

*REPORT OF THE ADVISORY
COMMITTEE ON MINORITY
VETERANS*



Annual Report

JULY 1, 2011

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Executive Summary

The 2011 Report of the Advisory Committee on Minority Veterans (ACMV) provides the Committee's assessments, observations, recommendations, and rationales that address the effectiveness of the Department of Veterans Affairs' (VA) provision of services to minority Veterans, their families, and survivors.

ACMV met its requirement to conduct a minimum of two meetings this year in accordance with Public Law 103-446 and VA Charter on the Advisory Committee on Minority Veterans dated March 17, 2010. The ACMV met on April 4-6, 2011, at VA Central Office (VACO) and received briefings from Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA), and select staff proponents. The ACMV also conducted a Veterans Town Hall meeting in Springfield, Virginia, on the evening of April 6. Ex Officio members from the Department of Health and Human Services (HHS), Department of Defense (DoD), Department of Labor (DOL), and Department of Commerce (DOC) provided briefings on their respective missions and services provided to Veterans. The site visit was conducted on April 7, 2011, at the Washington, DC VA Medical Center (VAMC); an exit briefing session was also conducted at VACO on the morning of April 8, 2011.

ACMV has historically highlighted a need for VA to:

- Continue and enhance targeted outreach to minority Veterans to encourage use of VA benefits and services to counter adverse conditions in minority communities.
- Enhance the utilization and visibility of Minority Veterans Program Coordinators (MVPC) as the key resource in promoting effective, culturally relevant, and targeted outreach to minority Veterans.
- Enhance the collection and analysis of demographic data which reflects the level of utilization of VA benefits and services by minority Veterans.
- Ensure that VA personnel succession planning initiatives facilitate an increase in the number of minorities in senior leadership positions of the Department.
- Ensure that VA healthcare initiatives address clinical disparities in the minority Veteran population.
- Ensure that all Veterans living in rural, highly rural, and insular areas are provided appropriate access to VA benefits and services.

During the course of conducting site visits and especially Veterans Town Hall meetings, ACMV has noted that Veterans of all races/ethnicities from World War II, Korean, Cold War, and Vietnam eras are in great need of VA's benefits and services. Many of these individuals are retired and living on fixed incomes during this period of a troubled national economy. These at-risk Veterans, their families, and survivors in many cases are not aware of the benefits and services VA has available to enhance their quality of life. In some cases, some feel that VA has placed their claims and concerns on the back burners. These individuals need the same emphasis on outreach

and assistance that is presently being given to Veterans of recent conflicts (Operation Enduring Freedom/Operation Iraqi Freedom).

The intent of ACMV's meetings was to assess, observe, and query on the effectiveness of VA's current initiatives for all Veterans, and to identify the impact these initiatives have on the unique needs of minority Veterans, their families, and survivors. While improving the system of outreach and delivery of benefits and services to these minority Veterans, VA will improve outcomes for all Veterans by being people-centric, results-driven and forward-looking in meeting the unique needs of minority Veterans. The 2011 report contains 13 recommendations that include 6 recurring recommendations:

- 1) Establish hiring and retention strategies and increase recruitment of minorities to improve minority representation within the Senior Executive Service (SES) ranks. (Recurring)
- 2) Review the current diversity and inclusion training and update the training modules to include areas of cultural competence.
- 3) Evaluate the effectiveness of outreach methods to minority communities conducted by individuals other than Minority Veterans Program Coordinators. (Recurring)
- 4) Develop and implement an action plan to increase the utilization of Minority Veterans Program Coordinators (MVPCs) in all departmental targeted outreach activities to minority Veteran communities. (Recurring)
- 5) Develop and implement, based upon input from minority Veteran focus groups, a culturally relevant communications strategy and promote awareness of VA benefits and services to targeted communities.
- 6) Veterans Health Administration Office of Rural Health perform a comprehensive needs assessment to determine the impact of transportation barriers on the health of minority Veterans residing in rural and highly rural areas. (Recurring)
- 7) Develop an action plan to increase access to VA programs, services, and facilities for Veterans living in rural and outlying territories and insular areas. (Recurring)
- 8) Develop a plan to implement, where applicable, *the Seventeen Recommendations To Donor Agencies Resulting From the Department of Interior Insular Area Health Summit September 2008*.
- 9) Develop and implement a strategy to enact guidelines in accordance with the Department of Health and Human Services (HHS) National Partnership Action Plan to end health disparities.
- 10) Establish an Office of Health Equity (OHE) similar to the Offices of Minority Health (OMH) within the Department of Health and Human Services. (Recurring)
- 11) Develop an action plan with a goal of effecting a meaningful reduction in racial disparity among active patients enrolled in the VA healthcare system.
- 12) Increase funding to collaborative partnerships, with Community Based Organizations (CBOs) and Non-Government Organizations (NGOs) that provide assistance to homeless Veterans.
- 13) Propose legislation that will change the reporting requirement for an annual report from the ACMV to a biennial report.

As we did in the 2010 ACMV Report, the ACMV respectfully requests that responses from VA proponents include specific data and updates to the recommendations. In addition, we also request that the proponents provide updates to their responses during ACMV's annual meeting normally held on or about November of each year at VACO. ACMV commends the senior leadership of the three VA Administrations, staff offices at VACO, Washington, DC VA Medical Center, DC VA Regional Office, and the Veterans at the Veterans Town Hall meeting in Springfield, Virginia, for their receptiveness to ACMV's comments and questions. We also thank VA officials for their outstanding support and services to minority Veterans, their families, and survivors. Special thanks to the staff of the Center for Minority Veterans for their continued outstanding support of ACMV.

In summary, we appreciate the Secretary's and the Department's confidence in ACMV's efforts and the Department's responses to the annual report. We hope this report assists the Department in its initiatives to provide services that are more people-centric, results-driven, and forward-looking to meet the needs of all Veterans, their families, and survivors.

Part I- Recommendations, Rationales, and VA Responses

The Advisory Committee on Minority Veterans (ACMV)
April 4-8, 2011

Background

The Committee conducted its meeting at VA Central Office (VACO), participated in a site visit to the Washington, DC VA Medical Center (VAMC), and facilitated a Veterans Town Hall Meeting in Springfield, Virginia. These sessions provided an opportunity for the members to conduct interviews with VA leadership; have direct contact with Veterans, family members, survivors, and Veteran Service Organizations; and formulate recommendations for the Department's consideration to improve the provision of benefits and services to minority Veterans, their family members, and the general Veteran population.

In formulating the recommendations below, ACMV proposes that the first step in establishing a powerful organizational climate for Diversity and Inclusion starts at the top with recruiting and retaining senior executives from all backgrounds and then developing a culturally competent team through training and development. With a culturally competent organizational culture as a foundation, the Department can develop culturally relevant outreach programs to reduce access barriers and disparities in health care and address the Department's priorities, particularly in reducing Veteran homelessness. Ultimately, top leadership must communicate that a long-term commitment to diversity and cultural competence is of strategic value in delivering patient-centered and equitable services and care to all Veterans.

Recommendations

A. Diversity

- 1. Establish hiring and retention strategies and increase recruitment of minorities to improve minority representation within the Senior Executive Service (SES) ranks by 2012, with a goal of attaining a significant increase in minority representation within the ranks of the SES within the Department by 2015.**

Rationale: As it endeavors to foster an environment that is diverse in membership, results-oriented, and high-performing, VA must have a workforce reflective of the communities it serves in order to truly provide patient-centered, culturally competent services to Veterans and their families. Acknowledging the importance of culturally competent healthcare practices, The Joint Commission published patient-centered communication standards (including cultural competence) in the 2011 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook and will be using

these standards for accreditation decisions sometime after January 2012.¹ To help organizations meet these standards, The Joint Commission published the monograph “Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals,” which offers recommendations for building organizational readiness including targeting recruitment efforts to increase the pool of diverse and bilingual candidates.²

The Department should equally focus on creating an environment that is inclusive and allows for the attraction and cultivation of talent to support the VA’s mission and priorities. The Management Directive 715 Report (Table A4-1) for VA for Fiscal Year (FY) 2010 reflected, the Senior Executive Service (SES) consisted of 322 employees. A closer examination reveals the following: 53.73% WM, 28.57% WF, 4.66% AAM, 4.97% AAF, 3.73% HM, 1.24% HF, .31% NH/PIM, 0% NH/PIF, .93% NA/ANM, 0% NA/ANF, 1.24% AM, and .31% AF. This data shows the disparity that exists at the senior levels of the agency, and the need to immediately implement a strategy to ensure that the Department's leadership is reflective of the community it serves. Additionally, the data presented in the Management Directive 715 FY 2010 EEO Report /FY 2011 EEO Plan also suggests that promotional opportunities for minorities stagnate at the GS-7/8 level of the organization.

As stated in the Chief of Staff's letter numbered 006-11-2 on February 11, 2011, there is a need for increased diversity within the SES, and the overall workforce within VA. In order to foster a nurturing environment that truly values a diverse workforce, the Office for Diversity and Inclusion, with the Secretary's support, must work with senior leadership to gain executive buy-in to level the playing field. This effort can be accomplished by providing senior leadership with cultural competence and sensitivity training to understand the vast and diverse Veteran community the Department employs, serves and interacts with in terms of service delivery.

Action Office: Office of Human Resource and Administration (HR and A), Office of Diversity and Inclusion (ODI)

VA Response: Non-concur

VA does not endorse race-conscious hiring goals as they violate Title VII of the Civil Rights Act of 1964, as amended. We do, however, strongly support outreach and retention strategies, including those that focus on groups with less than expected representation or low participation rates the workforce. These strategies are currently included in VA’s 5-year Diversity and Inclusion Strategic Plan for fiscal year (FY) 2009-2013. Among these strategies are targeted outreach to these communities for leadership development programs and Senior Executive Service (SES) recruitment.

¹ The Joint Commission (2010). Patient-centered communication standards for hospitals. Retrieved June 26, 2011 http://www.jointcommission.org/Advancing_Effective_Communication.

² The Joint Commission (2010). *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010.

2. Review the current diversity and inclusion training and update the training modules, by the end of FY 2011, to include the topics of cultural competence and emotional intelligence to ensure that they are relevant to address the Diversity and Inclusion challenges that are present in the VA.

Rationale: Building a diversity-sensitive and Veteran-centered organization not only relies on having a diverse blend of talented leaders at the top, but also a strong diversity and inclusion training program for all levels of employees. In order to develop diversity-sensitivity³, leaders need to develop self-awareness regarding potential biases, identify and empathize with diverse perspectives that may differ from their own, and then translate this new understanding into respectful and effective interpersonal relationships with others⁴. In essence, these skills are the foundations of emotionally intelligent and culturally competent behaviors. In order to strengthen these behaviors, the administration needs to provide opportunities for the SESs and all VA employees to participate in cultural immersion experiences within each area of the minority community it serves. This experiential forum often helps the leader and employees gain an understanding of the perceptions of the organization within the community, as well as stimulates new ideas from the top of the organization that lead to the creation of policy and action to create equitable solutions for all employees, specifically the underrepresented Federal employees that have experienced inequities in promotional opportunities. With the implementation of this experiential learning, the Department will afford an opportunity to provide valuable insight to senior leaders and employees of the stakeholder communities they serve: staff, Veterans, and their family members seeking assistance, and the public at large.

Action Office: Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA), HR and A , and ODI

VA Response: Concur-in-principle

VHA agrees to review current diversity and inclusion training and update training modules; however, this task may not be completed by the end of FY 2011. Given the scope of the task, we expect to complete this task by the end of the 1st quarter of FY 2012.

VHA has already commenced reviewing diversity and inclusion training programs. VHA launched a Diversity and Inclusion SharePoint site in November 2010 and a Community of Practice (COP) site in January 2011. The SharePoint site is open to all VA employees. The COP meets quarterly via conference calls that focus on relative cultural competency issues and topics. Calls to date include: VA Diversity and

³ Dreachslin, J.L. (2007). The role of leadership in creating a diversity-sensitive organization. *Journal of Healthcare Management* 52(3): 151-155.

⁴ Robertson, S.A. (2007). Got EQ? Increasing cultural and clinical competence through emotional intelligence. *Communication Disorders Quarterly* 29(1): 14-19.

Inclusion Strategic Plan and Cultural Competency (January 2011); and Lesbian, Gay, Bisexual, and Transgendered Cultural Competency (April 2011).

In addition, VHA conducted the Rural Health Professions Institute for 2011, which included experiential training on cultural competency. The National Equal Employment Opportunity (EEO) Managers Conference, June 2011, included a 3-hour experiential training session on cultural competency and unconscious bias. Many EEO managers are conducting cultural competency training at their Veterans Integrated Service Networks (VISN) and facilities. ODI will provide cultural competency and unconscious bias training to VISN 11 in FY 2012.

Cultural competency is included throughout our present instruction modules through a variety of face-to-face and resource materials found on the ODI Web site. Diversity and inclusion are topics that are aligned with cultural competency and also form the base knowledge in order to advance to the cultural competency level.

Current educational resources addressing specific and secondary elements of cultural competency and the cultural competency continuum include the following PowerPoint presentations:

- Suspending Judgment: A Key to Being Culturally Competent
- Diversity and Inclusion in VA's Workforce
- Diversity and Inclusion - Workplace Cultural Awareness - Honoring Differences
- Envisioning the Future, Honoring the Past-Generational Perspectives in the Workforce
- A Cohesive Approach: Performance, Innovation, and the Cultural Competency Continuum

In addition to the above, ODI partnered with VHA and the Rural Health Professions Institute for five separate trainings and in FY 2011 presented the Cultural Diversity and Competency Considerations for Health Care course for VHA medical professionals.

ODI presented training during FY 2011 in venues to include but not limited to:

- NCA Annual Conference (April 2011)
- VHA Pre-Conference for EEO Managers (June 2011)
- VA Acquisitions and Logistics to include the Acquisitions Academy (Ongoing)
- Human Resources Conference (July 2011 and August 2011)
- VHA and Rural Health Professions Institute (February, March, April, May, June , and August 2011)
- Three VBA Regional Offices with five more scheduled before the end of FY 2011

ODI continually revises and adapts diversity and inclusion curriculum based upon specific targeted audiences and client requests for specific training in order to address their needs and meet their objectives.

ODI will brief and discuss with ACMV members the inclusion of "emotional intelligence" into our existing presentations during their October 24-28, 2011 meeting at VA Central

Office. Discussion topics, for example, would focus upon the Committee's proposed and acceptable definitional terms, inclusion expectations, etc. After the discussion and by September 30, references to "emotional intelligence" and/or other specific relevant disciplines in ODI presentations will be adapted to address this recommendation.

Ninety-six percent of all NCA supervisory staff are in compliance with VA's Diversity and Inclusion Strategic Plan and have taken VA's on-line EEO and Diversity and Conflict Management Training for Managers. NCA's Office of Diversity Management and Alternative Dispute Resolution (ADR) Programs have partnered with the Human Resources offices and Labor Relations staff to develop inclusion and diversity initiatives for NCA. In May 2011, officials of the four offices met in St. Louis, Missouri, to work on strategies to implement overarching human capital investment architecture for NCA. This initiative encompasses equal employment opportunities for internal and external entities; outreach to Veterans and prospective applicants; recruitment; and cultural competency strategies. The group continues to meet monthly via teleconference to discuss progress and next steps. NCA is in the beginning stages of developing a nation-wide Special Emphasis Program, which will be tasked with identifying and addressing cultural competency skill gaps within the management and line staff. NCA continues to provide diversity training to managers through on-site visits and quarterly supervisory training sessions. At the National NCA Annual Conference, held in April 2011, in Milwaukee, Wisconsin, the ODI presented a three hour training session to all NCA supervisors on diversity, cultural competency, conflict management, sexual harassment prevention, and new initiatives relating to these topics in VA. The newly appointed Special Emphasis/Minority Veterans Program Specialist has participated in national special emphasis conferences (i.e. American GI Forum; Federally Employed Women's Training Conference), and is scheduled to attend the Annual Blacks in Government Training Meeting and National Organization of Mexican Rights. Through these venues, the specialist will develop skills to assist in the continued development of NCA's cultural competence and emotional intelligence strategies.

VBA will review current diversity and inclusion training. VBA will collaborate with ODI to review the specific diversity training modules. The Benefits Assistance Services (BAS) will promote diversity-training opportunities for outreach personnel and other field staff by working with ODI and other VA Education and Training programs. In addition, VBA will review current diversity training courses offered through the talent management systems.

Actions to Implement

* Pending = suspense date established and being monitored

VHA Action Plan – Recommendation #2					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Develop a comprehensive program to train VHA employees in the areas of cultural competency and unconscious bias.	Employee Education System (10A2B)	Assistant Deputy Under Secretary for Health (ADUSH) for Workforce Services	Conduct experiential training on cultural competency and unconscious bias at the Fall Cluster meetings. Results from this training will be used to establish a comprehensive plan for training VHA employees, in the areas of cultural competency and unconscious bias.	1 st quarter FY 2012	Pending
Distribute findings from Nuts and Bolts of Supervision (NABOS), New Supervisor Training, and the DOI Module to the field.	Employee Education System (10A2B)	ADUSH for Workforce Services	Upload findings to the NABOS coordinators in the field. Specific changes to the curriculum include the addition of content and experiential learning in the areas of cultural competency, sexual	4 th quarter FY 2011	Pending

			orientation, generational diversity, and an introduction to unconscious bias.		
ODI Action Plan – Recommendation #2					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Review and modify ODI diversity and inclusion training resources.	Office of Diversity and Inclusion (06)		Teleconference in August 2011 to discuss Committee’s expectations and definitional terms.	4 th quarter FY 2011	Pending
			Appropriate adaptations in ODI educational resources.	4 th quarter FY 2011	Pending
NCA Action Plan – Recommendation #2					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Develop a culturally competent workforce.	Office of Diversity Management and ADR Programs (40A)	Human Resources/ Labor Relations	Identify and address cultural competency skill gaps in the administration’s workforce.	4 th quarter FY 2012	Pending
Develop a Special Emphasis Program.	Office of Diversity Management and ADR Programs (40A)		Establish a nation-wide special emphasis committee.	4 th quarter FY 2012	Pending

Develop strategies to create an overarching Human Capital Plan that will include a culturally competent work environment.	Office of Diversity Management and ADR Programs (40A)	Human Resources/ Labor Relations	Create an overarching Human Capital investment architecture for NCA.	4 th quarter FY 2012	Pending
VBA Action Plan – Recommendation #2					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Review diversity training courses.	Benefits Assistance Services (27)	Office of Diversity and Inclusion	Determine the diversity training modules. Promote training for field staff.	1 st quarter FY 2012	Pending

B. Outreach

- 3. Evaluate the effectiveness of outreach methods to minority communities conducted by individuals other than Minority Veterans Program Coordinators (MVPCs) by the end of FY 2011, and develop and implement an action plan in FY 2012 to increase market penetration in targeted minority communities.**

Rationale: Although minority Veterans currently comprise of only 19% of the total Veteran population, they represent approximately 50% of the homeless Veteran population. As the number of minorities that are joining the military service rises with dramatic demographic shifts in the U.S. population (where racial and ethnic minorities made up about 90% of total U.S. population growth since the 2000 Census), minority Veteran numbers are projected to increase as the overall Veteran population declines. Establishing deeper relationships within minority communities will become increasingly important to build trust and reinforce the perception that VA supports minority Veterans and their families. Effective health service delivery to Veterans, in general as a primary mission of VA, is an issue of outreach and communication of useful information and culturally relevant interaction with patients to promote healing from injury and disease.

There are cultural differences within each group that make delivery of information and services difficult at best because the caregiver must be a trusted, culturally sensitive and understood healer. Not all Spanish-speaking people are alike culturally. There are close to 600 tribes in the United States with Veterans from all wars, and no two tribes are alike culturally. A rural African American culture is very different from an urban African American culture.

Though VHA indicated that it participates in community outreach, it appears that minority Veterans and their families are exposed to general health messages rather than outreach messages tailored to their unique cultures and health beliefs. VBA did not address outreach to minority Veterans during the meeting, and NCA demonstrated considerable improvements in reaching out to minority Veterans through its marketing materials and Minority Veterans Program Coordinators (MVPCs). In order to reach minority Veterans effectively and efficiently, outreach and education messages should be tailored for and targeted to reach specific minority communities since general messages may be less personally relevant and impactful.⁵ In order to prepare for the increasing minority Veteran population, it is necessary to develop and implement plans of action including specifically targeted outreach and education programs that provide benefits counseling, claims filing assistance, employment assistance, and small business development for minority Veterans.

Action Office: VHA, VBA, NCA, Office of Public and Intergovernmental Affairs (OPIA)

VA Response: Concur-in-principle

VHA agrees to evaluate the effectiveness of its outreach methods to minorities, and to implement changes to enhance outreach and communication to minority Veterans; however, evaluating existing outreach efforts to minority Veterans may extend beyond the end of FY 2011. VHA will continue to monitor and enhance outreach methods to reach Veterans; however, our outreach does not target specific ethnic groups of Veterans. Rather, our outreach efforts are intended to communicate to all Veterans, regardless of race, gender, ethnicity, or religion. VHA's Operation Enduring Freedom/Operation Iraqi Freedom office provides coordination and guidance for local VAMCs and their respective VISN for outreach to National Guard and Reserve Servicemembers who are returning from deployment in combat operations.

NCA has hired a full-time National MVPC. This position is responsible for developing outreach strategies and training field MVPCs and other participants who will be involved in outreach activities. Since coming on-board in June 2011, the National MVPC has attended two national special emphasis conferences, and received an in-depth briefing on the minority Veterans program in VA conducted by the Center for Minority Veterans Office. While attending the national meetings, the National MVPC interacted with various organizations and persons who will serve as a major resource in the development of NCA's outreach strategies.

⁵ Nickens, H.W. (1990). Health promotion and disease prevention among minorities. *Health Affairs* 9(2): 133-143.

NCA has participated in over eighty outreach and recruitment events to include those focused on minorities and Veterans (i.e., American GI Forum, HEROs and Heritage Program/Career Fair; Marine Corps League; Veterans Opportunity Expo, Veterans of Foreign Wars, Federally Hispanic Women’s Executives Conference, League of United Latin American Citizens National Women’s Conference, and many others). Staffing these events were employees who hold various positions within NCA to include cemetery directors, administrative staff, VACO personnel, as well as designated MVPCs.

This past Memorial Day, NCA held 118 ceremonies nation-wide reaching more than 100,000 people. These types of celebrations increase community awareness of the services and benefits provided by the administration. For 2010, NCA achieved a customer satisfaction index of 94 from the American Customer Satisfaction Index (ACSI). This is the fourth consecutive time in 10 years NCA has obtained this honor. ACSI is the only national, cross-industry measure of satisfaction with the quality of goods and services available in the United States.

VBA will collaborate with OPIA and Center for Minority Veterans (CMV) in the creation of an action plan for increased outreach and tailored messaging to targeted minority communities. VBA, in conjunction with OPIA, CMV, VHA, and NCA, will review and incorporate marketing strategies, materials, and feedback from other program coordinators (e.g., Women Veterans Coordinators). VBA will review after-action information to determine the effectiveness of the outreach delivery initiatives that include briefings, personal interviews, periodic conference booths and exhibits, and additional publications for minority communities (e.g., pamphlets and fact sheets that are printed in Spanish). VBA will increase and coordinate outreach activities, working with VACO elements, VBA regional offices, VAMCs, and VA cemeteries.

Actions to Implement

** Pending = suspense date established and being monitored*

VHA Action Plan – Recommendation #3					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Identify VHA program offices outreach efforts to minority Veterans.	Office of Communications (10B2)		Survey VISNs, VAMCs and program offices to identify outreach efforts to minority Veterans.	1 st quarter FY 2012	Pending
	Office of Communications (10B2)		Analyze data to determine most effective method of outreach.	1 st quarter FY 2012	Pending

	Office of Communications (10B2)		Use findings to develop comprehensive plan to be distributed VHA-wide to increase market penetration to minority Veterans.	1 st quarter FY 2012	Pending
NVO Action Plan – Recommendation #3					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Evaluate the effectiveness of outreach methods to minority communities conducted by individuals other than MVPCs by the end of FY 2011, and develop and implement an action plan in FY 2012 to increase market penetration in targeted minority communities.	National Veterans Outreach (075E)		Develop outreach plans, web resources, and training to assist VA administrations and program offices in unifying outreach communications through clear, accurate, consistent and targeted messaging.	4 th quarter FY 2011	Pending
			Provide project management of significant marketing and advertising contracts to ensure all Veterans and their families are aware of benefits and services. Advertising and marketing includes minority audiences as well as special emphasis areas.	4 th quarter FY 2011	Pending

VECS Action Plan – Recommendation #3					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Veterans Employment Coordination Service and ODI will provide CMV with annual data pertaining to its employment-related/recruitment outreach activities. If the recommendation is for other VA offices to evaluate their own effectiveness, we already do this through various affirmative employment reports, including MD 715 and the Federal Equal Opportunity Recruitment Plan/Report.	Veterans Employment Coordination Service (057)		Provide the Advisory Committee on Minority Veterans (ACMV) an update and status report during their 1st quarter FY 2012 meeting being held at VA Central Office.	1st quarter FY 2012	Pending
NCA Action Plan – Recommendation #3					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Determine the effectiveness of current outreach strategies.	Office of Diversity and ADR Programs (40A)	HR Communications Outreach Office	Conduct a three year analysis of current outreach measures to targeted communities to determine the level	4 th quarter FY 2012	Pending

			of effectiveness.		
Determine the skill level of MVPCs and other employees who participate in outreach events.	Office of Diversity and ADR Programs (40A)		Develop a training module that teaches outreach methodologies and techniques. Design and distribute new MVPC materials to assist coordinators in developing their local programs.	4 th quarter FY 2012	Pending
VBA Action Plan – Recommendation #3					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
VBA will meet with OPIA and CMV to create an action plan to increase outreach to minority communities.	Benefits Assistance Services (27)	Center for Minority Veterans Office of Public and Intergovernmental Affairs	VBA will gather materials from past and present marketing strategies to facilitate collaboration with CMV and OPIA.	1 st quarter FY 2012	Pending
VBA will review current outreach initiatives to identify areas requiring increased outreach.	Benefits Assistance Services (27)		VBA will review quarterly reports to identify areas where outreach should be increased and make recommendations.	2 nd quarter FY 2012	Pending
VBA will expand methods for targeted messaging to Veterans.	Benefits Assistance Services (27)	Center for Minority Veterans Office of Public and Intergovernmental Affairs	VBA will evaluate current messaging and devise a strategy to expand targeted outreach.	2 nd quarter FY 2012	Pending

4. Develop and implement an action plan to increase the utilization of Minority Veterans Program Coordinators (MVPCs) in all departmental targeted outreach activities to minority communities by 1st Quarter FY 2012. That MVPCs spend

an average of 25 hours per month on targeted outreach activities to minority Veteran communities with a goal of increasing the percentage of minority Veterans contacted to 60%.

Rationale: Review of MVPC reports from FY 2010 reflects that the outreach activities conducted by MVPCs resulted in minority Veterans being 40% of the overall total of Veterans contacted. As outlined in the VA Handbook 0801 for Minority Veterans Program Coordinators (MVPC), the primary purpose of MVPC outreach activities is to contact minority Veterans; therefore, the ACMV feels that a target of 60% is more appropriate to their responsibilities. MVPCs are the ambassadors or “eyes and ears” for the VA in minority Veteran communities. They are essential resources in developing targeted outreach messages and building trust-based partnerships with minority Veteran communities and other community stakeholders.

In addition, according to VA Handbook 0801 “Minority Veterans Program Coordinator” with respect to outreach, facility Directors should: “Ensure outreach to minority groups, supporting the MVPCs in conducting town hall/stakeholders/Veterans Service Organizations/Veterans meeting at a minimum twice per year to discuss issues and concerns.” It is unclear as to whether this is enforced consistently across all VA facilities. Given that in most facilities the role of MVPC is a collateral duty (less than or equal to 25%), it is imperative that facility Directors remain vigilant in ensuring MVPCs are fully integrated into facility operations to advocate on behalf of minority Veterans and to ensure that targeted outreach is conducted. In fact, the MVPC Handbook requires the VA facility director to “support the MVPC and ensure he/she is provided the necessary resources to effectively perform the functions inherent in this position (e.g. allow sufficient time to perform the duties, provide computer access/email, and fund project and or special programs, as required).” This population of Veterans will only grow over time, and MVPCs are essential in ensuring access to services and benefits through targeted outreach.

Action Office: VHA, VBA, NCA, and CMV

VA Response: Concur-in-principle

VHA agrees to increase the utilization of MVPC in all targeted outreach efforts to Veterans, including minority Veterans; however, developing and implementing an action plan may extend beyond the 1st quarter of FY 2012. Five VHA full-time MVPCs have made significant impacts in outreach to the minority Veteran communities. Full-time MVPCs work closely and collaboratively with community groups, Veterans Service Organizations, county, state and Federal officials to reach more minority Veterans; thus, significantly increasing the number of minority Veterans who are aware of VA benefits and health care services.

During the national MVPC training conference, NCA had seventy-one participants. During the training, the MVPCs were instructed in outreach strategies and how to develop a program. The Under Secretary for Memorial Affairs has mandated that all MVPC positions, which in the past were held by Cemetery Directors, be delegated to

another staff member so that more hours can be invested in outreach activities. The Under Secretary for Memorial Affairs and Office of Field Programs leadership participate quarterly in a NCA Minority Veterans Program briefing conducted by the Deputy Director, CMV, and Senior Management Analyst of the CMV office. The Deputy Under Secretary for Field Programs is working closely with regional leadership to ensure that hours per month of outreach activities are increased. In the FY 2011- 2015 NCA Strategic Plan, a strategy has been added which addresses redesigning the NCA Minority Veterans Program to ensure 90 percent of the reporting cemetery sites comply with critical elements as defined by the VA Handbook 0801.

VBA has designated MVPCs at all regional offices to conduct outreach to minority Veterans as part of their collateral duties. Outreach targeted to minority Veterans remains a top priority. Each regional office has an action plan for targeted outreach that requires MVPCs to conduct at least two town hall/stakeholders/Veterans Service Organizations meetings annually. Within available resources, VBA will continue to work toward the recommended outreach goals.

Actions to Implement

** Pending = suspense date established and being monitored*

VHA Action Plan – Recommendation #4					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
VHA will form a task group composed of representatives from the VISNs, VAMCs and program offices.	Office of Communications (10B2)		Conduct surveys and interviews with VISN and VAMC leadership regarding the role, and expectations of how MVPCs could be used more effectively.	1 st quarter FY 2012	Pending
VHA MVPC meets with VISN leadership.	Office of Communications (10B2)		Conduct surveys and interviews with MVPC to determine what assistance MVPCs need from VHA leadership.	1 st quarter FY 2012	Pending
	Office of Communications (10B2)		Collect and analyze data to develop an action plan to increase MVPC utilization in targeted outreach efforts to minority Veterans.	1 st quarter FY 2012	Pending

	Deputy Under Secretary for Health for Operations and Management (10N)		Review VISN outreach efforts to minority Veterans and develop a plan to increase the number of outreach efforts at the field level.	4 th quarter FY 2011	Pending
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VECS Action Plan – Recommendation #4

Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Although ODI and VECS do not specifically target minority Veterans, we will inform CMV of affinity group events that target minority populations to ensure MVPCs have an opportunity to participate in events where they may reach Veterans and/or their family members.	Veterans Employment Coordination Service (057)		VECS will provide ACMV with an update during their 1 st quarter FY 2012 meeting at VA Central Office meeting.	1st quarter FY 2012	Pending

NCA Action Plan – Recommendation #4

Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Ensure compliance with the critical elements as defined in VA Handbook 0801.	Office of Diversity and ADR Programs (40A)	Human Resources /Labor Relations	Redesign the MVPC program by developing on-site training and on-the-job instructions as well as a standard operations procedure guide for new MVPCs.	4 th quarter FY 2013	Pending
Realign MVPC	Office of Diversity and	Office of the Under	Revise the appointment	4 th quarter	Pending

duties	ADR Programs (40A)	Secretary for Memorial Affairs	criteria for field MVPCs.	FY 2011	
VBA Action Plan – Recommendation #4					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
MVPC will contact minority organizations to increase participation in outreach events.	Benefits Assistance Services (27)	CMV, VHA and NCA	Solicit minority organizations for outreach opportunities for the upcoming FY.	1 st quarter FY 2012	Pending
VBA will ensure that MVPCs conduct a town forum at least twice a year.	Benefits Assistance Services (27)		VBA will ensure VBA facilities meet outreach requirements of VA Handbook 0801.	1 st quarter FY 2012	Pending

5. Develop and implement, based upon input from minority Veteran focus groups, a culturally relevant communications strategy, by the end of FY 2011, to promote awareness of VA benefits and services to targeted communities.

Rationale: Members of the ACMV have experienced, first-hand through site visits and interaction with minority Veterans, the lack of a targeted communications strategy to reach the minority communities defined in the charter of CMV. This lack of communication has increased the chasm between minority Veterans and the majority community resulting in many minority Veterans going unenrolled for VA services and underserved by the Department. Members of the ACMV expressed the need to create targeted messaging to ensure that all Veterans are aware of the services and benefits afforded them, and how to connect with VA to receive these services. Additionally, images, imagery and messaging needs to be developed to ensure Veterans from all backgrounds are represented in the Department’s communications strategy to include: digital media, print media, online presence, etc.

Action Office: OPIA, VHA, VBA, NCA

VA Response: Concur-in-principle

VHA agrees to develop and implement culturally relevant communication strategy; however, developing and implementing a communication strategy may extend beyond the end of FY 2011. In the MVPC Handbook, VAMCs are tasked to conduct at least two town hall meetings each year. Minority Veterans at these town hall meetings are

provided various materials about VA benefits and health care services. Outreach methods such as the town hall meetings are tools used to educate minority Veterans and members of their community.

NCA continues the adaptation of One-VA support for minority Veterans' interest at the local community level. NCA, with the support of Veterans Service Organizations, affinity associations, minority institution of higher education, and faith-based groups will continue concentrating on improvements addressing the most apparent deficiencies and realize opportunity to improve performance. NCA's Office of Outreach has expanded its efforts to promote awareness of VA benefits and services to various communities. In FY 2010, NCA participated in sixty-six outreach events; and in FY 2011, we expect to participate in eighty-eight efforts. In addition to the Outreach Office, the Veterans Cemetery Grants Program staff participates in various outreach efforts to meet with State Directors of Veteran Affairs and Tribal Government Officials at National Tribal Government Conferences (e.g. National Congress of American Indians, United South and Eastern Tribal, Inc., Tribal Veterans Service Organizations, and individual Tribes) to promote the program and how VA, in its partnership, can assist in service to Veterans. In June 2011, NCA selected a full-time National MVPC who is tasked with enhancing the current MVPC program so that a greater awareness of NCA's benefits and services can be achieved.

VBA initiated a messaging campaign through the eBenefits portal that provides targeted messages to Servicemembers and Veterans about specific benefits based on personal and life-changing events. An example is messaging about the Native American Direct Loan program.

Actions to Implement

** Pending = suspense date established and being monitored*

VHA Action Plan – Recommendation #5					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Form VHA communication work group.	Office of Communications (10B2)		Identify existing VHA culturally communication strategies.	1 st quarter FY 2012	Pending
	Office of Communications (10B2)		Review and analyze strategies to determine effectiveness.	1 st quarter FY 2012	Pending
	Office of Communications (10B2)		Use findings to develop comprehensive	1 st quarter FY 2012	Pending

			culturally relevant communication strategy for dissemination VHA side.		
NCA Action Plan – Recommendation #5					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Identify and address areas of performance improvement.	NCA Outreach Office (41C2)		Continue working with VSOs, affinity associations, minority institution of higher education, etc. to identify areas to enrich the partnership between the organization and NCA.	4th quarter FY 2011	Pending
Improve Veterans' awareness of burial and memorial benefits.	Management. Support and Communication Services (41A)		Increase the percentage of Veterans who have heard about burial in a national and State or Tribal Government Veterans cemetery to 75 percent.	1 st quarter FY 2015	Pending
Expand the use of innovative methods for outreach to Veterans, their families, and the public.	Office of Diversity & ADR Programs (40A)	NCA Outreach Office	Acquire additional information from the Veteran population in order to evaluate the effectiveness of outreach programs.	1 st quarter FY 2013	Pending

VBA Action Plan – Recommendation #5					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
VBA will increase use of communications tools to reach Minority Veterans.	Benefits Assistance Services (27)	Center for Minority Veterans Office of Public and Intergovernmental Affairs	Create additional messages targeted to Minority Veterans.	1st quarter FY 2012	Pending

C. Access

6. That the Veterans Health Administration Office of Rural Health perform a comprehensive needs assessment to determine the impact of transportation barriers on the health of minority Veterans residing in rural, highly rural, and frontier areas.

Rationale: A member of the Advisory Committee provided a comprehensive briefing on the needs of the Veteran population in the Pacific Islands. A specific challenge in accessing care is the distance between islands (traversed by costly and time-consuming air transport): 1) Guam to Hawaii—3,820 miles; 2) Guam to American Samoa—3,629 miles; and 3) Guam to Federal States of Micronesia—570 miles. The issue of transportation is central to all outreach efforts and access to health care. Utilization of health care tends to decrease as distance traveled increases.⁶ In rural and remote areas such as the Pacific Islands and tribal communities, transportation to and from human services is woefully inadequate to overcome geographic barriers (long distances, mountain ranges, hazardous conditions in inclement weather). According to the VHA Office of Rural Health (ORH), 40% of American Indian/Alaskan Natives live on geographically isolated and dispersed reservations or tribal lands resulting in significant barriers to accessing quality care.⁷

For any outreach effort to succeed in eliminating disparities and healing patients, there must be a means for providers and Veterans to interact face-to-face. The primary mission in a patient-centric service is to bring the patient to the doctor or to bring the doctor to the patient; otherwise accurate diagnosis of a medical condition cannot occur. Partnering with community resources and leveraging pre-existing collaborations

⁶ Probst, J.C., Laditka, S.B., Wang, J., & Johnson, A.O. (2007). Effects of residence and race on burden of travel for care: cross sectional analysis of the 2001 U.S. national household travel survey. *BMC Health Services Research* 7:40. Retrieved April 30, 2011, from <http://www.biomedcentral.com/1472-6963/7/40>.

⁷ Department of Veterans Affairs, Veterans Health Administration, Office of Rural Health (ORH). (2011, January). Message from the director of the VHA office of rural health. *The Rural Connection* 1(1): 1-6.

including the MOU with Indian Health Services (IHS) can support the efficient assessment of transportation needs in order to ensure equitable access to services for minority Veterans in rural, highly rural, and frontier areas. Given the potential for rising gas prices and the inadequate transportation infrastructure in rural communities⁸, this needs assessment is an immediate priority in order to identify potential gaps and develop sustainable solutions for closing them.

Action Office: VHA

VA Response: Concur

In FY 2011, VHA’s Office of Rural Health (ORH) completed two types of comprehensive needs assessments in all VISNs -- the Geographic Needs Assessments and the Health Care Needs Assessments. These assessments are available for review on request. Additionally, VBA has implemented a pilot Transportation Study. ORH recommends the Committee consider consultation with the VA Transportation Office regarding Recommendation 6.

Actions to Implement

** Pending = suspense date established and being monitored*

VHA Action Plan – Recommendation #6					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Complete	ADUSH for Health Policy and Planning (10P1)		Conducted comprehensive geographic and health care needs assessments in all VISNs.		Complete

7. Develop an action plan to increase access to VA programs and services (VHA/VBA/NCA), and facilities for Veterans living in rural and outlying territories (insular areas) by 2nd Quarter FY 2012.

Rationale: During the Advisory Committee meeting, a member of the committee who resides on Guam provided an update on the needs and challenges for insular areas as follows:

1) Guam

- Veterans face numerous challenges in accessing health care:

⁸ Dabson, B., Johnson, T.G., & Fluhart, C.W. (2011, April). Rethinking Federal investments in rural transportation: rural considerations regarding reauthorization of the Surface Transportation Act. *Rural Policy Research Institute Policy Brief*, 1-20.

- There is no locally based Wounded Warrior or Residential Post-traumatic Stress Disorder (PTSD), Traumatic Brain Injury (BTI) treatment program.
- Returning Veterans with chronic PTSD, TBI had to wait receiving service connection category of at least 30% for the VA to cover transportation to Hawaii, and this process takes up to six months.
- There are no providers for Agent Orange and other Specialty Exams.
- There is no Home-Based Primary Care Program.
- There is no Skilled Nursing Facility and Long-Term Care Community Living Center.
- The recently constructed Community-Based Outpatient Clinic (CBOC) is too small to accommodate the number of Veterans seeking care.

To address these issues, VHA needs to allocate adequate resources and hire skilled and qualified personnel. Collaborating with DoD to use space for Veterans within the new Naval Hospital to be built on Guam may be one integrated solution.

- Space available in Veteran cemeteries is rapidly dwindling:
 - The cemetery will be completely filled by 2012.
 - No additional in-ground burials unless the coffin is oversized or it is a married couple.

To address this issue, NCA needs funding to perform environmental and geological testing on a new site immediately.

- Homeless Veterans: “Migrant” Veterans from off-island and on-island (homeless Veterans and family going from family to family and staying with them) are increasing in numbers.

It soon may be necessary to increase the number of vouchers for homeless Veterans to accommodate the needs and use space from the soon to be built Naval Hospital.

2) Saipan

- Veterans face numerous challenges in accessing health care and benefits:
 - VA has rented a space for the Rural Outreach Clinic, but the facility has neither personnel nor equipment (furniture, computers, etc.) in it.
 - Veterans often must pay out-of-pocket to be seen on Guam for their service-connected ailments. Itineraries are mailed but do not reach them on time.
 - VA toll-free numbers do not work with the exception of 800-827-1000, so Veterans cannot conveniently call for questions regarding health, GI Bill, or Memorial Services.

Given these challenges, it is essential that the relevant VA offices collaborate to fully evaluate the needs of minority Veterans in insular areas and develop an action plan to close these aforementioned gaps.

Action Office: VHA, VBA, NCA

VA Response: Concur

ORH has developed and implemented action plans to increase access to VA programs and facilities by expanding support and funding for telehealth services, through outreach activities, community based outpatient clinic development and expansion, home-based primary care program development, and transportation services. ORH has also completed the Geographic Needs Assessments and the Health Care Needs Assessments in all VISNs and continues to solicit input and information from rural and highly rural Veterans through focus groups, town hall meetings and numerous outreach activities, to better understand their needs and barriers to access.

VBA will collaborate with VHA to utilize the mobile Vet Centers for rural outreach. VBA will also utilize eBenefits to provide greater access to Veterans who live in rural and insular territories. VBA will determine the feasibility of using mobile Vet Centers and their employees to register rural Veterans in eBenefits. Currently, VA has 50 mobile Vet Centers to complement the 270 walk-in support Vet Centers.

Actions to Implement

** Pending = suspense date established and being monitored*

VHA Action Plan – Recommendation #7					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Complete	ADUSH for Health Policy and Planning (10P1)		Conducted geographic and health care needs assessments in all VISNs. Conduct town hall meetings and focus groups with rural and highly rural Veterans.		Complete
NCA Action Plan – Recommendation #7					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Execute FY 2011 Veterans Cemetery Grant Operating	NCA Veterans Cemetery Grant Service (40)		Award grants for all projects on the FY 2011 operating plan.	4th quarter FY 2011	Pending

Plan.					
Expand burial access for rural Veterans.	NCA Finance and Planning (41B)		Develop new rural policy for the Secretary's consideration.	4 th quarter FY 2011	Pending
Improve Veterans' awareness of burial and memorial benefits.	NCA Memorial Program Services (41A1)		Increase the percentage of Veterans who have heard about VA's headstones and burial markers in private cemeteries to 60 percent.	1 st quarter FY 2015	Pending
VBA Action Plan – Recommendation #7					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
VBA will collaborate with the VHA Vet Center Program to use mobile vans to conduct eBenefits in-person proofing.	Benefits Assistance Services (27)	Office of Field Operations VHA Vet Center	VBA will develop a formal training and access plan to promote the tools for granting premium eBenefits accounts.	2nd quarter FY2012	Pending

8. Develop a plan by the end of FY 2012 to implement where applicable the Seventeen Recommendations To Donor Agencies Resulting From the *Department of Interior Insular Area Health Summit September 2008*⁹ (pages 75 and 76 of report), and report progress on the plan to the ACMV during its annual meetings in Washington, DC beginning with the November 2011 ACMV meeting.

⁹ U.S. Department of the Interior (DOI). Future of healthcare in the insular areas summit. Retrieved May 12, 2011. http://www.doi.gov/oia/Firstpginfo/health_summit/documents/Entire%20Report_Insular%20Area%20Health%20Summit%20Report.pdf.

Rationale: The Veterans in the insular areas present unique challenges in developing systems to provide them with optimum care. However, this does not negate the Department’s responsibility to provide the best care possible. Then Secretary of VA, James Peake, stated the following during his remarks at the 2008 summit, “They (Insular Areas) share in a somewhat unique representation of the difficult challenges of rural health in general, complicated by the difficulties of island involvements. They have relatively small populations in terms of density and, therefore, lack the economic clout to bring all the services to bear that one would want. This is in the face of rising health expectations and the recognition of rising health care needs” (p. 29). The entire text of Secretary Peake’s remarks is located on pages 29-31 of the report.

A recent study¹⁰ examined perceptions of unmet health services needs among native Puerto Rican OEF/OIF Veterans and family members post deployment. Results of the qualitative study revealed that Veterans' unmet needs included psychological evaluations, mental health services, support groups, medical evaluations, and pain treatment. Denial and stigma emerged as factors that deter Veterans from seeking mental health treatment. The need for family support groups also emerged from the data.

Action Office: VHA

VA Response: Concur

VHA agrees to review the seventeen recommendations to donor agencies, and where applicable, develop plans for implementation. VHA recognizes that Veterans in insular areas present unique challenges in developing systems to provide them optimum care.

Actions to Implement

** Pending = suspense date established and being monitored*

VHA Action Plan – Recommendation #8					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Form work group.	Deputy Under Secretary for Health and Operations Management (10N)		Review 17 recommendations to donor agencies.	1 st quarter FY 2012	Pending
			Based on finding, develop a plan by the end of FY 2012 to implement where applicable to the 17 recommendations.	1 st quarter FY 2012	Pending

D. Disparities

¹⁰ Hannold, E.M., Freytes, I.M., & Uphold, C.R. (2011, April). Unmet health services needs experienced by Puerto Rican OEF/OIF Veterans and families post deployment. *Military Medicine* 176(4): 381-388.

9. Develop and implement by the end of FY 2011 strategy to enact guidelines in accordance with the Department of Health and Human Services (HHS) National Partnership for Action (NPA) Plan to End Health disparities, inclusive of holistic approaches to treating Veterans.

Rationale: On April 8, 2011, the Department of Health and Human Services (HHS) rolled out the National Partnership for Action (NPA) National Stakeholder Strategy for Achieving Health Equity and the HHS Action Plan for Reducing Health Disparities. This roadmap for reducing health and health care disparities is a comprehensive effort to address differences in health for racial, ethnic, and other underserved communities. VA was represented on the NPA Federal Team, and as a stakeholder is required to describe how the Department will address the strategies for achieving health equity and eliminating disparities. The HHS Disparities Action Plan outlines goals, strategies, and actions which will be taken to reduce health disparities among racial and ethnic minorities. The Disparities Action Plan builds on provisions of the Affordable Care Act which helps to address the needs of racial and ethnic minority populations by bringing down health care costs, investing in prevention and wellness, supporting improvements in primary care and creating linkages between the traditional realms of health and social services.¹¹ VA is a major health care organization and should be involved in the assessment and reduction of health care disparities within its facilities. According to a VA study performed by Saha et. al. (2007), health disparities exist in all clinical areas of the VA health care system and in studies examining quality indicators that represent intermediate outcomes, non-white Veterans generally fared worse than white Veterans.¹² These findings were consistent with those reported by the Agency for Healthcare Research and Quality in 2003 from the general population and every year thereafter. In addition, the VA study found that minority Veterans harbor less trust and more skepticism about the benefits of medical interventions relative to their risks than white Veterans. The report reflects that some African American Veterans in particular, rely on religious and spiritual avenues for coping with illness as opposed to medical therapies which are less culturally relevant.

With Veterans of all minority people groups, there are cultural differences within each group that make delivery of information and services difficult at best because the provider must be a trusted, culturally sensitive and understood healer. For minority Veterans, this means using a holistic approach to healing that is culturally relevant to all minority Veterans. What is relevant to white and foreign clinicians engender distrust and skepticism in the minority culture that has more often than not been neglected by the majority culture's business of healthcare that does not recognize the cultural relevance of holistic healing.

¹¹ Department of Health and Human Services (HHS). (2011). *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*.

¹² Department of Veterans Affairs, Health Services Research & Development Service (VA HSR&D). (2007, June). *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*.

Finally, the VA study also suggests that clinicians' diagnostic decision-making varies by Veteran race.¹³ Clinicians, medical and non-medical, are making diagnoses and treatment decisions based on biases and stereotypes rather than measured medical evidence interpreted by nurses and physicians. The cultures and belief systems of minority Veteran patients have two common elements that are excluded by the legal, scientific and current social/behavioral healthcare system. First, the authority speaking must be speaking the truth with compassion and respect. Second, the authority must be understood by the listener in the spirit. Minority groups have an identity that is more spiritually based. This is the cord that ties diverse minority cultures together. The locus of authority is Spirit and Truth rather than the clinicians and the misunderstood messages of the healthcare business system that have been adopted. Holistic healing beliefs and practices are a trusted reality in the cultures of minority Veterans. Patient belief in information offered depends upon the authority and integrity of the provider. If the process of every interaction does not value the whole person, spirit, soul, mind and body, then there is incomplete healing. For these reasons, a holistic approach to healing should become a part of the VHA Model of Patient-Centered Care and Cultural Transformation.

Action Office: VHA (Responses to recommendations 9, 10, and 11 are combined. See recommendation 11 for VA's response.)

10. Establish an Office of Health Equity (OHE) similar to the Offices of Minority Health (OMH) within the Department of Health and Human Services (HHS). The OHE would incorporate the OMH mission of improving health outcomes impacted by racial/ethnic differences, in addition to gender specific initiatives currently the responsibility of the VA Office of Women's Health (OWH), and also focus on the possible effects on clinical outcomes due to Veterans' sexual orientation.

Rationale: Although VHA has "concurred in principle" (2010 ACMV Report) with our original recommendation to establish an Office of Minority Veteran Health, there has been no presentation of the protocols that have been developed to address the health and protection of racial/ethnic and sexual orientation needs in Veteran populations. Furthermore, there was no presentation of the methods used to assess and ensure equitable delivery of healthcare services.

The mission of this office would be to gather, interpret, and evaluate research, and to develop health policies and programs to eliminate health disparities. This program may also be included in patient-centered care to ensure that all Veterans particularly those who experience disparities in care due to race/ethnicity, gender, and sexual orientation are receiving quality health care and positive health outcomes.

¹³ Ibid.

A systematic review and synthesis of evidence from studies comparing health care utilization and quality by race within VA was conducted by VA researchers.¹⁴ Their results indicate: “Racial disparities in VA exist across a wide range of clinical areas and service types. Disparities appear most prevalent for medication adherence; surgery and other invasive procedures- processes that are likely to be affected by the quantity and quality of patient–provider communication; shared decision making, and patient participation. Studies indicate a variety of likely root causes of disparities including: racial differences in patients’ medical knowledge and information sources, trust and skepticism, levels of participation in health care interactions and decisions, and social support and resources; clinician judgment/bias; the racial/cultural milieu of health care settings; and differences in the quality of care at facilities attended by different racial groups.” The researchers concluded that “existing evidence from the VA indicates several promising targets for interventions to reduce racial disparities in the quality of health care.”

Pursuant to the Patient Protection and Affordable Care Act, PL 111-148 of 2010, the HHS has received authorization and funding to establish six Offices of Minority Health for the purpose of improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities. Given the unique nature of the health care and outreach needs of Veterans and their families, the VA should establish an Office of Health Equity.

The review of existing programs and collaborations will not close the gap on disparities in clinical services for minority Veterans. Actions must include establishment of programs which acknowledge the disparity gap, and incorporate and implement robust measures.

Action Office: VHA

11. Develop an action plan by the end of the first quarter of FY 2012 with a goal of effecting a meaningful reduction in racial disparity among active patients enrolled in the VA healthcare system. A pilot should focus on reducing disparities in clinical outcomes such as blood pressure, glucose, and cholesterol control, at VA healthcare facilities with high concentrations of African American Veterans, as well as sites of high Hispanic/Latino, and Native American/ Alaska Native populations.

Rationale: According to Jha et. al. (2010), 9 out of 150 VA hospitals (6% of all VA hospitals) cared for nearly 30% of African American Veterans, and 42 hospitals (28% of all VA hospitals) cared for more than 75% of African American Veterans.¹⁵ In the decade following VA’s organizational transformation, the quality of care improved, and racial disparities were minimal for most process-of-care measures. However, these

¹⁴ Ibid.

¹⁵ Jha, A.K., Stone, R., Lave, J., Chen, H., Klusaritz, H., & Volpp, K. (2010). The concentration of hospital care for black Veterans in Veterans Affairs hospitals: implications for clinical outcomes. *Journal for Healthcare Quality* 32(6): 52-61.

improvements in clinical performance were not accompanied by meaningful reductions in racial disparity for important clinical outcomes such as blood pressure, glucose, and cholesterol control.¹⁶

As affirmed by the Institute of Medicine, linking clinical performance measures to race and ethnicity data can yield important insights for health care organizations seeking to improve the quality and equity of their care. Because cardiovascular disease and diabetes are major contributors to racial disparities in life expectancy, research studies in health disparities highlight the need for immediate and focused efforts to improve intermediate outcomes among black Americans in the VA and other health care settings.¹⁷

In the course of developing this proposed action plan, VHA has a large amount of past research to formulate initiatives as part of the action plan to reduce disparities. In spite of this research however, most VA studies have examined differences between whites and African Americans and have either excluded other groups or not included them in sufficient numbers for meaningful analysis. As the VA patient population becomes more diverse, it will be important to include sufficient numbers of Latinos and other minority groups in future studies.¹⁸

Action Office: VHA

VA Response: Concur-in-principle.

VA is constantly evaluating Veterans' needs; new health care models to make access more efficient and equitable; barriers to patient-centered access and outcomes; as well as the quality of care and services provided. The Principal Deputy Under Secretary for Health convened a Health Care Equality Work Group in June 2011, to address the reasons for inequality in health care whether they are cultural, clinical, spiritual, geographical, patient or provider, educational or related to other barriers for patients to receive appropriate individualized health care with desired outcomes. Small sub groups have been formed in targeted interest areas to ensure a broad view of issues, focused recommendations, and implementation of recommendations occurs to improve Veterans' experience with the VHA health care system.

The goals of this Work Group are to develop a VA systematic approach to continuously evaluate and communicate information related to equitable, Veteran-centric interactions with VA's health care system. The Work Group has begun to: 1) Review needs for education and training at the professional, patient, and community levels to address diverse and inclusive programs to benefit the Veteran population; 2) Evaluate

¹⁶ Trivedi, A.N., Grebla, R.C., Wright, S.M., & Washington, D.L. (2011). Despite improved quality of care in the Veterans Affairs health system, racial disparity persists for important clinical outcomes. *Health Affairs* 30(4): 707-715.

¹⁷ Ibid.

¹⁸ Department of Veterans Affairs, Health Services Research & Development Service (VA HSR&D). (2007, June). *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*.

behavioral and communication practices that impact provider/patient interactions, services and support systems; 3) Consult and review research literature and Veteran experiences related to social and economic impacts on care including cultural, spiritual, age and gender factors that affect Veteran experience with VA; 4) Convene discussions with subject-matter experts on clinical practices effecting service delivery, and capture data to better assess the needs of Veterans and provider satisfaction with services for potential areas of inequity; 5) Evaluate geographic and environmental factors regarding access and availability of health care in rural, highly rural, and other communities including the potential of toxic environmental exposures; and 6) Will provide initial recommendations in the form of a report to the Principal Deputy Under Secretary for Health on the Work Group's progress, further direction and deliverable milestones for implementation of recommendations to VHA leadership including enhancements or solutions to barriers for equitable health care and services delivery.

In 2011, VHA established several other initiatives to address disparities or inequality including implementing a patient aligned care team model at all VA primary care sites to enhance access, coordination, communication, and continuity of care for VA patients. A key facet of this model is to identify factors in high-risk patient populations with complex chronic medical problems to improve their health care and clinical outcomes. VA is making major investments to support patient health behaviors, including implementing health risk assessment and culturally-sensitive behavioral counseling at all of our facilities.

Also, because VA recognizes that healthy lifestyles are a function of whole communities and not limited to the health care system, VA is investing in a national program of telehealth that connects patients to their medical care teams outside of the traditional face-to-face clinical visit. VA's research program is providing a critical analysis of what we know about disparities and efforts to reduce them. To advance VA's position as national leaders in the campaign to address health disparities and inequalities, VA prioritizes research in this area, supports Centers of Excellence focused on health disparities research, and will explore strategies that can be implemented to improve access, processes of care, clinical outcomes, and will also highlight community partnerships that are needed to reduce disparities that lie beyond the health care system.

VA created the Office of Patient-Centered Care and Cultural Transformation to develop personal, patient-centered models of care for Veterans who receive health care services at VA's more than 1,000 points of care across the Nation. This will enhance VA's ability to continue as a national leader in innovation and showcase the future of high-quality health care to our Veterans.

VA is committed to the transparency of quality and safety performance measures, and in 2011, VA facilities began reporting comprehensive network and facility-level quality, safety, and satisfaction data by race (minority versus non-minority) and gender. Current comparison data for regional outcomes in key health areas can be found at VA's Hospital Compare Web site (<http://www.hospitalcompare.va.gov/index.asp>). Specific

references to VA's process of monitoring and tracking disparities, ethnicity and other statistical criteria may be found at:
http://www.va.gov/health/docs/Hospital_Quality_Report.pdf (pages 7, 15, 16 and 24).

Actions to Implement

* Pending = suspense date established and being monitored

VHA Action Plan – Recommendations # 9, 10, 11					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Complete	Principal Deputy Under Secretary for Health (PDUSH)(10A)		#9 – Recognizing the importance of a unified national effort to solve inequalities, VA joined Department of Health and Human Services as an active member of the National Partnership for Action to End Health Disparities.		Complete
Complete	Deputy Under Secretary for Health and Management (10N)		Established a designated office to develop strategies for a program of personal, patient-centered models of care for Veterans who receive health care services at more than 1,000 VA points of care across the Nation.		Complete
Complete	Deputy Under Secretary for Health Policy (10P)		VHA PDUSH established by charter a multidisciplinary team of subject matter experts in health care disparity and equality in June 2011.		Complete
The Office of Research and Development performs a literature review.	Deputy Under Secretary for Health (10A)		Work Group will develop guidelines, strategy, and policies as may be required by the recommendations.	1 st quarter FY 2012	Pending

Complete			The Evidence-based Synthesis Program is conducting a review of interventions that can reduce disparities and will publish results.		Complete
To be determined by the Health Care Equality Work Group.			#10 - Work Group will conduct research to examine potential for establishing an Office of Health Equity in addition to other current initiatives and make recommendations to VHA leadership.	1 st Quarter FY 2012	Pending
To be determined by the Health Care Equality Work Group.			#11 - Work Group will develop an action plan with the goal of effecting a meaningful reduction in racial disparity and other inequalities among patients enrolled in the VA health care system.	1 st Quarter FY 2012	Pending

E. Homeless

12. Increase funding to collaborative partnerships, with Community Based Organizations (CBOs) and Non-Government Organizations (NGOs) that provide assistance to homeless Veterans. This funding should enable more mental health programs and supportive services for low income targeted minority Veterans, regardless of gender in order to reduce minority Veteran homelessness by 25% by the end of FY 2012.

Rationale: Although VA has made great progress in reducing homelessness, minorities continue to be overrepresented among homeless Veterans¹⁹. In 2009, twice as many poor Hispanic Veterans used a shelter at some point during the year compared with poor non-Hispanic Veterans, and African American Veterans in poverty had similar rates of homelessness. Current estimates by the National Coalition for Homeless Veterans (NCHV) suggest that roughly 56% of all homeless Veterans are African American or Hispanic. Minority cultures do not look favorably on acknowledging mental illness or seeking help and treatment for mental health. In fact, the stigma of mental illness among some ethnic/racial minority groups may discourage people from seeking

¹⁹ U.S. Department of Housing and Urban Development (HUD) and Department of Veterans Affairs (VA), National Center on Homelessness Among Veterans. (2011). *Veteran Homelessness: A Supplement to the 2009 Annual Homeless Assessment Report to Congress*. Retrieved May 2, 2011 from <http://www.hudhre.info/documents/2009AHARVeteransReport.pdf>.

mental health care, medication, and counseling.²⁰ Therefore, illnesses like PTSD may be left untreated.

Given the disparate impacts of homelessness on minority Veterans, it is imperative that VA ensures that the mental health programs and supportive services funded are focused on the unique needs of homeless Veteran families, with a particular emphasis on reintegration services, emergency shelters, and transitional housing for not only homeless women Veterans with small children, but also for homeless male Veterans with small children (considering the rising number of U.S. households with single fathers). Hispanic, African-American, Asian, and Native American children are more likely than Euro-American children to reside in single-father families.²¹ Although no U.S. studies of the issues faced by single fathers were found, a study conducted in Australia revealed that single fathers faced challenges similar to single mothers including the need to leave situations of domestic violence to seek safety for their children, finding and maintaining secure and flexible employment, accessing childcare, and most importantly finding appropriate and affordable housing.²² In many cases, single fathers experience biases and stereotypes and have even more difficulty accessing services due to the untraditional nature of the household.

The VA should ensure that an integrated effort among the VHA, VBA, and OPIA be taken to address the health needs of homeless minority Veterans who may need ongoing and long-term care, particularly in the areas of mental health.

Action Offices: VHA, VBA and OPIA

VA Response: Concur

VHA has been working with community agencies to provide outreach and treatment services to homeless Veterans for more than 20 years. VHA recognized that effectively addressing the multiple needs of homeless Veterans rely on coordination of services from multiple sources, including Community-Based Organizations and Non-government organizations. In response to VHA's commitment to these organizations, VA developed the new Supportive Services for Veterans Families Program (SSVF), authorized by Public Law 110-387. The SSVF program, recently passed and awarded, will award grants totaling approximately \$50 million to non-profit organizations and consumer cooperatives providing supportive services to very low-income Veterans families by providing a range of supportive services designed to promote housing stability.

²⁰ Primm, A.B., Vasquez, M.J.T., Mays, R.A., Sammons, O., Posey, D., McKnight-Eily, L.R., Presley-Cantrell, L.R., McGuire, L.C., Chapman, D.P., & Perry, G.S. (2010, January). The role of public health in addressing racial and ethnic disparities in mental health and mental illness. *Preventing Chronic Disease Public Health Research, Practice, and Policy* 7(1): 1-7.

²¹ The Pennsylvania State University. (2006, Feb). Diversity in people: single-father families. *Diverse Issues* 7(1): 1-8. Retrieved May 2, 2011 [http://diversityeducation.cas.psu.edu/Newsletters/DIVol7\(1\).pdf](http://diversityeducation.cas.psu.edu/Newsletters/DIVol7(1).pdf).

²² McArthur, M., Zubrzycki, J., Rochester, A. & Thomson, L. (2006, Sept). 'Dad, where are we going to live now?' Exploring father's experiences of homelessness. *Australian Social Work* 59(3): 288-300.

The number of minority homeless Veterans participating in VA's specialized homeless program are roughly consistent with those seen in the homeless Veteran population. Specifically, in FY 2010, 48 percent of participants were White; 42 percent were African American, 7 percent were Hispanic, and 3 percent were another ethnicity. Although no significant changes in participation were evident among various ethnic groups over the last 5 years, clinical data suggests a gradual decrease in the participation of African American Veterans (from 46 percent to 42 percent). Conclusively, the SSVF program, along with VA's extensive array of other homeless Veterans and mental health programs, should address the needs identified, while playing a critical role in VA's plan to end homelessness among Veterans.

VHA has primary responsibility for funding allocated for homeless and low-income Veterans. VBA will continue to collaborate with VHA to assist minority Veterans and minority Veterans at-risk of homelessness through referrals and coordination.

Actions to Implement

** Pending = suspense date established and being monitored*

VA Action Plan – Recommendation #12					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Complete	Homeless (10NC1)		Develop a new Supportive Services for Veterans Families Program (SSVF), as authorized by Public Law 110-387. Award grants totaling \$50 million dollars to not-for-profits organizations that provide housing stability programs.		Complete

F. Legislative Change

- 13. Propose legislation that will change the requirement for an annual report from the ACMV to a biennial report.**

Rationale: Currently Public Law 103-446 requires the ACMV to submit an annual report to the Department by July 1st of each year, and that report with the Department's responses to the ACMV recommendations is due to Congress on September 1st of each year. The ACMV conducts its annual Washington, DC meeting normally within the first quarter of the fiscal year, and its site visit in the third quarter of the fiscal year. Therefore, the current timeframe precludes ample time for the Department to develop initiatives in response to the recommendations that can be reported during the ACMV's annual meeting in Washington, DC and be made part of the minutes reflected in the annual report. A biennial timeframe would allow the Department more time to develop, measure, and document initiatives that have been taken in response to the ACMV recommendations.

Action Offices: Office of General Counsel (OGC), Office of Congressional and Legislative Affairs (OCLA), Advisory Committee Management Office (ACMO), CMV

VA Response: Concur

CMV will submit a proposal to change the requirement for the ACMV Annual Report to a biennial requirement subsequent to receiving concurrence from appropriate staff offices and approval by VA leadership. The request will be submitted in the spring of 2012 with the FY 2014 legislative proposals.

Actions to Implement

** Pending = suspense date established and being monitored*

VA Action Plan – Recommendation #13					
Steps to Implement	Lead Office	Other Offices	Tasks	Due Date	*Current Status
Submit proposal to change ACMV Annual Report to become a biennial report beginning in FY 2013.	Center for Minority Veterans (00M)	Office of General Counsel	Secure concurrence from OCLA, ACMO, OGC	4th quarter FY 2011	Pending
		Advisory Committee Management Office	Submit proposal for change to in reporting requirement by end of 1 st Quarter FY 2012	1st quarter FY 2012	Pending

Part II - Briefing Highlights

April 4-8, 2011

Monday, April 04, 2011 Briefings:

Overview of the Federal Advisory Committee Act and Department of Veterans Affairs Advisory Committees (Acting Advisory Committee Management Officer)

- Provided briefing handouts/list of VA Advisory Committees names and objectives. Discussed role of ACMV and Designated Federal Officer.
- Federal Advisory Committee Act (FACA), Public Law 92-463; codified in 5 U.S.C. App, 41 C.F.R. Parts 101-6 and 102-3.
- Group managed by VA and includes nongovernmental members who meet regularly to give collective advice to the VA.

Center for Minority Veterans Update (CMV Staff)

- Provided briefing slides on minority Veterans' demographics,
- Key functions of the Center for Minority Veterans,
- Recurring ACMV Recommendations and VA Responses,
- Current CMV Areas of Focus and,
- Top concerns of the following Veteran populations:
 - o Hispanic,
 - o African American,
 - o Native Americans,
 - o Asian American and
 - o Pacific Islanders.

Ethics Training for Special Government Employees (Office of General Counsel)

- Provided briefing slides and information on Special Government Employees,
- Ethics advice,
- Financial disclosures,
- Ethics laws,
- Conflicts of Interest,
- Gifts, and
- Hatch Act, etc.

Minority Veterans Demographic Data (Office of Policy & Planning)

Provided briefing slides on the following:

- o Demographics
- o Socio-economics
- o Utilization of VA benefits and services
- o The way ahead including enhanced efforts to gather demographic data.

Office of Diversity and Inclusion (ODI) (Deputy Assistant Secretary, ODI)

- Discussed the Committee Management Directive 715, FY 2010 EEO Report/FY 2011 EEO Plan and the Department of Veterans Affairs Diversity and Inclusion Annual Report FY 2010.
- The three goals are:
 - o Create a diverse, results- oriented, high-performing workforce that reflects the communities we serve by identifying and eliminating barriers to equal opportunity;
 - o Cultivate a flexible and inclusive work environment that enables full participation through strategic outreach and retention and,
 - o Facilitate outstanding customer service and stakeholder relations by promoting cultural competency, accountability, education, and communication.
- OMB established ethnic race categories.
- Develop a targeted Hispanic outreach strategy to address the chronic under-representation of Hispanics in VA's workforce, particularly those with targeted disabilities.
- Accomplishments:
 - o Mandatory diversity training for Managers/Supervisors in four different areas, EEO Compliance, Reasonable Accommodations, Conflict Management, and Alternative Dispute Resolution.
- Deficiencies:
 - o .72 capital rate on discrimination rate (it is way too high)-reason for state of the art training, (rate has dropped to .67).
- Leadership development (integral part of development is on diversity).
- ODI initiated an adverse impact analysis project to identify and address potential barriers in VA's recruitment and selection processes.

Veterans Employment Coordination Service (Director, VECS)

- Provided briefing slides on the following:
 - o Government-wide Veteran Employment Initiative,
 - o VECS Mission,
 - o Background,
 - o Activities,
 - o Communication/Marketing Plan,
 - o VECS Success, and
 - o Contact Info.
- Helps Vets get jobs in the VA.
- "One-Stop" web portal as a single-source for Veteran employment information is at www.fedshirevets.gov.

Round Table Discussion with Ex-Officios

Department of Commerce, Defense, and Labor Ex-Officios provided brief overviews of their Department's mission and services provided to Veterans. These topics included:

- Transition Assistance Program
- Partnering with Veterans Affairs (i.e. E-benefits, Benefits Delivery Discharge, Integrated Disability Evaluation System)
- Disability Process System-members will be leaving the military with a disability rating).
- Veteran's unemployment rate.
 - o In 2010 the unemployment rate for all Veterans was 8.7%, compared with 9.4% for non-Veterans. Young male Veterans (those ages 18 to 24) who served during Gulf War Era II had an unemployment rate of 21.9% in 2010, not statistically different from the jobless rate of young male non-Veterans (19.7%)
 - o In March of 2011, the unemployment The Labor Department's Bureau of Labor Statistics reported on April 1 that the national unemployment rate fell slightly from 8.9% in February to 8.8% in March. This marks the 13th month of overall growth in jobs, although the increases remain small.
 - o The overall unemployment rate for all Veterans in March fell to 9% and to 10.9% for Veterans who have served on active duty since the 2001 terrorist attacks.

Committee After Action Review

ACMV Sub-Committees:

Health:

- Ms. Clara Adams-Ender
- Ms. Amanda R. Heidenreiter
- Dr. Wayne Nickens
- Dr. Celia Renteria Szelwach
- Mr. Benjamin Palacios
- Dr. Garth Graham (HHS - Ex-Officio)
- Dr. Robert Stanton (DOI - Ex-Officio)
- Ms. Vivieca Wright-Simpson (VHA-Ex Officio)

Benefits:

- Mr. Allie L. Braswell, Jr.
- Mr. Oscar B. Hilman
- Mr. James T. McLawhorn
- Mr. Lupe Saldana
- Ms. Shoshana Johnson
- Mr. Pedro Molina
- Mr. Joe Wynn

- Ms. Darlene Jones (VBA-Ex Officio)
- Mr. Gordon Burke (DOL-Ex Officio)

Tuesday, April 5, 2011 Briefings:

National Cemetery Administration (Acting Under Secretary for Memorial Affairs)

- Provided briefing handouts/NCA News.
- Provided updates on Committee Recommendations ref. MVPC Coordinator, Targeted Outreach, Inclusive Publications/Media, Homelessness, Leadership Tracking, and Diversity and Inclusion Strategic Plan.
- First Native American monument will be built at Riverside National Cemetery, CA. ACMV member is on the committee for this memorial. Donations are coming from several Native American Tribes.
- Two levels of leadership in the field: Cemetery Directors and Middle Managers.
- Gay/lesbian couples, cannot be buried together according to Federal Law, Federal Law states the couple must be male & female.
- If a service member's discharge has been upgraded, they can be moved to a National Cemetery.
- American Battle Monuments Commission (<http://www.abmc.gov/home.php>), manages members buried overseas and the Tribes want these members re-located to the States to be buried on Tribal lands. Second option is the Tribes can pay to have them returned to the States.
- Adult-unwed daughters can be buried in these cemeteries.
- Veterans have a burial option in every State in the Union.
- 90% of the Veterans will have a burial option.
- NCA has 5 Tribal applications, and possibly a 6th pending submission.
- If there is an 80,000 Veteran population in an area NCA will review/consider establishing a cemetery.
- NCA will send invites to the Committee members to the opening ceremonies located within their areas.

Veterans Health Administration Briefing/Update (Deputy Under Secretary)

- Secretary's 3 main priorities: healthcare access, reduce backlog VBA claims, end homelessness.
- Discussed health care, driving long distances and access.
- Telehealth, barely scratching the surface. This is a huge initiative for VHA.
 - o There is a greater demand in serving Veterans in rural areas.
- Need to train their providers and learn best practices – Veteran by Veteran – learn what the Veteran needs.

QUESTION: What is the most pressing challenge?

ANSWER: Old infrastructures/maintaining old buildings – getting assets located where there is growth, getting medical centers in the right places, budget deficits, the economy, etc. We do not understand or respond to culture effectively. VHA needs to

take one Veteran group at a time (African American, Asian, Hispanic, Native American, etc).

QUESTION: What is VHA doing to increase the sensitivity of their providers?

ANSWER: Need to be Veteran/Patient-centric – have Veterans/Patients take charge of their care.

The Committee encouraged/recommended that the speaker/VHA Leadership in the field support their Minority Veterans Program Coordinators and request an update of their outreach efforts to get an understanding of what these MVPCs have to deal with in providing outreach to Veterans in their areas.

Life is Power that Heals (Committee Member)

Provided briefing/handouts on topic - “physical injury of brain memory is the problem, power that heals is the only solution.”

Veterans Population in the Pacific Islands (Committee Member)

Provided a briefing on the challenges and conditions of Veterans residing in the Pacific Islands and available programs and services.

Paws for Purple Hearts Program Video (Recent OEF/OIF Committee Member)

Dogs in training learn about 99 different commands to assist Veterans with activities of daily living.

Veterans Benefits Administration (Principal Duty Under Secretary of Benefits)

VAs’ goals include:

- No case over 125 days and the SECVA goal is 98% accuracy rate
- Goal to go completely paperless
- Current accuracy rate is 84-85%

QUESTION: How are the adjudicators held accountable in overlooking critical evidence for claim and causing the delay?

ANSWER: Adjudicators need to build trust to go out and ask for assistance in obtaining records. Veterans have to request civilian records if they see a physician in the community and this takes time. We are trying to do away with this by building a complete record. VBA is building communication and engendering trust. VA must make sure we recognize the digital and economic divide. Generational divide as it relates to technology. WWII Vets prefers a phone call.

QUESTION/COMMENT: Still hasn’t heard how the adjudicator overcomes issues that are common sense (i.e. lost records). How are you factoring time line for appeals? If

there are three or more issues, one or more are denied. Then the Veteran comes back to file appeal which becomes part of the backload.

ANSWER: In overhauling new practice will simply call the Veteran instead of waiting the 60 days. Not able to answer all questions, however we addressing these type of issues.

QUESTION: How do you promote diversity and grow minorities to become leaders.

ANSWER: Effort and energy is put into junior employees (GS-12-13) to groom. 50% of the VBA workforce has been with VBA for 5 years. Promote training and opportunities of advancement. We were also successful in recruiting young people out of college.

COMMITTEE MEMBERS' COMMENTS:

- Select the best and brightest. You must use different rules in selection of minorities because they have never been valued and viewed in this way. Cultural Competency is important.
- Diversity is important for an organization. The organization should reflect the diversity of the community for which we live in to ensure every ethnic group is represented.
- Minorities live in the shadow of towering contradictions. When you look at the number, in order to move the needle you must confront the contradictions.
- Inclusion breeds opportunity. Concentrate on inclusion. Among minorities it peak's out at GS-8 (in VBA). Hope that you are including HBCU's, HACU, and Tribal colleges in your recruitment efforts.

QUESTION: How do you monitor regions with high error rates?

ANSWER: 57 RO's and we monitor their quality and provide detailed training - 80 hours. Training provided is performance based. If specific errors are noticed they will go back and review. We are very detailed on quality and review. How can we do better with quality? By automation, with technology we can get a boost in quality using technology. We must build trust and confidence among the Veterans.

COMMITTEE EX-Officio MEMBER (DoD): We are standing up a C&P office that is a part of their examination. This will be their job.

COMMITTEE MEMBER: Recommended the Speaker take a look at VA Form 21-0760 with reference to Post 9-11 GI Bill, Vocational Rehabilitation and other VA benefits to see if there is a disparity among the minority Veteran population. Also requested that VBA provide data regarding utilization of these benefits by minority Veterans.

CMV DIRECTOR: Issues with MVPCs located at the Regional Offices are on production and the only time they can outreach is during the weekends.

- MVPCs are not compensated for the weekend.
- Need to have access to their Directors.

Wednesday, April 6, 2011 Briefings:

Chief of Staff, Department of Veterans Affairs

2010 ACMV report is the first report with action items and proposed timeframes from the 3 Administrations.

Apologized for the delay in signing the report from last year but it took that long to incorporate the change in crafting responses to reflect an action plan and milestones. Advocacy is a mind set. You think Veterans and families, first.

- VA leaders will have another meeting in New Orleans to develop a VA creed.
- To be a competent organization-every part of the organization is performing to excellence.
- Reviewing hiring challenges and initiatives.

Panel Discussion:

Director, Center for Women Veterans
Director, Center for Faith Based and Neighborhood Partnerships
Office of Survivors Assistance

Director, Center for Women Veterans

- Center for Women Veterans was created in 1994, by Public Law 103-446.
- Primary Mission- monitor programs and services for women Veterans.
- Advocate for Women Veterans.
- Raise awareness of programs and Services for Women Veterans offered by VA
- Ensure women Veterans are treated with respect and dignity.
- Disparities in health care among women Veterans are immunizations and cardiac care.
- Expecting 700 registrants for the July 15-17, 2011 National Summit on Women Veterans' Issues.

Director, Center for Faith Based and Neighborhood Partnerships

- Three significant changes that exist currently under the Obama Administration.
 - o Name changed-White House Office for Faith Based Initiatives.
 - o Significantly interagency collaboration.
 - o Advisory Council for the White House.
- Grants.gov (search for grant opportunities/USAspending.gov (identify grant opportunities)).

- 12 Federal Agencies have Faith Based Centers.
- Goal to do at least 1 roundtable forum in rural communities.
- New Pilot Program in Durham, N.C., called families at ease.

Director, Office of Survivors Assistance

- Office of Survivors Assistance was created by Public Law 110-389 (serve as a resource regarding all benefits and services furnished by the Department to survivors and dependents of deceased Veterans; and survivors and dependents members of the Armed Forces).
- Key is Access.
- 530,000 Survivors.
- 35.2 million Veteran dependents (spouses, dependent children) of living Veterans.
- Included in the VA/NCA Strategic communication outreach plan.
- Presently finalizing OSA outreach brochure.

Acting Executive Director, Office of Small and Disadvantaged Business Utilization

- Basic for our business is the Small Business Act. This Act provides Government wide contracting goals.
- VA goals for SDVOSB 10% AND VOSB is 12%.
- SDVOSB AND VOSB's are priority goal for the VA.
- Thomas Lenny, new Director of OSDDBU.
- To do business with the VA you must be verified by January, 2012.
- OSBU is working on a May 25, in Chicago to have representatives from all VA acquisitions offices within VA.

* National Veteran Owned Small Business Symposium - August 18-25 in New Orleans, Louisiana

Panel Discussion:

Office of Public & Intergovernmental Affairs Representatives:

Assistant Secretary Public & Intergovernmental Affairs
 Director, Office of Tribal Government Relations
 Director, Homeless Program Office

Assistant Secretary Public & Intergovernmental Affairs

Office of Public & Intergovernmental Affairs has two components:

- Relationships with county, government, international and state.
- New programs (3 main ones are) New social media office (unblocked to Facebook and other social media sites) to engage and increase outreach to Veterans (Vietnam Veterans are our largest growing population of users on VA website).

- Office of Tribal Government Relations (some of the negotiations with tribal government were happening on an ad hoc basis) (Native American and Pacific Islander Veterans the rate of obesity is very high among these groups, if we could prevent 1 percent from developing diabetes it would save over 12 million dollars).
- VA Central Office Program to end homelessness.
- National Outreach Office to increase outreach to Veterans across the country (contract to buy advertising).
- Consumer Help Line.

Director, Office of Tribal Government Relations

President Obama issued an executive order to all federal agencies to develop an office of tribal government relations.

- Tribal Government Relations concentrate on the leadership
- Focuses on Five Regions:
 - 1st Region (ND, SD, MN, WI, MI, IA, OK, KS, and NE (VISNs 23,12, 11, and 15).
 - 2nd Region (CA, NV, UT (NN portion), CO, NM, TX, and AZ (VISNs 18, 19, and 21).
 - 3rd Region (WA, ID, MT, UT, WY, and OR).
 - 4th Region (FL, AL, MS, LA, NY, NC, and SC).
 - 5th Region AL, HI, Pacific Insular areas.
- Working with State Directors in Northwest to set up a Tribal meeting.
- In process of hiring representatives for Office Regions 4/5 will be covered by Central Office.
- Issue/Concern of Tribal Government.
 - Health care facilities offered by IHS and Tribal clinics.
- Pharmaceutical provided to these facilities are provided by VA, however, the contract is up next year.

Director, Homeless Program Office

There are 6 strategic pillars in regards to what we are going to do to end homelessness:

- Treatment and Prevention
- Outreach
- Education
- Income
- Community Partnerships
- Housing

Current estimate number of homeless Veterans on a given night, approximately 75,000; by July next year, estimate will be 59,000 or less.

SPEAKER: We do know targeted programs to minority Veterans are meeting and exceeding its goal. Each of you should participate in homeless summits/CHALLENGE meetings at the local VAMCs. Urban League and others need to be engaged in these meetings. We will make sure we get you engaged, as the SECVA wants us to connect to service providers.

QUESTION: How are you building relationships with all 500 to 600 cultures (Native Americans/Pacific Islanders)? Draw upon resources that you have if you want to build these relationships with Native Americans. If you come in dictating, it will become a survival issue. Involve those that you are going to serve with those within the Department.

ANSWER: We want to create our regional positions to build collaboratively relationships and invite employees within VA to brainstorm on these issues. The regional specialist will interact regionally. Acknowledged awareness of working with cultural communities in gaining trust and respect.

QUESTION/COMMENT: Committee member stated that she volunteered at the Baltimore Station where homeless Veterans are located in Baltimore. She asked what the Baltimore Station was doing for homeless women Veterans and was told that they were turned down for funding because statistically there were not enough homeless women Veterans.

SPEAKER: For several years there has been priority funding for women Veterans programs. Not familiar with this case. We do know that women Veterans are the fastest growing population, younger, and have children.

Assistant Secretary OPIA: Currently there are under 7,000 homeless women Veterans. We are doing a better job in counting homeless Veterans. 60% of homeless Veterans are from peacetime.

SPEAKER: There are Homeless Veterans Coordinator at each VAMC, network, and regional office.

Part III - Town Hall Meeting – Washington, DC VAMC Site Visit

Town Hall Meeting

Wednesday, April 6, 2011

Background

A Veterans Town Hall Meeting was held for the purpose of hearing Veterans, family members, and survivors' concerns, answering questions, and providing information concerning current initiatives underway by local VA facilities. VA leadership from the Washington DC VA Medical Center and Washington VA Regional Office, along with a representative from the Office of the Under Secretary for Memorial Affairs joined ACMV members on the panel during the duration of the Veterans Town Hall Meeting. Approximately 150 Veterans and other stakeholders were in attendance. We also were provided on-site support through the efforts of staff from AARP, Maryland Health Care System Veterans Center van, and the Minority Veterans Program Coordinator from the Washington, DC VA Medical Center. The majority of the Veterans in attendance were Vietnam Era Veterans, with the remainder being Cold War and Korean War Era. There were very few Veterans from the current conflicts in attendance. Many of these Veterans rely on written letters, face-to-face and telephone contact to secure the information they need from the VA.

Town Hall Meeting Observations

The common themes addressed during this session were as follows:

- Many Veterans were not clear as to the current status of their claims. Some were aware of the E-Benefits system, but most rely on telephone calls and letters for information.
- Veterans did not have a clear understanding of the appeals process and the evidence required to grant an increase in benefits.
- Veterans expressed frustration about the lack of accurate information they received from VA representatives by phone
- Veterans were frustrated with the delays encountered processing their claims.
- Advocates for homeless Veterans felt that increased emphasis based on priority was required on processing claims for homeless Veterans.
- Veterans needed assistance to properly file their claims.
- Veterans were not adequately aware of assistance available from various Veterans advocates within and external to the VA.
- Clarification was requested concerning accommodations that could be made for funeral arrangements based on religious and cultural preferences.
- Several Veterans expressed their appreciation for services received at VA facilities.

The themes addressed during the Veterans Town Hall Meeting demonstrate an ongoing need for each VA Administration to incorporate outreach as part of its mission. Veterans already utilizing VA benefits and services inform VA how it is doing via customer satisfaction surveys. The vast majority of Veterans are not constant users of VA benefits and services. Some of this is due to the fact that the past use of education and home guarantee benefits satisfied their needs at the time used. In many cases, Veterans do not discuss the benefits that are due with family members and spouses. Sadly, in many cases, when a Veteran expires, survivors are not aware of burial benefits for the Veteran, and survivor benefits that the spouse may receive. The minority Veteran population historically experiences challenges meeting financial and health issues. It is essential that public information and outreach services are provided to all Veterans, their families, and survivors to increase access to VA benefits and services during time of need.

Thursday, April 7, 2011 Briefings:

Washington, DC VAMC Site Visit

Panel Discussion: DC VA Medical Center

Director

Protocol & Special Event Coordinator (Director's Office)

Minority Veterans Program Coordinator

Deputy Chief Nurse Outpatient Operations (Women Veterans)

Homeless Coordinator

Designated Training Officer

Associate COS for Research

Business Office

VAMC Director

Addressed issues from Town Hall meeting concerning Veterans from the Community Living Center (CLC):

- VAMC conducts monthly Town Hall meetings at the CLC.
- Will have VBA representative to visit monthly to do claims.
- Received approval for a bus for the CLC.
- Alexandria CBOC is moving to Fort Belvoir Military Base.
- 71,633 enrolled Veterans.
- Academic affiliations (Howard University, Washington University, Georgetown University) joint deans and committee meetings.
- Over 2,400 staff representing 25 nationalities (minority representation 75%).
- 61% AA/1% American Indians/% Hispanics/% Asian.
- Over 500 homeless Veterans at winter haven.
- VLER (staff can pull up records from DoD/Fort Belvoir).

QUESTION: What is the status for construction of the new parking garage?

ANSWER: An average of 100 cars park at Soldier's Home every day. There is limited space due to completion of Fisher House and of domiciliary. Construction is not for a couple of years.

Minority Veterans Program Coordinator

- Hosted National Diversity Day.
 - o Presentation on Narrative Medicine-shift paradigm between patient and provider (provider sits down with patient and discusses what brought the patient to them).
- Developed cultural competence model for both staff and patients.
 - o Conduct in-service for staff (particular to mental health).
- Focusing on recruitment of minority Veterans in work place.

- Interns from HBCUs, HACU and native programs.
- Partnership with Washington Internships for Native Students (WINS) and American Indian Sciences and Engineering Society (AISES).
- Collaborate with HBCUs, CBC, Redskins Health Fair, Winter Haven.

Deputy Chief Nurse

- Offer comprehensive care and gender specific care.
- Awaiting ground breaking to a 5,000 facility (current space is 2,000).
- Currently seeing 2,500 women Veterans.

QUESTION: Do you see a lot of retired women Veterans coming into women's health?

ANSWER: Yes that population has increased.

Homeless Coordinator

- Providing health care and mental health for our homeless Veterans.
- 95% of male homeless population are Veterans/ 5% are women.
- Total Veterans housed 520/625, 83%.
- 77 bed domiciliary
 - payment based on income

Designated Training Officer

- Satisfied employee reaps a satisfied patient.
-
- **Developmental Programs**
 - One Day Self-Development-design personal development plan (6-month individual coaching/mentoring).
 - Succession Planning-employees need to position themselves to move into positions. Discuss performance based interviews/8 core competencies (High Performance Model).
 - Coaching and Mentoring Certification Workshop-core training to quality as a certification as a coach/mentor.
- **Leadership Development Programs**
 - School at Work (SAW) GS/WG 1-6 –work with reading and math skills/communication skills. A six month program.
 - Leadership Effectiveness, Accountability and Development (LEAD) - 1 year program, GS/WG 7-10.
 - Leadership Development Institute (LDI) Program-Enhance individual skills among a cadre of employees to assess their leadership potential and career with VISN for GS/WG 11-13.

Associate Chief of Staff for Research

- 247 active projects-90% clinical and relate to human studies.
- FY10 total grant funding \$17,817,406 (VA & non-VA).
- Research today improves health for everyone.
- Largest HIV population in all VA (partnership with area institutions in DC developmental center for AIDS research funded by NIH for 3.5 million dollars x 5 years).
- TBI/PTSD program is only related to OEF/OIF.
- Health Disparities are complex mix of socioeconomics.

QUESTION: Are the Veterans from the CBOCs included in these research studies? If yes, is there a comparative study being done between urban and rural Veterans using the CBOCs.

ANSWER: Yes.

QUESTION: How is this research translated to clinical practice?

ANSWER: Comparative effectiveness research, new science, to compare in a systematic way different approaches (diagnostics).

Business Office

- Priority Group 5 (Medicaid eligible, Non-Service connected) declines but moving to another group. Could be related to VBA grant of claim
- Priority Group 8.
- Huge number in Priority Group 1, 2, and 3.
- VA stopped collecting data on demographic but focus on gender. New enrollees are less than the last few years for both groups. More women have enrolled.

VSO PANEL

Blind Veteran Association

Cecilia Montenegro

President, Executive Committee VAVS, VAMC (also member of American Legion Auxiliary)

Blind Veteran Association

- Transportation issues among blind Veterans (to go to a blind center for non-service connected Veterans they would have to pay \$1,000, (Guam to Hawaii).
- Diseases prevalent among minorities that could lead blindness (diabetes, glaucoma).
- This could be an issue for both urban and rural Veterans.
- Blind Veterans feel independent once they participate in blind rehab.

- Become more dependent on family and this will lead to more health issues and depression.

President, Executive Committee

- People are willing to donate to assist Veterans (does special gift bags for Veterans).
- Very rewarding to help Veterans.

Part IV – Exit Briefing With VACO Leadership Representatives

Thursday, April 7, 2011 Exit Briefing

Topics discussed included Access, Diversity, Homelessness, Veteran Satisfaction, Burial Benefits, and Minority Veterans Program Coordinators (MVPC).

1. Access

- ACMV requested clarification on eligibility/access for transportation for blind Veterans and DAV transportation criteria for wheelchair bound Veterans.
- Impediments to access for Veterans identified as a lack of appropriate transportation and a lack of coordination of outreach initiatives.
- Veterans in insular areas pose unique challenges in providing access to benefits and services.
- Veterans in South Texas are aware of VA initiatives to increase access to medical care, but are still interested in a VA hospital being built in that area.
- Veterans have expressed frustration with the 800 lines used by the VA. Note: VA Secretary is aware of this issue and has set a 90-day timeline to identify challenges and solutions to 800 line issues.
- Native American Veterans have unique needs for traditional healing programs.

2. Diversity

- Continued focus on a lack of minorities in senior leadership of VA is required.

3. Homelessness

- Emphasis needs to be placed on the challenges in the homeless Veteran, Veteran employment, and incarcerated Veteran programs, not just the successes.
- Some view homelessness as a symptom of rather than a condition. A holistic approach to healing should be included in our healthcare model.

4. Veteran Satisfaction

Organizations need to accurately and continually measure client satisfaction to respond appropriately to changing needs.

5. Burial Benefits

- Veterans have requested information on accommodations that are made for burials based on religious and cultural needs.

6. MVPC

- Veterans in the communities are not aware of the role and presence of the Minority Veterans Program Coordinators.

Appendix A – Washington, DC Meeting Site Visit Agenda

Agenda

Sunday April 3

Travel Day

Monday April 4

**Administrative Briefings- VA Central Office (VACO) C-7
(810 Vermont Ave, NW, Washington, DC 20420)**

8:00 AM	9:30 AM	Ms. Lucretia M. McClenney , Designated Federal Officer and Mr. JT McLawhorn , Chairman Opening and Remarks/Introductions/Review Agenda/ACMV Admin
9:30 AM	10:00 AM	VA Advisory Committee Management- Ms. Vivian Drake , Acting Committee Management Officer
10:00 AM	10:15 AM	Break
10:15 AM	11:00 AM	CMV Update- Mr. Earl Newsome /Role of Advocacy- Chairman JT McLawhorn
11:00 AM	11:30 AM	VA Ethics Briefing- Ms. Anne Kopley , Attorney, Office of General Council
11:30 AM	12:30 PM	Policy and Planning Briefing/Update- The Honorable Dr. Raul Perea-Henze , Assistant Secretary for Policy & Planning and Mr. Dat Tran , Supervisory Management Analyst, Office of Policy & Planning
12:30 PM	1:30 PM	Lunch (On your own)
1:30 PM	2:45 PM	Human Resources and Administration Briefing/Update- The Honorable John I Sepúlveda , Assistant Secretary for Service Human Resources and Administration, Ms. Georgia Coffey , Deputy Assistant Secretary for Office of Diversity and Inclusion and Mr. Dennis May , Director of Veterans Employment Coordination Services
2:45 PM	3:00 PM	Break
3:00 PM	4:00 PM	Round Table Discussion w/Ex-Officios
4:00 PM	5:00 PM	Committee After Action Review/Submit Sub-Committee Notes
5:00 PM		Adjourn

Tuesday April 5

Administrative Briefings- VA Central Office (VACO) C-7

8:00 AM	8:30 AM	Ms. Lucretia M. McClenney , Designated Federal Officer and Mr. JT McLawhorn , Chairman Opening Remarks/Review Agenda
8:30 AM	9:30 AM	National Cemetery Administration Briefing/Update- Mr. Steve L. Muro , Under Secretary of Memorial Affairs
9:30 AM	9:45AM	Break
9:45 AM	11:45 AM	Veterans Health Administration Briefing/Update- The Honorable Dr. Robert A Petzel , Under Secretary for Health
11:45 AM	1:00 PM	Lunch (On your own)
1:00 PM	2:15 PM	Presentation by Dr. Wayne Nickens , Advisory Committee Member
2:15 PM	2:30 PM	Break
2:30 PM	4:30 PM	Veterans Benefits Administration Briefing/Update- Mr. Michael Cardarelli , Principal Deputy Under Secretary for Benefits
4:30 PM	6:00 PM	Committee After Action Review/Submit Sub-Committee Notes
6:00 PM		Adjourn

Wednesday April 6

Administrative Briefings- VA Central Office (VACO) C-7 and Town Hall

8:00 AM	8:30 AM	Remarks/Photo Op John Gingrich , Chief of Staff of Veterans Affairs
8:30 AM	9:00 AM	Ms. Lucretia M. McClenney , Designated Federal Officer and Mr. JT McLawhorn , Chairman Opening Remarks/Review Agenda
9:00 AM	9:15 AM	Break
9:15 AM	11:00 AM	Panel Discussion- Dr. Irene Trowell-Harris , Director of Center for Women Veterans, Rev. E. Terri LaVelle , Director of Center for Faith Based, Ms. Debra Walker , Office of Survivors Assistance, and Mr. Doug Carmon , NGO Ombudsman
11:15 AM	11:30 AM	Break
11:30 AM	12:30 PM	Office of Small and Disadvantaged Business Briefings- Mr. C. Ford Heard , Executive Director Administrations
12:30 PM	2:00 PM	Lunch (On your own)
2:00 PM	3:30 PM	Office of Public & Intergovernmental Affairs Briefing/Update- The Honorable Tammy Duckworth , Assistant Secretary of Public & Intergovernmental Affairs, Stephanie Birdwell , Director Assistant Secretary, and Ms. Susan Angell , Director of Homeless Programs
3:30 PM	4:15 PM	Travel From VACO To Town Hall (Springfield, Virginia)
4:15 PM	6:30 PM	Dinner /Prepare for Town Hall/Submit Sub-Committee Notes
6:30 PM	8:30 PM	VA Town Hall- Springfield Hilton Springfield, VA
8:30 PM	9:00 PM	Travel From Town Hall to Hotel
9:00 PM		Adjourn

Thursday April 7

Site Visit Briefings- Off Site/Administrative Briefings- DC VAMC (50 Irving Street, NW) and 1575 Eye Street NW, Suite 400

8:00 AM	8:45 AM	Travel From Hotel to DC VA Medical Center
8:45 AM	9:15 AM	Ms. Lucretia M. McClenney , Designated Federal Officer and Mr. JT McLawhorn , Chairman Opening Remarks/Review Agenda
9:15 AM	12:30 AM	Veterans Health Administration- DC VA Medical Center Briefing, Mr. Jeffrey T. Gering , Acting Medical Center Director
12:30 PM	1:45 PM	Lunch at DC VA Medical Center (On your own)
1:45 PM	2:30 PM	Travel To 1575 Eye Street NW, Suite 400 (across from VACO)
2:30 PM	2:45 PM	Break
2:45 PM	4:15 PM	Exit Briefing with Three Administrations
4:15 PM	5:00 PM	Committee After Action Review/Submit Sub-Committee Notes
5:00 PM		Adjourn

Friday April 8

Administrative Briefings- VA Central Office (VACO) C-7

8:00 AM	9:00 AM	Ms. Lucretia M. McClenney , Designated Federal Officer and Mr. JT McLawhorn , Chairman Opening Remarks/Review Agenda/Administrative Paperwork
9:00 AM	9:30 AM	Public Comments
9:30 AM	11:00 AM	Review Notes and Sub Committee Meeting
11:00 AM	12:00 PM	Draft of Report
12:00 PM	1:00 PM	Lunch (On your own)
1:00 PM	3:00 PM	Draft of Report

Appendix B – Committee Biographies

Advisory for Minority Veterans 2011 Bios

Clara L. Adams-Ender, Brigadier General (Retired), USA African American

Brigadier General Clara L. Adams-Ender is President and Chief Executive Officer of Caring About People with Enthusiasm (CAPE) Associates, Inc., a management consulting and inspirational speaking firm. She received her baccalaureate degree in nursing from North Carolina Agricultural and Technical State University, Greensboro, North Carolina; a Master of Science Degree in Nursing from the University of Minnesota, Minneapolis, Minnesota, and a Master of Military Art and Science degree from the Command and General Staff College, Fort Leavenworth, Kansas. She has also been awarded twelve honorary doctorate degrees in law, public service, humane letters and science. General Adams-Ender rose from a staff nurse in the Army Nurse Corps to become chief executive officer for 22,000 nurses, a Brigadier General and Director of Personnel for the Army Surgeon General. She was Vice President for Nursing at the prestigious Walter Reed Army Medical Center, and was the first female in the Army to be awarded the Expert Field Medical Badge. She also commanded an army post, a position equivalent to city manager, magistrate and mayor of a city. General Adams-Ender is a past Chair, Board of Directors, Andrews Federal Credit Union, and a former member of the Defense Advisory Committee on Women in the Services (DACOWITS). She was recently selected as Chair, Board of Directors, THE ROCKS, INC., and appointed to the Board of Medicine of the Commonwealth of Virginia. She has received many awards for her community service, including the Roy Wilkins Meritorious Service Award of the NAACP, the Regents Distinguished Graduate Award of the University of Minnesota and the Lifetime Achievement Award of the National Black Nurses Association.

Allie Braswell, USMC African American

Mr. Allie Braswell, Jr. served 13 years in the United States Marine Corps. He holds a Bachelor of Science degree in Information Technology from American Intercontinental University. Prior to his current role as President and CEO of the Central Florida Urban League, Allie held the position of Senior Manager of Global Strategies for Diversity and Inclusion at Walt Disney Parks and Resorts. Mr. Braswell is the past Chairman of Leadership Orlando Alumni and a member of the Board of Governors for the Orlando Regional Chamber of Commerce. Most recently, he was appointed as an Army Reserve Ambassador by the Chief of the Army Reserve. Allie also serves on the Board for Quest, Inc., and MyRegion.org. In May 2009, he was honored by the General Daniel “Chappie” James Chapter of the Tuskegee Airmen, Inc. in recognition for his service to the community. In his spare time, Allie enjoys spending time with his wife, Rosemary, and their five children.

Amanda Heidenreiter, Captain (Retired), USA
Asian American

Ms. Amanda Heidenreiter was commissioned as a Second Lieutenant into the United States Army Chemical Corps, May 2006. She attended all mandatory training prior to arriving at her first duty station. Ms. Heidenreiter deployed with 1 Brigade, 82nd Airborne Division out of Fort Bragg, North Carolina. She joined the military because she had a great family lineage of Army, Air force, Navy and Marines. Ms. Heidenreiter felt it was her patriotic duty and it has been the only lifestyle she has known; the military life. While deployed in support of OIF, she suffered injuries to her back, neck, knees and head. Ms. Heidenreiter was sent to Landstuhl Army Medical Center where the determination was made that her injuries required further treatment and care and was sent to Walter Reed Army Medical Center in Washington DC. There she was a Wounded Warrior from March 2008 to December 2009. On December 15, 2009, Ms. Heidenreiter retired from the Army as a Captain. While she was a Wounded Warrior, she participated in a program called Paws for Purple Hearts. Ms. Heidenreiter learned how to train Service Dogs that would eventually be placed with fellow Veterans if they met all the requirements for a Service Dog. Presently, she still helps them out, but now more as a networking assistant and attends college. Ms. Heidenreiter is working towards becoming a Physician Assistant. Ms. Heidenreiter resides in Maryland.

Oscar B. Hilman, Brigadier General (Retired), USA
Asian American

Brigadier General Oscar Bautista Hilman was born in Libmanan, Camarines Sur, Republic of Philippines. He graduated from Central Washington University with Bachelor of Science in Law and Justice and he received his Masters of Science Degree in Strategic Science from the United States Army War College. He received his commission through the Officer Candidate School in 1977. He was an enlisted man and attained the rank of Sergeant First Class (E-7) before commissioning as Second Lieutenant. His military education includes Armor Basic and Advanced Courses, Tank Commander Course, Combined Arms Services Staff Course, United States Army Command and General Staff College, United States Army War College. While assigned as United States for Property and Fiscal Officer for State of Washington (USC Title 10), he attended numerous courses in finance and resource management, procurement and contracting, audit and internal review, facilities and base management, supply and logistics management, and human resource management courses.

General Hilman served as Commander of the 81st Brigade Combat Team in support of Iraqi Freedom II (2004-2005) where his brigade received two combat streamers. His brigade secured seven forward operating bases (Scania, Camp Bucca, Tallil and Cedar, Kalsu, Baghdad, Green Zone, LSA Anaconda/Balad Air Base). While at Anaconda, the 81st Brigade set up a Joint Defense Operating Base to protect the air base and major logistic base. Soldiers of Task Force Tacoma conducted combat operations to protect thousands of military and civilians at LSA Anaconda and Joint Balad Air Base. Additionally, the 81st Brigade also assisted the Iraqis at their first national election and

transfer of sovereignty. He retired as Deputy Commanding General, I Corps and Fort Lewis.

His awards and decorations include: Legion of Merit with Oak Leaf Cluster, Bronze Star Medal with Oak Leaf Cluster, the Meritorious Service Medal with 4 Oak Leaf Clusters, Army Commendation Medal with 2 Oak Leaf Clusters, Global War on Terrorism Expeditionary Medal, Global War on Terrorism Service Medal, Humanitarian Service Medal, and the Combat Action Badge. General Hilman resides in Tacoma, Washington with his wife Patty.

**Shoshana N. Johnson, Specialist (Retired), USA
Black Hispanic**

Ms. Shoshana Johnson, a second-generation Army Veteran, was born in the Republic of Panama to Panamanian. She attended the University of Texas at El Paso, and later joined the US Army in September 1998. In February 2003, Specialist Johnson received orders to deploy to Iraq as a Food Service Specialist, (92G) with the 507th Maintenance Company, 552 Battalion 11th Brigade. On March 23, during Operation Iraqi Freedom, Specialist Johnson was in a convoy that was ambushed in the city of an-Nasiriyah. Specialist Johnson received a bullet wound to her ankle, causing injuries to both legs. She and 5 other members of the 507th Maintenance Company were captured and taken Prisoners of War. House raids conducted by US Marines in the city of Samarra, Iraq, resulted in the successful rescue of seven POWs on the morning of April 13. Specialist Johnson retired from the Army on a Temporary Disability Honorable Discharge on December 12, 2003. US Army officials identified Specialist Johnson as the first female POW of Operation Iraqi Freedom, and the first black female POW in US war history. Since her return to the United States, Specialist Johnson has received numerous awards, and recognition for her courage, valor, and service to the United States. She resides in El Paso, Texas.

**James T. McLawhorn, Jr.
African American**

Mr. James 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 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.

Pedro “Pete” Molina, USA
American Indian

Mr. Pedro “Pete” Molina is the first in the nation Assistant Secretary for Native American Veterans in the California Department of Veterans Affairs (CalVet), he was appointed by California Governor Arnold Schwarzenegger. In his tenure as Assistant Secretary Molina has worked on various initiatives including the 2010 Native American Day held at the State Capital to reach out to the Native American population. Other outreach efforts include the collection of reintegration forms from Native American Veterans, establishing a database filled with Native American contacts, creating the Native American Veterans Newsletter called the “Drum Beat,” and Memorandums of Understanding with Native American Health Care systems. Prior to being appointed to Assistant Secretary, Mr. Molina worked at the U.S. Department of Veterans Affairs where he served in many positions. He has served as American Indian Program Manager, Marketing & Community Relations Representative, Minority Veterans Program Coordinator (MVPC), and Hispanic Veterans Program Manager. Mr. Molina served in the U.S. Army from 1970 to 1973. He is a member of the Yaqui Nation from Tucson, Arizona. Mr. Molina resides in Fresno, California.

Wayne Nickens, M.D.
Native American

Dr. Wayne Nickens received a B.S. from Howard University in 1968 and an M.D. from George Washington University in 1972. In his 37 years of practice, Dr. Nickens has directed family practice clinics, served as Clinical Director and Medical Director of various hospitals, wellness centers, and chemical dependency treatment centers. Dr. Nickens is certified by the American Society of Addiction Medicine (ASAM) as an addiction medicine specialist. He is the author of *“Not Guilty, Not Crazy”, Alcoholism is an Inherited Disease* (1986) and wrote and developed the continuum of care program for chemical dependency treatment for the State of Nebraska, the Cherokee Nation, and Charter Hospital.

From 2007 to 2010 Dr. Nickens has taught Military Chaplains and Chaplain’s Assistants, soldiers, military commanders, Veterans, and families from his new book “Eat Me, the Ultimate Diet” at Tripler Army Hospital, AMR, and Schofield Barracks in Hawaii, and Fort Sill in Oklahoma, courses on the physical basis of stress related illness and a holistic model for healing. He was consulting researcher in a DoD research paper titled PTSD AND THE NATIVE SOLDIER published 2009. He is present chairman of the Hawaii chapter of the Blue Star Families. Dr. Nickens was also named Principal Investigator of a Congressional Medical Research Project to test Advanced Technology for measuring brain stress and effectiveness of interventions to promote healing in brain injury.

Dr. Nickens is serving on the board of the Veterans Engagement Research Center of Pittsburg, PA and has served the interests of homeless Veterans and their families nationally for 37 years. He is founder and Chief Overseer of the Healing Community, consultant to Native Hawaiian Veterans, LLC in Hawaii, the NANAINA Nurses, the Comanche Nation, and the Cherokee elders.

**Benjamin C. Palacios, Command Sergeant Major, USA (Retired)
Pacific Islander**

Mr. Benjamin Palacios retired from the United State Army in May 2003 after serving for 32 years; Mr. Palacios worked as the Vice President for Green Millennium Industries, Ltd., in Seoul, Korea. In November 2004, Ben joined the Anteon Corporations as a Business Development Manager for the Pacific region which covers the Republic of Korea, Guam, Japan, and Okinawa. In August 2007, Ben relocated back to Guam and opened his own consulting company. He assisted several companies to include COMARK, HNTB, CH2MHILL, and Kellogg Brown and Root and established their businesses on the island. He is an Associate Partner for Doran Capital Partners and opened and managed their office on Guam. He also served as an Advisor for POONGSAN Corporations and HK Industry, Ltd. In December 2009, Mr. Palacios started working for Science Application International Corporation (SAIC) as an Assistant Vice President, Regional Account Manager for Guam and CNMI region.

He is a member of numerous professional organizations to include the Association of the United States Army (AUSA), the Noncommissioned Officer Association (NCOA), the AFCEA, and the Pan Pacific American Leaders and Mentors (PPALM).

**Lupe G. Saldana, USMC
Hispanic**

Mr. Lupe Saldana was born in Corpus Christi, Texas. He attended the University of Corpus Christi on a boxing scholarship. After graduation, he began his public service career as a Commissioned Officer in the U.S. Marine Corps from 1965 to 1971. He rose to the rank of Captain while serving a tour of duty in Vietnam in 1968.

Mr. Saldana resigned his commission as a Regular Marine Corps Officer in 1971, while stationed at Headquarters Marine Corps in Washington, DC, to become a public servant and an advocate for Veterans' issues. He joined the American GI Forum in 1972 and was elected National Commander in 1979. As National Commander, he represented the American GI Forum before the Administration, Congress and Federal government.

In March 1980, Mr. Saldana was named a member of the Vietnam Veterans Memorial Committee (The Wall) and addressed the first National Vietnam Veterans Memorial Service on March 26, 1980. In October 2005, the Secretary of Veterans Affairs, James Nicholson, appointed him to serve as a Secretarial Appointee on the Advisory Committee on Women Veterans. In December 2010, he was re-elected to the Executive Committee of the Veterans' Entrepreneurship Task Force (VET-Force).

Mr. Saldana has a bachelor's degree in Business Administration and Economics and a graduate Certificate in Urban Affairs from American University. In 1984, he completed the Contemporary Executive Development Program for Senior Executives at George Washington University and the Washington Executive Seminar at the USDA Graduate School in June 1986. In May 2006, Mr. Saldana retired after 41 years of Public Service. He resides in Fairfax Station, Virginia.

**Celia Renteria Szewach, DBA, USA
Hispanic**

Dr. Celia Renteria Szewach provides project management and technical leadership of public health projects focused on rural, women, and minority Veterans as program manager for Atlas Research. She has over 21 years of experience as an internal and external consultant guiding large-scale change, business partnerships, client and community relations, and organizational communications in industries such as Fortune 100 defense, Fortune 100 food and beverage, durable manufacturing, pharmaceutical, healthcare, professional services, federal government, education, and non-profit.

As an officer and senior-rated parachutist in the U.S. Army Transportation Corps at Fort Bragg, NC, she coordinated logistics requirements for the 18th Airborne Corps Emergency Operations Center (EOC) during Desert Storm and managed logistical operations for two humanitarian service deployments in support of Hurricane Andrew disaster relief in Homestead, Florida and Haitian relief in Guantanamo Bay, Cuba. From 2006 to 2009, Dr. Szewach was appointed by the VA Secretary to serve on the 14-member VA Advisory Committee on Women Veterans. She also completed a three-year term on the Bay Pines VA Medical Center's Women Veterans Health Committee in St. Petersburg, Fla. Since 2007, she has served as founder and director of WOVEN Women Veterans Network, a global online community committed to helping women Veterans successfully transition from military service.

Dr. Szewach is a Certified Compliance and Ethics Professional (CCEP) and teaches ethics, leadership, and managing change for several universities. She holds a B.S. from the United States Military Academy at West Point, an MBA in International Trade from the University of Sarasota, and a Doctor of Business Administration (DBA) in Management from Argosy University. Her research interests include: Veterans' and women's health, ethics, leadership and culture change, emotional intelligence, and cultural competence/disparities in healthcare. She resides in Asheville, North Carolina.

**Joe Wynn, USAF
African American**

Mr. Joe Wynn, Executive Director of the National Association for Black Veterans (NABVETS) National Capital Area, serves as their Legislative Liaison on Capitol Hill. NABVETS, a certified Veteran service organization, headquartered in Milwaukee, Wisconsin, since 1978, has over 35 Chapters and thousands of members in cities around the country. In 2004, he founded the Veterans Enterprise Training & Services

Group, Inc. (VETS Group), a non-profit organization that provides entrepreneurial education, federal procurement training, employment assistance and other supportive services primarily for Veterans, people with disabilities and persons of limited means.

Mr. Wynn received an Honorable Discharge from the U.S. Air Force at the end of the Vietnam War and has been an advocate for Veterans for more than 19 years. Through the VETS Group, Joe is helping to develop an initiative to increase the number of capable and qualified Veteran and service-disabled Veteran owned businesses. Partnerships are being formed with large corporate enterprises to offer Veterans employment opportunities, business education, mentoring, technical assistance, growth capital, and access to international markets. In recent years, while also serving as a Senior Advisor to the Director of Government Relations for the Vietnam Veterans of America, Joe has provided testimony to Congress on matters pertaining to federal procurement and Veterans' employment; served on the Veterans Disability Benefits Commission; and is on the Executive Committee of the Veterans Entrepreneurship Task Force (VET-Force), which is composed of over 200 organizations and affiliates representing thousands of Veterans throughout the U.S. that monitor the impact of legislation on Veterans procurement programs.

Mr. Wynn is the current Chairman of the Armed Services and Veterans Affairs Committee for the NAACP-DC Branch; member of the Veterans Health Council and the Mayor's Veterans Advisory Board for the District of Columbia. In 2005, Joe was appointed by the Honorable Nancy Pelosi to serve as a Commissioner on the Veterans Disability Benefits Commission that completed its work in early 2008.