PROGRAM PROFILE

An Interdisciplinary Clinic for Former Prisoners of War

Dean L. Kellogg Jr, MD, MS, PhD; Holly Darling, LCSW, LCDC; Bennetta Crawford, LCSW-S; Andres J. Garcia, LCSW-S; and Veronica Camacho

Background: The former prisoner of war (FPOW) population is mandated to "receive the highest quality care and benefit services" from the US Department of Veterans Affairs (VA). Each VA medical facility is required to have a special Care and Benefits Team to meet this policy goal.

Methods: In South Texas, 40% of FPOWs had no VA primary care or clinic assignment. In consideration of the commitment of the VA to care for FPOWs, the unique POW-related medical and psychological issues, the geriatric age of many FPOWs, and the surprising number of FPOWs currently not receiving VA care, the South Texas Veterans Health Care System in San Antonio incorporated the concept of geriatric evaluation and management into its cognitive behavioral therapy team to create a specialized interdisciplinary FPOW Clinic. The main purpose of this project was to advise FPOWs of VA benefits and services as well as to facilitate the identification of overlooked conditions with a presumption of service connection, for example, exposure to Agent Orange.

Results: As most FPOWs are aged > 65 years, the FPOW Clinic was designed as an interdisciplinary team similar to that proven successful in geriatric medicine. Overlooked FPOW presumptive conditions were identified for 34% of FPOWs.

Conclusions: FPOW veterans are rapidly dwindling in numbers and may live in rural areas. Consistent with the VA's desire to adopt novel technological approaches, we propose to modify our FPOW Clinic by adopting telehealth.

Dean Kellogg is a Staff Physician, and **Veronica Camacho** is the Administrative Officer for the Geriatric Research, Education, and Clinical Center (GRECC); **Holly Darling, Bennetta Crawford,** and **Andres Garcia** are Social Workers all at the South Texas Veterans Health Care System in San Antonio. Dean Kellogg is a Professor at the University of Texas Health Science Center.
Correspondence: Dean Kellogg (dean.kelloggjr@va.gov)

Since the beginning of the American Republic, servicemen have been captured and held as prisoners of war (POWs), including > 130,000 in World War II , > 7,100 in the Korean War, > 700 in the Vietnam War, and 37 in Operation Desert Storm and recent conflicts.[1,2] Also, > 80 servicewomen have been held during these conflicts.[1-3] Of those living former POWs (FPOWs), almost all are geriatric (aged > 65 years) with a significant portion aged ≥ 85 years.

The physical hardships and psychological stress endured by FPOWs have lifelong deleterious sequelae on health and social functioning.[3-5] The experiences of FPOWs are associated with higher prevalence of chronic diseases and diminished functional performance in later life as demonstrated by a survey of FPOWs from World War II.[4] The survey assessed health and functional status in a random sample of 101 FPOWs and a group of 107 non-POW combatants from the same military operations. FPOWs reported a higher mean number of somatic symptoms than did non-POWs (7.2 vs 5.4, respectively; $P = .002$), a higher mean number of diagnosed health conditions (9.4 vs 7.7, respectively; $P < .001$), and used a greater mean number of medications (4.5 vs 3.4, respectively; $P = .001$). Among 15 broad categories of diagnoses, differences were found in gastrointestinal disorders (FPOWs 63% vs non-POWs 49%, $P = .032$), musculoskeletal disorders (FPOWs 76% vs non-POWs 60%, $P = .001$), and cognitive disorders (FPOWs 31% vs non-POWs 15%, $P = .006$). FPOWs had a significantly higher proportion of 7 extrapyramidal signs and 6 signs relating to ataxia. On the Instrumental Activities of Daily Living scale, FPOWs were more likely to be impaired than were non-POWs (33% vs 17%, respectively; $P = .01$). In addition, FPOWs have an increased risk of developing dementia, and this risk is doubled in FPOWs with posttraumatic stress disorder (PTSD) compared with non-FPOWs without PTSD.[5]

These data indicate that FPOW status is associated with increased risk of disability and loss of independence. Federal statutes established the presumption of a relationship between FPOW status and many comorbidities for VA disability determinations in recognition of such data and to overcome lack of medical records during POW confinement and to accord benefit of the doubt where medical science cannot conclusively link disease etiology to FPOW status, to FPOWs.

SERVICE-CONNECTED CONDITIONS

The historical development of conditions with a presumption of service connection for adjudication of VA compensation/disability claims began in 1921 with the Act to Establish a Veterans' Bureau and to Improve the Facilities.[1] The act simplified and streamlined the claims adjudication process by eliminating the need to obtain evidence on the part of the veteran. The presumption of service connection also facilitated increased accuracy and consistency in adjudications by requiring similar treatment for similar claims. This "presumptive" process relieved claimants and VA of the necessity of producing direct evidence when it was impractical to do so.

In 1970, the first presumptives specific to FPOWs were legislatively established and covered 17 diseases for a FPOW who had been confined for ≥ 30 days (Pub. L. 91-376). The 30-day confinement requirement was later relaxed, and additional presumptives were established that related to diseases that were more common among FPOWs than they were among non-FPOWs. These disorders included traumatic arthritis, stroke, heart disease, osteoporosis, peripheral neuropathy, cold injuries, as well as a variety of digestive and neuropsychiatric disorders. If a FPOW is diagnosed as having ≥ 1 of these conditions and it is judged to be ≥ 10% disabling, the condition is presumed to be a sequelae of the POW experience, and it is classified as a service-connected disability (Table).

TABLE Conditions With a Presumption of Service Connection for Former Prisoners of War[a]

Conditions
Psychosis
Any anxiety state
Dysthymic disorder
Residuals of frostbite
Posttraumatic osteoarthritis
Heart disease or hypertensive vascular disease
Stroke and the residual effects
Osteoporosis
Beriberi
Chronic dysentery
Helminthiasis
Malnutrition (including optic atrophy)
Pellagra
Other nutritional deficiencies
Irritable bowel syndrome
Peptic ulcer disease
Peripheral neuropathy
Cirrhosis of the liver

[a]Codified at 38 USC. § 1112(b) and CFR § 3.309(c).

FPOW CARE AND BENEFITS TEAMS

Several Veterans Health Administration (VHA) directives have been issued, including the recent VHA directive 1650, which requires that each VHA medical facility have a special Care and Benefits Team (CBT) that is charged with the evaluation and treatment of FPOWs to ensure that "FPOWs receive the highest quality care and benefit services."[6] CBTs must be composed of a clinician trained in internal medicine or family practice; a clinician who is certified through the VA Office of Disability and Medical Assessment to conduct General Medical Compensation and Pension evaluations; a FPOW advocate who typically is a VHA clinical social worker; and a Veterans Benefits Administration (VBA) FPOW coordinator appointed by the local VBA regional office. CBTs can be expanded to include other members as needed. The CBTs are tasked with facilitating interactions between FPOWs, the VHA, and the VBA.

CBTs face several challenges in meeting their responsibilities. For example, the POW experience often results in psychological trauma that foments denial and distrust; hence, thoughtful sensitivity to the sequelae of captivity when approaching FPOWs about personal issues, such as health care, is required. Establishing trusting relationships with FPOWs is necessary if their needs are to be effectively addressed.

While the VHA is mandated to provide priority treatment for FPOWs, including hospital, nursing home, dental, and outpatient treatment, a significant number of FPOWs do not avail themselves of benefits to which they are entitled. Often these FPOWs have not used VA programs and facilities because

they are uninformed or confused about VA benefits for FPOWs. As a result, referrals of eligible FPOWs to appropriate programs can be overlooked. Maximizing the service-connected disability rating of FPOWs not only impacts the disability pensions received by these veterans, but also impacts their eligibility for VHA programs, including long-term care and Dependency and Indemnity Compensation, a monthly benefit paid to spouses, children, and/or surviving parents.

In 2013, the FPOW Committee of the South Texas Veterans Health Care System (STVHCS) noted that 40% of FPOWs in our region had no VA primary care or clinic assignment. In consideration of the commitment of the VA to care for FPOWs, the unique POW-related medical and psychological issues, the geriatric age of many FPOWs, and the surprising number of FPOWs currently not receiving VA care, we expanded the concept of the CBT team to create a specialized interdisciplinary FPOW Clinic to address the unique needs of this predominantly elderly population and to involve more FPOWs in the VA system.

The main purpose of this clinic was to advise FPOWs of all VA benefits and services to which they may be entitled by identifying overlooked FPOW presumptives. As the number of FPOWs continues to decrease, outreach to FPOWs and family members has become critical, especially as increased benefits and special services might be available to this increasingly dependent older population. An informal survey of FPOW advocates across the nation found that 21% of FPOWs had disability ratings from the VA of ≤ 60%, including some who had no VA disability rating at all. Thus, an additional goal of the project was to develop a clinic model that could be disseminated throughout the VHA.

DESIGN

The design of the FPOW Clinic team is based on an interdisciplinary model that has proven successful in geriatric medicine.[7] The team comprises a physician, a social worker, and a registered nurse.[8] All members have expertise in geriatric medicine and specific training in FPOW-related issues by completing a VA employee education training session on FPOW case management. Completion of this training ensured that team members were:

- Familiar with the experiences of FPOWs as well as about the medical, psychosocial, and mental health conditions that affect FPOWs;
- Knowledgeable about FPOW presumptive conditions;
- Familiar with the VBA process for rating FPOW disability claims; and
- Capable of FPOW case coordination, workflow, and communications between the FPOW Clinic team and the VBA to avail FPOWs and their families of all eligible benefits.

In-person FPOW clinic visits and chart reviews helped identify overlooked FPOW benefits. To facilitate case management, a representative of the VBA attended the initial evaluation of each FPOW in the clinic to confirm any overlooked presumptive benefits and to familiarize FPOWs with the claims process. FPOWs were also given the choice to officially enroll in the FPOW clinic for primary care or to remain with their current health care provider. Special efforts were made to enroll those FPOWs who had no STVHCS assigned primary care clinic.

The clinic was scheduled for 4 hours every week. Initial patient visits were 2 hours each and consisted of separate evaluations by each of the 3 FPOW Clinic team members who then met as a team with the addition of the VBA representative. The purpose of this meeting was to discuss overlooked benefits, address any other specific issues noted, and to devise an appropriate interdisciplinary plan. Findings of overlooked benefits and other relevant outcomes then were conveyed to the FPOW. For FPOWs who opted to continue in the clinic for their primary care, subsequent appointments were 1 hour.

IMPLEMENTATION

STVHCS FPOW advocates identified and sent letters to FPOWs announcing the opening of the clinic and its goals. Phone calls were made to each FPOW to address questions and to ascertain their interest. The FPOW advocates then worked directly with schedulers to make clinic appointments. Forty-one FPOWs responded to this initial invitation and attended the new clinic. Subsequently, this number increased through FPOW consults placed by STVHCS primary care providers.

The service-connected disability rating of

clinic patients ranged from none (6% of attendees) to 100% (28% of attendees). For 34% of patients, clinic attendance resulted in identification application for overlooked presumptives. VBA evaluation resulted in increased service-connected disability ratings for nearly one-third of clinic patients. All clinic patients without a service-connected disability prior to FPOW clinic evaluation received an increased service-connected disability rating. Overall, 60% of the FPOWs who attended the clinic opted to receive their primary care at the FPOW clinic.

The FPOW Clinic successfully identified overlooked presumptives and facilitated the determination of appropriate service-connected disabilities. Interestingly, the FPOW Clinic encountered an unanticipated challenge to identifying overlooked FPOW benefits—veterans' medical conditions that are listed by the VHA as being service-connected in the Computerized Patient Record System did not always reflect those listed officially in VBA records. This led to occasional identification of apparently overlooked FPOW presumptives that were already recognized by the VBA but not reflected in VHA records. This issue was addressed by ensuring that VBA representatives attended postclinic meetings with clinic staff and avoided the need to pursue supposedly unrecognized benefits that were recognized.

TELEHEALTH

At present, FPOWs from World War II outnumber those of all other conflicts; however, this group is rapidly dwindling in numbers. World War II FPOWs are aged > 85 years, and therefore among the most frail and dependent of veterans. Often they are homebound and unable to physically travel to clinics for assessment. To serve these veterans, we are modifying the FPOW Clinic to utilize telehealth. The Telehealth FPOW Clinic will obtain relevant data from review of the electronic health record and telehealth-based clinic visits. Telehealth also may be used for assessments of Vietnam War veterans (eg, Agent Orange exposure), atomic veterans, and Gulf War veterans. Once fully designed and implemented, we believe that telehealth will prove to be a cost-effective way to provide clinic benefits to rural and older veterans.

CONCLUSIONS

The VHA provides priority medical treatment to FPOWs as well as timely and appropriate assessment of their eligibility for veterans' benefits. The complexities benefit programs established for FPOWs is often beyond the ken of VHA physicians, social workers, and nurses. Because of this unfamiliarity, referrals of eligible FPOWs to appropriate programs can be overlooked. We established a clinic-based interdisciplinary team (FPOW Clinic) that was fully trained in FPOW benefit programs to identify overlooked benefits for FPOWs and were able to increase the disability rating on approximately one-third of the FPOWs seen in the FPOW Clinic. A telehealth-based version of the FPOW clinic is now being developed.

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

References

1. Henning CA; Congressional Research Service. POWs and MIAs: status and accounting issues. https://fas.org/sgp/crs/natsec/RL33452.pdf. Published June 1, 2006. Accessed March 16, 2020.
2. Klein RE, Wells MR, Somers JM. *American Prisoners of War (POWs) and Missing in Action (MIAs)*. Washington, DC: US Department of Veterans Affairs, Office of Policy, Planning, and Preparedness; 2006.
3. Skelton WP 3rd. American ex-prisoners of war. https://m.vfwilserviceoffice.com/upload/VA%20Report%20on%20Former%20POWs.pdf. Updated April 2002. Accessed March 16, 2020.
4. Creasey H, Sulway MR, Dent O, Broe GA, Jorm A, Tennant C. Is experience as a prisoner of war a risk factor for accelerated age-related illness and disability? *J Am Geriatr Soc.* 1999;47(1):60-64.
5. Meziab O, Kirby KA, Williams B, Yaffe K, Byers AL, Barnes DE. Prisoner of war status, posttraumatic stress disorder, and dementia in older veterans. *Alzheimers Dement.* 2014;10(3)(suppl):S236-S241.
6. US Department of Veterans Affairs, Veterans Health Administration. VHA Directive 1650. Special Care and Benefits Teams Evaluating or Treating Former Prisoners of War. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=7481. Published July 31, 2018. Accessed March 16, 2020.
7. Boult C, Boult LB, Morishita L, Dowd B, Kane RL, Urdangarin CF. A randomized clinical trial of outpatient geriatric evaluation and management. *J Am Geriatr Soc.* 2001;49(4):351-359.
8. Kellogg, DL Jr. Geriatric Research, Education and Clinical Center (GRECC): former prisoners of war (FPOW) clinic, methods, procedures & training manual. https://www.southtexas.va.gov/grecc/docs/FPOW_toolkit.pdf. Updated January 28, 2015. Accessed March 16, 2020.