

**SECRETARY OF VETERANS AFFAIRS  
ADVISORY COMMITTEE ON FORMER PRISONERS OF WAR**

**REPORT OF APRIL 2006**

**Issue1: Training**

**Comment 1:** Web-based training offers a wide spectrum of benefits to those being trained, including the chance to complete training modules on one's own time and in one's own space. That being said, the VA's apparent increasing reliance on web-based FPOW-specific training, even when complemented by "talking head" video interviews with former POWs, cannot duplicate the emotional and visceral impact of live, face-to-face encounters with former POWs. The executive secretary of this committee has participated in multiple such forums sponsored by various VAROs and/or VISNs, as have several other members of this committee,. These individuals, as well as many other XPOWs, are ready and willing to assist in future such seminars by sharing their experiences.

**Recommendation 1:** Conduct regional training seminars (which include participation by former POWs served by or residing near the hosting VISN or VARO) as needed to ensure that all personnel directly involved in FPOW care and rating decisions have received this training opportunity.

**Comment 2:** Web-based training does not permit optimum flow of participant questions, nor does it encourage feedback and crosstalk among participants. More importantly, web-based training does not permit ... much less encourage ... joint training of medical and rating personnel. We have found this interaction, along with the professional relationships which develop between physicians and raters, to be the most valuable product of the seminars as related to providing improved service to XPOWs.

**Recommendation 2:** Within the context of *Recommendation 1*, further develop in-person training modules of interest and use to both medical and rating personnel. Such training should include adequate time for facilitated crosstalk combined with candid exchange of issues and ideas between the two professional communities.

**Comment 3:** Documented participant feedback regarding the efficacy of *all* POW-related training, whether seminars or web-based, would permit continuing improvement in the content of the training modules. We have found no way to evaluate how much the trainees are allowed/encouraged to put their newly enhanced knowledge and motivation to use after attending a seminar. Anecdotally, these professionals appear to be rapidly consumed by the pressures of other demands, rather than being utilized by their managers to work more extensively with the XPOW-veterans.

**Recommendation 3:** Develop a questionnaire, or some other feedback mechanism, through which trainees can comment on the usefulness of the particular training module or seminar, as well as how much they have been allowed/encouraged to initiate improvements in their local XPOW program. Such a questionnaire might be web-based, with appropriate tabulation of trainee inputs and a required report to the appropriate VACO office and a copy to this committee. This survey should be accomplished within one year of receiving the training, but no less than 6 months after, in order to evaluate local support for techniques and concepts taught in the seminars.

**Comment 4:** The preparation of DIC claims is, at best, daunting for the grieving beneficiaries and difficult for their advisors. The sharp and continuing rise in the rate of mortality among XPOWs, especially those from WW II, promises concomitantly large numbers of DIC claims. It is our understanding that the regional FPOW coordinators *should* contact the survivor and assist in the preparation of the required forms but that they are often ill-equipped to facilitate this process.

**Recommendation 4:** We recommend that training be provided to appropriate DVA personnel to ease the burden attendant to the completion of DIC paperwork. Such training should include guidance as to the *minimum* requirements, as well as a full understanding of what must be done to gain the *maximum* benefits for the survivor. Among the factors to be emphasized by VHA personnel is that of the *duration* of the marriage as it relates to DIC payment. We have found that this is often not fully explained to the survivor. Dr. Tellez, of our committee, along with other members of his XPOW group in California, has developed a well organized packet to consolidate the data needed to ease the stress on a widow/widower in case of the loss of a loved one. We recommend that this tool ... or one similar ... be made available to anyone who might find it useful throughout the VA.

#### **Issue: C&P Examinations**

**Comment 5:** The matter of medical personnel being allowed inadequate time to conduct a comprehensive C&P exam for XPOWs continues to be of great concern to this committee. **[This has been a repeatedly addressed concern by this committee for AT LEAST the past 10 years!]** We are well aware of demands on physicians to complete as many cases as possible, as well as the concern that there simply is not enough time to dedicate the four hours for a C&P exam of former POWs long advocated by this committee. Apparently, this is based on the time allotted for each patient.

**Recommendation 5:** Recognizing the demand for accurate accounting of time spent on particular medical procedures, and since it does not appear to be possible for the "system" to allot the needed time for these exams, we recommend that physicians qualified to conduct C&P exams on XPOWs be instructed to "unbundle" the various aspects of the exam and report the individual clinical elements included in the exam in order to appropriately justify to the "system" the total time spent on the exam.

**Comment 6:** The FPOW C&P exam is a “forensic” examination, the results of which have long term impact on the FPOW and his or her family. This clearly separates it from other, more routine, examinations.

**Recommendation 6:** We recommend that physicians certified to conduct C&P examinations of XPOWs be instructed as to the legal nature of the examination and its attendant documentation as well as the effects of certain reporting nuances on the ability of the rater to best serve the veteran. This would greatly improve the ability of that rater to provide the best possible rating for the XPOW.

**Comment 7:** The concept of the “team approach” to conducting C&P exams of XPOWs is laudable, and should include the spouse’s input during the interview/history phase of the examination. Too often, the FPOW seems to be spring-loaded to the “I’m fine” response (a trait which appears to be much more common in this group of veterans). The spouse, more often than not, will apply a bit of corrective spin on such a response to facilitate the asking of “the next question” needed to bring out the whole story.

**Recommendation 7:** We recommend that the spouse be encouraged to attend as much as possible of the former POW’s C&P examination. This should be a matter of routine for physicians certified to conduct C&P exams of XPOWs.

**Comment 8:** Sending a former POW to “the psych ward” during the course of a C&P exam can be unnerving, at best.

**Recommendation 8:** If there is a reasonable need for the FPOW to be seen by mental health professionals, we recommend in the strongest possible terms that they be invited to the C&P examining physician’s office, rather than having the FPOW sent to “the psych ward” to be seen.

### **Issue: Osteopenia/Osteoporosis and PTSD**

**Comment 9:** The body of knowledge resulting from original research related to many aspects of XPOW health by the Robert E. Mitchell Center (REMC) is widely acknowledged. Evidence continues to grow supporting a link between former POWs with PTSD and the increased risk for later development of osteopenia/osteoporosis. Additionally, supporting evidence of the link between PTSD and osteopenia/osteoporosis is seen in early (at the time of release of the POW) significantly elevated levels of serum cortisol followed, decades later, by cortisol levels well below normal.

**Recommendation 9:** Given this association between PTSD and osteopenia/osteoporosis, the committee strongly recommends that all former POWs, particularly those with PTSD, be screened for bone loss using the DEXA scan method.

**Comment 10:** The documented link between XPOWs with PTSD and later onset of osteopenia/osteoporosis meets the criteria stated in 38 CFR of 10/07/04 for designation of this disorder as a presumptive.

**Recommendation 10:** The committee recommends that osteopenia/osteoporosis in former POWs with PTSD be established as a presumptive disorder.

### **Issue: Regionalization and Centralization for Special Populations**

**Comment 11:** The committee strongly supports the concept of regionalization and centralization for special populations and services. This approach was described by Undersecretary for Benefits Cooper in the context of Benefits Delivery at Discharge processing at Salt Lake City and Winston-Salem. Principal Deputy Undersecretary for Health Kussman also spoke of “regionalization for certain special populations,” and Deputy Director of Compensation and Pension Services Simmons described consolidating claims so that death benefits become “regular work” for designated personnel. The relatively small population of XPOWs as well as the highly unique nature of their care and ratings strongly supports application of this concept to this group.

**Recommendation 11:** The concept of regionalization and centralization in the processing of FPOW claims, from C&P exam to rating, should be considered a matter of highest priority. For years, this committee has recommended such regionalization and centralization for exams and ratings of former POWs. Calling them “centers of excellence,” we have advocated that Jackson, MS, Seattle, WA, San Diego, CA and, perhaps, others equally qualified, be certified for treatment and processing of XPOWs as a “special population.” The population of this group is shrinking and the urgency of correct, expeditious handling of their needs is rapidly increasing due to the fact that they are dying at an exponentially increasing rate ... now estimated at 3000 annually.

### **Other Recommendations**

**Recommendation 12:** The committee recommends consideration of any and all means by which the staff of the Robert E. Mitchell Center can be woven into the fabric of care supporting the DVA. Among those mechanisms should be consideration of certification as VA providers and “work without pay” status for REMC employees within VISN 16.

**Recommendation 13:** The committee requests that we be briefed at our October 2006 meeting as to the status and number of certified FPOW physicians, and that such information be provided at least annually. We also request an update on the plans to maintain adequate numbers of *current* physicians throughout the VA.

**Recommendation 14:** Over the years, this committee as well as numerous veterans’ organizations, have found very useful the annual report on the numbers of former POWs from each conflict/theater, previously prepared by Dr. Charles Stenger. The availability and concurrency of this report appears to have eroded dramatically since

Dr. Stenger is no longer preparing it. We recommend that the report be reinstated, updated, and made available to this committee ASAP. We are aware that several VSOs have also depended on the availability of this report.

**Recommendation 15:** The committee recommends that all notifications of disability rating changes include a warning to the recipient that there may be tax implications and that they should conduct their attorney, accountant or tax preparer.

**Recommendation 16:** The committee requests that we be briefed on the use and usefulness of tabletop displays used for outreach to former POWs.