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

Attorney Miller serves as the first Director of the newly-established District of Columbia Office of Veterans Affairs, within the Executive Office of the Mayor. He was appointed, by Mayor Anthony A. Williams, in October 2001, and was unanimously confirmed, by the Council of the District of Columbia. 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. Prior to his appointment, he was responsible, for representing veterans, before the United States Court of Appeals for Veterans Claims. Attorney Miller was also an attorney, in the Department of Veterans Affairs Office of General Counsel, for seven years.

Attorney Miller is a retired surface warfare Naval Reserve Commander, who completed twenty-eight years of honorable active duty and reserve naval service. He served, on active duty, as the Office-In-Charge, of the USNA Pawcatuck (TAO-108), and for six years, as a naval reservist, in the Office of the Naval Inspector General.

Attorney Miller earned a Bachelor's of Science Degree, in Political Science, from the U.S. Naval Academy. He graduated Cum Laude from the Howard University School of Law in Washington, D.C., where he received a Juris Doctor Degree. He also earned a Master of Laws Degree, from the George Washington University National Law Center.

Attorney Miller is an active member of the National Association of Black Veterans and the American Legion. He resides in 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, (Retired)

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 Human 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**