“HONORING OUR COMMITMENT: IMPROVING VA’S PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS”

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QUALIFY OF LIFE FOUNDATION’S WOUNDED VETERAN FAMILY CARE PROGAM

BEFORE THE

COMMITTEE ON VETERAN’S AFFAIRS

UNITED STATES SENATE

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Mr. Chairman, Members of the Committee, my name is Andrea Sawyer, and I am an Advocacy Navigator for the Quality of Life Foundation (QoLF), a national non-profit organization founded in 2008 to address the unmet needs of caregivers, children and family members of those who have been wounded, ill, or injured serving this nation.

As you know, over the years, legislation and policy with respect to caregivers has fortunately evolved. Congress passed the *VA MISSION Act of 2018* which made substantial changes to the original Program of Comprehensive Assistance for Family Caregivers (PCAFC). The changes include: (1) expanding PCAFC eligibility to caregivers of Pre-9/11 veterans and (2) expanding eligible care conditions to include illness and noncombat-related injuries.

Initially, the legislation was greeted with great fanfare. New generations of veterans and caregivers would now be eligible, and those who were ill or otherwise injured would have the option of having a loving family member at their side. By broadening eligibility, Congress acknowledged the argument caregivers had been making for years--by being present at the veteran’s side, caregivers were able to facilitate growth, maintain progress that was made in therapies, and offer a more complete medical picture to the specialists who were not able to be with the veteran all the time. This led to improved outcomes for many warriors and a cost-savings for the government.

Congressional Intent vs. Implementation

Congress clearly expressed its intent in the new legislation. As it had done with the original legislation creating the program, Congress again made sure to leave no doubt that injuries other than physical injuries were to be considered, emphasizing on multiple occasions that, “serious injury (including traumatic brain injury, psychological trauma, or other mental disorder,)” be considered. It is important to note that Congress had the opportunity to change the eligibility requirement from seriously injured to the stricter “catastrophically” injured, a term which had been very clearly in the lexicon at the time of the passage of the legislation. However, Congress chose to stay with the more inclusive, “seriously injured.”

As a result of this new legislation, the Department of Veterans Affairs drafted new implementing regulations, including revising the criteria for admission and developing new application, assessment/evaluation, and approval/denial processes. As a result, and due to the complexity of the new evaluation and appeals processes, QoLF refocused its efforts and created both educational resources for those applying for the program, as well assisting in the preparation of clinical appeals for those who have been denied. Through our work, our staff has developed a unique understanding of the operational and policy questions and challenges surrounding the roll-out and implementation of this program. Let me be clear, however, QoLF is NOT offering any clinical judgement, we are simply assisting the caregiver and veteran to identify factual errors and omissions in the record, gather documents supporting their case, and articulate their arguments in clear and concise language.

As we have assisted in the drafting of these clinical appeals, we have found that while the legislation as passed broadened the program, the VA's implementing regulations and guidance have vastly narrowed the number of individuals who would qualify for the stipend and other PCAFC services. In many cases, it seems the VA has exchanged a program intended for seriously injured to one only for those who were catastrophically injured. BOTH categories of veterans often require a caregiver to achieve their maximum level of functionality and highest quality of life. For example, under the original program, the veteran and caregiver simply needed to prove that the veteran required assistance with defined Activities of Daily Living (ADLs). These include bathing, toileting, dressing, transferring, eating, and incontinence. Once that need for assistance was established, then the amount of time that the caregiver was required to assist the veteran with the established ADLs was calculated. This amount of time and number of areas of assistance determined the caregiver's stipend level.

Under the new regulation, however, a veteran must now require assistance with an ADL "each and every time" it is completed to qualify. Such a strict application of the rules within PCAFC inhibits even low levels of independence for those who may be able to perform an ADL infrequently by excluding them from the program. One caregiver offered, "The constant reminder of 'we will end this benefit any time there might be a hint of recovery or improvement,' does not encourage improvement." The strict interpretation of the regulation particularly disadvantages those with dementia, severe illness, traumatic brain injury, and other conditions that are relapsing and remitting and does not serve the best interest of the veteran.

Furthermore, when testifying before Congress on February 6, 2018, Secretary Shulkin stated that the Department wanted to make this change to standardize and align the PCAFC program with other VA programs such as Aid and Attendance(A&A). However, even A&A does not have such strict standards. Its standards simply state that the veteran must require assistance on a "regular" basis—leaving flexibility to allow for the encouragement of independence rather than the fear that any such demonstration of independence will result in being removed from the program.

Also concerning in its severity, under the new Supervision, Protection, and Instruction standard, the veteran must need "continuous daily care," rather than having to prove, as in the original program, that the veteran requires supervision for safety. In the Code of Federal Regulations (CFR) comments, the VA itself gave the example that a veteran who was experiencing dementia, but was only sundowning, would not qualify for the program because the veteran only needed episodic care and did not meet the "continuous daily care" requirement. Would you want to leave your loved one with dementia alone in the hopes he or she would only need you in the evening? If your loved one had a moderate to severe traumatic brain injury and was able to independently walk the dog in their very familiar neighborhood, would you trust them to go to the store unsupervised with the family's credit card? Again, the lack of flexibility in this standard demonstrates a complete lack of acknowledgement of the illnesses and injuries Congress was trying to address.

Understanding that new regulations and directives must be promulgated to effectively enact legislation, the above examples clearly underline the great disparity between Congressional intent and the operationalization of the PCAFC. We encourage Members of Congress to continue to work with VA staff and relevant organizations to thoroughly review the implementing regulations, directive memos, and training modules to ensure that those caregivers and veterans Congress intended to serve are included in this program.

Process Challenges

With the drafting of the new regulations and directives, QoLF staff, along with several other Veteran Service Organizations have made repeated inquiries to the VA requesting information on the decision-making process, standard operating procedures, and training documents to both educate and caregivers and inform our appeals efforts. While information was sometimes provided, we and other VSO's were often denied access to critical procedural information needed to assist veterans and caregivers. To overcome this obstacle, our staff took from October 1, 2020 to September 30, 2021, to review cases of veterans and caregivers who applied under the new regulation to better understand the changes that had taken place. Through this documents review, we painstakingly recreated the application and evaluation documents that were available, as they were intended to give a picture of the functionality and care needs of the veteran and the role the caregiver plays in filling those needs for assistance with ADL's or providing supervision, protection, and instruction. We have attached those documents to this testimony for your review.

Primarily, we would like to applaud VA's attempt to standardize this process and create expansive assessment instruments intended to capture the care needs of the veteran as well as their stated goal, mentioned above, to align the PCAFC program with other related VA programs. However, as we have worked with veterans and caregivers to develop their clinical appeals, we have noticed issues with both the application and appeals process, often resulting in the undue exiting of caregivers from the program. The process and issues are as follows:

1. **Veteran Application Intake or Reassessment Interview**: This document reviews basic biographical information that speaks to the qualifying criteria for the program. It goes over dates of service, ratings, address, etc. The basic biographical information for the caregiver is also listed. The major areas of concern that we have noted on this document include:
    A. *The ratings considered are often incorrect, leaving an incomplete picture of the veteran's previously established need for assistance*. Caregiver Support Staff are only able to access the VHA system which may or may not include the most up to date VBA rating. Any ratings increases or new conditions must be added manually, leading to both coding and transcription errors. This section is often copied and pasted onto multiple other forms, and, therefore, if the error occurs here, it is repeated elsewhere. In addition, seriously wounded, ill, and injured

veterans are often assessed for Special Monthly Compensation, Aid and Attendance, and housebound status. While these ratings indicate a higher level of need for assistance, their documentation is not easily identifiable during the PCAFC intake process, leaving an incomplete picture of the veteran's current needs and missing an opportunity to align these programs and evaluations. For example, we recently assisted a caregiver and veteran who, among other errors, was listed as missing an eye when he was actually missing his colon and rectum, obviously requiring different types of care and assistance. To be clear, both of the veteran's eyes are fully intact and functional, but a coding error led to a completely false narrative of the veteran's needs. After pointing out this error and requesting new exams to rectify the problem, we were told that the appeal was a "self-report," and that they had to go with what was in the record.

We are finding that a large percentage of applications have these errors in the ratings, but we have also been informed that CSP staff will be able to access VBA ratings from VBA "in the near future." However, the program has required ratings information since its inception, but it is still not reliably accessible. Because one of the qualifying criteria of the program is a 70% rating, it is vitally important that CSP be able to access this information sooner rather than later.

B. *Existing Fiduciaries, Guardianships, and Conservatorships are often not documented.* During the intake interview, CSP staff are required to ask about fiduciaries, guardianships, and conservatorships because, similar to the programs listed in the previous section, these designations require a proven level of need for supervision, protection, and instruction. Thus, if the CSP staff fail to ask the question, a documented need for assistance is missing from the caregiver's application. So far, we have had multiple cases where guardianships and the need for a fiduciary were not documented, resulting in at least two veterans with an active guardianship being exited from the program. While this is likely a training issue, we cannot be sure because, again, we have requested but not seen the training documents.

2. **PCAFC/PCM Collaboration:** This document lists 5-7 basic questions that are supposed to be filled out by the veteran's Primary Care Manager in collaboration with the CSP. The CFR states that this collaboration is to be done to the maximum extent possible. The major areas of concern include.

A. *The PCM is rarely the person filling out the document, meaning that the input of the clinical staff most familiar with the veteran is not considered.* While the VA is not tracking the number of assessments filled out by the PCM vs. CSP staff, ninety percent of the cases that Qualify of Life Foundation have reviewed have not been filled out by the Primary Care Manager. Instead, there is a note put in by CSP staff, usually the social worker, that says the CSP staff member did a review of the Electronic Health Record and answered the questions for the physicians. In at least one instance, a PCM has responded, in the record, that they do not agree with the conclusion that was drawn by the CSP staff.

B. *The information requested from the PCM is too generic and does not speak to the veteran's care needs.* Questions consist of describing the treatment plan if one exists, listing medication, asking if the veteran is able to understand the treatment plan, if the caregiver is involved with the veteran and treatment plan, if the caregiver is able to understand the treatment plan, if the care needs can be safely carried out in the home, and if there is evidence that the veteran has been recommended for institutional care. None of these questions speak to the veteran's need for supervision and assistance with safety or the physician's opinion as to whether the veteran needs an attendant.

C. *Veterans often have multiple PCMs or no assigned PCM.* Due to high turnover rate and COVID, even when the PCM is consulted, veterans may not have consistently seen his/her PCM or the same PCM in the VA. As such answers and notes often cannot truly reflect the needs of the veteran due to a lack of familiarity. One veteran we are assisting has had approximately 12 PCM's in the last 5 years. The number is approximate because there were temporary PCM's that the veteran didn't know were assigned.

D. *Only twelve months of records are reviewe*d. In the PCM collaboration document, there is a specific statement that says, "Documentation for collaboration should be within twelve months from the valid application received date or reassessment date, as applicable." Due to COVID, many veterans have not been able to go to the VA to see their providers, leaving a lack of information. In addition, many veterans who have significant care needs may also be medically stable and do not see their PCM regularly. This does not indicate that their brains have healed or their paralysis remitted, it simply means that they did not have a level of medical need to see a primary care manager. Lack of evidence of seeing a primary care manager does not equate to a lack of need for assistance. Many injuries from Post 9/11 and earlier conflicts have become medically stable, and there is no progress to be made or new therapies to offer. Conditions are stable and static. The need for assistance remains, but the need to see the PCM beyond periodic evaluation does not exist. For example, neuropsychological testing for those with brain injuries that shows a particular lack of executive functioning is not normally repeated once the maximum level of functioning is achieved (usually about 24 months post-injury). Nerve conduction tests for those with paralysis, pinched nerves, etc. are usually not repeated once loss of sensation is documented. In both cases, the need for assistance likely still exists, but the veteran no longer sees the PCM to address those issues. Therefore, due to the 12 month limitation, evidence may be missed documenting the need for assistance, especially for those who have been injured for multiple years.

E. *Specialists are often not consulted.* Due to the severity and complexity of their illnesses and injuries, many veterans see specialists beyond primary care. Neurologists, spine specialists, oncologists, orthopedists, psychologists, psychiatrists, etc often provide the majority of a veteran's care depending on the need. Those doctors would be better able to answer the questions about the veteran's treatment plans, needs for assistance, and possible need for institutionalization in the absence of a caregiver, but are often not consulted.

F. *Case management is often lacking*: Over the years, VA has struggled to provide comprehensive holistic and proactive case management, especially to the severely injured— the target population of PCAFC. In some cases, VA even documented that they were unable to provide the case management across multiple facilities, even for care for which they are paying. Even so, the VA has stated that "management of medications and appointments are not qualifying activities" for the PCAFC program. However, caregivers of those who are unable to manage their own care have had to spend extraordinary amounts of time navigating systems of care on behalf of the veteran and monitoring medication. Without this type of assistance, many veterans who otherwise require a caregiver would not be able to navigate the complex bureaucracy of the VA and would lose access to the programs and services they desperately need. Therefore, the need for assistance with case management should be considered a qualifying factor under the Supervision, Protection and Instruction standard of the PCAFC program.

3. **Veteran Assessment:** This interview, normally conducted by a social worker, includes an assessment document that repeats much of the information about ratings, medical conditions, and medications that the veteran takes that can be found on other forms. The veteran is also supposed to be asked if they see outside providers. The veteran must go through and answer questions about employment, educational history, substance abuse/mental health history, history of pain, dietary concerns, daily diet, exercise, treatment goals, changes in health, memory, concerns for their safety, and if and how they feel the caregiver is supporting their treatment goals. Then the caregiver is asked to weigh in on all of those aspects while the veteran is present. The caregiver must answer questions about the veteran's participation in childrearing, household chores, how the caregiver assists in ADL's, concerns the caregiver has surrounding the veteran's memory, mental health, sleep habits, safety in the home, safety outside the home, preparations the caregiver makes if they have to be away from the veteran, etc. Our issues surrounding this evaluation include:

A. *CSP staff often fail to ask about information from outside providers*. Many veterans that have multiple serious medical conditions also have multiple insurance options, including TRICARE, Medicare, and/or private health insurance. As a result, many use a hybrid collection of medical providers. As such, all of the treatment records need to be available for VA CSP to make an accurate decision on whether or not a veteran has a clinical need for assistance.

B. *Even if VA is aware of outside community care providers, time is not always allowed to collect and add outside records into the system before files are sent to the decision-making Caregiver Eligibility and Assessment Team (CEAT).* Therefore, those records, most of which are records from specialists or even other VA providers like Vet Centers, are not included in the information used to make a decision about the level of assistance needed. We often have cases that from the receipt of the call to inform the caregiver of the beginning of the reassessment process to a determination being made is less than 14 calendar days. These cases usually conclude with removal from the program. Given the complexity of the medical care required by these individuals, this is not a long enough period of time to gather, assess, and evaluate the necessary records.

C. *Outside records are often not visible to the veteran/caregiver nor are they entered in the electronic medical record*. If a veteran and caregiver submit outside records, several scenarios can ensue, all depending on the policy at individual VA Medical Center. If the Caregiver Support Team at a VA has scanning authority, then the CSP staff can scan the records directly into the veteran's chart. Unfortunately, this scan is not able to be seen by the caregiver and veteran in the MyHealtheVet record as the images are scanned into a different system. If CSP staff do this, they usually place a note in the Electronic Health Record that notes that outside records were scanned into the veteran's record and are usually identified by name and the records system in which they were input so CEAT can potentially see the records. If a CSP does not have scanning capabilities, then the veteran and caregiver may be told to take the records to the Records Office and have them scanned in. In this scenario, the records can take weeks or months to upload and still cannot be viewed by the veteran and caregiver through MyHealtheVet. Most applications are pushed forward without indication that the records have been added to the veteran's record. Another scenario has the CSP tell the veteran and caregiver to take the veteran's outside records to the PCM to have the PCM decide if they should be added to the record for consideration. In one instance, the veteran submitted 760 pages of mental health records from the Vet Center he attends for weekly mental health appointments only to be told by his physician that the records would not be added to his chart because it would take months to get that much material added to his record. In scenarios such as this, the CEAT is making decisions without all of the necessary information. This variation in policies and procedures at VA Medical Centers causes undue confusion and hardship on the part of the veteran and caregiver. To address this, QoLF recommends that the local CSP staff be given scanning privileges to ease this already difficult process.

D. *"Duty to assist" is not practiced in this process.* In the VA, there is a standard of "duty to assist" a veteran to seek care and to collect records. In the process of CSP evaluation, this duty to assist would translate to the CSP staff helping the veteran and caregiver gather outside records and ensuring their appropriate placement in the VA medical record. While there are certainly some very helpful CSP staff, often the veteran and caregiver are left to their own devices to track down records and ensure their proper use.

4. **Veteran Functional Assessment:** This assessment repeats much of the same information from the Veteran Assessment, but instead of it being done as a psychosocial interview and a listing of concerns, it is an exam that is supposed to gauge the functional ability of the veteran to perform both physically and cognitively. It is performed by a clinician (nurse or therapist) who usually has not read the information from the preceding

Veteran Assessment. Each ADL is broken down into separate components and the veteran and caregiver are asked how the caregiver assists the veteran in the performance of those specific functions. The examiner then has a list of dependency choices, which after listening to the veteran and caregiver describe the assistance given, chooses a level of assistance that the veteran needs— this ranges from independence to complete dependence. Then there is a list of questions on criteria for Supervision, Protection, and Instruction. The following are concerns related to this portion of the assessment:

A. *Scoring is unknown for SPI criteria.* Under the program, veterans are evaluated for the ability to perform ADL's and the need for Supervision, Protection, and Instruction. After reviewing multiple assessments, it is clear that a specific set of question and qualitative matrices are used to score and evaluate a veteran's ability to perform ADL's. The veteran is then assigned a defined level of functionality for ADL's. With respect to SPI, however, there are no clearly defined questions, or, as mentioned above, no cognitive evaluation tools administered, that relate back to the areas of evaluation for SPI functionality (self-neglect, self-direction, etc.), nor qualitative measurements for levels of functionality, leaving the evaluation matrix unknown. As a result, it is incredibly difficult to determine how functionality is assigned for each item, and even more difficult to appeal a denial if a caregiver is unclear why he or she was denied in the first place. This leaves many veterans, especially those living with severe mental health disorders, severe brain injuries, and dementia, who are often evaluated under SPI, without a caregiver.

B. *Supervision, Protection, and Instruction questions do not directly correlate to items on the criteria for consideration.* There are multiple categories under consideration for Supervision, Protection, and Instruction such as self-preservation, safety both inside and outside of the home, medication management, self-neglect etc. Each category has questions that the examiner asks to understand the need for assistance within that category. These questions do not necessarily correlate to the specific item on the Supervision, Protection, and Instruction checklist. For example, a standard question for self-preservation would be, "If the house were on fire, what would you do?", asked of the veteran for a response. The question itself has multiple layers of thought processes. First a veteran has to be able to identify a fire. He has to then acknowledge that fire is a danger. Then he has to be able to formulate a plan to deal with the danger— get help, get out, etc. He has to be able to then put whatever plan there that he created into action. If that plan is not executable, then the veteran has to be able to think of an alternative plan and execute the plan. Simply asking a veteran, "What would you do if there was a fire?", and recording an answer does not only speak to self-preservation, it speaks to multiple layers of thought processes and execution. Any failure at any step could result in catastrophe. This question does not address the actual step at which the process may fail for the veteran, nor do we know how the answer is considered.

C. *No actual measures of cognitive function are administered during the functional assessment portion of supervision, protection, and instruction*. In the ADL portion of the Veteran Functional Assessment, the veteran can demonstrate her ability to perform the ADL's. In the Supervision, Protection, and Instruction portion of the exam, one of the key components of demonstrating functional ability is a person's cognitive impairment. There is no assessment of cognitive impairment administered as part of the Veteran Functional Assessment. Despite easily administered, validated and available tools, such as MoCA and SLUMS testing, a key detector of even mild cognitive impairment/dementia is not administered in this assessment.

D. *Evaluator and veteran are mismatched.* While a clinician (nurse, PT, OT, LCSW) is required to perform the functional assessment, he/she is often mismatched with the veteran and likely has no prior involvement with the veteran. For example, a physical therapist could be performing the assessment on a veteran with a severe mental health disorder and be unfamiliar with the manifestations of the disorder. While there are set questions to ask, again, without having a clear set of evaluation criteria, it is unknown if an assessor's clinical background or lack thereof would impact the decision of choosing a functionality level.

E. *Questions should be asked of Specialists, not just veterans and caregiver*s. Again, due to the complexity and severity of the injuries sustained by veterans applying for the program, they often see a myriad of specialists. As indicated above, and especially for Supervision, Protection, and Instruction, having a specialist's feedback on a veteran's functionality—especially when the injuries and illnesses are not readily apparent-- would dramatically impact the level of evidence that is provided for functional deficits in this area. Those specialists would be able to point to specific areas of concern that they have noted in treatment, something which if captured early in an injury or progression of dementia, may not be found in the last twelve months of records because there would have been no reason to revisit that particular deficit in the notes once it was established by testing or evidence. To remedy this lack of information, QoLF has asked some veterans and caregivers to give their mental health provider or neurologists the same list of Supervision, Protection and Instruction criteria by which by the veteran and caregiver are scored. These specialists are then able to offer direct clinical information and recommendations regarding the veteran's true needs and deficits. However, as helpful as this information is, we have also experienced pushback when asking providers to fill out this document for the VA record, as "the questions would elicit a lot of information in regards to the needs of a veteran," and the local CSP offices have also discouraged the use of this form including this vital information because it is not the appropriate place in the process. However, as mentioned above, there is often no place in the process for the specialists to provide their clinical judgement.

F. *Has the Veteran Functional Assessment Instrument been validat*ed? This is a question the VSO community has been asking since the summer of 2020. VA used the Special Medical Advisory Group (SMAG) to develop a functional assessment, and held a public meeting to share their final recommendations for the creation of this instrument. The instrument was developed using items from MNChoices and FASI, two individually validated assessments and the SMAG combined the instruments to make a new instrument. SMAG was very careful to say that the newly developed instrument would need to be validated. As of yet, no one has seen the full instrument, and no one has seen the scoring criteria. Thus, we do not know if the instrument that is being used to assess the functional ability of the veteran is actually a valid instrument when compared to other existing validated instruments.

5. **CEAT Review and Decision:** The Caregiver Eligibility Assessment Team (CEAT) is the decision-making body that reviews the application, assessments, and records to make a decision on whether a veteran qualifies for the PCAFC. To make a decision, the CEAT must determine that the veteran meets specific criteria. The majority of these criteria are straightforward, but we have found issues in some of them:

   A. *The veteran must need six months of continuous personal care services*. The CEAT uses the assessments to determine if the veteran has a need for ADL or Supervision, Protection, and Instruction assistance that will last for six months or more. As previously discussed, not knowing the actual scoring matrix makes it nearly impossible to determine how a veteran qualifies for the program. We do know, however, that to determine the tier under which the veteran qualifies, 3 questions must be answered. The questions follow: Does the veteran need ADL assistance? Does the veteran need supervision, protection, and instruction? And is the veteran unable to self-sustain in the community? The third question is the one that creates issues. Rather than ask, "Is the veteran able to self-sustain in the community?" that requires a simple yes or no answer, the question is reversed and asks if the veteran is UNABLE to self-sustain in the community. The answer to this question determines the tier level of the veteran. Reviewing this question in the context of clinical appeals has demonstrated that the majority of field staff on the CEAT do not know how to interpret this question. Because it is a double negative, they will incorrectly answer "NO," and then expound on all of the ways the veteran requires assistance. Rewording this question would make it less confusing for the CEAT and correct some tier leveling errors.

   B. *The program is in the best interest of the veteran.* This specific criteria is defined in the CFR as a clinical decision based on, "consideration, by a clinician, of whether participation in the program significantly enhances the veteran's or service member's ability to live safely in a home setting, supports the veteran's or servicemember's potential progress in rehabilitation, if such potential exists, increases the veteran's or servicemember's potential independence, if such potential exists, and creates an environment that supports the health and well-being of the veteran or servicemember." In our view, this criterion offers needed flexibility to the eligibility determination by allowing clinical judgement to trump all other criteria. It is important to note, we have not seen a case that rejects the personal care criteria found in section (A) above, but accepts that the program is in the best interest of the veteran. This is a problem, for example, because a veteran with relapsing and remitting Multiple Sclerosis may not qualify under the 6 months of continuous care requirement, but it would be in their best interest to be in the program with a caregiver.

C. *There is a lack of evidence and standards cited for the CEAT decision.* Despite a clear legislative mandate for an explanation of evidence used and why the veteran-caregiver dyad did not meet the criteria for eligibility created by the *Transparency and Effective Accountability Measures for Veteran Caregivers Act*, CEAT decisions still lack the specificity of documents used for determination and only offer generic criteria for rejection. Without having this information, once eligible veterans and caregivers are left reeling from a decision regarding injuries and needs for assistance that have not changed, while some hidden decision-making criteria has now deemed them ineligible for PCAFC. This inexplicable exiting of caregivers from the program has led to a trail of confusion, fear, anger, and resentment on the part of the caregivers and veterans. Some have gone as far to say, "The VA says I'm cured." While this seems to be hyperbole borne out of frustration, on a recent call with VSOs, representatives from the VA said that the reason for the high denial rate was that many veterans had recovered from their injuries for which they were previously found eligible. While, thankfully, some may have recovered, a person missing 90% of his frontal lobe is not going to grow it back, nor did his need for supervision change. A quadriplegic did not suddenly gain functionality, and a veteran with serious mental illness that constantly dissociates from reality did not suddenly become cured of his mental illness. But, their caregivers were all reduced. A more likely explanation in most cases is that the rules changed, leaving many whom this committee intended to qualify, ineligible or reduced in tier.

D. *VHA should be using the VBA standard of "tie goes to the veteran" as precedent to remove any ambiguity on "close calls."* While understanding that this is a stipend and not a benefit, the VBA standard for determining eligibility is relevant. Under 38USC5107(b), "In accordance with the principals that the VA is focused on veteran centric care, the Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant." In layman's terms, the tie goes to the veteran.

6. **Further steps for approval beyond the first CEAT decision:** If the veteran and caregiver make it through steps to receive an initial positive CEAT decision for tiering, then they face the additional steps of Caregiver Training and an additional, lengthy interview called the Veteran In-Home Assessment which goes into even greater detail about the veteran and caregiver's day to day interactions. At the completion of both of those steps, the CEAT then does a final review and if approved the caregiver is accepted

for participation in the program for a one year increment before the process starts over again.

Mental Health/Emotional Toll

When Congress passed the *MISSION Act*, in addition to expanding eligibility to future generations, they took the additional step of making it mandatory for veterans and caregivers to be allowed to give input on how the caregiver assists the veteran. This step was codified because of the understandable outcry from the community that, under the original program, they were not consulted on the veteran's daily needs and assistance provided in the home.

Unfortunately, in trying to address the need to include input from those impacted, the VA appears to have overcorrected by requiring the veteran and caregiver to participate together in the process at almost every turn. While their input is certainly needed, the ongoing and exhaustive nature of repeated interviews takes an emotional toll on those participating, as they must relive and retell the most intimate, humiliating, and private parts of their lives to complete strangers, most of which is unnecessary because it is documented in their medical record. Imagine sitting next to your seriously injured husband while describing in degrading and explicit detail the assistance you provide when he loses control of his bowels due to his brain injury. Furthermore, veterans with mental health disorders, dementia, and traumatic brain injuries often are not aware of their deficits and must now sit and listen as their parent, spouse or other family member relays the information.

During the assessment/reassessment process, the veteran and caregiver have 3 interactions/interviews with the Caregiver Support Program. In two of those interactions, the veteran and caregiver are required to list everything the veteran can no longer do and everything the caregiver has to either do for the veteran or assist the veteran in doing. According to all of the caregivers and veterans with whom we have spoken, they must do all of the interviews together. The veteran must list his own deficits and then the caregiver must describe all assistance provided. If the veteran and caregiver make it beyond the first CEAT decision, an additional interview is required that repeats the same information. If the veteran and caregiver complete all the steps and are successfully approved for the program, then there is a ninety minute quarterly check-in call that repeats the same information. And at the end of the twelve month cycle, re-assessment for participation in the program occurs. If one fails to participate in any one of these steps, then participation in the program ceases. If one "sugar-coats" the information for the emotional benefit of their loved one, then participation ceases. To our knowledge, no other federal disability support program (i.e. Social Security Disability Insurance, VA's own disability ratings schedule, etc) requires a veteran and/or caregiver to go through this experience with such frequency.

QoLF staff recently conducted a call with a number of caregivers who care for some of our nation's most seriously injured veterans, many of whom have given Congressional testimony themselves. When asked about the impact of the repeated assessments, the consensus was that they took such a psychological toll that they were not sure that they even wanted to stay in the program. One caregiver stated, "We have spent the last fifteen years focusing on every improvement our son has made, and in one week, the PCAFC reassessment process wiped that out. I had to recount everything he could not do in front of him. My son who was a nuclear engineer now struggles to put Legos together. He wept during the assessment. I asked if he could leave and was told no. As a mother, it broke my heart and I wondered if this program was worth continuing if this was the toll it took on him. When he starts to recover mentally, we have to go through it all again for the quarterly assessment."

Other formerly Tier 3 caregivers who have been denied are refusing to appeal because of the mental health toll the evaluation takes on their veterans and themselves. One caregiver whose husband cannot even get out of bed without assistance stated, "When my husband received notice that he was being removed from the program, he was both angry, and relieved. Knowing that he still has to depend on me for daily support, only now he knows I have to do it without any [financial] support from the VA. He was also relieved that he will no longer have to sit through an appointment every three months where he must describe in excruciating detail the things that he, as a grown man, can no longer do without the support of another person. For that reason has chosen not to pursue an appeal at this time, even though he knows that it is unfair to me. The relief that he feels knowing that he will no longer have to be humiliated by an ongoing parade of new providers is a relief to me."

The reassessments for the legacy caregivers who have, in some cases, been providing care for more than fifteen years, have taken an even greater toll. One such caregiver said, "The indignity of being forced to repeat all of [the veteran's] disabilities each time we have quarterly and annual assessments is unacceptable. This year alone, within the span of one week in January, [the veteran] and I spent almost 7 hours… listing IN DETAIL all of the activities of daily living [the veteran] cannot perform for himself, the level of assistance needed. I was also asked if he needed a consult for sexual function ([the veteran] does not date). I don't need to tell you my heartbreak and concern as I watched our typically upbeat, cheerful son spend time in his room quietly staring into the distance in the days that followed. We spent all our time distracting him with games, movies and a busy schedule to break him out of the funk. All created by THE organization mandated to care for him and to support me. What causes the most stress for me coordinators and assessors ask? The caregiver support programs cause the most angst and stress in my life."

While Congress did mandate periodic reviews and veteran and caregiver participation should be welcome, it did not mandate quarterly check-ins and annual reviews. You certainly did not mandate that these interviews needed to be conducted with both veteran and caregiver together for the entirety of the assessments. It is not necessary, and, in fact, it may be detrimental, for a veteran to be present while a caregiver lists all of the assistance that they have to provide due to the veteran's injury. Alone, the caregiver can give an honest accounting of the veteran's deficits in the home, and the VA can use medical records as evidence. Please note, while the caregivers with whom we have spoken and for whom we have done appeals have universally stated that this dual participation is required, we do not know if this is standard operating procedure because we have never received the requested documents detailing this portion of the program.

As we focus on policy, sometimes what seems a trivial practical requirement actually has a much more lasting and unintended devastating impact. These are human beings, who, in many cases, have devoted their lives to assisting their loved ones. We owe them the respect that comes with listening to what matters to them. Unfortunately, however, according to another caregiver, after she submitted information to the VA, she was told "I should feel 'lucky' that I had not been totally removed from the caregiver system because they were trying to get all the Legacy caregivers off the system. My husband gave more than 20 years of his life serving his country and can no longer function as he once did, and I should feel lucky? I find that statement offensive and appalling."

In a time where mental health treatment and lowering suicide rates are touted as being a priority, the assessment for the PCAFC is creating a mental health crisis for already vulnerable veterans and families. While on the surface, it seems a trivial requirement, many caregivers report that it takes weeks for their veteran to recover from the quarterly interviews done by the Caregiver Support Program, only to turn around and do it again in a short timeframe.

Conclusion

VA has shared that there is an over 80% denial rate for the initial wave of newly eligible applicants. Official information regarding Legacy caregivers--those post 9/11 caregivers who were enrolled in the original program--is still pending, but our caseload indicates a high number of denials and drops in tier. Given the information presented above, we respectfully ask the Committee to work with the VA and when appropriate, relevant non-profit organizations, on the following items:

- Given the number of places outlined above that a caregiver's application can go awry, the Quality of Life Foundation asks for an immediate moratorium on reassessments until a thorough review of the issues previously mentioned can be completed. In the meantime, reinstate at least Tier 3 Legacy participants, and review the Tier 1 and Tier 2 drops to make sure that specialists, instead of or in addition to the PCM, have the opportunity to clinically review applications prior to determination.
- Work with the VA to realign the program with Congressional intent. Specifically address the population Congress intended to include in this program and the more stringent standards implemented by the VA.
- Increase transparency related to the decision-making process. VA needs to make full assessments, instruments, and decision-making criteria available, including training materials to ensure that caregivers, veterans and advocates have a clear picture of the criteria being used to determine eligibility.
- As part of the CEAT review, immediately re-draft the problematic question mentioned above. Rather than, "Is the veteran unable to self-sustain in the community?," ask instead, "Is the veteran able to self-sustain in the community?" Following our review of cases, this simple change could address a number of unintended lowering of tier level.
- Immediately change the requirement and re-train staff that the veteran does not have to be present for the caregiver's interview and lengthen the timeframe for check-ins and reassessments to lessen the burden on caregivers and veterans.
- While we fully recognize the need to evaluate all of those who apply for the program, we ask that the process for those being re-assessed, especially those who have already sacrificed for so many years to be a family caregiver, be modified to reflect the years of service, "on-the-job" training, and medical evidence that has previously been considered for eligibility under the original program.

- Require VHA to honor its “duty to assist” standard. Ensure that specialists are consulted and that records are obtained from outside providers before files are sent for review.

Mr. Chairman, the Quality of Life Foundation thanks you for holding this hearing and for the opportunity to be here today. We look forward to answering any questions you may have.

Enclosure: Compilation of Educational Materials Prepared by Quality of Life Foundation

Application Process of the Program of Comprehensive Assistance for Family Caregivers
(Legacy and New Participants)
As Compiled by Quality of Life Foundation

Background

The VA MISSION Act of 2018 created a new standard for the VA's Caregiver Support Program's (CSP) Program of Comprehensive Assistance for Family Caregivers (PCAFC). It also expanded eligibility beyond Post 9/11 caregivers. These changes prompted a revision in the evaluation process which VA established in CFR RIN 2900-AQ48 issued October 1, 2020. The new standards are defined in VHA Directive 1152(1) issued October 1, 2020. Two significant changes are: (1) the Activities of Daily Living (ADL) standard requires care to be provided "each and every time" an ADL is performed and (2) the standard for Supervision, Protection, and Instruction (SPI) now requires "continuous daily care".

Application and Evaluation Process

The following outlines the steps of the evaluation process that the Caregiver Support Program uses to determine if a veteran qualifies for the Program of Comprehensive Assistance for Family Caregivers. The process utilizes standardized forms available through VHA and posted in medical records. The forms cannot be altered.

For applicants (including non-Post 9/11 veterans), the evaluation process for PCAFC begins with the submission of your VA Form 10-10 CG, Step 1 below. The local Caregiver Support Program handles the review process for both new and Legacy applicants,

Steps

1. **Veteran Application Intake**-- (This is called the Reassessment Interview for Legacy Participants—a Post 9/11 caregiver that was in the Program before 10/1/2020.) This form gathers basic information such as dates of service of the veteran, rated disabilities, and other biographical and logistical information about the veteran and caregiver. It includes basic information about age, address, etc.

2. **Veteran Assessment**- This is an interview in which both the veteran and caregiver are asked a set of questions. The interviewer may ask what the veteran is rated for, what diagnoses they have, and what medications they are on. Even if they do not ask these questions, you should check with the interviewer to make sure all of this information is complete and correct because it is an important evaluation requirement. The VA CSP interviewer usually just copies and pastes this information out of the record. Again, you should carefully review this information once it is placed into MyHealtheVet because it is not uncommon to have errors that are best corrected at this time. Do not trust that the VA has the ratings, diagnoses, or medications correct.

This is also the time to tell the VA CSP if the veteran sees outside doctors. If the veteran sees outside doctors, then please gather those records from those doctors, including community care doctors. Do NOT assume that VA has them.

There will be a standard set of questions that the interviewer, usually a social worker, will ask both the veteran and the caregiver about what the veteran's employment, educational, substance abuse/mental health history, etc. are. The interview will move on to history of pain, dietary concerns, daily diet, exercise routine, etc. The interview will also include other topics such as treatment goals and changes in health. The interviewer will ask the veteran if (s)he feels that the caregiver is supporting their treatment goals. The last question for the veteran will be about home services the VA provides.

In the caregiver portion of the interview, there are specific questions about how the caregiver provides assistance with each ADL. If you have been at this for a long time, it is helpful to write down what you do each day to make sure that you capture all of the assistance you are providing and how you do so. (Some of it becomes so rote that you forget that it actually is a caregiver duty.)

They will also ask if the caregiver has concerns about the veteran's sleeping habits, memory, treatment goals, concerns for the veteran's safety, preparations the caregiver has in place if they are going to be away from the veteran, and if there are any concerns that the caregiver has about the veteran. This is your chance to list all the extra concerns about the veteran's care that you have or duties which you perform that you have not been able to fit in one of the above answers.

If you have a VA fiduciary, this is your time to say so. When this information is posted to MyHealtheVet, make sure that it is accurate, and if not, email in the changes you would like to see notated.

3. **Veteran Functional Assessment**— This functional assessment/interview is done by a different person than the Veteran Assessment. They will NOT have read your answers to the Veteran assessment, so give complete answers to questions they may ask and provide information you feel is relevant to the assessments they are doing.

   The Veteran Functional Assessment is required to be performed by a health professional, most likely the nurse assigned to the Caregiver Support Program. VA has very specific definitions of each ADL and Supervision, Protection, and Instruction criteria. (See the sheet on ADL and SPI evaluations.) The CSP staff will request the caregiver describe what they do for the veteran for each ADL. Be as specific and as expansive as possible. Describe what makes it necessary for you to do each thing for the veteran—for example in toileting, if you say I must clean the veteran's bottom after defecating each time, say why—such as he is missing both arms. Always say what you do, why you do it, and how often you do it (each time, daily, weekly, monthly, etc.)

For the safety and supervision portion of the assessment, they will ask a set of specific questions. Expound on each and every question that is relevant. Answer with what you do, why you do it, and how often you do it. Never just say, "I help with medication management." Instead say, "I help with medication management of ___# of medications because the veteran cannot manage them due to _____________ and I have to do this (each time, daily, weekly, monthly), however often you have to do it. If meds are given, once a day say that. If you monitor medication the veteran is taking, explain why you have to do that. If you have to monitor the friends and family of the veteran because they are easily exploitable due to judgement issues, say so, and explain what disability causes that to be so, and how often/in what situations it happens.

There will be a series of questions about self-direction, exploitation, self-neglect, memory, etc. Once again, be very specific. State what diagnosis requires you to do each thing and how often. The Caregiver Support Personnel will write down your answers, but then they are required to assign the veteran/caregiver a functional level based on each ADL or SPI (See the Sheet on ADL and SPI evaluations to follow). At the end, it is important that you add whatever concerns you have or duties you perform that have not yet been covered. Make sure you read over of the information recorded during this assessment and correct any misinformation as soon as this information is uploaded to MyHealtheVet.

4. **PCM Collaboration**—The Caregiver Support Program team is required to contact the Primary Care Manager (PCM) in order to ask a few questions. The question that appears to be weighted most heavily is, "Without a caregiver, would the veteran require institutionalization?" Another key question is, "Does the caregiver understand the treatment plan?"

   Normally, this questionnaire is only sent to the PCM. HOWEVER, it is strongly suggested that you urge the CSP to ask questions of the veteran's other specialized doctors. For example, if your caregiving centers on Alzheimer's, urge the CSP to talk to the neurologist who manages the condition. If the caregiving needs revolve around a spinal cord injury, then the person who manages the chronic pain, the doctor who orders PT, the physical therapist, etc. should also be contacted.

For mental health disorders, ask them to reference the last neuropsych examination, talk to the treating psychiatrist and psychologist/LCSW (licensed clinical social worker). Note that the standardized evaluation form only requires the CSP team and PCM to go back 12 months from the date of the start of the Legacy review. Therefore, you need to tell the assessor specific concerns that may not have been addressed in the past 12 months, but lend credence to the need for a caregiver—things such as a neuropsych assessment, loss of part of the brain or the body, or the extent of a spinal cord injury. Do NOT depend on your doctors to do this paperwork. Read it over when it is entered in MyHealthEVet to make sure that it is accurate and get it corrected immediately, if necessary.

Once all these pieces are completed, the assessment is sent off to the Centralized Eligibility Assessment Team (CEAT). The decision is made at that level by a team of medical staff that is separate from your local Caregiver Support Program team. The CEAT notifies your team of their decision, and your local team will notify you of the CEAT decision. The target timeline from application submission to initial approval/denial determination is 90 days.

If the veteran and caregiver are approved for the program, several more steps must be completed before the veteran and caregiver are able to receive pay. These include: (1) caregiver training and (2) an in home assessment of health of both the veteran and caregiver. This in home assessment is to ensure the caregiver is able to provide care safely (both mentally and physically). After these steps, the application returns to the CEAT for final approval. Pay is backdated to the date of the application to the program.

If the veteran and caregiver are denied, the veteran and caregiver will be referred to the Program of General Caregiver Support Services.

Assessment of the Activities of Daily Living as Compiled by Quality of Life Foundation

Background

The VA MISSION Act of 2018 created a new standard for the VA's Caregiver Support Program's (CSP) Program of Comprehensive Assistance for Family Caregivers (PCAFC). It also expanded eligibility beyond Post 9/11 caregivers. These changes prompted a revision in the evaluation process which VA established in CFR RIN 2900-AQ48 issued October 1, 2020. The new standards are defined in VHA Directive 1152(1) issued October 1, 2020. Two significant changes are: (1) the Activities of Daily Living (ADL) standard requires care to be provided "each and every time" an ADL is performed and (2) the standard for Supervision, Protection, and Instruction (SPI) now requires "continuous daily care". This sheet describes only the part of the Veteran's Functional Assessment Instrument that deals with Activities of Daily Living (ADL's).

How To Prepare for the Evaluation:

Under the application process step known as the Veteran's Functional Assessment, a nurse with the Caregiver Support Program will ask you, the caregiver, and the veteran how you assist with each Activity of Daily Living (ADL) listed below. If you have been providing care for a long time, it is helpful to write down what you do each day to make sure that you capture all of the assistance you are providing and how you do so. (Some of it becomes so rote that you forget it is actually a caregiver duty.)

During the assessment, be as specific and as expansive as possible. Describe what makes it necessary for you to do each thing for the veteran—for example in toileting, if you say I must clean the veteran's bottom after defecating each time, say why—such as he is missing both arms. Always say what you do, why you do it, and how often you do it (each time, daily, weekly, monthly, etc.)

Activities of Daily Living (ADL's)

1. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before a person. (This does NOT include meal planning or preparation.)
2. Grooming: Broken down into two parts
   a. Oral hygiene: The ability to use suitable items to clean teeth or dentures and/or the ability to insert/remove dentures into/from the mouth, and manage denture soaking and rinsing with use of equipment.)
   b. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
3. Bathing: The ability to bathe self, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower or reminders to bathe.
4. Dressing: This is divided into three parts
   a. Upper body dressing: The ability to dress/undress above the waist, including fasteners, if applicable
   b. Lower body dressing: the ability to dress/undress below the waist, including fasteners
   c. Putting on/taking off footwear: The ability to put on and take off footwear that is appropriate for safe mobility, including fasteners, if applicable.

5. Toileting hygiene: The ability to maintain perineal/menstrual hygiene and adjust clothes before/after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing the equipment.
6. Prosthetics (Use of Assistive devices): (This includes only prosthetic or orthopedic devices that replaces or supports a body part or function of a body part, does not include supports, belts, lacing at back, etc.) Ability to adjust special prosthetic or orthopedic appliances.
7. Mobility: This falls under two parts
    a. Positioning/Transfers: This falls into six parts:
        i. Roll left and right: the ability to roll from lying on back to left and right side, and return to lying on back
        ii. Sit to lying: The ability to move from sitting the side of the bed to lying flat on the bed
        iii. Lying to sitting on side of bed: the ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor and with no back support.
        iv. Sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed
        v. Chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair or wheelchair
        vi. Toilet transfer: The ability to get on and off a toilet or commode
    b. Mobility (Walking, Manual Wheelchair, Motorized Wheelchair /Scooter): This includes a variety of tasks depending on the type of ambulation. Each form of ambulation should be asked about and the tasks performed for each type of ambulation the veteran uses.

How the Assistance Provided is Evaluated

Once you, the caregiver, and the veteran have described the assistance you give to the veteran, the Caregiver Support Program nurse will then assign a level to the veteran's ability to function for each ADL that best describes his/her level of functioning EACH AND EVERY TIME s/he performs the task. This is based on the description you provide. The levels of functioning are as follows:

1. Independent: Person completes the activity by him/herself with no assistance from a helper.
2. Setup/Clean-up Assistance: Helper sets up or cleans up, person completes activity on their own.
3. Supervision or Touching Assistance: Helper provides verbal cues and/or touching/steadying assistance as person completes an activity. Assistance may be provided throughout the activity or intermittently. (This does NOT include reminders to perform the ADL.)
4. Partial/Moderate Assistance: Helper provides less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
5. Substantial/Maximal Assistance: Helper doe more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
6. Dependent: Helper does all the effort. Person does none of the effort to complete the activity. Or the assistance of two or more helpers is required to complete the activity.
7. Person refused: Person chooses not to respond to a question for any reason.
8. Not attempted: Person did not attempt this activity or task because there is a short-term medication condition that precludes the person from performing per physician orders. OR

due to safety concerns the person did not attempt to do the activity due to the likelihood of a negative health outcome.

9. Not applicable: This specific activity or task is not something that the person typically completes. This is not because the person cannot complete the task.

Finally

Once this assessment is uploaded to MyHealtheVet, look over the assessment to make sure that it accurately reflects the veteran's functional ability and your description of the assistance that you provide the veteran.

Assessment of Supervision, Protection, and Instruction as Compiled by Quality of Life Foundation

Background

The VA MISSION Act of 2018 created a new standard for the VA's Caregiver Support Program's (CSP) Program of Comprehensive Assistance for Family Caregivers (PCAFC). It also expanded eligibility beyond Post 9/11 caregivers. These changes prompted a revision in the evaluation process which VA established in CFR RIN 2900-AQ48 issued October 1, 2020. The new standards are defined in VHA Directive 1152(1) issued October 1, 2020. Two significant changes are: (1) the Activities of Daily Living (ADL) standard requires care to be provided "each and every time" an ADL is performed and (2) the standard for Supervision, Protection, and Instruction (SPI) now requires "continuous daily care". This sheet describes only the part of the Veteran's Functional Assessment Instrument that deals with Supervision, Protection, and Instruction.

How To Prepare for the Evaluation:

Under the application process step known as the Veteran's Functional Assessment, a nurse with the Caregiver Support Program will ask you, the caregiver, and the veteran how you assist with each aspect of Supervision, Protection, and Instruction listed below. If you have been providing care for a long time, it is helpful to write down what you do each day to make sure that you capture all the assistance you are providing and how you do so. (Some of it becomes so rote that you forget it is a caregiver duty.)

During the assessment, be as specific and as expansive as possible. The CSP staff will request the caregiver describe what they do for the veteran for each aspect of Supervision, Protection, and Instruction. Describe what makes it necessary for you to do each thing for the veteran.

For the safety and supervision portion of the assessment, they will ask a set of specific questions. Expound on each and every question that is relevant. Answer with what you do, why you do it, and how often you do it. Never just say, "I help with medication management." Instead say, "I help with medication management of ___# of medications because the veteran cannot manage them due to _____________ and I must do this (each time, daily, weekly, monthly), however often you have to do it. If meds are given, once a day say that. If you monitor medication the veteran is taking, explain why you have to do that. If you must monitor the friends and family of the veteran because they are easily exploitable due to judgement issues, say so, and explain what disability causes that to be so, and how often/in what situations it happens.

Aspects of Supervision, Protection, and Instruction

1. Medication management: The caregiver's role may be defined as no help or supervision, medication setup, visual or verbal reminders, or medication administration.
2. Self-preservation: The judgement and physical ability to cope, make appropriate decisions and take action in a changing or potential harmful situation.
3. Self-neglect: The veteran may ignore the need to care for themselves due to or through:
    a. substance abuse that leads to health and safety concerns,
    b. behaviors that pose a threat of harm to self or others,
    c. dehydration or malnutrition,

    d. hygiene that may compromise health,
    e. impairment of orientation, memory reasoning/judgment,
    f. inability to manage medication or to seek medical treatment that may threaten health or safety and/or,
    g. unsafe/unhealthy living conditions.
4. Risk of neglect, abuse, or exploitation by another person.
5. Support level to maintain safety in the home, such as assistance with activities that require remembering, decision-making, or judgement.
6. Support level to maintain safety outside of the home, such as assistance with activities that require remembering, decision-making, or judgement.
7. Delusions/hallucinations: Person engages in markedly inappropriate behavior that affects a person's daily functioning and social interactions. Behavior is characterized by a radical change personality and a distorted or diminished sense of reality which may be displayed as catatonic behavior, delusions, disorganized speech, hallucinations, or though disorder.
8. Agitation: Person has a tendency, or would without intervention, to become suddenly or quickly upset or violent as displayed through agitation, anger, or frustration.
9. Impulsivity: Person has a propensity, or would without an intervention, for sudden or spontaneous decisions or actions which may be displayed as a disregard for personal safety
10. Self-direction: This is based on legal capacity. Is the veteran able to identify their own needs? Can this person provide/arrange for their health and safety?

How the Assistance Provided is Evaluated

Once you, the caregiver, and the veteran have described the assistance provided to the veteran, the Caregiver Support Program nurse will notate the veteran's level of functioning based on interventions needed and how often they are needed. This is based on the description you provide. The answers will help determine if assistance is needed from a caregiver to maintain a veteran's personal safety on a DAILY basis.

Finally

Once this assessment is uploaded to MyHealtheVet, look over the assessment to make sure that it accurately reflects the veteran's functional ability and your description of the assistance that you provide the veteran.

PCAFC Qualifying Criteria for the Veteran

1. The member is either a veteran or a member of the Armed Forces undergoing a medical discharge?
2. The individual has a serious injury incurred or aggravated in the line of duty or active military, naval, or air service: on or after Sept 11, 2001, or before May 7, 1975?
3. The individual is in need of personal care services for a minimum of six continuous months base on any one of the following: an inability to perform an activity of daily living (ADL) or a need for supervision, protection, and instruction (SPI)?
    a. Is the individual unable to perform an activity of daily living?
    b. Is the individual in need of supervision or protection based on symptoms or residuals of neurological or other impairment or injury?
    c. Is the individual unable to self-sustain in the community?
4. It is in the best interest of the individual to participate in the program?
5. Personal care services that would be provided by the family caregiver will not simultaneously and regularly be provided by or through another program?
6. The individual receives care at home or will do so if VA designates a family caregiver?
7. The individual receives ongoing care for a primary care team or will do so if VA designates a family caregiver?