

**UNITED STATES DEPARTMENT OF VETERANS AFFAIRS**

**ADVISORY COMMITTEE ON  
FORMER PRISONERS OF WAR**

**BIANNUAL MEETING**

Monday, April 16, 9:15 a.m.

Washington, D.C.

**Participants:**

Thomas McNish, M.D., Chairman  
R. James Nicholson, Secretary, U.S. Department of Veterans Affairs  
Michael Ambrose, M.D.  
Ken Farmer  
Robert W. Fletcher  
Paul Galanti  
Robert E. Hain, M.D.  
Michael J. Kussman, M.D.  
Laurent Lehmann, M.D.  
Giles Norrington  
Mary Owen  
Linda Piquet  
Phil Riggins  
Robert E. Smith, M.D.  
Charles Stenger, M.D.  
Fernando Tellez, M.D.  
Lily Trehwella

**By Agenda:**

**I. Welcome and Comments**

Mr. Nicholson opened the meeting at 9:15 a.m. by welcoming the participants. He then offered an update on the VA, noting that the current war in Iraq is a unique war, dangerous everywhere and at all times, a unique environment which is producing unique injuries and putting a unique stress on health care and facilities, not least because the survival rate from serious injuries is much higher. To the four major acute treatment centers 17 Level 2 centers have been added. \$1.1 billion has been budgeted for nonrecurring maintenance of those facilities. The next big step is to move from paper to electronic medical records. He stated that he is chairing an inter-cabinet task force which includes Secretary Gates to push for this. Benefits are another challenge. Last year 806,000 veterans applied for benefits for service-connected disablement, both physical and mental. Each must be evaluated separately, which is now taking an average of 177 days, which, Mr. Nicholson conceded, is too long. Burials are also increasing, as veterans of World War II and Korea

are reaching the ends of their lives, at a rate of about 1,800 a day. Six new cemeteries will be opened in the next year. Support from Congress is good: the '08 budget request is \$87 billion, a 77% increase in spending for the VA in the last six years.

## **II. General Information**

Dr. McNish thanked Mr. Nicholson and welcomed guests, opening up a general discussion. A number of anecdotal cases were discussed, as well as the personal health problems of some of the participants. The question of certification of physicians and raters in dealing with former POWs was raised and discussed, the consensus being that more needed to be trained and certified and that better use should be made of them. Outside doctors, paid by the exam and unknowledgeable of POW presumptives, are seen as a problem. There are, from all conflicts, about 26,000 former POWs alive in the U.S. today, of whom probably 10,000 don't want to talk to the VA.

## **III. Robert E. Mitchell Center Update**

Director Dr. Hain announced that the super clinic in Pensacola is under construction and should be completed before the end of this year and its opening is anticipated for the early spring of 2008. He discussed the association of osteopenia and osteoporosis with PTSD and added that there is a relationship between PTSD and many health problems, including coronary artery disease. Dr. Ambrose raised again the issue of compensation and pension examinations by doctors who do not realize how their examination will affect the veteran, whose examinations are cursory or too limited in scope. Dr. Smith mentioned the DVD which he would show portions of in the afternoon. The discussion of comp-and-pen exams broadened into a general discussion of problems and solutions relating to the exams, evaluations, and subsequent appeals and the necessary training for dealing with issues unique to POWs.

## **IV. Veterans Health Administration Update**

Dr. Kussman spoke after the luncheon break, asking the meeting if the special POW coordinator who is supposed to be in every VA medical center to understand the special issues of and assist POWs is working or not. He stated that an effort is being made to develop ID cards that identify POWs. This "POW identifier" would set in motion the correct care and response for POWs. He is very proud of the VA's electronic health records, which was a "homegrown" development, but cautioned that because it was "homegrown," it has no friends because industry hasn't benefited and there are no vendors lobbying on the Hill for it. He pointed out that the VA is ten years into a major transformation begun in the mid-'90s, and spearheaded by Dr. Kaiser, whom he called a visionary. Dr. Kussman called for enforcement of standards which would obviate geographical differences in delivery of care, benefit packages, and medical decisions. He stated that at the end of FY '06 of the 615,000 service members no longer on active duty, about 205,000 have come to the VA for one thing or another, of whom about 73,000 have

had symptoms of mental issues. Of those, 34,000 have symptoms consistent with PTSD, and if you take the vet centers another 5,000 can be added, for a total of around 39,000. The number one diagnosis is musculoskeletal, followed by mental health. Third is GI, but dental rather than digestive. Traumatic brain injuries are the sentinel health care issue of the current war, followed by polytrauma. The survival rate for wounded soldiers is 90% and if a wounded soldier makes it to an aid station the survival rate is 98.7% which is previously unheard of. PTSD is a growing problem, not least because of the potential stigma of the mental health label.

#### **V. Employee Education System Update**

Dr. Smith said that POW posters which originally went out to 50 of the regional offices a few years ago have been resurrected with a few changes. There are three posters per center. Easels have been provided for their display and the new posters were distributed in March. The POW DVD is in its beta phase, about 90% ready. Portions were played for the meeting. POW case management training sessions were initiated in early March in Jacksonville, Florida and will be held next in Manchester, New Hampshire, followed by Seattle, Washington in August. The POW VHI website is progressing. The historical section is complete up through Vietnam. Dr. Lehmann has provided the mental health presumptives, but the medical presumptives are still being finished. Ms. Trehwella provided an update on VISN 11, which is made up of medical centers in Detroit, Ann Arbor, Battle Creek, and Saginaw, Michigan; Danville, Illinois; Marion, Fort Wayne, and Indianapolis, Indiana, with 20 community-based outpatient clinics, serving approximately 1.4 million veterans. A POW report card has been initiated in VISN 11. Each medical facility is required to provide a report every two months. All providers are certified. A support group for POWs and their partners and close family members meets the first Tuesday of each month. Each hospital must participate in three outreach activities a year in the community. Focus groups have been formed. Town hall meetings have been held to recruit former POWs who have not yet been contacted. Recognition days are held. And currently there is a PTSD support group in all facilities. In FY '04 220 C&P exams were completed. In FY '05 that number was 111 and in FY '06 it was 20. There is ongoing training for new and current providers. When a POW's record comes up, it's flagged in the computer system to alert for priority care. Mr. Galanti spoke about his activities in Virginia, where he is now chairman of the board of Veterans Services. They started a group called Families of the Wounded, and he told several moving stories about situations they encountered and dealt with.

#### **VI. Adjournment**

The meeting was adjourned for the day at 4:01 p.m.

Tuesday, April 17, 9:02 a.m.

Washington, D.C.

**Participants:**

Thomas McNish, M.D., Chairman

Michael Ambrose, M.D.

Mr. Baker

Alice Booher

Ken Farmer

Robert W. Fletcher

Ms. Fuller

Paul Galanti

Robert E. Hain, M.D.

Laurent Lehmann, M.D.

Bradley Mayes

Giles Norrington

Linda Piquet

Robert E. Smith, M.D.

Charles Stenger, M.D.

Fernando Tellez, M.D.

Lily Trehella

**By Agenda:**

**I. Welcome**

Dr. McNish opened discussion on the time and location of the next meeting. This led to a discussion of whether to hold the meeting in a problem area, and that led to a discussion of ongoing problems. Dr. Ambrose suggested recognizing excellence by holding the meeting in a center of excellence. Gainesville, Florida was tentatively selected. Dates in September and October were discussed with the 22<sup>nd</sup> of October most likely.

**II. Compensation and Pension Update**

Mr. Mayes, the director of the Compensation and Pension Service, has been on the job for only a few months, detailed in October, 2006, and officially confirmed on Christmas Eve. Rather than do a formal presentation, he invited recommendations and questions and comments to which he could respond. Dr. McNish suggested working from the Advisory Committee's previous report. Mr. Mayes stated that there were over 400,000 claims awaiting decision currently, and that it is taking on average 177 days to process

Advisory Committee on Former Prisoners of War Biannual Meeting

April 17, 2007

Page 2

each claim, which he concedes is too long. However, for American ex-POWs the numbers in January were better, about 112 days. Discussion then turned to decision notifications, and the language in which they are written. Mr. Smith noted that they are

lagging in technology and there is no reason why a vet should not be able to go to a website to determine his current status. Mr. Mayes pointed out that the BDN payment system is a legacy system, created in 1975, and a more modern system is needed. The VETSNET system is moving forward, but because it is also about ten years old, it is not presently web-enabled, but is on a platform which can support modernization. Dr. Ambrose pointed out the need for closer communication between C&P examining doctors and the raters who deal with their reports, so that each can better understand the other's needs. Dr. Joelle Harbour was lauded for her outstanding job in this and other areas.

### **III. Veterans Health Initiative Update**

After a break for lunch, Dr. Lehmann began his talk by remarking on a slogan floating around the VA in the last year, "This isn't your father's VA." The VA has dealt with many criticisms over the past decade and has updated itself to become a leader in performance and quality in a number of areas. It is now dealing with a much younger population. But of the 600,000 OEF OIF veterans eligible for VA care, only about one third -- 205,000 -- have come in for it. The VA sees 4 to 5 million individual veterans a year. Dr. McNish asked if traumatic brain injuries will be the Agent Orange of this war, and Dr. Lehmann agreed that this was the case. A mild TBI screener has been developed, and every returning vet will be screened. 85% will recover from mild TBI in six months to a year. There will be follow-up for the 15% with varying degrees of problems. There is an increase of osteopenia and osteoporosis in the ex-POW population which is ultimately service-connected, and requires a presumptive. Bone density can be established with a DEXA scan, and machines for these scans are not expensive and should be more widely available in VA medical facilities. This agenda item ended with continued discussion of the time and place for the next meeting, with Gainesville and October 22<sup>nd</sup> being generally accepted.

### **IV. Discussion of 2006 Recommendations and Responses**

Dr. McNish led a free-ranging discussion which began with training and moved to the question of unbundling examinations, breaking them down into their component parts, and the bureaucratic confusion over this concept and the time spent on those component parts, and the appropriate credit given. Dr. Lehmann pointed out that it came down to the difference between a forensic examination and a clinical examination. Dr. Ambrose observed that the physical exam takes less time than gaining a POW's confidence, eliciting his history, and relating that history to the problems under evaluation. Such initial exams typically take a minimum of four hours, and can take more. Ms. Piquet wondered if doctors tracked their start and end times in such exams, and was told that typically they do not. Training of both examining doctors and raters in POW issues, presumptives, and needs was again discussed. Mr. Smith was informed that he should

Advisory Committee on Former Prisoners of War Biannual Meeting

April 17, 2007

Page 3

provide a list of ex-POW certified physicians annually, and stated that he could and would do that. Dr. Stenger has been volunteering to do an annual report for the VA which appears each May. There was discussion about the timing of the report, and Dr.

Stenger was told that, inasmuch as he was in the process of retiring, he should stop volunteering his efforts and turn the report over to the VA for preparation.

**V. ID Cards**

There was no real discussion of ID cards at this time.

**VI. Adjournment**

The meeting was adjourned for the day at 3:38 p.m.

Wednesday, April 18, 2007, 9:00 a.m.

Washington, D.C.

**Participants**

Michael J. Ambrose, M.D. (Chairman)

Robert W. Fletcher

Paul Galanti

Laurent Lehmann, M.D.

Thomas M. McNish, M.D.

Michael Nacincik

Giles Roderick Norrington

Linda S. Piquet

Robert Smith, M.D.

Charles R. Stenger, M.D.

Fernando A. Tellez, M.D.

William F. Tuerk, Under Secretary for Memorial Affairs in the Department of Veterans Affairs

By Agenda:

**I. Welcome and Comments**

Dr. Ambrose called the meeting to order at 9:00 a.m.

He had a draft of the medical working group report, which he read from, for discussion and revision. Dr. Stenger asked him to emphasize an active integration of the physicians and the raters. Dr. Lehmann suggested including a concrete example. Mr. Norrington suggested that if there's a denial of a claim, the rationale be explained. Dr. Lehmann said that raters don't usually have questions; they accept the medical evidence. Dr. Tellez suggested emphasizing this one particular examination. Mr. Norrington said that would be true of any C&P exam. Dr. Lehmann said there are two priority groups for the claims process: Former POWs, and OEF/OIF.

## **II. Welcome and Comments (cont'd)**

Dr. McNish suggested, "To improve the lines of communications between the FPOW examiners and raters, we restate our recommendation to integrate raters into the examination process and physicians into the rating process, and a more thorough understanding of each other's roles and active communication between the two, especially if there are any questions from either the physician or the rater about any claim that will reduce the need for remands and reevaluations." Dr. Ambrose suggested that only physicians and raters who are trained and certified to examine POWs be allowed to do so. Ms. Piquet asked what type of certification and by whom. Dr. Ambrose said that Dr. Hain had asked that we include an annotation about the Andrews Institute.

Dr. Tellez asked if we were recommending that diabetes be a presumptive service-related condition. Mr. Norrington said no. Dr. Stenger said it's proposed legislation. Dr. Ambrose said we hadn't discussed it during the current meeting.

Dr. Stenger said the Pensacola group has discussed the much higher rate of diabetes. Dr. Ambrose and Mr. Norrington disagreed.

Ms. Piquet asked what type of claims Centers of Excellence would make decisions on. Dr. Ambrose suggested that it should be former POWs. Ms. Piquet suggested making it clear that not all of the claims would go to Centers of Excellence, and asked why train these local physicians and these local raters if all of the claims are going to be rated in Centers of Excellence. Dr. Ambrose said, "The Centers of Excellence should provide evaluations and ratings for those FPOWs who are rated less than 50 percent, or who have not had an initial POW protocol examination." Dr. Tellez asked why 50 percent, and said that at 60 percent IU is automatic. Ms. Piquet said one at 60, or one at 40 for a combined of 70.

Dr. Ambrose said the Level I regional polytrauma centers and 17 Level II centers were models for the proposed Centers of Excellence. Mr. Norrington said, "One of the things that we have said in the past and currently is that although we recognize that Seattle and Jackson are, for our purposes, the models, that San Diego, for example, and Cleveland, most recently, have been excellent models for the kind of care." Mr. Ambrose added, "and Detroit." Dr. Ambrose said at least four were needed, if not six to eight. Ms. Piquet asked if it was written that the exam would be at the VA's expense. Dr. Ambrose said, "no, but I can."

Under Secretary Bill Tuerk joined the meeting, and everyone introduced themselves.

### **III. Veterans' Cemeteries**

Mr. Tuerk spoke at length about veterans' cemeteries and the National Cemetery Administration (NCA).

He said he has heard many jokes about his job. He said, "the hallmark of the culture of NCA is we've got one chance with each family and only one. And the last thing we want to be is rigid and bureaucratic and try to force families to adapt to us rather than us adapt to families."

He said it wasn't true that his clients don't get to complain, as his clients are the families of veterans. Michigan State University does customer satisfaction surveying, and reports that VHA has higher customer satisfaction than private hospitals. VHA's ratings are at 78 percent, but NCA's are at 97 percent, the highest of any organization, public or private.

All veterans except those with dishonorable discharges are eligible for burial, as are the veterans' spouses and minor children. At Arlington all veterans are eligible for interment in their columbarium, but only "distinguished veterans" are eligible for ground burial.

NCA has 125 national cemeteries and 1,527 employees, 73 percent of whom are veterans. A new cemetery opened on Monday at West Palm Beach. There are 2.97 million gravesites. In 2006 there were 100,000 burials.

Most veterans choose not to be buried in a national or even a state veterans' cemetery.

NCA provides headstones and markers, not only to those who are buried in veterans' cemeteries, but to every veteran who chooses to be buried in any cemetery. It also provides memorial headstones and markers for deceased veterans whose remains are not available for burial, either because they're lost at sea, MIAs whose remains aren't repatriated, but also more typical circumstances where veterans choose to be cremated and have their ashes spread to the winds, and people who choose to have their remains donated to science. In Arlington, memorial stones are installed where the ground slopes too much for actual burials.

Last year NCA buried 100,000 persons, provided almost 350,000 headstones and markers, and mailed over 400,000 presidential memorial certificates to every veteran's family who requested one. They will provide duplicate certificates for sons and daughters if requested.

#### **IV. Veterans' Cemeteries (cont'd)**

NCA has been cleared to request an increase of some \$10 million for operations and maintenance in fiscal year 2008, a 7 percent increase.

\$223 million, 44 percent of NCA's total budget, is devoted to adding new capacity to the cemeteries, either in the form of expanding existing cemeteries or opening new cemeteries.

In 2006, there were more veteran deaths than any other year, ever. In 2007 a similar number is expected, about 686,000, slowly declining to about 600,000 per year by 2015. The number of World War II veteran deaths is declining, but the number of Korean War deaths is still increasing.

There are four known living U.S. World War I veterans, and a much larger number of widows. The last Civil War widow only recently died.

NCA's practice is to get the cemetery up and operating for several months before the ceremonial official dedication. NCA is having that at Sacramento, a very large new cemetery, on Sunday. NCA is still waiting for Governor Schwarzenegger to RSVP. There are existing cemeteries in San Francisco, one at the Presidio, right at the base of the Golden Gate Bridge. Both of them are closed for first burials. NCA is considering Alameda Naval Air Station for a columbarium, and perhaps NCA's first mausoleum.

Other new cemeteries have recently opened or will soon open near Detroit, Pittsburgh, and Atlanta. Further ahead are Birmingham, Philadelphia, and Columbia, South Carolina. In Philadelphia it depends on a land deal with Toll Brothers, a developer who wants zoning concessions for their other properties.

Arlington can't get an irrigation system.

To build a cemetery in a swamp, the land level is raised by digging fill dirt from large holes, which become lakes.

A bald eagle did a fly-over at one funeral. The tree it nests in cannot be touched.

#### **V. Veterans' Cemeteries (cont'd)**

There were two national cemeteries in Florida until Monday, now there are three. There will soon be five. Plus Bay Pines, which is now open only for cremated remains. There are water issues with Florida cemeteries. At Bakersfield, California, conversely, the problem is too little water. Xeriscaping instead of grass is used at such desert cemeteries, with pulverized red granite, raked daily.

At Abraham Lincoln National Cemetery near Joliet, Illinois, like other cemeteries, there are too many burial space and too few columbarium spaces, as more people are choosing cremation. Burial space for cremated remains is also provided.

NCA provides burials and headstones, but does not provide funeral home services such as embalming and caskets.

NCA provides money for state veterans' cemeteries. NCA provides 100 percent of the costs to equip a cemetery as it opens and all the heavy equipment needed to maintain a cemetery, then the state operates and maintains it. There are 65 such state cemeteries, and 4 more under construction.

Every state has at least one veterans' cemetery, either national or state. For 83 percent of veterans, there is a cemetery within 75 miles of their home. By fiscal year 2010, there should be some burial option within 75 miles of 90 percent of all veterans.

Maintenance is an unending job. Crypts and vaults are used to prevent caskets from collapsing.

Headstones should always be in straight lines and at the same level, should always be white, and shouldn't rock or teeter. Trees should be avoided, except around the edges of the cemetery.

DoD provides military funeral honors at every veteran's committal ceremony. There will be at least two members of the military present at every committal ceremony, one of whom will have served in the branch that the deceased served in. That's the minimum requirement; there are usually more. If there aren't, volunteers from the service organizations fill in.

Every veteran gets the same service. The only exception is Medal of Honor winners, who get a special designation on their headstones.

**VI. Veterans' Cemeteries (cont'd)**

Veterans of the current war who don't make it back alive can be buried in closed cemeteries if their families prefer, as a few spaces are held in reserve for such contingencies.

Former POW status, and almost anything else the family wants, can be put on a headstone. NCA is being sued by Wiccans who want pentacles on their headstones.

Spouses are entitled to be buried in the same gravesite, with their name on the other side of the headstone. If the spouse is also a veteran, they can have a separate gravesite if they prefer.

There are delays in opening the San Diego cemetery due to environmental concerns.

A 2 percent slope is optimal for cemeteries, so that the grass gets watered but not waterlogged.

Congress has compelled NCA, with all new cemeteries, only to do upright headstones. There are advantages and disadvantages to this. You can run a mower over a flat headstone, but you still have to edge it.

Twenty, twenty-five years ago some veterans' cemeteries were national disgraces. That is not so today.

**VII. Adjournment**

The recorded portion of the meeting was adjourned at 10:45 a.m.

\* \* \*