Advisory Committee on former Prisoners of War
Biannual Meeting
October 24-26, 2005

Seat #1: Dr. Laurent Lehman, MH VHA Liaison
Seat #2: Bob Smith, M.D., retired Navy
Seat #3: COL Rhonda Cornum, M.D., active-duty military, FPOW in Desert Storm
Seat #4: Robert W. Fletcher, Korean War FPOW, 33 months in prison camp
Seat #5: Giles Norrington, Vietnam FPOW, for 4 years
Seat #6: Michael Ambrose, M.D., retired director, Robert E, Mitchell Center
Seat #7: Fernando Tellez, M.D., FPOW in Germany
Seat #8: Clarence Earl Derrington, European FPOW
Seat #9: Paul Galanti, Vietnam FPOW for almost 7 years
Seat #10: Dennis Rhoades, Designated Federal Officer

Charles Woolford, Director, Wichita Regional Office
Dr. Bob Hain, Director, Mitchell Center for POW Studies
Jeff Robbins, National Program Director for Podiatry Service
Dr. Walter Cox
David Unterwagner, Assistant Director, St. Louis Regional Office

Monday, October 24, 2005

9:00 a.m. – Opening Remarks & Introduction of Committee Members

Welcome:

Dr. Michael Ambrose
Ronald R. Aument, Deputy Under Secretary for Benefits
Kent D. Hill, Director KCVAMC
Peter L. Almenoff, M.D., Director VA Heartland Network

Dr. Michael Ambrose: Tom McNish, Chairman, isn't able to attend due to a family emergency.

Kent Hill: Welcome Dr. Ambrose, Former Prisoners of War, and other invited guests that are here at the Kansas City VA Medical Center today. We extend our thanks to Prisoners of War that have endured on our behalf. We appreciate you. We are at your disposal during your meeting; we are here to assist you.

Dr. Peter Almenoff – Hope you enjoy our town during your visit. I have been reading a book Prisoners of Hope that has a lot of stories about courage and faith and people of honor. A lot of stories about people like you. You are true American heroes and have made our country better.

VBA update from Mr. Aument.

Veterans Benefits Administration Update, Ronald R. Aument – Admr. Dan Cooper sends his greetings. He was unable to be here today as he just returned from vacation. I am pleased to be here today to share with you VBA's challenges and to hear any concerns you may have to share.

The issue of consistency of benefits determination is a major concern for VBA. For a number of years we have been aware of differences between the amounts of payments. There is a variance among states. This has become a big issue in the last year. We don't have a consistent measurement system to measure and assess consistency. We were measuring accuracy, but not consistency. We are transitioning to a place where we have better tools to evaluate consistency. In December we were seeing news articles which raised visibility of consistency. Knight Ridder raised the issue, but Chicago Sun Times really brought attention with state by state comparisons and concluded that the State of Illinois was at the bottom. The spin the story took reported some administrative failings that drove the payment differences. The issue started to gain political traction and received awareness from Illinois delegation.

Then-secretary Principi called in the Inspector General to review the issue of consistent VBA payments. In late December the IG began to study the variance in payments. In May they published the results of their findings. They found demographic issues.

Retired enlisted men received more than officers. Veterans who were represented tended to receive higher than average payments over those that were not represented. There were probably a dozen different demographical factors that they were able to establish a correlation with the amount of payments – conflict era, age, years of services – were factors.

The awarding of 100% disability payments and high-end payments were driving the averages for some states high.

Suggestions for resolving the variances included getting into more sophisticated analyses. Multi-variant analysis requires a great deal of expertise. We have done that by contracting with some defense analysis organizations to generate reports. We expect a completed report by next fall. This will give us an idea of what measures we can use to follow these trends. Average annual payments on a state by state measure was not the best method to measure.

We need to do a better job of outreach to better serve veterans of specific populations, such as veterans of older generations and older conflicts where there may be benefits for which they are eligible. They may need assistance to apply.

We should conduct an intense review of PTSD disability claims. They studied seven different states. In a large percentage, VBA had not done a good job of evaluating the

PTSD factors in patients. IG reported that if we had, in fact, erroneously issued VBA disability payments for 100% PTSD, it could have resulted in 20 billion dollar overpayment.

We are looking at 21 cases for review. An initial scan of those claims found the same results of the IG – approximately 25% of claims were deficient.

Protected rating is an award of service connection that has been established for 10 years or more, it is closed for further review. Roughly 20% of the cases have a protected rating.

Another 20-25% of cases looked at did not contain a reference to the stressor event. The information did turn out to be in the file, but it was not spelled out in the rating decision.

VBA continues to evaluate the remaining cases. It is expected that the missing stressor event will be found in 90-95% of cases. What this means to POWs is that a POW event qualifies as the stressor event and that closes the file for further review.

VBA will take the next step to review 72,000 cases. It remains controversial. There is intense opposition to this among the veteran stakeholder communities, and a large amount of resistance among committee membership as well. There is a very vulnerable group of veterans that this affects. We are sensitive to that.

Fletcher: You made my day with that – every member of our chapter in Richmond, VA is concerned about losing their disability because they are getting word of this. The news stories are presented in a way that raises concerns. IU is only a factor when it relates to PTSD. We are not looking separately at IU – only when it relates to PTSD.

There was a case where 60% was granted for PTSD, but they wouldn't address IU at the same time. It has to go to DVA to evaluate the IU claim, it took 2 or 3 years to get the 40% for IU which made him 100% disabled. It shouldn't have had to take 2 or 3 years to get that. They should have been able to do that at the same time.

Ambrose: To help address this concern, suggest making rating decisions at fewer locations. Currently there are 57 locations across thee country that make these rating decisions

There are a lot of phony POWs out there. There are a lot more Vietnam era vets that claim to be a POW, than there were actually POWs. VBA is taking a look through Vietnam Veteran POW networks to identify and address the phonies.

Award rating variability can be greatly affected by the physician that does the evaluation. If the physician has a great interest in POWs, they take a personal interest to be sure the ratings are done completely and fairly. In many locations the rating is done by PAs that don't have thee full understanding of how to evaluate to conduct the rating examination.

Our committee has supported making certain centers of excellence to issue rating decisions. We support reducing thee number of locations that make thee rating decisions.

Aument: We are designing plans for aiding consistency of ratings, creating templates, considering mandating use of templates, training, and guidelines. It is our expectation in the upcoming year we should have agreed-upon exam templates

Ambrose: When looking at developing templates, may want to revisit a project that was looking at a system similar to turbo tax that would run through series of questions/options that aids in thee determining ratings.

Fletcher: One office indicated (VISN 11) that the POW exams were only given 15 minutes per exam (not four hours). It was even said to a veteran that you are only trying to get more money, it will only take 15 minutes.

Smith: Vietnam era POW pursuing getting benefits felt it was an inadequate medical exam, even though it did take four hours. We want to see consistency in the raters. There is a high turnover rate and poor or little training.

Norrington: Training programs should be located in one area. Centralized training would facilitate consistency.

Aument: Training is an area that is being evaluated. Models outside of the traditional classroom setting are being considered.

Ambrose: The Benefits Delivery at Discharge program is a good idea, however a military physician does not know how to conduct a retirement physical. They won't have the information to determine disability ratings. Their exams take 15 minutes. Unless the military physicians are trained on the VA standards and given the time to do the examination, it won't be effective.

Aument: One of the things we are trying to do to address that is to establish MOUs that outline criteria for training and conducting exams. We signed an MOU with Mansfield for a single discharge and disability rating exam. 85 to 90 sites have signed MOU agreements. These MOUs provide for the VHA physicians to do the rating exams.

Audience: WWII veterans are averaging age of mid-eighties, as are their spouses. They have a great deal of difficulty applying for the benefits they deserve.

Aument: This is true and our ability to provide case management services is challenged.

Fletcher: VBA tends to send a quantity of confusing information to new widows when what they need is only one page to sign and to include a copy of death certificate and marriage license to get their benefits.

Aument: Suggestion noted. Will take this back to regional offices.

Audience: Encouraged by the fact that you were making the statement that training will be emphasized.

Aument: Absolutely, my boss ADMR. Cooper places a great emphasis on training. It is one of the most important things we can do to ensure accuracy and consistency of our work product. It is some of the best investment we can make in our workforce and our mission.

10:00 am. – break

10:15 a.m.

Jeffrey M. Robbins, D.P.M.
Director Podiatry Service
VHA Central Office

Presentation on amputation prevention.

P.A.C.T.
Preservation Amputation Care and Treatment

Voluntold – volunteer + told
Define Quality as doing the right thing right, and doing it right the first time.
We are the premiere institute in performing amputations. That being said, we need to do better because we need to be able to do fewer amputations.

Veterans Medical Programs
Emphasized importance of highest quality care for amputees.

1993 PACT program launched:

-Developed to meet the changing needs of veterans
-Established a model of care to prevent or delay amputations
-Proactive early identification of at risk populations
-Track from the date of entry to discharge back to the community

PACT Directives
1993
-Established program
-First issued directive to each medical center to establish a care system

1996
-Tied to performance measures – foot screening

2001

-Called for improved measures – high-risk foot registry

There is a rating system that ranks patients risk from 0 (normal risk) to 3 (highest risk). This program will be launched next month. Facilities will be able to determine risk and contact patients that have not been seen within the last year and are at a high risk so we can provide treatment to prevent amputations.

Routine Foot Screening
-Neurologic – monofilamenet test
-peripheral vascular
-deformity inspection

Intervention
Interventions are wholistic and are multidisciplinary and interdisciplinary.
-Foot Risk Score 0
 -control blood sugar
 -patient education
 -smoking cessation (must be willing)
 -refer to podiatry
 -annual screening

Intervention
-Foot risk Score 1
 -same, plus closer screening

Intervention
-Foot Risk Score 2 and 3
 -same, plus refer to podiatry sooner, refer immediately if ulceration or infection
 -annual screening for frs2

Good Foot Hygiene

Physicians should model the behavior they expect their patients to follow.

Evaluating how well we are doing with prevention of amputation.

High Risk patients include those with diabetes and end stage renal disease.

Emphasis is on foot care, inspecting feet for changes, and wearing proper shoes.

Diabetes is viewed as a chronic disease that you can live with. Cancer is viewed as life-threatening and patients are willing to take drastic measures in their own care to fight the disease.

Conclusion: VA is the benchmark in amputation prevention. VA needs to do an even better job. Prevention continues to be the emphasis in the high risk patients.

The Codes that VBA uses are totally different than ICD9. That created a problem with CRSC. Codes for physicians and treating illnesses use the same ICD9 codes. Codes that VA uses to assign disability ratings are different. They are two different coding systems.

Preservation Amputation Care and Treatment

Topics: Suggested Meeting Dates for meeting in Washington:

Unterwagner: Response to Mr. Aument: in our office we have most senior persons dedicated to rating for POW cases. One person is dedicated full time to rate POW cases. This is an effort in our office to gain consistency. We also have MOUs with military institutions; examinations are done by VHA staff.

Ambrose: How much time is allotted for the examination? Is it a set time or is it open ended.

Unterwagner: Does not know, will investigate and report back to the committee.

Ambrose: It is the medical history review that takes additional time.

Unterwagner: Intend to go back to the office and discuss with staff the issue of allowing plenty of time for thoroughly investigating the medical records.

Rhoades: There will likely be a reporter from KC Star here this afternoon.

Ambrose: No objections.

Recommend reconvening at 1:15 to meet some of the POWs that will be coming for the Open Forum.

12:30 p.m. – Opening Remarks for Afternoon Session and Introduction of Committee Members

Dr. Ambrose introduced Dr. Walter Cox. Dr. Cox was presented with a plaque and recognized for his contribution to the VA and the community at large, for his leadership within the Department of Veterans Affairs, and working with the POW Advisory Committee. Dr. Cox expressed his appreciation and stated that his work with the POW Advisory Committee has been rewarding.

Dr. Ambrose opened the meeting to the floor asking for comments from the audience. This was the time for POWs present to speak up and discuss how they have been treated at this facility. The committee expressed interest in both positive and negative responses and questions.

Question: What are the criteria for dental treatment and availability?

Response: Shari Grewe, Patient Representative responded that POWs should be able to have their teeth cleaned every three months. She also invited anyone having any problems in this regard to talk with her at a later time and she would see that appropriate and timely treatment is obtained if justified.

Robert Fletcher, Committee Member, went into detail regarding dental treatment and stated that if the treating facility is not able to schedule an appoint within a specific time frame that the POW is allowed to see an outside dentist.

The Staff Assistant to the Director will follow-up with getting information to the POW group.

Another member of the audience volunteered that dental treatment from this facility had been most accommodating until about a year ago. He suggested that staffing shortages and funding shortages may be creating some of the problems.

Question: Parkinson's Disease – What is being done? Is there a link between being a POW and having Parkinson's?

Response: There is a Blue Ribbon Committee focused on some of the different diseases which may be a result of having been a POW. A more definitive answer could not be provided at that time.

Among the POW group at the Kansas City facility, there are about five individuals with Parkinson's.

Question: Mr. Ed Slater, Service Officer, POW, raised an issue regarding a veteran who felt he was entitled to a Purple Heart for his service time. Records had been reviewed and it was explained to the veterans that there was no evidence to substantiate his request. There will be continued efforts made to help the veteran understand why his request has been denied.

Lack of Parking Spaces presents a major problem for many of our handicapped and/or elderly veterans.

Response: At the conclusion of their visit, Dr. Ambrose will be presenting Mr. Kent Hill, Director a list of issues and concerns.

Medical center staff acknowledged that parking is a concern, and is being addressed.

Question: Can we go to an outside doctor if we are unable to get an appointment within thirty (30) days?

Response: Regulations say if a POW is unable to schedule an appointment within thirty (30) days, that yes, they can see an outside physician at the expense of the VA.

Mr. Slater stated that although there are times when a POW sees an outside physician, it is not encouraged as often the work does not meet our standards and is frequently over-priced. In Mr. Slater's words, "We have to clean up the mess."

Question: 1. Often medications prescribed by a private sector physician are not carried at this facility. What needs to be done to make any particular medication available to our veterans? 2. This same veteran needed to see a cardiologist and was told an appointment wouldn't be available for nine (9) months. 3. Also, he needed dental care and an appointment was put off for many months.

Response: There are times when a medication is not available. Prescriptions written by outside physicians must be reviewed and approved by our primary care physicians and if it is not a part of our formulary we are not able to provide the medication.

A committee member asked if there is a POW medicine team that sees all of the POWs at this facility?   He said that such a team is strongly encouraged by Headquarters.

Dr. Steve Warlick, Chief, Primary Care said that we have had a system in place for around 1 year. Regarding medications written by outside physicians, our primary care physician requires clinical information and the prescription. If the primary care physician is familiar with the medication, he can rewrite the prescription or may even write a substitute prescription. However, there is also the possibility that the primary care physician is not familiar with the medication and/or may not feel comfortable filling it.

Question: Veteran's doctor is Dr. Vogelsang. POW veteran suffers with headaches and was told there was nothing further we could do for him here. He went to a pain clinic and had his records reviewed. They diagnosed him with arthritis, gave him an epideral and prescribed "ArthritX". He was told to take his prescription to the VA to be filled. The VA pharmacy told him we do not carry the medication and as a result he had it filled at a local pharmacy at a cost of over $100.

Response: Dr. Ambrose asked if we have a pain clinic. Ms. Grewe said we do and willfollow up with the veteran to arrange for pain medication.

Question: There are times that I do not get my second, third, fourth refill of a prescription before the prescription expires.   The medication is still needed however, since the prescription has expired it can no longer be filled. What should he do to avoid this dilemma?

Response: It was explained to the veteran that prescriptions do expire after one year. He should let the pharmacy know you are a POW. When you see your primary care

physician discuss your prescription to ensure it is rewritten before it expires in order to have continuity in obtaining refills.

Dr. Ambrose referenced a system used at Ann Arbor, Michigan where POW status is recognized as soon as a social security number is entered. Recommendation has been made to reinstate the veteran's POW status on ID cards.

The committee asked if there were any questions specific to POW benefits. No one had any questions; however, discussion ensued regarding SBC, DIC, and other areas of concern for the POW veteran.

Question: The committee asked if those present knew what to do if a POW becomes ill while traveling?

Response: Specific criteria must be met. It was suggested that a pamphlet be made available discussing private hospital care during an emergency situation. Glenna Greer indicated she would provide the directive discussing this issue to Carolyn Wright, POW Coordinator, KCVAMC.

Question: Another question presented by the committee was, "If your husband expires, do you know your benefits?"

Response: Mr. Fletcher commented that many POW spouses do not know what type of benefits they are entitled to receive upon the death of their husband. Depending upon circumstances, length of marriage, service-connection percentage, some spouses would receive more compensation than others.

Dr. Tellez stressed that POWs should complete an advance directive so the surviving spouse will know hat to do upon their demise. Completing the form will help the family.

Tony Barnett, Medical Media said he will arrange for POWs and their spouses to view a ten minutes film explaining the advance directive and its use.

A special compliment was extended to Carolyn Wright, POW Coordinator. Her work with the POW and his spouse is helpful and appreciated. Dr. Ambrose stated that the spouse should be with the POW during meetings to assist with questions they may have or any facts that should be known to the facilitator of a meeting.

It was also suggested that POW meetings be held once a week and that there be two different facilitators presiding over the meeting for the POW and one for presiding over the meeting for the spouse. The spouse plays an important part in the wellbeing of our POW population, and their input during meetings is essential.

There was discussion regarding adjudication officers and how ratings are obtained. There are two levels of appeal, 1) Board of Veterans Appeals and 2) Court of Appeals.

It was pointed out that annual raised of 3 or 4% do not take in consideration the upgraded cost of medications. Mr. Dennis Rhoades commented that Congress does not take into consideration cost of living adjustments.

Miscellaneous Subjects of Discussion:

1. Veteran feels our phone system is inadequate and needs improvement.

2. Eligibility for CHAMPVA

3. HealthE Vet – Veteran stated that website is wonderful; however, not always user friendly.

Glenna Greer, Staff Assistant to the Director assured the committee and POWs present that she had made a list of the voiced concerns and will be reviewing them with the Director. Ensuing discussion and resulting comments will be provided to the committee.

SPECIAL PRESENTATION BY: Carolyn Wright, POW Coordinator.

Ms. Wright provided highlights of the POW Program available at this facility. She discussed the different groups, activities, strengths, opportunities and challenges faced by our POW population. One note of particular interest is the writing of a book, titled "Prisoners of War", in which her members are involved. It is to be published and available in the near future. A second book is already in the writing stages and it will include additional POW stories and bring the first book up-to-date.

The committee showed great interest in Ms. Wright's program and wanted to ensure she has a voice in and direct access to the "front office." She assured them she is well received

Meeting adjourned at 4:00 p.m.

Biannual Meeting October 25, 2005

Report from the Robert E. Mitchell Center for POW Studies –

a. Dr. Hain provided an update of the status of the Robert E. Mitchell Center in Pensacola Florida. The Mitchell Center is the only program in existence that works with three branches of the armed services in this field, and currently sees over half of today's surviving Vietnam POWs. The Center provides assistance to former POWs from World War II all the way through Desert Storm. The Center is now open, although the president has not been officially appointed as of this time. Research projects underway at this time include studies to determine if there is any increased incidence of carotid artery disease and/or increased tendency toward diabetes, as well as prostate cancer and peripheral

neuropathy. Studies planned in the near future include determining whether the calcium losses from starvation diets may affect bone density. POW's will receive annual extensive examinations to treat physical and/or mental conditions resulting from their POW experiences.

b. Polytrauma Rehabilitation Centers (PRCs). The mission of the PRCs is to provide comprehensive inpatient rehabilitation services for individuals with complex cognitive, physical and mental health conditions of severe and disabling trauma and provide support to their families. Intensive clinical and social work case management services are essential to coordinate the complex components of care for polytrauma patients and their families. Coordination of rehabilitation services must occur seamlessly as the patient moves from acute hospitalization through acute rehabilitation and ultimately back to his or her home community.

c. A Seamless Transition Office was opened in Washington to provide case-management assistance for those transitioning from the military to VA care. A VHA Directive requires all VA Medical Centers to appoint a POW Case Management Team. Twenty-two VISNs received awards for completing all three portions of the directive. KCVA has not yet developed a POW Case-Management team. The Team would include trained staff to evaluate, treat, and assist former POW's in receiving effective medical/psychological care/treatment. Of major concern is the cooperation required between VHA and the military to successfully meet the challenges of the endeavor to provide top-quality healthcare and/or rehabilitation services to our Nations former POW's.

"One VA Meeting the Needs of the Prisoner of War Veteran" seminars – Dr. Robert Smith, Education

a. Consultant of the Employee Education Service presented a web-based training initiative to educate POW Providers and Comp & Pen rating officials to effectively provide treatment and appropriate documentation to process claims for Veteran benefits. The web-based training modules will include patient education information which can be downloaded and printed. As stated by Dr. Smith "Quality of care starts with quality of education". Respective experts will be assigned to train physicians and rating officials to alleviate breakdowns in communication, care, and benefits. A need exists for a training video and/or real time audio conferences to be developed which will be available to all regional offices. Dr. Smith explained the plan for the web-based training will be broken down in 15-20 minute learning modules. This will assist with quick referencing of pertinent information and to alleviate cognitive overload.

b. Dr. Smith discussed avenues to publicize POW-assistance information such as purchasing table-top displays that will be sent to all Regional Offices and VA Medical Centers and encouraged former POWs to attend all major conventions. The next meeting will be held in Branson, MO in November. A booth will be set up

advertising available POW medical treatment and benefit services. Dr. Smith is also looking into the possibility of placing advertisements at ball parks.

3. Other VA Issues – Dr. Lehmann

a. Rating inconsistencies – A discussion among members focusing on the disappointment and discouragement encountered when assisting POWs applying for benefits. In the past, inconsistency in evaluation method among rating officials and difficulties in obtaining medical records has caused complications, delays, and denials of benefits to those deserving. St. Petersburg VA Medical Center in particular was singled out as a major roadblock in approval of veteran benefits. The committee agreed to report these issues to the newly developed Veteran's Disability Commission with recommendations to request an investigation of business practices.

b. Hurricane Katrina – Dr. Lehmann reported on the swift action of military personnel and VA providers to offer assistance to disaster victims.

c. My Healthe Vet – This site is continually evolving, with positive feedback received from patients. Currently a web-based communication system is being developed for patients to converse with their VA Providers. Community-based sites will be established for those without computers and/or telephones.

d. Identifying POWs in VA Medical Centers – Dr. Lehmann reported on initiatives to identify POWs in VA Medical Centers by placing an identifier on ID cards and/or flag in the computerized medical record.

e. Purple Hearts – Concern was noted on the congressional requirement to receive a Purple Heart. Many POWs feel that that alone should qualify them for this honorable medal. This is currently being pursued with Congress.

f. PTSD – Diagnosis was first made in 1980. Since that time Outreach Education and Rehab innovative teams have been developed to promote wellness. There are 44 programs across the country including the Kansas City VA Medical Center. A psychological first aid manual has been developed by the National Center for PTSD.