



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 4, 2007

Thomas M. McNish, M.D.
Chairman
Advisory Committee on Former Prisoners of War
3103 Elm Gate
San Antonio, TX 78230

Dear Dr. McNish:

Thank you for submitting the October 2006 report of the Advisory Committee on Former Prisoners of War. I was pleased to attend your April meeting to hear firsthand about the work of the Committee.

The contributions of the Committee reflect the commitment of your members to meeting the needs of this important group of veterans. The Committee's recommendations continue to enhance our outreach and training programs, as well as expand treatment and benefits for former prisoners of war. A copy of the enclosed report will be sent to leaders of the Senate and House Committees on Veterans' Affairs.

The Committee's assistance is invaluable to the Department and has led to improvements as we work together toward our common goal—better services to all veterans, especially former prisoners of war. Again, thank you for your contributions.

Sincerely yours,

A handwritten signature in black ink, appearing to read "R. James Nicholson", is written over a horizontal line.

R. James Nicholson

Enclosure

**Advisory Committee on Former Prisoners of War (FPOW)
Department of Veterans Affairs (VA)
Response to the Committee's Recommendations**

October 2006 Meeting - - Report received at VA March 13, 2007

Recommendation 1. The Committee is encouraged by the evident commitment to state-of-the-art training in regards to the processing and treatment of FPOWs. Not least, we applaud the increasing emphasis on web-based training as an adjunct to, but not as a replacement of, face-to-face training opportunities. This concern was articulated in our April 2006 meeting report. Thus, we continue to be concerned about the application of this training.

a. Of medical and rating personnel primarily responsible for treatment and processing FPOWs, how many (or what percentage) have attended at least one formal training seminar?

VA Response: The Employee Education System (EES) maintains a database of all individuals who have attended the Case Management Training. EES conducted a Case Management Training Program March, 5-8 in Jacksonville, Florida. During the April meeting, EES reported to the Committee on the status of training to date. To date, 1,393 VA employees have received this training. EES also plans to conduct Case Management Training in Manchester, New Hampshire in June 2007, and Seattle, Washington in August 2007.

b. Of the medical and rating personnel trained, how many (or what percentage) are assigned to positions from which they directly influence the treatment and processing of FPOWs?

VA Response: Although EES trains VA employees in the rating techniques and examining procedures for former POWs, many of those who attended the training cannot be matched with current decision-making positions. Because many of the trainees have been promoted, it is impossible to determine how many previously trained employees are still in decision-making positions. However, the training is intended to provide the knowledge and skills that these individuals will utilize when working in any VA position where they might contribute to programs benefiting former POWs.

c. As a follow on, how many have been assigned to these positions after attending the meeting?

VA Response: VA is unable to determine how many people who attended this training have been assigned to these positions.

Recommendation 2. We have noted previously that we have found no way to evaluate how much the trainees are allowed or encouraged to put their newly enhanced knowledge and motivation to use after attending a seminar. As noted previously, we are concerned that these professionals may be quickly consumed by other demands, rather than being utilized by their managers to work more extensively with the FPOW veterans. Develop a questionnaire or some other feedback mechanism through which trainees can comment on the usefulness of the particular training module or seminar. Such a questionnaire might be web-based with appropriate tabulations of trainee inputs, 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.

VA Response: EES provides each training course attendee a questionnaire to evaluate the training course. The results of the survey are provided to the course faculty who make improvements or changes as needed. VA also contracted with a company to develop a survey to be sent to participants 6-9 months after completing the course. As soon as VA completes field-testing this instrument, the survey will be available online for future course attendees. The results of these surveys will be shared with the appropriate VA Central Office and the FPOW Advisory Committee. The Compensation and Pension Service maintains a training staff dedicated to providing the highest quality of training for service representatives and rating officials. The program has a comprehensive evaluation which solicits feedback from trainees throughout the training process. Results are used to address any training design, content, or implementation issues that are raised.

Recommendation 3. This committee has noted that the preparation of dependency and indemnity compensation (DIC) claims is daunting for the grieving beneficiaries and emotionally taxing for their advisors. The sharp and continuing rise in the rate of mortality among FPOWs, especially those from WWII, promises concomitantly large numbers of DIC claims. It is our understanding that, as a matter of policy, the regional FPOW coordinators should contact the survivor and assist in the preparation of the required forms, but that the coordinators often are ill-equipped to facilitate this process. Recognizing the need for timeliness and uniformity in the preparation of DIC claims, Dr. Fernando Tellez, a member of this committee, and other San Diego-based FPOWs and service officers, have created a packet of information and questionnaires responsive to the needs of surviving spouses and other family members (see attached). Perhaps such a document could be distributed VA-wide for the use of those assisting aging veterans. We recommend that training be developed for appropriate VA personnel to ease the administration and emotional burdens attendant to the completion of DIC paperwork. Such training should include guidance on 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 VA personnel is the duration of the marriage as it relates to DIC payment. We have found that this is often not fully explained to the survivor.

VA Response: VA revised its rating manual (M21-1 MR, Part IV, Subpart iii, Chapter 1, Part 7) in 2005 to provide specific guidelines for the special handling of FPOW death claims. The claims folder is given directly to the POW Coordinator. If the application for DIC is not included or fully completed, the POW Coordinator contacts the survivor and makes a personal visit, if possible. The POW Coordinator assists with the completion of the appropriate paperwork, and a flash is attached to the outside of the claims folder to easily identify it as a FPOW case. VA believes that its employees give the best service possible to all veterans, including former POWs.

Dr. Tellez's packet contains helpful information as long as the forms and guidance are updated as the information changes. The forms are designed to be completed by the veterans' service organization member having power of attorney for the FPOW. Also, some of the applications are not VA documents (for example, the social security application).

Recommendation 4. As this committee noted in our April 2006 report, the body of knowledge resulting from original research conducted by the Robert E. Mitchell Center (REMC) related to many aspects of FPOW health is widely acknowledged. Evidence continues to grow supporting a statistically significant link between former POWs with post traumatic stress disorder (PTSD) and the increased risk of osteopenia/osteoporosis. This committee recommends that a Blue Ribbon Panel be formed to conduct a thorough assessment of the peer-reviewed literature related to the apparent link between osteopenia/osteoporosis among former POWs with and without PTSD. Obviously, this may also directly affect non-POW veterans.

VA Response: VA will review the research that the Committee has identified to determine if it meets the guidelines for consideration of diseases associated with detention or internment as an FPOW. The guidelines, established in response to the Committee's recommendations, are set forth in 38 CFR 1.18. If the results of the research meet the guidelines, VA will take further action.

Recommendation 5. Also noted in our earlier report, evidence of the link between PTSD and osteopenia/osteoporosis also documents that low serum cortisol in patients with PTSD is a marker of this condition. Given this apparent association between PTSD and osteopenia/osteoporosis, the committee strongly recommends that all former POWs, particularly those with PTSD, be screened for bone loss. This should be done using the DEXA-scan method to ensure reliable data.

VA Response: VHA's Office of Medical Services (OMS) is working on guidelines for diagnosis and treatment of male osteoporosis which are due out later this year. This guidance will not address former POWs as a specific subset population; however, the OMS recommends that any veteran who was subjected to significant malnutrition or

exercise deprivation be considered for a bone density scan to rule out osteopenia/osteoporosis. This stipulation would cover most, if not all, former POWs. VHA uses the DEXA method to screen these patients

Recommendation 6. This committee believes that the documented link between FPOWs 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. The committee again recommends that osteopenia/osteoporosis in former POWs with PTSD be established as a presumptive disorder.

VA Response: As stated in the response to recommendation number 4, VA will review the research that the Committee has identified to determine if it meets the guidelines for consideration of diseases associated with detention or internment as a FPOW.

Recommendation 7. As this committee has stated in the past, we strongly support the concept of regionalization and centralization for special populations and services. This approach was described by Under Secretary for Benefits Cooper in the context of Benefits Delivery at Discharge processing at Salt Lake City and Winston-Salem. Principal Deputy Under Secretary for Health Kussman also has spoken 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. For years this committee has advocated such centralization, referring to, for example, Jackson, Mississippi, San Diego, California, and Seattle, Washington, as (our words) Centers of Excellence. For reasons beyond our understanding, there has been an apparent systemic resistance to this approach regarding former POWs. The relatively small population of FPOWs as well as the highly unique nature of their care and ratings suggests that no significant burden would be imposed to the VA system by the application of this concept to this group. We are convinced that this could be accomplished without depriving these veterans of their local care and benefit relationships. 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. 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...already estimated at 3,000 annually. Although we acknowledge freely that this is a repeat recommendation, we also acknowledge our frustration at having made little or no progress in this most important matter.

VA Response: VA has ongoing FPOW case management training that encourages strong partnerships between regional offices and their corresponding medical centers. The joint training initiative recommended by the Committee should accomplish the goal of this recommendation. Centralization would remove the personalized service now being given by each regional office and medical center. VA believes FPOWs are best served through local VA regional offices and medical centers. Successful service to FPOWs by the Committee's noted "Centers of Excellence" is due in large part to the

proximity of the facilities to the veterans served and the strong partnership between the regional offices and their corresponding medical centers. Centralization is not currently in VA's plans, but will be reconsidered if the need arises.

Recommendation 8. The problem of outreach to contact former POWs not yet in the VA system is widely acknowledged. Exacerbating this problem are the age and possible skepticism of the FPOW as well as the likelihood of frailty or failing health. In some regions, VA medical personnel have initiated home visits—often in the company of local service officers—to bring service right to the doorstep of the FPOW. The committee recommends that VA medical and benefit professionals highly trained in matters relating to the POW experience be encouraged to conduct home visits in cases where it seems unlikely that the FPOW will otherwise be able or willing to travel to the VAMC for the protocol examination and rating application.

VA Response: VA concurs with this recommendation and will provide guidance to the field, including criteria for home visits based on the lengthy experience of the Puget Sound FPOW program, in the upcoming revision to the Veterans Health Initiative (VHI) on care of former POWs. This information will also be incorporated into ongoing training of VHA and VBA staff.

Recommendation 9. The matter of interpreting diagnostic codes, whether in the award letter or by the Department of Defense reviewers considering, for example, Combat Related Special Compensation (CRSC), is, in some cases, problematic. The lack of transparency almost certainly adds to the length of the review process and may result in miscalculation of the award. The committee recommends that the award letters include detailed explanations of the relevant diagnostic codes or that an index of diagnostic codes be appended to award letter.

VA Response: Title 38, Code of Federal Regulations, Part 4, Rating Schedule for Disabilities, is an extensive document composed of an index to disabilities listed under 15 main body systems. This generalized document allows for a rating specialist to determine a diagnostic code based upon the veteran's diagnosed disability and level of impairment. The diagnostic code given is explained in detail within the body of the rating decision under reasons and bases. Providing an index of diagnostic codes appended to the award letter would not be beneficial to the Combat Related Special Compensation Board. They have complete access to the information VA has with regard to diagnostic codes and percentages because of their direct "view only" access to VA's system. Therefore, no change in current procedure is warranted.

Recommendation 10. Our most recent experience in Chicago, and previously in both Los Angeles and San Francisco, makes it clear that in regions where unimpeded crosstalk between medical and rating personnel is routine, the rating process proceeds more smoothly and more quickly. For example, both medical and rating professionals in Chicago spoke of "walking across the parking lot" to see clarification of some knotty

issues. We realize that proximity plays a major role in facilitating face-to-face discussions, but we are convinced that e-mail and telephone crosstalk would be equally effective. We also are convinced that the best way, perhaps the only way, to make such dialogue a matter of routine is by making it a matter of policy by VISN, VAMC and VARO directors. We recommend the benefits of open and continuing dialogue between medical and rating professionals be an agenda item at one of the upcoming leadership conferences, such as the National Leadership Board. This committee would be pleased to ensure that one or more of our members will be available to discuss the matter in that forum.

VA Response: VBA has not finalized its agenda for the summer leadership conference. The Committee's recommendation will be considered, and the Committee Chairman contacted if additional information is needed. VHA holds biennial conferences. The coordinators of next year's conference have been notified of the Committee's interest.

Recommendation 11. The committee again 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.

VA Response: Staff at the Robert E. Mitchell Center, personnel at VISN 16, and local leadership of the new Pensacola Outpatient Clinic are sharing resources and information about health concerns and treatment of FPOWs. VA expects joint VA/REMC collaboration to continue. REMC presented an update about this collaborative work at the FPOW FACA meeting in April.