September 2014

VA HEALTH CARE

Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program

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Why GAO Did This Study

In May 2010, Congress required VA to establish a program to support family caregivers of seriously injured post-9/11 veterans. In May 2011, VHA implemented its Family Caregiver Program at all VAMCs across the country, offering caregivers an array of services, including a monthly stipend, training, counseling, referral services, and expanded access to mental health and respite care. In fiscal year 2014, VHA obligated over $263 million for the program.

GAO was asked to examine VA's implementation of the Family Caregiver Program. This report examines how VHA is implementing the program, including the types of issues that have been identified during initial implementation. GAO obtained and reviewed relevant policy documents and program data and interviewed officials from VHA's Caregiver Support Program office. GAO also met with officials from five VAMCs and their corresponding Veterans Integrated Service Networks to obtain information on program implementation at the medical facility level.

What GAO Recommends

GAO recommends that VA (1) expedite the process for implementing a new IT system that will enable officials to obtain workload data; and that VHA (2) identify solutions to alleviate VAMCs' workload burden in advance of obtaining a new IT system, and (3) use data from the new IT system, once implemented, and other relevant data, to re-assess the program and implement changes as needed. VA agreed with GAO's recommendations.

What GAO Found

The Veterans Health Administration (VHA)—within the Department of Veterans Affairs (VA)—significantly underestimated caregivers' demand for services when it implemented the Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program). As a result, some VA medical centers (VAMCs) had difficulties managing the larger-than-expected workload, and some caregivers experienced delays in approval determinations and in receiving program benefits. VHA officials originally estimated that about 4,000 caregivers would be approved for the program by September 30, 2014. However, by May 2014 about 15,600 caregivers had been approved—more than triple the original estimate. The program's staffing was based on VA's initial assumptions about the potential size of the program and consisted of placing a single caregiver support coordinator at each VAMC to administer the program. In addition, each VAMC was to provide clinical staff to carry out essential functions of the program, such as conducting medical assessments for eligibility and making home visits. This led to implementation problems at busy VAMCs that did not have sufficient staff to conduct these program functions in addition to their other duties. As a result, timelines for key program functions, such as those for completing applications within 45 days and making quarterly home visits to caregivers, are not being met. VHA has taken some steps to address staffing shortages; however, some VAMCs have not been able to overcome their workload problems because the program continues to grow at a steady rate—about 500 approved caregivers are being added to the program each month. Federal internal control standards emphasize the need for effective and efficient operations, including the use of agency resources.

The Caregiver Support Program office, which manages the program, does not have ready access to the type of workload data that would allow it to routinely monitor the effects of the Family Caregiver Program on VAMCs' resources due to limitations with the program's information technology (IT) system—the Caregiver Application Tracker. Program officials explained that this system was designed to manage a much smaller program, and as a result, the system has limited capabilities. According to federal standards for internal control, agencies should identify, capture, and distribute information that permits officials to perform their duties efficiently. However, outside of obtaining basic aggregate program statistics, the program office is not able to readily retrieve data from the system that would allow it to better assess the scope and extent of workload problems at VAMCs. Program officials also expressed concern about the reliability of the system's data, which they must take steps to validate. The lack of ready access to comprehensive workload data impedes the program office's ability to monitor the program and identify workload problems or make modifications as needed. This runs counter to federal standards for internal control which state that agencies should monitor their performance over time and use the results to correct identified deficiencies and make improvements. Program officials told GAO that they have taken initial steps to obtain another IT system, but they are not sure how long it will take. However, unless the program office begins taking steps towards identifying solutions prior to obtaining a new system, VAMCs' workload problems will persist and caregivers will not be able to get the services they need.

_____ **United States Government Accountability Office**

Contents

Abbreviations

CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CSC	caregiver support coordinator
DOD	Department of Defense
IT	information technology
PTSD	post-traumatic stress disorder
TBI	traumatic brain injury
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

September 18, 2014

The Honorable Richard M. Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
House of Representatives

Since the beginning of the Iraq and Afghanistan conflicts in 2001, advancements in medical care and body armor have reduced fatality rates, allowing more servicemembers to recover from catastrophic physical and psychological injuries, including multiple limb loss, traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD). The cumulative number of post-9/11 veterans who were wounded in action was 1.3 million in 2012—nearly triple the 482,000 post-9/11 veterans who were wounded in action in 2001.[1] Given the increased number of recovering veterans, the need for caregivers has grown substantially. Family members most often serve in this role and are referred to as "family caregivers." A RAND study estimated that there are 1.1 million family caregivers of post-9/11 veterans and that each year they provide personal care services valued at $3 billion, enabling seriously injured veterans to live at home rather than in institutions.[2] These caregivers assist with the tasks of everyday living—as well as making and keeping appointments, helping navigate the Department of Defense's (DOD) and the Department of Veterans Affairs' (VA) complex health care systems, serving as advocates, and making decisions on medical, legal, financial, and benefit issues.

Caregivers enable those for whom they are caring to live better quality lives and can contribute to faster rehabilitation and recovery; however,

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[1]Defense Manpower Data Center, cited in *Family and Medical Leave Act is Essential for Military Caregivers*, U.S. Congress Joint Economic Committee (February 2013).

[2]RAND, *Hidden Heroes: America's Military Caregivers* (RR-499-TEDF. Santa Monica, Calif., April 2014).

time spent caregiving can lead to the loss of income, jobs, or health care and can exact a substantial physical, emotional, and financial toll, according to RAND and others. In addition to assisting veterans with activities of daily living, family caregivers may have other concurrent responsibilities, such as raising children or caring for aging parents. Some veterans will need caregiver assistance for many years or throughout their lifetimes. To the extent that family caregivers' well-being is compromised, they may become unable or unwilling to fulfill their caregiving role, leaving the responsibilities to be borne by other social institutions. According to RAND, improving family caregivers' well-being and ensuring their continued ability to provide care requires a multifaceted approach—including training, health care coverage, and support services—to reduce the burdens caregiving may create and to bolster their ability to serve as caregivers more effectively.

To provide greater support for caregivers of post-9/11 veterans, Congress passed legislation requiring VA to establish a program to assist caregivers with the rigors of caring for seriously injured veterans.[3] In May 2011, the Veterans Health Administration (VHA)—which operates VA's health care system—established the Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program) at each of its VA medical centers (VAMC) across the United States.[4] In accordance with applicable requirements, the program provides approved primary family caregivers with a monthly financial stipend, the amount of which is based on the amount and degree of personal care services—such as assisting with bathing and eating—provided to the veteran, and geographic location. The program also provides caregivers with other types of assistance, including training, referral services, counseling, some

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[3]See Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, 124 Stat. 1130 (May 5, 2010) (codified at 38 U.S.C. § 1720G). References to a "caregiver" in this report mean the individual approved by VA to serve as the veteran's primary caregiver. While a veteran may have up to three approved caregivers at a time under the program, see 38 C.F.R. § 71.25(a)(1), only the primary caregiver is eligible for the full range of services authorized by the statute. 38 U.S.C. §§ 1720G(a)(3)(A), (a)(7)(B).

[4]VA implemented the Family Caregiver Program concurrently with the Program of General Caregiver Support Services at each of its VA medical centers. Unlike the Family Caregiver Program, which is available to veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001, the Program of General Caregiver Support Services is available to veterans of all eras. Both programs are administered by the National Caregiver Support Program Office in VA's national headquarters and are collectively called the Caregiver Support Program.

mental health services, and respite care.[5] Additionally, primary family caregivers approved for the Family Caregiver Program may be eligible for coverage through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) if they have no other coverage. As of May 2014, about 15,600 caregivers were approved for the Family Caregiver Program, and the estimated obligations for fiscal year 2014 are over $263 million.

You asked us to review VA's efforts to support the family caregivers of seriously injured veterans through its implementation of this program. This report examines how VHA is implementing its Family Caregiver Program, including the types of issues that have been identified during initial implementation.

To examine how VHA is implementing the Family Caregiver Program and to identify the types of issues that transpired during initial implementation, we met with officials from VHA's Caregiver Support Program office—the office responsible for managing and overseeing the Family Caregiver Program. We obtained and reviewed the program's authorizing legislation and implementing regulations as well as relevant policy and management documents, including the program's implementation plan, policy guidebook, and the orientation manual for caregiver support coordinators (CSC), who administer the program at the medical facility level.[6] In addition, we obtained and reviewed information on the numbers of CSCs and approved caregivers for each VAMC, and other program statistics from the Caregiver Support Program office, including aggregate data from weekly reports on the numbers of applications and caregiver approvals. We spoke with Caregiver Support Program officials about these data, and

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[5]Respite care is offered for veterans to help alleviate caregiver burden and may include in-home care by VA staff, short-term institutional stays such as at a nursing home, or adult day health care. The program also includes a peer support mentoring program and a toll-free National Caregiver Support Line staffed by licensed clinical social workers who answer questions from caregivers, veterans, and members of the public.

[6]VA issued the Family Caregiver Program regulations in an interim final rule on May 5, 2011. See 76 Fed. Reg. 26148, adding Part 71, Caregivers Benefits and Certain Medical Benefits Offered to Family Members of Veterans, to Title 38 of the Code of Federal Regulations. Although VA established a 60-day public comment period, it stated that the regulations set forth in the interim final rule were effective immediately in order to ensure timely implementation of the program. VA stated that it would announce a final rule, incorporating any changes made in response to public comments, in a subsequent Federal Register notice, which had not occurred during the period of our review. See 76 Fed. Reg. 26158.

they explained that data from their information technology (IT) system is not reliable unless additional steps have been taken to verify them. We confirmed that the data we obtained from program officials had been verified, and therefore, we determined that these data were sufficiently reliable for the purposes of our report. Additionally, we applied federal standards for internal control related to capturing information and monitoring performance to assess the ability of the Caregiver Support Program office to oversee the program as well as standards for efficiency and effectiveness of operations.[7]

To understand how the Family Caregiver Program was being implemented at the medical facility level, we interviewed officials at five VAMCs, including the directors, selected staff such as departmental leaders, clinicians, and CSCs. We also interviewed program officials from the five Veterans Integrated Service Networks (VISN) who oversee the program at these facilities to obtain their perspective on the implementation of the program.[8] However, the information we obtained from interviews with VAMC and VISN officials cannot be generalized. We selected a nonprobability sample of VAMCs based on geographic dispersion and a range of CSC-to-approved caregiver ratios—from 1:34 to 1:167. The VAMCs we selected were Washington, D.C. (VISN 5); Fayetteville, North Carolina (VISN 6); Temple, Texas (VISN 17); Fort Harrison, Montana (VISN 19); and Palo Alto, California (VISN 21). We also met with organizations that represent veterans to obtain their views on the program and its implementation. Finally, we interviewed a non-generalizable sample of 11 caregivers of veterans who are approved for VHA's Family Caregiver Program at some of the VAMCs we contacted to obtain their experiences and perspectives on this program.

We conducted this performance audit from June 2013 to September 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

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[7]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[8]VA's health care system is divided into 21 regions called VISNs. Each of VA's 21 VISNs is responsible for managing and overseeing medical facilities within a defined geographic region.

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA's Family Caregiver Program is designed to provide support and services to family caregivers of post-9/11 veterans who have a serious injury incurred or aggravated in the line of duty. The program provides approved primary family caregivers with a monthly financial stipend as well as training and other support services, such as counseling and respite care.[9]

Family Caregiver Program Eligibility Requirements

The Family Caregiver Program has a series of eligibility requirements that must be satisfied in order for family caregivers to be approved.

- To meet the program's initial eligibility criteria the veteran seeking caregiver assistance must have a serious injury that was incurred or aggravated in the line of duty on or after September 11, 2001.[10] According to the program's regulations, a serious injury is any injury, including TBI, psychological trauma, or other mental disorder, that has been incurred or aggravated in the line of duty and renders the veteran or servicemember in need of personal care services.

- The veteran must be in need of personal care services for a minimum of 6 continuous months based on any one of the following clinical eligibility criteria: (a) an inability to perform one or more activities of daily living, such as bathing, dressing, or eating;[11] (b) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury such as TBI, PTSD, or other mental health disorders; (c) the existence of a psychological trauma or a mental disorder that has been scored by a licensed mental health professional, with a Global Assessment of Functioning score of 30 or

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[9]Other approved caregivers—referred to as secondary family caregivers—are eligible for training, counseling, and certain lodging and subsistence, for example, but not the stipend or CHAMPVA coverage.

[10]The applicant could also be a servicemember who is undergoing medical discharge from the military.

[11]The activities of daily living that veterans may need assistance with to qualify for the program include dressing or undressing; bathing; grooming; toileting; eating; mobility such as from the bed to a chair; and frequently adjusting a prosthetic or orthopedic device that cannot be done without assistance.

less,[12] continuously during the 90-day period immediately preceding the date on which VHA initially received the application; or (d) the veteran has been rated 100 percent service connected disabled for the veteran's qualifying serious injury and has been awarded special monthly compensation that includes an aid and attendance allowance.[13]

- To be considered competent to care for the veteran, family caregivers must meet certain requirements including (1) having the ability to communicate and follow details of the treatment plan and instructions related to the care of the veteran; (2) not determined by VA to have abused or neglected the veteran; (3) being at least 18 years of age; and (4) either being a family member—such as a spouse, son or daughter, parent, step-family member, or extended family member—or an unrelated person who lives or will live full-time with the veteran.

- Family caregivers must also complete required training before being approved for the program.

Family Caregiver Program Organizational Structure

VHA's Caregiver Support Program office is responsible for developing policy and providing guidance and oversight for the Family Caregiver Program. It also directly administers the program's stipend, provides support services such as a telephone hotline and website, and arranges CHAMPVA coverage for eligible caregivers.[14] Furthermore, the office provides funding to VAMCs to cover certain program costs, such as the salaries of the CSCs, who implement and administer the Family Caregiver Program at the local VAMC level, as well as the costs VAMCs

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[12]The Global Assessment of Functioning assessment is a well-established mental health examination that uses a score of zero to 100 to determine an individual's ability to function psychologically and socially. An individual who has been assessed as having a psychological trauma or mental disorder and has been scored at 30 or less generally requires a higher level of care that would include constant supervision.

[13]VA's Aid & Attendance is a financial benefit for veterans who require assistance from a caregiver. It can be added to a veteran's existing pension if the veteran requires assistance with activities of daily living or for safety. Veterans who are bedridden, severely visually impaired, or reside in a nursing home due to mental or physical incapacity also may qualify.

[14]Primary family caregivers approved for the Family Caregiver Program qualify for CHAMPVA if they are not eligible for TRICARE and are not entitled to care or services under a health plan contract (as defined in 38 U.S.C. § 1725(f)), including Medicare or employer provided health insurance. Caregivers covered by CHAMPVA can receive medical services from community providers or, when available, from VAMCs.

incur for having their clinical staff, such as nurses, conduct the program's required in-home visits to approved caregivers and their veterans.

CSCs are generally licensed social workers, clinical psychologists, or registered nurses, and they have both clinical and administrative responsibilities. Their clinical responsibilities may include identifying and coordinating appropriate interventions for caregivers or referrals to other VA or non-VA programs, such as mental health treatment, respite care, or additional training and education. Their administrative responsibilities may include responding to inquiries about the program, overseeing the application process, entering information about applications and approved caregivers into IT systems, and facilitating the processing of appeals. As of May 2014, there were 233 CSCs assigned to 140 VAMCs or healthcare systems across the country.[15] Additionally, each of the 21 regional VISN offices also has a VISN CSC lead for the program, who provides guidance to CSCs and helps address their questions or concerns.

Family Caregiver Program Funding

Congress authorized over $1.5 billion for the Family Caregiver Program and other caregiver services for fiscal years 2011 through 2015. VHA's actual and estimated obligations for the program for fiscal years 2011 through 2015 have increased at a steady rate. (See fig.1.)

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[15]While CSCs administer the Family Caregiver Program at 151 VA facilities, they are assigned to 140 VAMCs or healthcare systems, which may include more than one VA facility. We present program statistics based on CSC assignments because that is how they are tracked by the Caregiver Support Program office.

Figure 1: Actual and Estimated Obligations for the Family Caregiver Program, Fiscal Years 2011 through 2015

Dollars (in millions)
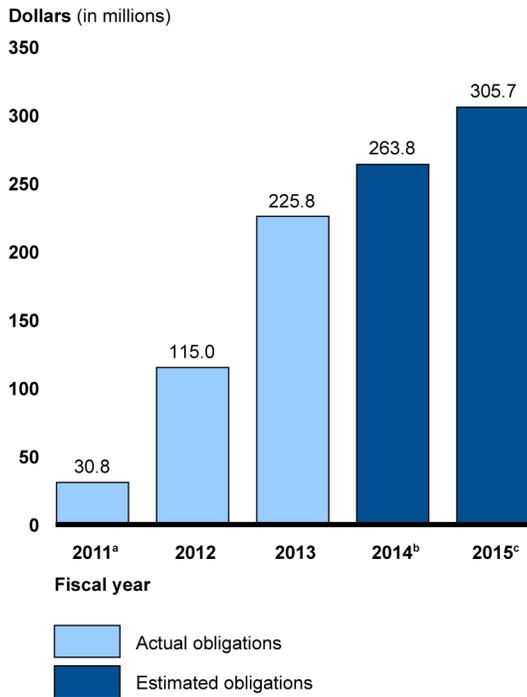
Source: GAO analysis of VHA information. | GAO-14-675

[a]Obligations for fiscal year 2011 cover a partial year since the program was implemented in Spring 2011.

[b]Most current estimated obligations according to VHA's Office of Finance.

[c]Estimated obligations published in the President's Budget for fiscal year 2015.

The Caregiver Support Program office uses this funding to cover costs such as program staffing, general caregiver education and training, caregiver stipends, CHAMPVA costs for primary family caregivers, the Caregiver Support Line, the Caregiver website, and outreach materials. It also provides funding to VAMCs to cover certain program costs rather than requiring the VAMCs to pay for them directly from their medical facilities' budgets. These costs include CSC salaries, reimbursement for home visits, respite care, and mental health services as well as assistance with travel expenses for eligible caregivers when accompanying the veteran to an appointment.

| Family Caregiver Program Application Adjudication Process | The Family Caregiver Program application has a sequential, multistep adjudication process. CSCs are responsible for overseeing this process and for ensuring that all steps of the application process are completed within 45 days, as outlined in the program's guidance. CSCs are expected to cultivate relationships with VAMC medical staff to request their assistance in performing medical eligibility assessments and completing the home visits—2 key steps in the process. For applications that cannot be fully adjudicated within the program's 45-day goal, the CSC may request additional time to process the application from the Caregiver Support Program office.[16] The steps of the application process are as follows: |

Step 1: Application Review. After the caregiver and veteran submit an application for the program, the CSC reviews the application and determines the caregiver's potential eligibility.[17]

Step 2: Initial Eligibility Determination for the Veteran. The CSC then determines whether the veteran is a post-9/11 veteran enrolled in VHA (or servicemember undergoing medical discharge) and has a documented line-of-duty injury.

Step 3: Final Eligibility Determination for the Veteran. After initial eligibility has been determined, a VHA medical provider is to complete a medical assessment to determine the medical condition of the veteran, their need for a caregiver, and all other program eligibility criteria. The provider then determines the veteran's rating for the stipend amount the primary family caregiver is eligible to receive. The stipend amounts are organized into three tiers. The stipend amount that the caregiver could receive is based on the assigned tier level and the geographic location of the veteran's residence. Tier 3 indicates the highest level of injury and need for a caregiver and has the highest level of payment, while Tiers 2

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[16]The stipend for primary family caregivers is paid retroactive to the date that the joint application is received by VHA or the date on which the eligible veteran begins receiving care at home, whichever is later. Similarly, caregiver benefits are effective as of the date that the joint application is received by VHA or the date on which the eligible veteran begins receiving care at home, whichever is later. Benefits are provided once the individual is designated as a family caregiver.

[17]Caregivers apply for the program using the 10-10CG form, Application for Comprehensive Assistance for Family Caregivers Program, and it may be submitted online, by mail, by phone, in person, or by fax.

and 1 indicate the lower levels of injury and correspondingly lower levels of payment.[18]

Step 4: Eligibility Determination for the Caregiver. While the veteran's eligibility is being verified, the CSC determines the caregiver's eligibility for the program by conducting an assessment of the caregiver's ability to serve in that role, either through a phone call or in-person meeting.

Step 5: Review of Program Services. Once the veteran and caregiver have been determined eligible for the program, the CSC schedules a joint meeting to discuss the types of Family Caregiver Program services for which they may be eligible once they complete the application process and are approved for participation in the program. This would include a discussion of the stipend payment as well as potential coverage through CHAMPVA.

Step 6: Caregiver Training. The caregiver must complete the program's training class, which is offered online, through self-instruction with a workbook and a CD or DVD, or where available, through 2 days of facilitated classroom instruction. The training covers 10 competencies, including self-care, nutrition, and medication management.

Step 7: Home Visit. Within 10 days after the caregiver completes the training, an initial home visit is conducted to determine if the caregiver has the physical capacity and skills necessary to provide medical care to the veteran, and if the home is safe and adequately equipped. Since the initial home visit includes physical assessment and medical components, it must be completed by a medical professional such as a registered nurse, nurse practitioner, clinical nurse specialist, physician assistant or physician. When a veteran requires a caregiver due to a mental health diagnosis, the home visit is to be completed by or in collaboration with a mental health provider.

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[18]A caregiver whose veteran is rated tier 3 receives a stipend that is the equivalent of 40 hours per week of the wage for a private sector home health aide in the veteran's geographical area. A caregiver whose veteran is rated tier 2 receives the equivalent of 25 hours per week of the wage for a home health aide, and a caregiver whose veteran is rated tier 1 receives an amount equivalent to 10 hours per week. Although a set quantity of hours is used to determine the stipend amount, the hours are not meant to equal the actual number of hours that a family caregiver may provide to the veteran.

Step 8: Notification of Program Eligibility. Once the home visit assessment has been completed and the results confirm that the caregiver is prepared to provide satisfactory care of the veteran, the CSC completes the final approval of the caregiver. This entails sending approval paperwork to the caregiver, including the direct deposit form for the stipend, and updating the relevant VHA systems, including the program's IT system and the veteran's medical record.

Caregivers who are denied eligibility for the program, or who believe that the veteran's condition is more severe than the rating indicates, may appeal the decision. CSCs coordinate with VAMC patient advocates and other VHA staff to process these appeals—requests for review and reconsideration—first with the VAMC director and subsequently at the VISN level, if necessary.[19]

As of May 2014, approximately 15,600 caregivers had been approved for the program. About 6,000 of these caregivers were assigned to Tier 3 (highest level) for their stipend payments, about 6,000 to Tier 2 (middle level), and 3,600 to Tier 1 (lowest level). The average monthly payments per tier were approximately $2,320 for Tier 3, $1,470 for Tier 2, and $600 for Tier 1. At this time, almost 8 out of 10 of the caregivers approved for the Family Caregiver Program were spouses, while other approved caregivers were parents, relatives, and friends. Most of these caregivers were assisting veterans with mental health diagnoses or brain injuries who may also have had other physical injuries or disabilities. Specifically, 92 percent of these veterans have a service-connected mental health condition, 63 percent have PTSD, and 26 percent have a TBI.

The program requires interim quarterly home visits for its approved caregivers, unless otherwise clinically indicated. These visits are to be conducted by clinical staff, but CSCs may also conduct them if they have a clinical background, such as being a registered nurse or a clinical psychologist.[20] The home visits serve multiple purposes and are intended to monitor the well-being of the veteran. They are also used to determine whether the caregiver continues to have the physical capacity and skills

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[19]A Patient Advocate Program is stationed at every VAMC to address patient inquiries and complaints as well as to provide assistance with filing clinical appeals.

[20]The CSCs who conduct the quarterly home visits are generally precluded from conducting the initial home visit assessment due to potential conflict of interest.

necessary to provide medical care to the veteran, and whether the home remains safe and adequately equipped. The Caregiver Support Program office also permits home visits to be conducted by telephone after 1 year of satisfactory home visits has been completed for cases that do not pose exceptional medical risk.

Some VAMCs Had Difficulty Meeting Higher-Than-Expected Demand and Data System Limitations Have Impeded VHA's Ability to Monitor Workload

VHA officials significantly underestimated the demand for the Family Caregiver Program. As a result, the program did not have sufficient support for the ensuing workload at some VAMCs, and the resulting staffing shortages impeded the timeliness of key functions and negatively impacted services to caregivers. Furthermore, VHA's Caregiver Support Program office does not have ready access to the type of data that would allow it to monitor and manage the program's workload due to the limited capabilities of its data system, which was designed to manage a much smaller program.

Program's Staffing Not Adequate to Handle Higher-Than-Expected Demand at Some VAMCs

VISN and VAMC officials told us that the program's initial staffing did not provide sufficient resources to support the unexpectedly high and increasing workload since the program began in 2011. VHA officials originally estimated that approximately 4,000 caregivers would be approved for the program by the end of fiscal year 2014. This estimate was based on the number of expected post-9/11 veterans and servicemembers who have serious medical or behavioral conditions involving impairment in at least one activity of daily living or who require supervision or protection, using available data from the Veterans Benefits Administration and DOD.[21] However, the number of individuals approved for the Family Caregiver Program far exceeded the original estimate: by May 2014, almost 30,400 caregivers had applied and about 15,600 had been approved. (See fig. 2.)

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[21]VA's interim final rule explains the basis for this estimate. See 76 Federal Register 26148, at 26160.

Figure 2: Number of Actual Applications and Approvals Compared to VHA's Projected Number of Approvals for Family Caregiver Program, Fiscal Years 2011-2014
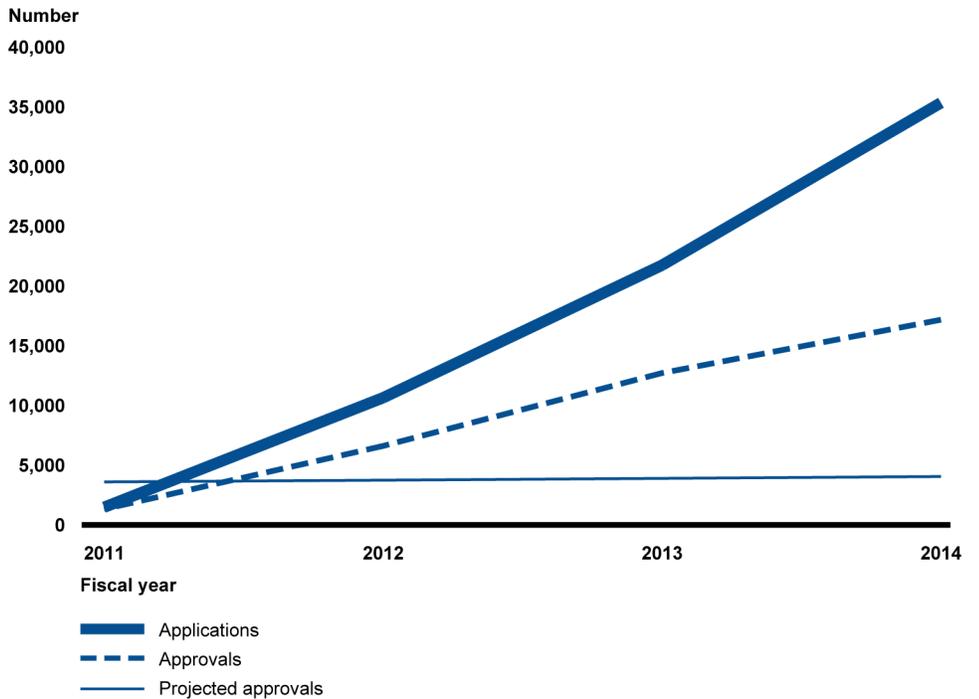
Source: GAO analysis of VHA information. | GAO-14-675

Caregiver Support Program officials told us that after 3 years of operation, demand for the Family Caregiver Program remains high: system-wide, there has been no appreciable decrease in the number of caregivers submitting applications for the program. In fact, the number of "in-process" applications for the Family Caregiver Program more than doubled from 1,966 in April 2013 to 4,318 in May 2014. As of May 2014, 98 VAMCs had more than 50 approved caregivers. (See fig. 3.)

Figure 3: VA Medical Centers (VAMCs) Grouped by Number of Approved Family Caregivers, as of May 2014
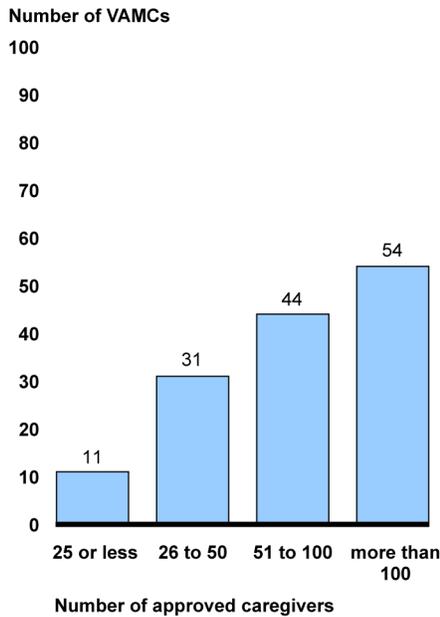
Number of VAMCs

Number of approved caregivers	Number of VAMCs
25 or less	11
26 to 50	31
51 to 100	44
more than 100	54

Number of approved caregivers

Source: GAO analysis of VHA information. | GAO-14-675

Note: While caregiver support coordinators (CSC) administer the Family Caregiver Program at all 151 VA facilities, they are assigned to 140 VAMCs or healthcare systems, which may include more than one VA facility. We present program statistics based on CSC assignments because that is how they are tracked by the Caregiver Support Program office.

The initial arrangement for CSCs and VAMC staff that VHA established for this program proved inadequate in the face of such high demand. The program initially placed a single CSC at each VAMC largely to perform administrative and caregiver support functions, with the expectation that each VAMC would provide the program with physician, nursing, and administrative staff as needed to perform specific program functions. However, VISN officials and VAMC officials we spoke with said that there are too few CSCs to handle the program's workload effectively. Specifically, at some VAMCs, CSCs have been unable to perform all of the routine administrative tasks associated with their approved caregivers, as initially expected.[22] For example, some VISN and VAMC

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[22]CSCs' administrative tasks include entering data on the number of applications, approvals, appeals, and other information about the local program into the Caregiver Application Tracker system, as well as entering clinical notes into the veteran's medical record and caregiver's file.

officials told us that the number of appeals filed by veterans and caregivers has become an unexpectedly large component of CSCs' workload, making it difficult to fulfill the full range of their responsibilities. A Caregiver Support Program official clarified that while CSCs typically work with the VAMC patient advocates to handle appeals, they may be taking on greater responsibility for the appeals process at VAMCs with large numbers of appeals for the program.

Caregiver Support Program officials acknowledged that the workload for the Family Caregiver Program has been burdensome for some CSCs, depending on the number of their approved caregivers and the amount of assistance they have at the local level. As of May 2014, the number of approved caregivers per CSC varied widely across VAMCs, ranging from 6 to 251. (See fig. 4.) Caregiver Support Program officials stated that their office does not use a formal CSC-to-caregiver target ratio because staffing decisions are largely the domain of local managers and the use of a specific workload ratio by the Caregiver Support Program could limit VAMCs' discretion in determining when to request additional CSCs. (See app. I for a list of VAMCs' CSC-to-caregiver workload ratio.)

Figure 4: VA Medical Centers (VAMCs) Grouped by CSC-to-Caregiver Workload Ratios, as of May 2014
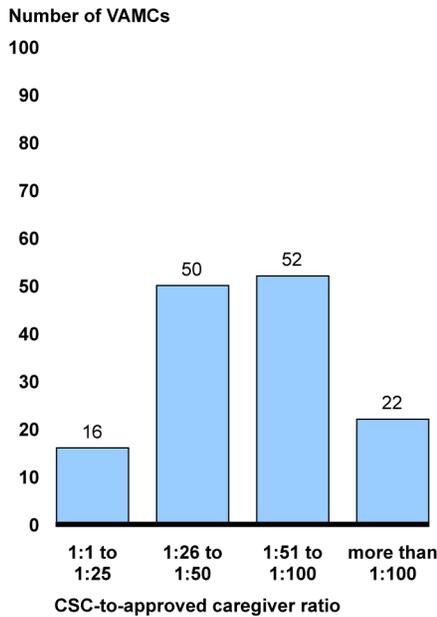
Number of VAMCs

CSC-to-approved caregiver ratio

Source: GAO analysis of VHA information. | GAO-14-675

Note: While caregiver support coordinators (CSC) administer the Family Caregiver Program at all 151 VA facilities, they are assigned to 140 VAMCs or healthcare systems, which may include more than one VA facility. We present program statistics based on CSC assignments because that is how they are tracked by the Caregiver Support Program office.

Furthermore, Caregiver Support Program officials had expected VAMC officials to direct their clinical staff to perform the medical assessments and home visits needed by the Family Caregiver Program as part of their ongoing care to veterans. However, VISN and VAMC officials we contacted told us that their facilities do not have sufficient medical staff to effectively manage the additional workload generated by the Family Caregiver Program, which they view as a collateral duty. According to most VISN and VAMC officials, obtaining clinical staff for the program can be difficult at VAMCs where directors may not consider the Family Caregiver Program to be a high priority. For example, officials at one VAMC told us that lack of support from the VAMC director led to a situation in which the director refused to have nurses conduct home visits for the Family Caregiver Program. At another facility, a VAMC director told us that lack of support by her predecessor led to large backlogs of unprocessed applications and incomplete home visits for the Family Caregiver Program, which she discovered following her recent transfer to that facility. According to some VISN officials, this dynamic sometimes

placed CSCs, as the administrators of the local Family Caregiver Program, in the position of pleading for support from VAMC physicians and nurses. In May 2014, a Caregiver Support Program official explained that although the office has issued program policy and guidance to medical facilities, it also plans to issue a directive that outlines organizational responsibilities for the Family Caregiver Program, including those at the VAMC level. This official did not provide a specific timeframe for the issuance of the directive but stated that it would occur following the issuance of final program regulations.

VISN and VAMC officials we spoke with noted that the Family Caregiver Program's approach of having VAMC physicians conduct medical assessments for program eligibility has been a challenge. Physicians at the VAMCs we contacted were already experiencing heavy workloads prior to the implementation of the Family Caregiver Program, and some physicians were not able to take on additional tasks that they viewed as collateral duties, according to VISN and VAMC officials. Some physicians who were initially willing to conduct medical assessments could not continue doing so when the number of applications for the program increased. VISN and VAMC officials also stated that some physicians do not want to perform medical assessments because they are concerned that having a role in determining eligibility for a program that includes a financial stipend could compromise their clinical relationship with the patient. As a result of these factors, the number of physicians willing to conduct medical assessments for the program is limited at some VAMCs. CSCs at some VAMCs told us that the typical wait time for a medical assessment can be a month or longer.

VISN and VAMC officials also agreed that providing nurses for the home visits needed by the Family Caregiver Program has posed problems and remains an ongoing challenge. These officials explained that most clinic nurses are already too busy to assume an additional workload. Officials at one VISN told us that some nurses who originally agreed to conduct quarterly home visits for the Family Caregiver Program stopped doing so after home visits became a burden, due to the increasing number of approved caregivers. In addition, VAMC and VISN officials at every location we contacted told us that home visits to remote areas require long driving times, which are challenging to accommodate. Staff at one VAMC we contacted pointed out that their catchment area covers 147,000 square miles, and some of their caregivers live over 8 hours away, requiring nurses to contend with multiple overnight stays per month and dangerous travel conditions in the winter.

Staffing Shortages Impeded Timeliness of Key Functions and Negatively Affected Services to Caregivers Despite Actions Taken to Address Them

Timelines for key functions of the caregiver program, such as those for adjudicating applications within 45 days or making quarterly home visits to family caregivers, are not being met because CSCs at some VAMCs were not able to obtain sufficient support from medical facility staff. As a result, some caregivers have had to wait longer for an eligibility determination and to receive program benefits. Staff at many of the VAMCs we contacted told us that delays exist at some or every step of the application process for the Family Caregiver Program, including determining caregiver eligibility, administering medical assessments, and conducting initial home visits. Officials at all of the VAMCs we contacted stated that there were applications at that facility that had been open for longer than 45 days, and one VAMC had over 400 open applications, some going back to June 2013. According to the Caregiver Support Program office, in June 2014, 111 VAMCs had applications that had been in process for 45 to 90 days; most of these facilities (95 percent) had 20 or fewer applications in this category. Additionally, the office reported that 65 VAMCs had applications that had been open 91 days or more; most of these VAMCs (85 percent) had 25 or fewer applications in this category.

Furthermore, home visits are not always being made on a timely basis. At one VAMC, initial home visits to assess caregivers' skills, which are supposed to take place within 10 days of the caregiver's completion of core training, took from one to two months to complete, which delayed eligibility determinations. Staff at some of the VAMCs we contacted were also struggling to maintain the quarterly schedule for follow-up home visits due to the larger-than-expected number of approved caregivers. At one VAMC, CSCs told us that follow-up home visits occur every 6 to 9 months, in contrast to the program's standard of every 90 days. Delays in home visits could be problematic because these visits provide medical staff with an opportunity to assess the welfare and environment of the caregiver and veteran—issues that may not be evident during clinic visits, such as whether special dietary needs are being met and whether medications are being properly administered.

At some VAMCs, the volume of administrative and procedural activities performed by CSCs has curtailed or even displaced their ability to provide services to caregivers and veterans. VISN staff we spoke with told us that as a result of the high workload burden, CSCs who are overwhelmed do not have the ability to perform some caregiver support functions offered by the Family Caregiver Program, such as support groups and counseling. Caregivers and officials from non-VA organizations told us that some CSCs do not return caregivers' phone calls. One caregiver recounted that when she became desperate to learn how to manage a

veteran with increasingly severe symptoms from a TBI, her CSC told her that hers was one of many requests and that the program could not provide counseling for caregivers. This caregiver subsequently received services from a non-profit organization.

Officials from the Caregiver Support Program and the VAMCs we contacted also told us that they have taken steps to address staffing shortages for the Family Caregiver Program, although some of the steps have had limited success. For example,

- In recognition that some VAMCs had more approved caregivers than originally anticipated, the Caregiver Support Program office began to allow VAMCs to request additional CSCs in August 2011. By May 2014, VAMCs had submitted 99 requests for salary funding to the Caregiver Support Program office for adding one to five more CSCs to their facility. Specifically, the requests from VAMCs totaled 112 additional CSCs, of which the Caregiver Support Program office approved about 94 additional positions.

- In March 2014, the Caregiver Support Program also began funding temporary CSCs, who were hired for terms of 120 days. As of May 2014, the office has funded 10 CSCs on a temporary basis. According to a Caregiver Support Program official, these CSCs must meet the same qualifications as a full-time CSC, and their duties are to be established at the local level. In addition, some VAMCs have provided their own clerical support to CSCs for routine administrative tasks.

- In August 2012, the Caregiver Support Program office also began allowing VAMCs to conduct home visits by telephone after 1 year of satisfactory home visits had been completed for cases that do not pose exceptional medical risk. Some of the VAMCs we contacted are planning to expand their use of follow-up telephone contact with caregivers in lieu of in-person home visits. However, officials at one VAMC told us that they did this with only three to four families because they considered almost all families approved for the Family Caregiver Program to be at risk because of the high proportion of caregivers who were caring for veterans with PTSD who were not clinically stable.

- VAMCs have also tried various approaches for improving physicians' willingness and ability to participate in the Family Caregiver Program. For example, officials from the Caregiver Support Program office told us that some VAMCs use a multidisciplinary team—instead of individual physicians—to make determinations for eligibility and for the level of financial stipend, enabling the workload to be shared by

multiple clinicians. Another VAMC hired a physician on a part-time basis just to perform eligibility examinations for the program. One VAMC with serious workload backlogs is examining the option of using physicians who are already under contract for conducting medical assessments for determining disability benefits, instead of using VAMC treatment physicians. The VAMC director who is exploring this option mentioned that this approach could also resolve physicians' concerns about compromising the physician/patient relationship posed by determining eligibility for a program that includes a financial stipend. However, Caregiver Support Program officials stated that regardless of the approaches VAMCs may take to conduct the medical assessments, the program's regulation requires that the physician making eligibility determinations for the Family Caregiver Program be a member of the veteran's treatment team.[23]

- To increase nurses' willingness to provide assistance to the program, some VAMCs offered their nurses overtime pay to conduct home visits, and other VAMCs made temporary work-sharing arrangements with nearby VAMCs for nursing coverage. Officials in the VISNs we contacted told us that some VAMCs have used the funding they received for additional CSC positions to hire nurses for the sole purpose of conducting home visits for the program because of the heavy workload. Some officials also told us that they consider the home visit reimbursement amounts to be insufficient to cover their expenses, such as for GPS units, other electronic devices, and time needed for associated administrative activities. However, an official with the Caregiver Support Program office stated that this should not be necessary because the program's reimbursement for home visits covers salary expenses, travel costs, and time for administrative activities.

- Some VAMCs have also hired contractors to conduct home visits, although contractors may not be available in some locations.

A Caregiver Support Program official stated that the budget for the Family Caregiver Program has been adequate to meet operating costs as of March 2014. Nonetheless, VHA officials at all levels told us that VAMC directors were cautious about requesting additional CSCs or hiring additional nurses for making home visits. These officials explained that

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[23]The regulation provides that the "approval and designation will be a clinical determination authorized by the eligible veteran's primary care team." 38 C.F.R. § 71.25(f).

VAMC directors are concerned that when the Family Caregiver Program's initial 5-year budget authorization expires, the cost of the additional nurses and CSCs could shift from the Caregiver Support Program office to the VAMCs. VAMC directors stated that their caution is based on experience, in that this shift has occurred in the past with other new VHA programs that had initially received funding support from their program offices. Caregiver Support Program officials acknowledged VAMC officials' concerns about the program's funding and added that they are aware of some VAMCs—even facilities with growing numbers of approvals—that are cautious about requesting additional CSCs. Nonetheless, a Caregiver Support Program official stated that VHA continues to request funding for the Family Caregiver Program, including a funding request for fiscal year 2015 that was submitted with the budget request.

Notwithstanding incremental efforts to improve staffing levels for the program at some VAMCs, CSCs and VAMC staff predict that staffing shortages and the ensuing workload problems are likely to recur because VHA's current staffing of the program is not sufficient and overall approvals continue to increase at a steady rate—about 500 approvals per month. As a result, according to VAMC officials, some facilities have not been able to overcome the workload problems that developed upon program implementation. A Caregiver Support Program official stated that program officials recognize the need to formally re-evaluate key aspects of the Family Caregiver Program, including program staffing and the processes for eligibility assessments and home visits, in light of the fact that the program was designed to manage a much smaller caregiver population. This is consistent with federal internal control standards, which emphasize the need for effective and efficient operations, including the use of agency resources such as human capital.[24]

VHA's Oversight of the Family Caregiver Program Is Impeded by IT System Limitations

The Caregiver Support Program office does not have ready access to the workload data that would allow it to monitor the effect of the Family Caregiver Program on VAMCs' resources due to limitations with the Caregiver Application Tracker—the IT system that was established for the program. According to federal standards for internal control, agencies should identify, capture, and distribute pertinent information in a form and

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[24]See GAO/AIMD-00-21.3.1.

time frame that permits officials to perform their duties efficiently.[25] However, the Caregiver Support Program office is not able to easily retrieve data that would allow it to better assess workload trends at individual VAMCs—such as the length of time applications are delayed or the timeliness of home visits—even though these data are already captured in the Caregiver Application Tracker. Consequently, Caregiver Support Program officials only retrieve these data on an ad hoc, as-needed basis, which limits their ability to assess the scope and extent of workload problems comprehensively at individual VAMCs and on a system-wide basis.

A Caregiver Support Program official told us that the office becomes aware of workload problems at some VAMCs through various informal information channels, such as CSCs' requests for application extensions and communication with the CSCs and VISN CSC leads.[26] However, relying on informal information channels does not provide the office with a comprehensive picture of the program's workload across all VAMCs, and this puts it in a reactive position of addressing workload issues after problems have already developed. Having a system that allows for easy retrieval of data would better position the office to proactively identify both existing and potential workload problems at VAMCs and work with their CSCs to identify solutions before problems develop or worsen. It would also facilitate access to data needed for pinpointing where certain processes may be getting stalled. For example, a Caregiver Support Program official told us that it would be helpful to be able to track the status of the various phases of the application process to identify the phases that are taking too long, which would help the office to better determine how to improve the overall timeliness of application adjudication.

A Caregiver Support Program official explained that the Caregiver Application Tracker had to be developed quickly due to time constraints and was designed to manage a relatively low volume of information for what was conceived to be a much smaller program. It is a web-based system designed to facilitate the exchange of information about approved

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[25]See GAO/AIMD-00-21.3.1.

[26]According to this official, in these instances, they provide coaching and support to the CSC and VISN CSC lead and may work with them on identifying solutions, which may include the development of an action plan with the support of VAMC leadership.

caregivers between VAMCs and other VHA entities, including the Health Administration Center, which processes the caregiver stipend payments and administers CHAMPVA. CSCs are responsible for entering nonclinical data into the system, which includes information related to the application process and the status of home visits. The Caregiver Support Program office manages the system and uses its data to monitor certain aspects of the program. Specifically, a program official explained that the system can generate a few basic reports that have been preprogrammed, including a weekly report with aggregate data on the status of applications and stipend payments. The Caregiver Support Program office uses these data to monitor the program as well as data from other sources, including data on the number of approved caregivers who have completed training and the number of telephone calls to the Caregiver Support Line.[27] However, data that are not contained in the preprogrammed reports must be extracted from the system on an ad hoc basis.

Caregiver Support Program officials told us that they take steps to validate the data they obtain from the system because they have observed some inconsistencies—particularly with ad hoc data—and as a result, they have concerns about its reliability. These officials told us that each time they extract ad hoc data from the system, they validate the data through additional sources to ensure its accuracy. Caregiver Support Program officials explained that they have already taken steps to verify the sources of the data that are used for the system's reports and do not need to verify these data every time a report is generated. Nonetheless, these officials noted that they will periodically compare the current weekly data that is reported by the system with data from the prior week to ensure that there are no drastic changes which would indicate a need for additional verification.

Program officials explained that the system has no agility or flexibility to perform additional tasks beyond its basic tracking functions, and retrieving data from the system on an ad hoc basis often requires time-consuming manual procedures. These officials explained that the

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[27]A Caregiver Support Program official told us that additional oversight efforts have included an annual quality assurance audit on specific outcome measures, periodic caregiver surveys about the national caregiver training program, and an analysis of the program's impact on the health and well-being of approved caregivers and their veterans that was completed by VA's Office of the Actuary in January 2014.

system's data files are organized by veteran, and all of the veterans who apply for the program are captured in the system whether or not their caregivers were approved. As a result, the system that was designed to manage 5,000 records by the end of 2015 had over 30,000 records as of May 2014. Officials said that the system's limited capabilities became more apparent as the number of records in the system increased, which made retrieving data on an ad hoc basis more difficult and time consuming. For example, according to program officials, in response to our request for the number of VAMCs with applications over 45 days old, they had to download all of their relevant data into a spreadsheet, review the data for accuracy, make the necessary corrections, and then manually count the number of applications over 45 days old. A Caregiver Support Program official told us that it took three people about 8 to 10 hours in total to pull this information together.

Officials further explained that the Caregiver Application Tracker is a stand-alone system that is not integrated with other VHA systems, and as a result, it cannot perform sophisticated functions or searches that would require pulling information from these other systems. Officials told us that this hinders their ability to monitor certain aspects of the program and results in time-consuming efforts to compile program-related data.[28] For example, the use of respite care—one of the benefits of the Family Caregiver Program—is tracked by a different VHA system. To determine how many veterans in the Family Caregiver Program are using respite care, program officials told us that they must download their data into a spreadsheet and then upload this information to the IT system for respite care use in order to crosswalk the information. Furthermore, data on Family Caregiver Program appeals are maintained in the Patient Advocate Program's tracking system, which is also managed by a different VHA office. Caregiver Support Program officials told us that they have to request appeals data from this office, and to date, there have been a few requests for caregiver appeals data in response to congressional inquiries. However, because the Patient Advocate Program's tracking system was not designed in a way that allows them to easily retrieve information that is specific to the Family Caregiver Program, the Caregiver Support Program office had received a report for only one of the inquiries as of May 2014. A Caregiver Support Program

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[28]Officials also told us that because of this limitation, administrative tasks for the Family Caregiver Program require entering or retrieving data from multiple information systems, such as clinical patient records and benefit records.

official told us that they are working with the Patient Advocate Program to identify methods to obtain the appeals data they need, such as by capturing whether an appeal is related to the Family Caregiver Program.

As a result of these system limitations, the Caregiver Support Program office does not have the capability to routinely track and analyze the type of workload data it needs to produce a meaningful assessment of the program's impact on VAMCs. According to federal standards for internal control, agencies should conduct monitoring activities to assess the quality of performance over time and should use the results to correct identified deficiencies and make improvements.[29] However, the lack of ready access to comprehensive workload data impedes the program office's ability to proactively identify and correct workload problems as they manifest or to identify and make modifications as necessary to ensure that the program is appropriately structured to meet caregivers' demand for its services. Consequently, a Caregiver Support Program official told us that the program office has only been able to assess workload problems and make interim adjustments, such as allowing VAMCs to request additional CSC positions, based on informal feedback and has not been able to conduct a formal re-assessment of the program that is based on comprehensive program data.

A Caregiver Support Program official acknowledged that they recognize the need for a more capable, flexible system that can interface with other departmental systems. This official also told us that program office officials are working with their information technology office to develop the requirements for a comprehensive system and that they are exploring the possibility of whether an existing VHA system could be adapted to meet their needs. However, this official was not sure how long it would take to obtain another IT system and whether this effort would be displaced by higher priorities. As a result, it is not clear when program officials will have access to comprehensive workload data for the Family Caregiver Program to better assess how it is functioning. Although it will be difficult to identify changes needed to improve the program's efficiency and effectiveness without these data, VAMCs' workload problems will persist—and caregivers will not get the services they need—unless the program office begins taking steps towards identifying solutions.

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[29]See GAO/AIMD-00-21.3.1.

GAO-14-675 VHA Family Caregiver Program

Conclusions

Family caregivers play a crucial role in caring for seriously injured post-9/11 veterans by taking on critically important and often stressful responsibilities for their well-being and potentially keeping them out of costly institutions. The Family Caregiver Program was intended to provide supportive services to this caregiver population, but VHA significantly underestimated program demand. The subsequent stress on resources at some VAMCs resulted in delayed application decisions and home visits—ultimately limiting services to caregivers. Incremental steps to alleviate staffing shortfalls have benefited the program in some locations, but these efforts will not likely be sufficient in light of the steady growth of approved caregivers in the program. After 3 years of operation, it is clear that VHA needs to formally reassess and restructure key aspects of the Family Caregiver Program, which was designed to meet the needs of a much smaller population. This would include determining how best to ensure that staffing levels are sufficient to manage the local workload as well as determining whether the timelines and procedures for application processing and home visits are reasonable given the number of approved caregivers.

To accomplish this, the Caregiver Support Program office will need to take a strategic, data-driven approach that would include an analysis of the program's workload data at both the aggregate and VAMC levels. It will therefore be necessary for VHA's Caregiver Support Program office to obtain an IT system that will facilitate access to the types of data—including interfacing with other VHA systems, such as systems for clinical patient records and respite care—that would allow it to more fully understand the program's workload and its effect on VAMCs, CSCs, and caregivers. The current approach of relying on informal information channels limits the program office's ability to comprehend the scope and magnitude of workload problems system-wide and leaves it in a reactive position of adding staff to the program only after significant workload problems have developed. A more capable IT system would enable the Caregiver Support Program to comprehensively monitor the program and proactively identify both actual and potential VAMC workload problems and target areas where improvements could be made. However, without a clear time frame for obtaining another IT system, workload issues will persist unless the Caregiver Support Program office starts to identify solutions to help alleviate VAMCs' workload burdens, such as modifications to the timelines and procedures for application processing and home visits, and the identification of additional ways to provide staffing support. If the program's workload problems are not addressed, the quality and scope of caregiver services, and ultimately the services that veterans receive, will continue to be compromised.

Recommendations for Executive Action

To ensure that the Family Caregiver Program is able to meet caregivers' demand for its services, we recommend that the Secretary of the Department of Veterans Affairs expedite the process for identifying and implementing an IT system that fully supports the program and will enable VHA program officials to comprehensively monitor the program's workload, including data on the status of applications, appeals, home visits, and the use of other support services, such as respite care.

We also recommend that the Secretary of the Department of Veterans Affairs direct the Undersecretary for Health to

- identify solutions in advance of obtaining a replacement IT system to help alleviate VAMCs' workload burden, such as modifications to the program's procedures and timelines, including those for application processing and home visits, as well as the identification of additional ways to provide staffing support, and

- use data from the IT system, once implemented, as well as other relevant data to formally reassess how key aspects of the program are structured and to identify and implement modifications as needed to ensure that the program is functioning as envisioned so that caregivers can receive the services they need in a timely manner.

Agency Comments and Our Evaluation

We provided a draft of this report to VA for review and comment. While the draft was at VA for comment, officials from VHA's Management Review Service expressed concerns with two of the three recommendations in the draft report.

- Officials expressed concern that our recommendation to expedite the process for identifying and implementing an IT system for the Family Caregiver Program was directed to the Undersecretary for Health. They explained that obtaining a new IT system would require the involvement of multiple offices within VA, including central offices that are under the Secretary of VA. Based on this information, we revised our recommendation and have redirected it to the Secretary to ensure that it is inclusive of all necessary offices within the department.

- Officials also commented on our recommendation about using data from the new IT system to formally reassess key aspects of the program and make modifications as needed. They suggested broadening the recommendation to include data from other sources, such as any data they may obtain through the solutions they implement in advance of obtaining a new IT system. In consideration of this information and the fact that we refer to relevant data from

other IT systems in our report, we modified our recommendation to state that the Undersecretary for Health should use data from the IT system, once implemented, as well as other relevant data to formally reassess how key aspects of the program are structured.

As a result of these revisions, VA concurred with all three of our recommendations in its letter, which is reprinted in appendix II. VA also provided technical comments, which we incorporated as appropriate. In concurring with our third recommendation to use data from the IT system as well as other relevant data to reassess the program, VA did not mention using data from the new IT system as part of its evaluation. As a result, we are concerned that VA's proposed actions only partially address this recommendation. Specifically, VA's response focused on using relevant information from solutions developed in response to our second recommendation as well as other relevant data to formally reassess key aspects of the program. A VHA official explained that no one knows how long it will take to develop the new IT system, or how long it will be before data from the system are available, and as a result, VHA developed their response based on actions they knew they could accomplish. However, the substance of our recommendation is focused on using comprehensive workload data from the new IT system as the foundation of a data-driven program analysis. Without such data, VHA will not be positioned to make sound, well-informed decisions about the program, potentially allowing it to continue to struggle to meet the needs of the caregivers of seriously wounded and injured veterans.

We are sending copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made major contributions to this report are listed in appendix III.

Randall B. Williamson
Director, Health Care

Veterans Integrated Service Networks (VISN)	Veterans Affairs Medical Center (VAMC)	Location	No. CSCs	Approved Caregivers	Caregiver Support Coordinator (CSC) to Approved Caregiver Ratio
VAMCS with CSC-to-approved caregiver ratio of 25 or less					
16	Veterans Healthcare System (HCS) of the Ozarks	Fayetteville, AR	1	6	1:6
4	Coatesville VAMC	Coatesville, PA	1	7	1:7
19	Grand Junction VAMC	Grand Junction, CO	1	8	1:8
20	Alaska HCS	Anchorage, AK	1	10	1:10
4	Lebanon VAMC	Lebanon, PA	1	11	1:11
23	VA Black Hills HCS	Fort Meade and Hot Springs, SD	1	12	1:12
19	Sheridan VAMC	Sheridan, WY	1	15	1:15
15	John J. Pershing VAMC	Poplar Bluff, MO	1	16	1:16
2	Bath VAMC	Bath, NY	1	18	1:18
18	West Texas VA HCS	Big Spring, TX	1	19	1:19
15	VA St. Louis HCS	St. Louis, MO	2	40	1:20
10	Chillicothe VAMC	Chillicothe, OH	1	23	1:23
11	VA Illiana HCS	Danville, IL	2	47	1:24
23	Iowa City HCS	Iowa City, IA	2	48	1:24
2	Albany VAMC - Samuel S. Stratton	Albany, NY	2	48	1:24
1	Manchester VAMC	Manchester, NH	2	50	1:25
VAMCS with CSC-to-approved caregiver ratio of 26 to 50					
9	Huntington VAMC	Huntington, WV	2	52	1:26
16	Michael E. DeBakey VAMC	Houston, TX	2	51	1:26
21	VA Sierra Nevada HCS	Reno, CA	2	53	1:27
23	Sioux Falls VA HCS	Sioux Falls, SD	1	27	1:27
4	Wilmington VAMC	Wilmington, DE	2	58	1:29
23	Fargo VA HCS	Fargo, ND	1	29	1:29
7	Birmingham VAMC	Birmingham, AL	2	59	1:30
2	Canandaigua VAMC	Canandaigua, NY	1	30	1:30
4	VA Butler HCS	Butler, PA	1	31	1:31
16	Alexandria HCS	Alexandria, LA	2	62	1:31
16	Gulf Coast Veterans HCS	Biloxi/Gulfport, MS; Mobile, AL; Pensacola & Panama City, FL	4	126	1:32

Veterans Integrated Service Networks (VISN)	Veterans Affairs Medical Center (VAMC)	Location	No. CSCs	Approved Caregivers	Caregiver Support Coordinator (CSC) to Approved Caregiver Ratio
4	Clarksburg - Louis A. Johnson VAMC	Clarksburg, WV	2	64	1:32
23	St. Cloud VA HCS	St. Cloud, MN	1	32	1:32
15	Robert J. Dole VAMC	Wichita, KS	1	34	1:34
16	Jack C. Montgomery HCS	Muskogee, OK	2	67	1:34
3	VA Hudson Valley HCS	Castle Point and Montrose, NY	2	68	1:34
3	Northport VAMC	Northport, NY	2	68	1:34
1	VA Boston HCS	Boston, MA	2	69	1:35
19	VA Salt Lake City HCS	Salt Lake City, UT	2	70	1:35
7	Tuscaloosa VAMC	Tuscaloosa, AL	1	35	1:35
10	Cincinnati VAMC	Cincinnati, OH	1	36	1:36
1	VA Maine HCS - Togus	Augusta, ME	1	36	1:36
1	White River Junction VAMC	White River Junction, VT	1	36	1:36
19	Cheyenne VAMC	Cheyenne, WY	1	36	1:36
16	Overton Brooks VAMC	Shreveport, LA	1	36	1:36
12	William S. Middleton Memorial Veterans Hospital	Madison, WI	1	37	1:37
1	Providence VAMC	Providence, RI	1	37	1:37
11	Battle Creek VAMC	Battle Creek, MI	2	74	1:37
23	Omaha - VA Nebraska-Western Iowa HCS	Grand Island, Lincoln, and Omaha, NE	2	75	1:38
12	Clement J. Zablocki VAMC	Milwaukee, WI	1	38	1:38
12	Oscar G. Johnson VAMC	Iron Mountain, MI	1	40	1:40
7	Carl Vinson VAMC	Dublin, GA	2	79	1:40
3	James J. Peters VAMC	Bronx, NY	3	123	1:41
8	West Palm Beach VAMC	West Palm Beach, FL	2	82	1:41
8	C.W. Bill Young VAMC	Bay Pines, FL	3	127	1:42
20	Jonathan M. Wainwright Memorial VAMC	Walla Walla and Yakima, WA	1	42	1:42
16	Central Arkansas HCS	Little Rock, AR	1	43	1:43
6	Durham VAMC	Durham, NC	3	130	1:43
20	Mann-Grandstaff VAMC	Spokane, WA	2	85	1:43
7	Wm. Jennings Bryan Dorn VAMC	Columbia, SC	2	87	1:44
5	Martinsburg VAMC	Martinsburg, WV	1	45	1:45

Appendix I: Veterans Affairs Medical Centers
by CSC-to-Approved Caregiver Workload
Ratio, as of May 2014

Veterans Integrated Service Networks (VISN)	Veterans Affairs Medical Center (VAMC)	Location	No. CSCs	Approved Caregivers	Caregiver Support Coordinator (CSC) to Approved Caregiver Ratio
6	Beckley VAMC	Beckley, VA	1	45	1:45
4	Pittsburgh HCS	Pittsburgh, PA	1	45	1:45
1	Edith Nourse Rogers Memorial Veterans Hospital	Bedford, MA	1	45	1:45
10	Chalmers P. Wylie Ambulatory Care Center	Columbus, OH	1	48	1:48
6	Salem VAMC	Salem, VA	1	48	1:48
4	Erie VAMC	Erie, PA	1	48	1:48
4	Wilkes-Barre VAMC	Wilkes-Barre, PA	1	48	1:48
21	VA Palo Alto HCS	Livermore, Menlo Park, and Palo Alto, CA	4	196	1:49
20	VA Roseburg HCS	Roseburg, OR	2	98	1:49
VAMCS with CSC-to-approved caregiver ratio of 51 to 100					
6	Salisbury - W.G. (Bill) Hefner VAMC	Salisbury, NC	3	153	1:51
11	John D. Dingell VAMC	Detroit, MI	1	51	1:51
21	San Francisco VAMC	San Francisco, CA	1	52	1:52
4	Altoona - James E. Van Zandt VAMC	Altoona, PA	2	103	1:52
1	VA Connecticut HCS	Newington and West Haven, CT	2	105	1:53
16	G.V. (Sonny) Montgomery VAMC	Jackson, MS	2	106	1:53
17	VA Texas Valley Coastal Bend HCS	Harlingen, TX	2	108	1:54
16	Oklahoma City VAMC	Oklahoma City, OK	1	54	1:54
15	Marion VAMC	Marion, IL	1	54	1:54
22	VA Southern Nevada HCS	North Las Vegas, NV	3	166	1:55
11	Richard L. Roudebush VAMC	Indianapolis, IN	2	111	1:56
11	VA Northern Indiana HCS	Marion and Fort Wayne, IN	2	112	1:56
16	Southeast Louisiana VA HCS	New Orleans, LA	1	56	1:56
18	Amarillo VA HCS	Amarillo, TX	1	56	1:56
12	Jesse Brown VAMC	Chicago, IL	1	56	1:56
20	Portland VAMC	Portland, OR and Vancouver, WA	3	172	1:57
10	Louis Stokes Cleveland VAMC	Cleveland, OH	2	114	1:57
23	VA Central Iowa HCS	Des Moines and Knoxville, IA	1	59	1:59
19	VA Montana HCS	Fort Harrison, MT	2	122	1:61

Appendix I: Veterans Affairs Medical Centers
by CSC-to-Approved Caregiver Workload
Ratio, as of May 2014

Veterans Integrated Service Networks (VISN)	Veterans Affairs Medical Center (VAMC)	Location	No. CSCs	Approved Caregivers	Caregiver Support Coordinator (CSC) to Approved Caregiver Ratio
9	Lexington VAMC	Lexington, KY	1	61	1:61
23	Minneapolis VA HCS	Minneapolis, MN	1	62	1:62
11	Aleda E. Lutz VAMC	Saginaw, MI	1	62	1:62
1	VA Central Western Massachusetts HCS	Northampton and Leeds, MA	1	62	1:62
12	Captain James A. Lovell Federal Health Care Center	North Chicago, IL	1	63	1:63
10	Dayton VAMC	Dayton, OH	1	64	1:64
3	New York Harbor HCS	New York City, Manhattan and Brooklyn, NY	1	64	1:64
2	VA Western New York HCS	Batavia and Buffalo, NY	1	65	1:65
21	VA Pacific Islands HCS	Honolulu, HI	3	197	1:66
6	Asheville VAMC	Asheville, NC	1	67	1:67
6	Hunter Holmes McGuire VAMC	Richmond, VA	2	136	1:68
9	Mountain Home VAMC	Mountain Home, TN	2	136	1:68
8	Miami VA HCS	Miami, FL	2	137	1:69
20	White City or VA Southern Oregon Rehabilitation Center	White City, OR	2	144	1:72
20	Boise VAMC	Boise, ID	1	72	1:72
15	Kansas City VAMC	Kansas City, MO	1	72	1:72
19	VA Eastern Colorado HCS	Denver, CO	3	232	1:77
22	VA Greater Los Angeles HCS	Los Angeles, CA	2	155	1:78
8	North Florida/South Georgia VA HCS	Gainesville and Lake City, FL	2	162	1:81
3	VA New Jersey HCS	East Orange and Lyons, NJ	2	162	1:81
8	James A. Haley VA Hospital	Tampa, FL	2	164	1:82
5	Maryland HCS	Baltimore and Perry Point, MD	1	83	1:83
17	Central Texas Veterans HCS	Marline, Temple and Waco, TX	3	256	1:85
18	Southern Arizona VA HCS	Tucson, AZ	1	86	1:86
22	VA San Diego HCS	San Diego, CA	3	271	1:90
12	Tomah VAMC	Tomah, WI	1	91	1:91
18	Phoenix VA HCS	Phoenix, AZ	3	282	1:94

**Appendix I: Veterans Affairs Medical Centers
by CSC-to-Approved Caregiver Workload
Ratio, as of May 2014**

Veterans Integrated Service Networks (VISN)	Veterans Affairs Medical Center (VAMC)	Location	No. CSCs	Approved Caregivers	Caregiver Support Coordinator (CSC) to Approved Caregiver Ratio
11	VA Ann Arbor HCS	Ann Arbor, MI	1	95	1:95
18	El Paso VA HCS	El Paso, TX	1	96	1:96
17	VA North Texas HCS	Bonham and Dallas, TX	3	287	1:96
21	VA Northern California HCS	Mather and Martinez, CA	3	291	1:97
4	Philadelphia VAMC	Philadelphia, PA	1	99	1:99
7	Ralph H. Johnson VAMC	Charleston, SC	2	197	1:99
VAMCS with CSC-to-approved caregiver ratio of 101 to 150					
9	Robley Rex VAMC (Ft. Knox)	Louisville, KY	2	204	1:102
7	Charlie Norwood VAMC	Augusta, GA	1	106	1:106
2	Syracuse VAMC	Syracuse, NY	1	107	1:107
6	Hampton VAMC	Hampton, VA	2	220	1:110
21	VA Central California HCS	Fresno, CA	1	111	1:111
18	Northern Arizona VA HCS	Prescott, AZ	2	224	1:112
15	VA Eastern Kansas HCS	Leavenworth and Topeka, KS	2	225	1:113
7	Central Alabama VA HCS	Montgomery and Tuskegee, AL	2	241	1:121
22	VA Long Beach HCS	Long Beach, CA	2	245	1:123
22	VA Loma Linda HCS	Loma Linda, CA	3	375	1:125
18	New Mexico VA HCS	Albuquerque, NM	2	251	1:126
15	Harry S. Truman Memorial	Columbia, MO	1	133	1:133
12	Edward Hines, Jr. VA Hospital	Hines, IL	1	134	1:134
8	VA Caribbean HCS	San Juan, PR	3	429	1:143
9	Tennessee Valley HCS	Nashville and Murfreesboro, TN	3	451	1:150
VAMCS with CSC-to-approved caregiver ratio of 151 or more					
8	Orlando VAMC	Orlando, FL	3	472	1:157
20	VA Puget Sound HCS	Lakewood and Seattle, WA	2	331	1:166
17	South Texas Veterans HCS	Kerrville and San Antonio, TX	2	342	1:171
5	Washington D.C. VAMC	Washington, DC	1	181	1:181
9	Memphis VAMC	Memphis, TN	2	367	1:184
6	Fayetteville VAMC	Fayetteville, NC	3	570	1:190

**Appendix I: Veterans Affairs Medical Centers
by CSC-to-Approved Caregiver Workload
Ratio, as of May 2014**

Veterans Integrated Service Networks (VISN)	Veterans Affairs Medical Center (VAMC)	Location	No. CSCs	Approved Caregivers	Caregiver Support Coordinator (CSC) to Approved Caregiver Ratio
7	Atlanta VAMC	Decatur, GA	1	251	1:251
	Total (140 VAMCs)		**233**	**15,661**	

Source: GAO analysis of Veterans Health Administration documents. I GAO-14-675

Note: While caregiver support coordinators (CSC) administer the Family Caregiver Program at all 151 VA facilities, they are assigned to 140 VAMCs or healthcare systems, which may include more than one VA facility. We present program statistics based on CSC assignments because that is how they are tracked by the Caregiver Support Program office.

Appendix II: Comments from the Department of Veterans Affairs

August 8, 2014

Mr. Randall Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, *"VA HEALTH CARE: Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program"* (GAO-14-675). VA generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's recommendations and provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
*"VA HEALTH CARE: Actions Needed to Address Higher-Than-Expected Demand
for the Family Caregiver Program"*
(GAO-14-675)

Recommendation 1: **To ensure that the Family Caregiver Program is able to meet
caregivers' demand for its services, we recommend that the Secretary of the
Department of Veterans Affairs expedite the process for identifying and
implementing an IT system that fully supports the program and will enable VHA
program officials to comprehensively monitor the program's workload, including
data on the status of applications, appeals, home visits, and the use of other
support services, such as respite care.**

VA Comment: Concur. To ensure that all caregivers' requirements are identified and
addressed expeditiously, the Veterans Health Administration (VHA) will work through
the Information Technology (IT) governance boards to prioritize this new IT system
requirement into the fiscal year 2015 budget operating plan. Once appropriately
prioritized, VHA will ensure their business requirements for the caregivers' system are
identified such that cost estimates can be developed, project timelines for development
and implementation can be established, and funding can be identified in the budget
operating plan. Once the plan is approved, the Office of Information and Technology
will ensure this project is managed through the Project Accountability Management
System for rigorous oversight through milestone and techstat reviews, thereby ensuring
systematic management of all phases of IT system development and implementation.
The target implementation date will be driven by the scope and complexities of these
requirements.

GAO Recommendation: **GAO also recommends that the Secretary of the
Department of Veterans Affairs direct the Undersecretary for Health to:**

Recommendation 2: **Identify solutions in advance of obtaining a replacement IT
system to help alleviate VAMCs' workload burden, such as modifications to the
program's procedures and timelines, including those for application processing
and home visits, as well as the identification of additional ways to provide
staffing support.**

VA Comment: Concur. VHA will identify solutions to alleviate VA medical centers'
workload burden by exploring options such as modifications to procedures and timelines
for the Program of Comprehensive Assistance for Family Caregivers. Target
Completion Date: April 15, 2015.

VHA will identify additional ways to provide staffing support through engaging VA
medical center and Veterans Integrated Service Network-level leadership as well as
VHA Central Office Program Office leadership, including Primary Care and Mental
Health, to increase support of staffing at the medical center level. Target Completion
Date: January 15, 2015.

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Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
*"VA HEALTH CARE: Actions Needed to Address Higher-Than-Expected Demand
for the Family Caregiver Program"*
(GAO-14-675)

Recommendation 3: Use data from the IT system, once implemented, as well as
other relevant data to formally reassess how key aspects of the program are
structured and to identify and implement modifications as needed to ensure that
the program is functioning as envisioned so that caregivers can receive the
services they need in a timely manner.

VA Comment: Concur. Using relevant information from solutions developed in
response to Recommendation 2 and other relevant data, VHA will formally reassess
how key aspects of the Program of Comprehensive Assistance for Family Caregivers
are structured. Target Completion Date: June 30, 2015.

VHA will identify and implement modifications to policies and procedures, consistent
with effective solutions developed in response to Recommendation 2, within the
Program of Comprehensive Assistance for Family Caregivers, as needed, to ensure
that the program is functioning as envisioned so that caregivers may receive the
services they need in a timely manner. Target Completion Date: April 15, 2015.

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Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, Director, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact above, Bonnie Anderson, Assistant Director; Frederick Caison; Christine Davis; Cathy Hamann; Jacquelyn Hamilton; Giao N. Nguyen; and Chan-My J. Sondhelm made key contributions to this report.

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