Veteran Warriors Caregiver Program Recommendations – As of May 1, 2017

I. RECOMMENDED CHANGES AND CORRECTIONS TO THE CURRENT "POST 9/11" CAREGIVER PROGRAM:

The following recommendations are made with the continuity and potential expansion of the program in mind. They are also made to bring the entire program and all participants into compliance with the Final Rule and Law. Each is based on actual occurrences or situations in which Coordinators, Social Workers, Supervisors and Leaders have created or used an internally created definition, process, policy or personal opinions to execute the program requirements rather than following the letter and intent of the law. In absence of overt direction based in the law, the Director and Deputy must be actively involved and responsible for retraining, broadcasting of process changes to the entire enterprise and managing any deviations from revised protocols. This includes joint operational conditions in which other VHA leaders are involved in the implementation and execution of policy changes and process alterations.

1. A team comprised of an Internal Medicine physician, a Neurologist, a Psychiatrist and an Orthopedist, as well as clinical compliance expert will review all revocations in the last 24 months for compliance with the law and policy. The review will entail all of the veteran's medical records (both VA and Non-VA) as well as any psychiatry records (both VA and Non-VA) and any external records that pertain directly to the veteran's ability to remain in the home, with a caregiver. These will include but are not limited to; law enforcement records, family member statements – must have direct, daily interaction with the veteran and any other agency or service that has direct (at least weekly) interaction with the veteran.

2. A compliance review expert will provide guidance to the Director to implement one document to be used for "In-Home Assessments" and another for "phone / quarterly assessments". These documents are used universally in the civilian clinical world and as the VHA must remain Medicare compliant, this particular issue is imperative to provide uniformity across the enterprise.

3. The Director will establish a training program for all Coordinators, Social Workers and their leadership of the program. This training will be comprised of the use of universal official forms for all assessments, training on the actual process of conducting assessments and documenting the results, the processes by which a Coordinator is to consistently and promptly respond to requests from the veteran or caregiver, the processes by which recommendations of providers are managed with the veteran and caregiver, additional training on providing comprehensive documentation to the veteran and caregiver of any action or recommendations in their case.

4. The Director will provide retraining to all employees in the program as to the law and policy requirements and criteria; especially focusing on consistency in application of the criteria. All incoming new employees will go through the same training to be completely familiar with the law and policy.

5. The Director will immediately screen all Coordinators, Social Workers, Nurses and any program support personnel to confirm that they are credentialed properly for the position. Any personnel who are not credentialed to conduct assessments will be replaced. In multiple cases, there are Social Workers conducting In-Home Assessments and quarterly assessments. These assessments are the basis for participation in the program and Social Workers do not have the proper and necessary medical training to be conducting them. As an example; Definition and recognized Scope of Practice for LCSW (LICENSED Clinical Social Worker) https://abecsw.org/clinical-social-work/clinical-social-work-described/

6. The Director shall establish a policy by which any local appeal board or VISN appeal board members will be comprised of at least one (1) primary member of the veteran's care team (not a CSC) and that the credentials and

names of all board members will be made available to the veteran, caregiver or their agent acting on their behalf, within three (3) business days prior to the convening of said board.

7. The Director shall mandate that all records pertaining to a veterans case be solely maintained in the veteran's medical records and that no further exclusive use of alternative record systems will be allowed.

8. The Director shall provide immediate retraining to all program employees with regard to altering or removal of any files, records or pertinent document of the program. We have found numerous instances of these actions by VA employees and these actions are violations of **44 U.S.C. Chapter 31, § 3106;**

    i. Unlawful removal, destruction of records

    (b) FEDERAL AGENCY NOTIFICATION.—The head of each Federal agency shall notify the Archivist of any actual, impending, or threatened unlawful removal, defacing, alteration, corruption, deletion, erasure, or other destruction of records in the custody of the agency, and with the assistance of the Archivist shall initiate action through the Attorney General for the recovery of records the head of the Federal agency knows or has reason to believe have been unlawfully removed from that agency, or from another Federal agency whose records have been transferred to the legal custody of that Federal agency.

9. Use contracting of nurses to do "In-Home" assessments; (the credentials should be consistent with our Clinical Reviewer's credentials – Social Workers are not medically trained, nor qualified to make medical recommendations for veterans. Medicare, Social Security and most states (Medicaid) use this process to free up their employees.

10. We have identified hundreds of cases where the ONLY respite care being offered to those CG's requesting it is to admit the veteran in-patient to the psych ward at the VA hospital. This is contrary to the law, the best interest of the veteran and defies the VA's own respite program protocols. Director shall include in retraining; clear direction and policy on providing respite care to caregivers.

11. According to the OIG 2014 report, the CATS program was not fully functional then and was being 'phased out". We have discovered that some CSC's are using it to communicate about veterans cases, including about contemplating and designing revocations without medical supporting evidence and not copying this information over to the veterans medical records.

12. We recommend a complete discontinuance of the use of CATS and require all CSC personnel utilize the patients' medical records exclusively for all communication.

13. Email for CG's – there is no consistent policy in the enterprise as to email use by CSC's with CG's. This is unacceptable. The Secure Messaging system does not include the CSC program. CSC's are not consistent in responding to calls only email (to include secure messaging) provides full transparency and continuity for all involved.

14. No revocation or tier reduction without complete medical and/or psychological evaluation of veteran within 30 days of recommendation to revoke or lower tier (unless requested by the veteran or CG).

15. No longer allow solely "Records Review" to revoke or review appeal. VA's own track record of thoroughness of records is abysmal. VA EHR is STILL not functional, therefore it tends to follow that the records from injuries sustained in combat are NOT complete if available at all.

16. All reductions or revocations recommendations must be reviewed by a Clinical Reviewer (Medical) from outside the VISN, NOT Social Workers. Social Workers are not medically trained.

II. AFTER CORRECTIONS ARE MADE TO EXISTING PROGRAM, CONSIDER EXPANSION OF THE PCAFC TO ALL ERAS:

1. Merge all VA programs that handle "in home care" under ONE umbrella; including their budgets.

2. Have one centralized INTAKE assessment to the UMBRELLA of all "In-Home VA provided or contracted services.

3. The Intake Counselor will use a universal (VACO and Medicare approved) intake form to assess the needs of the veteran.

4. The I/C will review ALL the programs that the veteran is eligible for and create intake application for each on behalf of the veteran.

5. I/C will track all applications for the veteran until such time as veteran is "enrolled" under a specific program.

6. I/C will be responsible for confirmation of receipt of application and any necessary supporting information, coordinator with veterans medical / psychiatric providers (both VA and civilian) to insure all records are up to date.

7. I/C will liaison with all program providers to correct any deficiencies in the application processes or assist in obtaining any additional information necessary to complete the application process.

    a. Skilled Home Health Care
    b. Homemaker/Home Health Aide (H/HHA) Services
    c. Home Telehealth
    d. Hospice Services
    e. Respite Care
    f. Medical Foster Homes
    g. Domiciliary Care
    h. Adult Day Health Care
    i. State Veterans Homes
    j. Aid and Attendance

8. Identify budgets for these programs and restrictions as to combining the programs.

9. Expand the "Tiers" of eligibility to be similar to the Veteran Directed Care program (has 12 Tiers). This would truly capture the level of care necessary to assist the veteran in the home environment and not create such large

gaps in types of care; Current Tier 3 is “40” hours…but the level of care necessary for bed-bound veteran and a TBI (but ambulatory) veteran are vastly different and require different ancillary services.

10. Lower the Stipends, but ADD IN funding from the other programs. This would keep with the “stipends” aspect of Aid and Attendance and the Post 9/11 program but if used in concert with the expanded tiers and rated appropriately, the actual costs of the program would be less catastrophic to the VA budget.

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