**WRITTEN TESTIMONY OF KATHLEEN DAHL, RN**

**PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES LOCAL 2028**

**VA PITTSBURGH HEALTH CARE SYSTEM**

**BEFORE**

**HOUSE COMMITTEE ON VETERANS’ AFFAIRS**

**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

**FEBRUARY 5, 2013**

**EXECUTIVE SUMMARY**

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Chairman Coffman, Ranking Member Kirkpatrick and Members of the Subcommittee.

Thank you for the opportunity to testify before the Subcommittee on the critical issues surrounding the Legionnaire’s Disease outbreak at my facility, the Pittsburgh VA Healthcare System. I hope my testimony will assist the Subcommittee in its efforts to ensure that patients and workers are adequately protected from Legionnaires going forward.

As President of AFGE Local 2028, I represent approximately 2,500 non-management employees at the University Drive (UD) and Heinz facilities representing a wide range of positions. These include plumbers, engineers, physicians and nurses, and support personnel making patient appointments and working in medical labs among other functions.

As a union President, it is my duty and privilege to ensure that all of our employees are provided a safe working environment and preventions to maintain this environment at all times. Therefore, when an incident such as the current outbreak occurs, it is my job to ensure that employees receive adequate personal protective equipment, timely notices of exposures, and timely testing to ensure proper treatment.

Management is required by statute and regulation to contact me regarding all changes in working conditions, information that needs to be disseminated to employees, and to request input and suggestions from the union. Equally important, I am the person who employees talk to when they have concerns, especially when they are afraid to voice those concerns to management on their own.

As indicated in my timeline (Appendix A), I was not aware of any potential Legionella outbreak at my facility until the morning of November 16th, when Director Terry Wolf called the union Vice President Antoine Boyd. In that call, Director Wolf informed him that the water supply at UD was being tested for Legionella bacteria because some patients had reported feeling ill, and similar testing would begin at Heinz at soon as possible, that the water supply would be flushed with chlorine over the weekend (Nov. 17-18) and that water conservation would be in effect for approximately two weeks until test results on the water came back.

On November 16th at 12:36PM, management put out its first all-employee notice at both UD and Heinz. We were informed that there would be no tap water for hand washing, drinking or bathing. Employees were instructed to use bottled water for hand washing for visibly soiled hands or following care of patients with Clostridium Difficile. Later on the 16th, UD and Heinz held town hall meetings for staff but none of the union officers could attend given the short notice.

The news about water conservation did not alarm me initially. Back in 1994, when I started at the VA, I was advised not to drink the water because it had problems with Legionella, and I knew that Legionella had been in the pipes since at least 1981. However, over the next few weeks, through various emails from staff, union local officers and the media began to realize that management may have learned about this outbreak much earlier than they represented to us. This demonstrates VA’s failure to comply with OSHA requirements about notification and precautions. For example, I first assumed that flushing of the water system on November 13th and 14th was related to a steam line break earlier that month. Also, I was one of several employees notified between November 5th-9th of pertussis exposure. We were sent to Employee Health, where we were screened and given the antibiotic azithromycin.

Later, the pertussis incident raised two red flags in my mind: first, if management followed OSHA rules about notice and screening for a pertussis outbreak, why didn’t they follow these rules for a Legionella outbreak after receiving two confirmed cases in early November? Second, was it a coincidence that management provided the same antibiotic for pertussis exposure that would also be prescribed for Legionella exposure?

Other events prior to November 16th suggest that confirmation of the outbreak occurred earlier.

On the 15th I learned through an email forwarded to Local President Colleen Evans at HD that Executive Leader Melham had contacted supervisors in her service line. Executive Leader Melham told them to wear masks when washing their hands and drink bottled water because water had tested positive at UD for the same Legionella bacteria recovered 20 years ago. She attributed this recurrence to the failure of an old copper silver system that had been installed to eliminate the organisms, and she stated that efforts were underway at UD to hyperchlorinate water and conduct additional surveys at Heinz and HD.

After I learned that plumbing staff was already flushing the water system as early as November 13th, I questioned whether employees were instructed to wear masks and were they provided with these personal protective equipment (PPE). In my discussions with the employees involved with Legionella remediation, I learned that they were not provided with any PPEs and there were no communications from management that PPEs were provided. I also inquired about PPEs at a January 2013 meeting with Director Wolf, Chief of Staff Sonel, and national AFGE leadership. I was disturbed when COS Sonel responded that he did not know that plumbing staff should be provided PPEs to flush the water systems and had not made any effort to determine if they were needed under OSHA guidelines or VA’s own policy.

Based on my growing concerns about the events unfolding around November 16th, I requested a meeting with management to ensure that employees received more accurate information. The meeting took place on November 20th and included union officials and executive leadership from the facility. During the meeting AFGE representatives raised the issue of delayed notification to the union and employees as well as management’s failure to link Legionella with employees diagnosed with pneumonia or exhibiting other respiratory symptoms.

I also asked COS Sonel why management had not surveyed employees over recent absences and illnesses as required by OSHA. His reply was troubling and dismissive. He stated that employees were more likely to be exposed to Legionella in their own homes. Deputy Director Cord said that the symptoms could be related to the flu since it was flu season. I reminded them that many of our employees are over 50, smokers, ex-smokers, diabetics, on corticosteroids and chemo which could place them at risk. At that point, management agreed to evaluate employees if they reported to employee (occupational) health. When I asked how employees would be treated, the response from management was if they had symptoms and reported to Employee Health, they would obtain a Chest X-ray and if necessary, treat with azithromycin.

I requested that they do an employee survey as required by OSHA and referred to a sample OSHA letter on its website. COS Sonel replied that they could not conduct a survey because it would violate HIPAA (which I knew to be incorrect based on my knowledge of OSHA).

At the end of this meeting I was not confident that our employees would be screened and evaluated for this work exposure. I utilized social media and email campaigns to inform our employees about symptoms related to Legionella and Pontiac Fever, including early flu like symptoms (slight fever, headache, aching joints/muscles, lack of energy, tired feeling and loss of appetite) or common pneumonia like symptoms (high fever, cough [dry first then phlegm producing], shortness of breath, chills or chest pains). If employees had any of these symptoms we instructed them to report to Employee Health. If the employees were turned away they were also told to notify the union.

After the meeting, I learned of several instances where employees who went to Employee Health for screening were turned away and made to feel they had no right to be there. Employees were also denied urine antigen tests (it should be noted that the urine test is inferior to the blood test because Legionella virus only shows up in urine for 30 days but can detected in the blood for 12 weeks). We reported this issue to management, and I was pleased that it was corrected in some cases but not consistently. For example, many employees were told they had bronchitis and given the azithromycin, which can cause false positives if tested later.

Director Wolf did send out a letter to employees (dated December 5th) but it was not fully compliant with OSHA and placed more of the burden on employees to seek screening.

I also learned during this process that OSHA guidance on Legionella requires the union to participate in inspections after an outbreak is confirmed, and the union should be jointly involved in potential abatement procedures and to participate in periodic collections of water samples. These requirements were never met.

I do want to commend management for not trying to exclude AFGE from the process of the Root Cause Analysis when the employee requested a union representative be present, or from the meeting with Congressman Tim Murphy when he came to the VA to inquire about the Legionella situation. More generally, I believe Director Terry Wolf is genuinely concerned about the well-being of the patients and staff, and the VA is currently doing everything in its means to appropriately manage Legionella in our water system. However, there are still serious concerns regarding OSHA compliance.

Therefore, I urge that the following actions be taken in the future to prevent and remediate this type of outbreak, and to ensure the well-being of patients and employees.

* More training of management and rank and file employees on OSHA guidelines for inspections, notifications, screenings and PPEs for employees working on plumbing.
* If elevated Legionella levels are detected, start using bottled water and limited showers immediately and continue doing this as long as a risk of outbreak exists.
* Review the VA’s practices of using employees other than certified plumbers to address these water system issues.
* I also believe that the VA should revise its procedures for testing of Legionella in the pipes, included improved communication between the construction teams and infection prevention teams. Our piping system is complex and has many “loops” that require testing. Our construction is constant and sometimes requires shut off to water supplies. When water sits stagnant it can breed the Legionella colonies. Perhaps we could have a stronger policy to demonstrate what happens when there is water interruption. We need to find ways to rid the system of the many “dead legs” that exist.

APPENDIX A: TIMELINE OF EVENTS SURROUNDING 2012 LEGIONELLA OUTBREAK AT PITTSBURGH VA HEALTHCARE SYSTEM

Prepared by Kathi Dahl, President, AFGE Local 2018

**November 6, 2012**

• AFGE receives email notice received about Sprinkler System interruption at University Drive due to a water line break.

**November 14, 2012**

• AFGE receives email notice of Heinz Steam Outage at Heinz for steam line repairs. The following work was conducted: workers shut down the main steam service from the Boiler Plant to the hospital buildings, A/C shop technicians replaced 5 inch gate valve and failed gaskets on 8x5 gate valve and then returned steam service and HVAC systems to full operation. Building numbers affected were 32, 49, 50, 51, 52, 53, 54, 69, 70, and 71. This email included a utility outage contingency plan that indicated the steam outage would affect the entire Heinz campus except for the Villas. Domestic hot water was not available in the inpatient wings and conventional baths for patients were not available, patients instead used “bath in a bag.” There was no space heating available so extra blankets were provided to the patient units. No steam available for cooking or dishwashing for food services. Boiler plant and AC shop had additional staff on hand to bring the boilers and campus steam supply back to operating conditions as soon as possible.

**November 15, 2012**

• AFGE received email regarding University Drive (UD) Emergency Heat and Flush for November 15-16. Work was conducted in the following affected areas: Building 1, 3 West, 4 West, 5 West and Ambulatory Surgery Unit from 12am-7am on November 15-16, 2012. AFGE was informed FMS employees would notify the Patient Care Coordinators (PCC) when it was safe to use hot water once the flushing operations are completed.

• AFGE received email from one of our union safety stewards at Heinz at 2:11pm. He understood there was a problem at University Drive and there were several cases of polar water that were sent to Oakland. He had heard Heinz would be under water shut down and 400 cases of bottled water were ordered. He wanted to know if the union safety officer James Dozier or I knew anything about the water shutdown. I responded to him that we had notice or alert for the water outage.

**November 16, 2012**

• I received an email from AFGE Local 2028 Executive VP at approximately 12:17pm telling me that VAPHS Director Terry Wolf called the Heinz union office because she was unable to contact me. The Executive VP’s email indicated that the Director informed him they were testing UD water supply for Legionella bacteria because some patients were not feeling well. He was also told that they would begin flushing the water supply with chlorine for 24 hours starting on Saturday, November 17 and then flush the water supply with regular water on Sunday, November 18 for the whole day. He was advised by the Director that employees would be instructed to use hand sanitizers for hand washing and use bath wipes in lieu of showers for patients. The Director told him that the water conservation would be in effect for at least 2 weeks while they wait for the culture results to come back. In addition, she had told him that testing would begin at Heinz as soon as possible. She informed him of a town hall meeting this same day at 12pm and 4pm at the Heinz and UD facilities. One of our safety Stewards at UD did attend this meeting with the Logistic team on Friday.

• Email from the Director’s office was sent out to all VA employees regarding the restricted water usage at UD and Heinz campuses. This email went out at 12:36pm. The employees were instructed that effective immediately, there would be restrictions from using tap water for hand washing, drinking and bathing at UD and Heinz campuses for all patients, employees, volunteers and visitors. They encouraged everyone to use hand sanitizer when possible instead of hand washing with soap and water. They indicated the instances to use bottled water for hand washing was after care for a patient with Clostridium Difficile and when visibly soiled. At this time the Director’s office provided numbers for incident command center and where to request hand sanitizer and signage.

• There was a town hall meeting scheduled for a 12-1pm live meeting, but the message was not forwarded to me until 12:41pm.

• I received an email from Highland Drive (HD) AFGE Local 3344 President Colleen Evans. She had forwarded me an email from Executive Leader Mona Melham dated Thursday November 15, 2012 at 8:16pm. This email was addressed to supervisors as a high alert message that testing the water system at UD revealed Legionella organisms similar to those recovered 20 years ago. She stated it was attributed to the failure of the old copper-silver system installed to specifically eliminate the organisms. She also indicated other hospitals were dealing with similar issues; efforts were underway to test the Heinz and HD campuses. She informed them that Legionella is a micro-organism (bacteria) that can cause pneumonia when inhaled by immunocompromised and/or debilitated patients. Legionella is easily treated with ciprofloxacin, azithromycin or erythromycin. She instructed the supervisors to refrain from using water fountains and sinks until further notice and that if they had to wash their hands to wear a mask to prevent inhalation of aerosolized droplets.

• HD AFGE Local 3344 President Colleen Evans included me in email at 1:04pm to executive leadership. In this email she wanted to know why she was hearing from bargaining unit employees about the Legionella outbreak, hot water flushing, potential fire hazards and “plans” to test water at Heinz and HD sites. She wanted to know why she had not received one notice from VAPHS leadership.

**November 18, 2012**

• I sent an email to James Rowlett (incident command) and Director Terry Wolf regarding employee concerns about hand hygiene and using the little bottles of water to do so. There was an issue where the employees were puncturing holes in the tops of the bottles to spray the water rather than pour the bottles in order to conserve water. AFGE recommended for future incidents that management consider using 5 gallon water dispensers as often used by campers. Mr. Rowlett immediately responded and added Environmental Management Services (EMS) and logistics supervisors to advise them to be prepared to address this issue first thing Monday morning.

• I received a phone call from Marge Engwer (VA Safety Chief) that vendors were coming on Monday to provide hand washing stations.

• The Director’s office sent out an email notification to all staff at 6:35pm that water restrictions were still in effect at University Drive and reminded everyone of the same information provided in the first Legionella notification to employees. They indicated this would be for approximately 2 weeks or until further notice.

**November 19, 2012**

• AFGE received an email from our union safety steward at 8:26am inquiring if we had been cleared to use the water. She indicated that they were taking necessary precautions in regards to their postage and folder machine.

• AFGE Local 3344 President Colleen Evans sent another email at 9:21am as a follow up to the unanswered November 16 email stating again that restrictions and precautions were in place for UD and Heinz but she had still not received notification or information at HD. She asked someone to tell the union office if HD had Legionella in the water. She wanted to know if and when the water would be tested at HD. The Deputy Director David Cord responded to her at 9:48am indicating that he had a call scheduled with her at 10am and would update her then.

• By end of the day when I had caught up with the emails and activities up to this date, I became suspicious that we had not been informed in a timely manner about the Legionella. At 4:20pm I emailed Director Terry Wolf that I was requesting a meeting between her and the union to discuss the facts surrounding the Legionella situation at the VA. At this time I informed her that an employee had approached me earlier that day and had been diagnosed with bacterial pneumonia. The employee was out for 4 weeks and this was her first day back. I expressed concerns to the director as to whether the Legionella was related to her pneumonia. I also wanted clarification for the rumors about whether the wrong pipes had been flushed at Heinz. Some of the concerns I raised was whether cold water instead of hot water was being flushed and whether tap water was safe to be used to serve coffee. The Director forwarded the email to the Deputy Director David Cord, Associate Director, Chief of Staff Dr. Sonel, and Infection Control Chief Dr. Muder. Deputy Director Cord responded at 4:52pm that he was acting as Director and would be able to meet the following day 1pm.

**November 20, 2013**

• We had a meeting between the union and management about Legionella at 1pm. Attendees included myself, Local 3344 President Colleen Evans, Local 2028 Safety Officer James Dozier, Deputy Director David Cord, Associate Director Lovetta Ford, Dr. Sonel, and Dr. Muder.

* At this meeting, the union expressed to leadership that as healthcare workers we understand the risk of exposures and that Legionella had been in the pipes for several years so was not a surprise.
* We expressed concerns that VA was conducting heat flushes prior to our notification and that we were not notified in a timely manner. VA indicated that they did not heat flush the pipes. I told them I had a notice that they did. They insisted they did not. Deputy Director Cord stated that it would put me, as the Local President, in a difficult position if I had that information and was not able to tell anyone.
* We were concerned about all of the construction being conducted, all of the “dead legs” within the plumbing system, and what was VA’s testing protocol since Legionella existed in the pipes since 1981. VA advised they were routinely monitoring the pipes. The union stated that OSHA provides routine maintenance guidelines for flushing pipes with the presence of Legionella. Deputy Director Cord stated they had been conducting routing maintenance and monitoring the piping system. The union stated that Legionella has to be controlled since it can’t be eradicated from the pipes once it is there. He indicated they were monitoring levels of Legionella.
* VA verbally provided the union with the plan to treat the situation with hyperchlorination. They had contacted CDC and were following their guidelines.
* We requested the plan for employee exposures to Legionella. They indicated that healthy employees were not at risk. I reminded them that many of our employees are over 50, smokers, ex-smokers, diabetics, using corticosteroids and chemotherapy which could place them at risk. Leadership responded that Legionella is more likely to exist in our homes and is not necessarily contracted from the hospital. I reminded Dr. Sonel that Legionella was at hospital and that if there were 2 or more diagnosed Legionella cases, OSHA recommends it be treated as a Legionella outbreak. I asked if they were going to survey employees that were out for more than 3 days to let them know that there was an exposure. They indicated they could not survey employees since it was a HIPAA violation. I indicated it was a Legionella outbreak and OSHA guidelines provide a voluntary survey letter to employees when an outbreak occurs. They did not agree and did not commit to complete any survey.
* The union asked how we should respond to employees indicating they had or have pneumonia or respiratory symptoms or symptoms related to Pontiac fever. Deputy Director Cord said they should go to their Personal Care Provider (PCP). I indicated that CA-2 forms should be completed for an occupational exposure. Once again they indicated the employees’ illness may not necessarily be associated with Legionella from the hospital since they could be exposed at home. They also indicated that it was flu season and if this might be the cause of their illness. Eventually, the VA agreed to evaluate employees if they reported to Employee Health. When I asked about the treatment plan, they said they would evaluate the employee and provide a chest X-ray and medicate with the antibiotic azithromycin. I was not comfortable at the end of this meeting that our employees would be screened and evaluated for this work exposure.
* The union utilized social media and email campaigns to inform our employees about symptoms related to Legionella and Pontiac Fever, including early flu like symptoms (slight fever, headache, aching joints/muscles, lack of energy, tired feeling and loss of appetite) or common pneumonia like symptoms (high fever, cough [dry first then phlegm producing], shortness of breath, chills or chest pains) to report to Employee Health. If employees were turned away they were instructed to notify the union.

**November 21, 2012**

• I forwarded the heat and flush announcement from November 14, 2012 to the Associate Director Lovetta Ford. She apologized and acknowledged the announcement and explained that when she denied the heating and flushing of the pipes prior to November 16 on the November 20 meeting, she was referencing the corrective action from CDC.

• I received an email from Local 3344 President Colleen Evans that on November 20th, special showers would be installed in 2 rooms on each floor of the consolidation building at UD.

• AFGE received an email from Occupational Safety Specialist for the VA Kevin Geeting that we are approaching when the application for the Voluntary Protection Program (VPP, safety program) will be submitted and he wanted continued commitment from the 2 locals regarding participation in the VPP application.

• AFGE received an update from Deputy Director Cord that all the shower heads were installed and they were able to place in line filters in the consolidation building to create 2 shower rooms for each floor. Hand washing stations would be available on November 25, 2013.

**November 23, 2013**

• AFGE received a copy of a complaint letter from OSHA and VA’s response to their complaint. The letter stated, “Employees may potentially be exposed to a Legionella outbreak in the consolidation building.” The response provided by VA Deputy Director Cord indicated that during routine testing, VA found some suspect samples of Legionella and they had contacted CDC for assistance. He also stated “no cases of employee exposure have been identified.”

**November 25, 2013**

• AFGE safety officer James Dozier states to VA safety that it is imperative to have hand washing stations in the Nutrition and Food Services at UD and Heinz campuses due to food handling. Health and safety issues were expressed for patients and staff.

**November 26, 2012**

• AFGE Local 3344 President Colleen Evans informed VA Safety Officer Geeting that they were withdrawing support for VPP in light of several safety issues that had occurred recently where VA failed to include or inform her local. She expressed that she no longer had confidence that the union would be an equal and informed partner.

• I verbally informed VA Safety Officer Geeting that Local 2028 concurred with Local 3344’s opinion and we would not be able to support VPP at this time.

**November 30, 2012**

• Water restrictions at UD were lifted but remained in effect for all other campuses until further notice.

• Hyperchlorination at HD was initiated due to some positive testing areas for Legionella. However, the treatment was moved to December 7-9.

• AFGE was notified that UD restrictions should remain in place for the ice machines. VA Indicated Facility Management Service would begin cleaning them over the weekend.

**December 3, 2012**

• AFGE Local 2028 Steward inquires about getting “water buffalos” in the villas. They did not receive hand washing stations for over 120 veterans and 60 employees. VA responded by sending hand washing stations that were no longer needed at UD.

• I informed Deputy Director Cord that I had an interview with the newspaper and had a discussion about four employees that I was aware of being treated for respiratory symptoms. I told him that I had advised the newspaper that the union is still content with the immediate response to the situation but would be monitoring how the employee exposures, if any, would be handled.

**December 4, 2012**

* Hand washing stations delivered to Building 69 Villas.
* AFGE began receiving inquiries from employees about an earlier pertussis scare which may have been due to a Legionella exposure. AFGE informed the Director about the employees concerns on a phone call. She was very sincere and was concerned about the well-being of our employees and if they have any symptoms she wants them evaluated and treated.

**December 5, 2012**

• Deputy Director Cord phones me to caution that my discussion with the newspaper bordered a HIPAA violation. I verbalized that I did not agree that my comments were violating any privacy issues. During this call I informed Deputy Director Cord I had been contacted by several news stations for on camera interviews and had been advised by AFGE leadership. I informed him that all of my future communication with the media would be through AFGE leadership and the national Communications department.

• AFGE received information from a 5th employee that suggested that they may have had “Pontiac fever” the week of November 5-9 on the same week of our Pertussis scare. He had received azithromycin.

• Director sends out an email to all employees stating that the VA is working confirm specifics about the Legionella exposure. VA says they are trying to determine if illness reports are pertinent to the outbreak and the source of infection for each reporting employee that they sought medical care for pneumonia in recent months. She provides a list of symptoms related to Legionella and tells employees to report to their PCP or Employee Health. If they have pneumonia, they should tell VA as soon as possible.

**December 18, 2012**

• AFGE was interviewed by Joint Commission Bill McCully and Vicki Pritchard. The Join Commission asked the union if something could be done to better protect employees. The union again requested urine antigen tests from the VA for those employees with symptoms.

**December 19, 2012**

• 2 plumbers came to the union office, expressing concerns that they may have to provide depositions. They expressed fear that management will try to place blame on the employees. They stated that they were never trained to do water treatments (Chlorination). They indicated that at the end of their shift on December 14 they were asked by their supervisor to sign a form that they were trained to do water treatments. They did not sign.

**December 31, 2012**

• AFGE received an email notice with a list of employees that were scheduled to meet with Root Cause Analysis (RCA) team for the Legionella issue scheduled for January 3, 2013.

**January 3, 2013**

• RCA analysis with a pipefitter and an infectious disease nurse.

**January 9, 2013**

• RCA interview with a plumber.

**January 25, 2013**

• AFGE received a communication from an employee voicing concerns about his qualifications to complete Heinz Mixing Valve Project as COR on this project.

**January 30, 2013**

• HR sends out OSHA notice of employees’ right to access medical and workplace exposure records.

BIO OF KATHI DAHL

Kathi Dahl, RN, has worked at the Pittsburgh VA Healthcare System since 1994, starting as a fee basis nursing assistant. After her graduation from Carlow College (now known as Carlow University), she worked as a graduate nurse technician at the Heinz facility. Later, Ms. Dahl was converted to a full time permanent employee and promoted to a Registered Nurse position. At Heinz, she worked in long term care and palliative care. In 2002, she transferred to the University Drive facility and worked in acute care on a surgical unit, medical/surgical unit and then an outpatient clinic.

Ms. Dahl was elected President of AFGE Local 2028 in December 2011. Previously, Ms. Dahl served as the local’s Steward, Recording Secretary for 3 years, OWCP – WHAT IS THE TITLE (Worker’s Compensation) for 3 years, Chief Steward for Title 38 professionals for 3 years and Executive Vice President.