



Combined Veterans' Association

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H

September 26, 2003

Capital Asset Realignment for Enhanced Services
U.S. Department of Veterans Affairs
Washington D.C.

To the CARES Commission,

For a great many years, veterans in Northwest Washington have been patiently and relatively quietly waiting for medical care closer to home. Some have braved the worsening traffic and long drives, while still others have chosen to do without, putting their health at risk.

Those that decide to use the VA system must first wait for an appointment. This takes longer, on average, than most veterans are willing to wait; especially if they must wait for a specialty clinic appointment. Waits have been known to average from 30 to 90 days. Some have waited more than six months.

Upon obtaining their appointment, many veterans must endure in excess of 6 hours of round trip driving which doesn't even include the traffic difficulties, which have become a daily occurrence. Some veterans are not capable of driving themselves due to pain or endurance issues. Vans are available, but do not service veterans with wheelchairs or walkers.

Once these veterans get to Seattle, they must now attempt to locate a parking space. This has become an impossible task for anyone who comes with an afternoon appointment or is in a wheelchair van that requires a space to one side or the other of their van. If the veteran comes 1-1/2 hours before their appointment, they just might have a better chance of getting a parking space. This requires that those in distant areas must leave home for their appointment from 4 to 6 hours in advance. After waiting up to two hours past their appointment time to see their physician, they must now brave the drive home with only enough money in their pocket to pay half of the cost of the travel. They will have spent the better part of a day for that appointment, not to mention the frustrations of traffic, parking, and waiting.

There are over 110,000 veterans living in a 5-1/2 county area (Whatcom, Skagit, Island, San Juan, Snohomish and Chelan), which represents one of the largest veteran populations per capita in the State. There are over 1/6th of



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the state's veterans in this area with no VA facility within reasonable distance.

This 5-1/2 county area, about the size of Vermont, has 46,000 MORE veterans than Vermont, which has a VAMC AND three CBOC's. Some states have CBOC's equivalent to one for every 10,000 veterans. For Washington State, that number is one for every 167,000! At the very least, NW Washington needs two CBOC's to better serve its veterans.

Washington State, as a whole, ranks 12th among states for veteran population but only receives funding enough to rank 30th in the nation for VA spending. Washington State is a large, rural State and should not be treated as if it were urban. Smaller facilities, in greater numbers, would serve the veterans better and even save the VA money on transportation. I have spoken with several medical facilities in Skagit & Whatcom Counties who are willing to partner with the VA to service veterans while continuing to serve their communities. This cooperation would help not only the VA as it's service percentage numbers would rise, but also the communities and the veterans in the areas these CBOC's would serve.

Please do not forget the veterans of NW WA. Don't let CARES forget the Enhancement of Services... don't run over the veterans who have sacrificed everything for the freedoms of this nation.

Thank You

David L. Lingenfelter
President, CVA
Past Commander, DAV Chapter 19
Chaplain, American Legion

Added notes:

United General Hospital in Sedro Woolley has medical facilities and is eager to talk with the VA about using its recently updated facilities to help serve veterans.

Madrona Medical in Bellingham is also eager to talk with the VA about using its doctors and facilities.

Approximately \$78.5 million is projected for 2003-5 to help fund veterans needs while in 2002 \$136 million has been earmarked for immigrant education.

**STATEMENT OF
JAY E. WOODBURY
NATIONAL SERVICE OFFICER
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
VANCOUVER, WASHINGTON
SEPTEMBER 26, 2003**

Mr. Chairman and Members of the Commission:

On behalf of the members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 20.

Since it's founding more than 80 years ago, the DAV has been dedicated to one single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and its members.

One of the VA's primary missions is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services—that are unmatched in the private sector. Moreover, VHA has been cited as the nation's leader in tracking and minimizing medical errors.

As part of the CARES process, VA facilities are being evaluated to ensure that VA delivers more care to more veterans in places where veterans need it the most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at a current level, as required by law. Additionally, we will remain vigilant and monitor the VA to ensure their focus is on the most important element in the process, enhancement of services and timely delivery of high quality health care for our nation's sick and disabled veterans.

Furthermore, local DAV members are aware of the proposed CARES market plans and what the proposed changes would mean for the community and surrounding areas in VISN 20. The goal of the draft national plan is defined savings for reinvestment in veterans' health care, doctors, nurses, and modern health care equipment. To plan for the future of VA's health care

system, it is essential to make sure the capital asset decisions of today are going to be in line with the medical needs of our nation's veterans through 2022. Bottom line, the draft national plan should show where working smarter today will avoid imbalances between the size and location of health care facilities and meet the needs of our veterans and their demand for health care in the future.

The VA's Southern Oregon Rehabilitation Center and Clinics (VA SORCC) is VA's only freestanding rehabilitation center, serving both regional and national resources for underserved special populations, e.g., homeless, chronically mentally ill, and substance abuse, providing residential treatment in psychiatry, addictions, medicine, bio-psychosocial, physical, and vocational rehabilitation. The VA SORCC provides veterans with individualized, compassionate, and high quality care. The primary outpatient medical and mental health care is offered to veterans living in the Southern Oregon and Northern California region. The VA SORCC serves inpatients from all over the United States and 40% come to the White City VA SORCC from outside of the VISN 20 marketplace. The service area for outpatient care includes Jackson, Josephine, Klamath, and Lake Counties, though additional veterans receive care at the White City VA SORCC from Siskiyou, and other counties in northern California. The outpatient service area for the VA SORCC area includes over 40,000 veterans. Closure of the White City facility will displace current domiciliary patients, as well as patients from the 52-bed domiciliary being transferred from the Portland VAMC; therefore, caution must be taken when considering realigning White City to other VA facilities in the area.

VISN 20 has two VA facilities in the Northern state of Washington: Walla Walla and the Vancouver division of the Portland, Oregon VA Medical Center. These were among the sites mentioned for additional review and potential mission change, closure, or realignment. The growth in Washington's population over the last decade, along with their increasing demand for health care services, provides a compelling reason to continue finding innovative ways to meet the care requirements of veterans in the greater Washington area, not to cut services currently in existence.

In essence, we concur with the solutions proposed to realign the resources in VISN 20 as outlined in VISN 20's Proposed Market Plan and not the Draft National CARES Plan. Specifically, the VISN's plan included establishing CBOC's in Washington, and Ontario, Oregon, to meet the increase demand for health care services; however, the Draft National Plan proposes to close the Vancouver facility, which was built in 1998.

Unlike the Draft National CARES Plan, we believe VISN 20's Proposed Market Plan is a common sense approach to aforementioned gaps in VISN 20's health care, whether primary or specialty care. If veterans are unable to access the necessary medical care they are in need of, then the entire point of providing medical services to those who served our nation in its time of need is frivolous. The CARES proposals for VISN 20 incorporate the ability to both redirect funding to allow for more access in VISN 20 as well as the accessibility to specialized care through private and or continued VA means. The outcome expected is that for which CARES was established: to provide the best care possible to veterans with the resources available, and to protect those needs. The DAV concurs with the proposals for VISN 20 and we look forward to the implementation of these proposals.

In closing, the local DAV members of VISN 20 sincerely appreciate the CARES Commission for holding this hearing and for its interest in our concerns. We deeply value the advocacy of the Commission on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important proposals.



STATE OF WASHINGTON
DEPARTMENT OF VETERANS AFFAIRS

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September 16, 2003

Everett Alvarez Jr.
Chairman, Capital Asset Realignment for Enhanced Services
U.S. Department of Veterans Affairs
Washington D.C., 20420

Dear Chairman Alvarez:

On behalf of the Washington State Department of Veterans Affairs (WDVA), I respectfully submit the following comments to you and the CARES Commission.

Washington State is the home of more than 670,000 veterans and the goal of WDVA is to ensure services are available to meet their current and future care needs. The basis for projecting these needs, whether by WDVA or by the VA, is data on veteran population and the enrollment figures. After contending for years that the VA's data under-represented the population in Washington State, the 2000 U.S. Census verified that Washington's population has grown over the past decade, in spite of a national decline.

The years of under-representing the veteran population have led to other inequities that are perpetuated through the VA system and the CARES processes. VISN 20 projections for enrollments, funding, and need for facilities are each based on artificially low projections. When coupled with the elimination of outreach programs the result is even lower utilization by the veterans community and continually lower enrollments, despite an increasing veteran population.

My testimony will address several specific areas within the VISN 20 Proposal as well as the use of data to project demand for care.

Projecting Enrollment:

I am concerned about the VA's processes that fail to factor in the real demand for veteran's health care in Washington State. The VA has used artificially low numbers that are based solely on current enrollment. Again, this is not representative or reflective of the real demand for veteran's health care. Projections based on current enrollment will also create a system that is ill-prepared to handle the demands of the future. The CARES process must recognize that Washington's veteran population grew by 4% from 1990 – 2000 while the national veteran population declined by 5%. While the VISN 20 did update its population and enrollment

projections based on the most current Census data, the VA has yet to update its database with 2000 Census information.

In addition to the basic population calculations, I have concerns with the method used by the VA to assess a state's capital requirements. The number of veterans currently enrolled is the basis for future projections; however, in Washington, only 11% of the state's veterans are active users of the VA Medical Centers. One reason is a lack of outreach to locate veterans eligible for care. As one example, the VA Puget Sound Health Care System recently discontinued a partnership with WDVA to locate veterans in need of care. Officially, the reason was a lack of funding; however, I believe part of the reason was a desire by the VA to keep enrollments down, which in turn keep enrollment projections down and keep budgets down.

To correct the inequity of basing future capital needs on current enrollment numbers, the CARES Commission needs to take into account the pattern of growth in Washington's veteran population over the last decade and the impact the economy has on the provision of health care services. The process should evaluate how the remaining capital facilities and the reallocation of resources made available by the CARES process are aligned to meet this growing demand.

Another way to examine the distribution of resources within the VA is to examine the VA expenditures in all states. I have long contended that citizens in Washington State do not receive an equitable share of the federal tax dollars they pay. Washington State is now ranked 12th in veteran population. While Washington may be 12th in population, its veterans rank 30th in total VA expenditures. The CARES Commission must recognize that Washington State is already receiving fewer resources than it's population dictates and aim to realign resources in a more equitable manner. (See attached VA Expenditure Information.)

Access:

I am greatly concerned about the rural areas of the state with significant need and a lack of VA facilities or services to meet their need. These areas are grossly underserved and have high concentrations of minority veterans, particularly Native Americans and Hispanics. Again, the lack of outreach has served to further disenfranchise veterans who are not fortunate enough to live near a VA facility.

The VISN 20 Proposal aims to, "Increase the primary care outpatient services in three markets and at all care sites through planned CBOC and DoD joint ventures..." (Source: Appendix A-National CARES Plan). However, the plan does not adequately address the need for care in rural and remote areas of the state. Veterans in areas such as Bellingham and Leavenworth/Wenatchee have long advocated for a CBOC or other type of contracted primary care in their region. Currently, veterans must overcome the obstacles of extremely long driving distances and harsh weather conditions, to receive basic primary care. The CARES Commission and VISN 20 have the opportunity to address this imbalance by ensuring that a CBOC or other cooperative agreement with local providers is in place. As our veteran population ages and becomes increasingly frail, so will the urgency of this issue.

According to the Millennium Health Care Act, states were directed to develop CBOCs. Washington State was slated for eight CBOCs; yet, only four have been established. The

reason again was a lack of funding; however, the result is that Washington State is not prepared to transition into the future of health care delivery. When the number of CBOCs in Washington State is compared with that of other states, Washington clearly lags behind in the establishment of this important community resource. For example:

STATE	VETERAN POPULATION	CBOC
Washington	670,628	4
Minnesota	446,864	23
New Mexico	187,006	13
Arizona	563,842	13
Colorado	437,515	11
Montana	106,060	10
Georgia	752,684	9
South Carolina	414,690	8
Alabama	435,831	7

The few CBOCs located in Washington play a significant role in the provision of primary care and the CARES Commission would do well to further study their placement in relation to the distances veterans must travel. If a CBOC is not the answer in a particular area, options such as contracted services or mobile clinics should be considered to meet the needs of the aging veteran population, especially in rural Washington.

Long Term/Nursing Home Care:

I would also like to address plans to contract for nursing home care in Vancouver and Walla Walla. WDVA undertook a Master Planning process to assess demand for long-term care in our State Veterans Homes. Projections for Washington are staggering. In the next 20 years, Washington veterans over the age of 65 will number 220,000. That's 20,000 more than today. The number of veterans over the age of 85 will triple—from 8,400 to 27,000.

The dramatic aging of our state's veteran population will lead to an increase in their medical requirements and will place significant demands on the VA Medical Centers, especially nursing homes. However, the lack of outreach and enrollment of veterans in Washington State has resulted in projections for long-term care that are artificially low.

As CARES reviews plans to contract long-term care out in both Walla Walla and Vancouver; the option of state / federal partnerships should be explored. Washington State and the National Association for State Directors of Veterans Affairs (NASDVA) have advocated for cooperative agreements between the VA and the State Veterans Homes in providing long-term care for veterans with 70% or greater disability. (See attached NASDVA Resolution.) Such state / federal partnerships would allow the VA to utilize another resource in the provision of care in facilities that are subject to VA surveys and have standards that are comparable or exceed those of VA nursing homes.

Contracting Mental Health Services:

In regard to the provision of mental health services at Vancouver and Walla Walla, I have significant concerns about whether the community is prepared to handle the demand and how

the VA will ensure that community contractors receive necessary training and oversight. Currently, there are no community inpatient psychiatric beds in Walla Walla and limited community beds in the Tri Cities and Yakima. The proposed realignment of mental health services in Walla Walla will result in no VA inpatient psychiatric beds in all of Eastern Washington. Such a change will call for significant training and recruitment efforts in both areas and their surrounding communities to ensure practitioners have the knowledge, skills and abilities to treat veterans with PTSD and other war-related trauma.

WDVA has established a comprehensive network of mental health providers and has been a critical player in providing services to veterans in their local communities through a statewide PTSD Network. The CARES process should take into consideration how a state / federal partnership could serve the mental health and transitional needs of veterans.

Waiting Times:

Any CARES plan that realigns or consolidates services within VISN 20 must also consider the subsequent effect on veteran waiting times. According to VISN 20 documentation, more than 65% of primary care appointments at Washington facilities – for existing patients – are made within 30 days. The same is not true for specialty services, especially in the state’s largest medical centers that lag behind the VISN 20, and are significantly behind the Veterans Health Administration averages. For example:

JUNE 2003 Data Puget Sound Health Care System Average	Veterans Health Administration Average
Next available <i>Cardiology</i> appointment 39.2 days.	VHA average is 27.2 days.
Wait times for next available <i>Orthopedics</i> appointments are double that of the VHA at 89.6 days.	VHA average is 44.3 days.
Wait times for next available <i>Urology</i> appointments are 30 days longer than VHA 65.2 days.	VHA average is 35.3 days.

Realignments within VISN 20 should focus on how some resources can be directed to areas with significantly high waiting times.

In addition, if consolidations or contracting are utilized in rural areas of the state, we must make every effort to ensure that waiting times for these veterans do not increase, but rather decrease as a result of the changes. We must maintain the high quality of services veterans are receiving, regardless of whether the care is provided by VA providers or through community contracts.

Realignment and Consolidation:

In regard to campus realignment and consolidation of services, I understand the need to evaluate and if necessary realign the missions of capital facilities. The Washington Department of Veterans Affairs with its three Veterans Homes and statewide Veterans Services

Network has undertaken similar initiatives to ensure our services meet the current and future demands of our veteran population.

However, reductions to the bricks and mortar of the VA must take into consideration how services will be provided elsewhere in the VA or in local communities. Collectively we must ensure that our veterans receive accessible, high quality primary, specialty and long term care services that are as good or better than those they receive today.

Summary:

CARES must re-examine the health care needs of veterans by not using arbitrarily low projections based solely on current enrollment. The CARES process must address the growth in Washington State's veteran population by aligning services to meet veterans' health care needs. Whether those services are provided in traditional VA settings, or through innovative partnerships, we must ensure that veterans receive care that is as good or better than the care they receive today.

We cannot afford to perpetuate the inequities of the past by relying on population projections based on outdated and inaccurate data. The reality is that the veteran population in Washington State has grown, those veterans are aging, and their demand for care will grow exponentially over the next several decades.

To serve the needs of our veterans, the VA must reach out and form partnerships with the many willing state and community providers. Additionally, VISN 20 must establish additional Community Based Outpatient Clinics to provide primary care services to veterans and eliminate the need for them to travel long distances and suffer long waits for routine care.

Finally, any restructuring of services must ensure the remaining resources are redirected to areas with the highest need, including reducing waiting times and increasing access to care.

Chairman Alvarez, your commission has the opportunity to ensure the veterans of Washington State are not forgotten. Your continued work with Dr. Les Burger, Veterans Integrated Service Network 20 Director and other veteran leaders in Washington State will determine how the needs of our state's veterans are met. I look forward to working more closely with you and other members of the CARES Commission and encourage you to contact me at 360-725-2151 should you have any comments or concerns.

Sincerely,

A handwritten signature in black ink that reads "John M. King". The signature is written in a cursive style with a horizontal line underneath the name.

John M. King
Director



STATE OF WASHINGTON
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September 15, 2003

Everett Alvarez Jr.
Chairman, Capital Asset Realignment for Enhanced Services
U.S. Department of Veterans Affairs
Washington D.C., 20420

Dear Chairman Alvarez:

Chairman Alvarez and members of the CARES Commission, thank you for the opportunity to testify before you today. My name is Keith Sherman, and I am here representing the Governor's Veterans Affairs Advisory Committee (VAAC).

The VAAC consists of seventeen members appointed by the Governor of the State of Washington whose mission is as follows:

To serve in an advisory capacity to the Governor and Director on matters pertaining to the Department of Veterans Affairs and to acquaint themselves fully with the operations of the department and recommend such changes to the Governor and the Director that they deem advisable.

I would like to first make clear that the VAAC is here today to work with you in determining the most appropriate uses of the VA's facilities and resources to serve each of the 670,628 veterans living in Washington State. We appreciate your diligence in holding these hearings across the country and know you want to ensure the VA is able to meet the demands of the future.

However, before I get into the testimony of the VAAC, I'd like to share our thoughts on the CARES process – specifically on what CARES has done and what it hasn't done.

When the CARES process began, there were several front page articles which likened the process to a military BRAC. Politicians got involved, the press had a field day, and the VA spent a considerable amount of time reassuring the veterans community that CARES wasn't about closing facilities. The newspapers even reported that no Washington State facilities were slated for closure. Yet, here we are today and the closure of significant portions of two Washington State facilities is exactly what we're talking about.

It's no secret that the veteran's community is adamantly opposed to simply closing facilities and losing the valuable services they provide. In Washington State, our veteran



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population is growing and they're getting older. We need to ensure there are services available to care for them ten, twenty, fifty years from now.

However, when the veterans community is told that services will be provided as well or better than through the current system, most will be willing to listen to proposals altering where the service is located. We can be trusted with the facts of how CARES will work, but we need all the facts. If a "realignment" is in the best interest of veterans in a particular area because a facility will have crumbled from age in twenty years, then tell us how the service will be provided.

The CARES Process is meant to serve veterans. It needs to be a process that is open, honest and most importantly understandable to the veterans being served.

As I indicated earlier, the VAAC serves as an advisory body to the Governor and State Department of Veterans Affairs. The VAAC also holds hearings throughout the state to ensure we have our finger on the pulse of the veterans community and we would like to include some questions, concerns and suggestions of many veterans we've encountered.

Of Washington's 670,628 veterans, only a fraction are actively using the VA Health Care System. There are many reasons for this, and some of the most commonly heard are listed below:

- **Travel times and distances.** In urban settings, mileage is not always an accurate indicator of travel times. Many aging veterans find it difficult to navigate congested roadways, in Washington this is especially true in the Seattle / Tacoma area. To ensure care is accessible, consideration must be given to the amount of time it takes to reach an appointment not just the number of miles.
- **Long waiting times for appointments.** Once a veteran decides to access the VA care they are entitled to, the response time to address their medical needs – especially for specialty care – must reflect the urgency of the veteran's medical condition.
- **Lack of outreach.** The VA recently stopped outreach to educate veterans on the benefits they are entitled to. There are many veterans, some with service connection, who simply don't know how to access the benefits the VA provides.
- **Frustration / Perceptions about the VA.** Many veterans have attempted to access the VA only to be overloaded with paperwork and other requirements or have heard horror stories from others about their apparent experiences with the VA and are afraid of going through the hassle.

While on the surface, these issues may not seem relevant to a commission studying capital facilities, in truth they are very closely related. Through reorganization and restructuring, the VA has the opportunity to reach veterans who are in need of care and to better align those services to meet their needs. Some ways this can be accomplished are through:

- **Community Based Outpatient Clinics.** The need for primary care, especially in rural Washington is great. Communities such as Bellingham and

Chairman Alvarez
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Leavenworth/Wenatchee are ready to work collaboratively with the VA to provide access for thousands of rural veterans. Nationwide, there are rural hospitals and clinics struggling to survive that would likely welcome the opportunity to partner with the VA and at the same time benefit local veterans.

- **Planning to meet the demands at all facilities.** For example, while the VAAC understands that changes are not currently being proposed for American Lake, this facility served over 210,000 veterans last year and is projected to serve 216,000 in 2003. It is important that CARES study how the facility will stand the test of time to meet the enormous demand our aging veteran population will place on it in the coming years.
- **Closely aligning services and facilities to meet the needs of an aging veteran population.** As one example of how CARES can look toward the future of the veteran population, the commission should examine the availability and waiting times for services such as specialty care and determine how resources can be realigned to areas in high demand, such as Orthopedics and Urology.
- **Cooperating with State Departments of Veterans Affairs.** In areas where states provide long term care services, the VA should cooperate with State Departments of Veterans Affairs. For example, when CARES results in contracting out of long-term care, state and federal partnerships should be formed with States to care for all veterans, regardless of service connection rating.

The VAAC recognizes that the need for additional funding is great. However, in our current economic climate, we understand that we all must live within prescribed budgets. Therefore the question becomes, how can we work together to provide the best and most appropriate services to veterans? I sincerely hope the information we've provided will shed some light on the situation in Washington State.

Chairman Alvarez, you have before you a tremendous opportunity to serve the needs of all veterans. On behalf of the VAAC, we thank you for your consideration. Please do not hesitate to contact me or any of the VAAC members listed below should you have additional questions.

Sincerely,



Keith Sherman
 VAAC Volunteer

Contact information:
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