



Testimony

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of Representatives

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VA HEALTH CARE

Improvements Needed to Manage Higher-Than- Expected Demand for the Family Caregiver Program

Statement of Randall B. Williamson
Director, Health Care

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

I am pleased to be here today to discuss improvements needed to manage the higher-than-expected demand for caregiver support services provided by the Department of Veterans Affairs (VA). My statement today is based on our September 2014 report that examined how the Veterans Health Administration (VHA)—which operates VA’s health care system—is implementing its Family Caregiver Program, including the types of issues that have been identified during initial implementation and our recommendations for improvement.¹ 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, and post-traumatic stress disorder. The cumulative number of post-9/11 veterans who were wounded in action was 1.3 million in 2012—nearly triple the 482,000 veterans who were wounded in action in 2001.

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.” These caregivers assist with the tasks of everyday living—as well as making and keeping appointments, helping navigate 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, time spent caregiving can lead to the loss of income, jobs, or health care insurance and can exact a substantial physical, emotional, and financial toll, according to RAND and others. 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.

To provide greater support for caregivers of post-9/11 veterans, Congress passed legislation requiring VA to establish a program to assist

¹GAO, *VA Health Care: Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program*, [GAO-14-675](#) (Washington D.C.: Sept. 18, 2014).

caregivers with the rigors of caring for seriously injured veterans.² In May 2011, VHA established the Program of Comprehensive Assistance for Family Caregivers (Family Caregiver Program) at each of its VA medical centers (VAMC) across the United States. 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 mental health services, and respite care. Additionally, primary family caregivers approved for the Family Caregiver Program may be eligible for medical 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.

For our September 2014 report, 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. 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 as of May 2014. We spoke with Caregiver Support Program officials about these data, and 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

²See 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).

information and monitoring performance to assess the ability of the Caregiver Support Program office to oversee the program as well as internal control standards for efficiency and effectiveness of operations.³

To assess program implementation 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. 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. 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 interviewed a non-generalizable sample of 11 caregivers of veterans who were approved for VHA's Family Caregiver Program at some of the VAMCs we contacted to obtain their experiences and perspectives on this program. Additional information regarding the scope and methodology of our work is available in our report.

We conducted the work in accordance with generally accepted government auditing standards.

In brief, our September 2014 report stated that

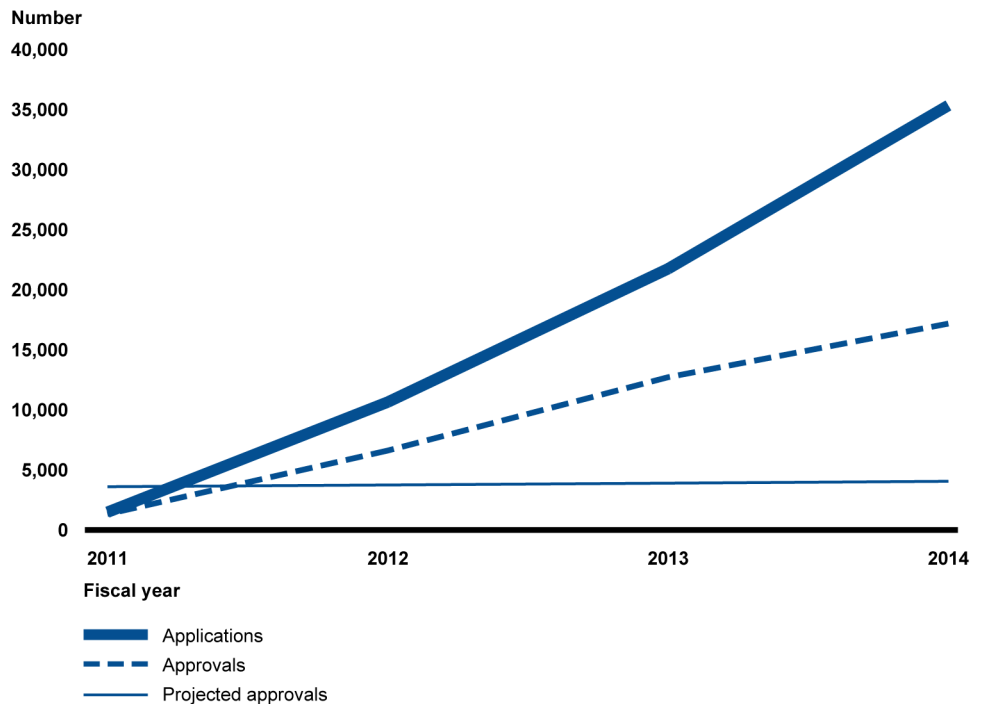
- VHA significantly underestimated caregivers' demand for services when it implemented the Family Caregiver Program. As a result, some VAMCs had difficulties managing the larger-than-expected workload, and some caregivers experienced delays in approval determinations and in receiving program benefits. VHA officials originally estimated that about 4,000 caregivers would be approved for the program by September 30, 2014.⁴ However, by May 2014 about 15,600

³GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

⁴This 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 the Department of Defense. VA's interim final rule explains the basis for this estimate. See 76 Federal Register 26148, at 26160.

caregivers had been approved—more than triple the original estimate. (See fig. 1.)

Figure 1: Number of Actual Applications and Approvals Compared to VHA's Initial Estimates of Projected Number of Approvals for Family Caregiver Program, Fiscal Years 2011-2014



Source: GAO analysis of VHA information. | GAO-15-245T

The program's staffing was based on VA's initial assumptions about the potential size of the program and consisted of placing a single CSC at each VAMC. 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 processing applications for new caregivers within 45 days and making quarterly home visits to caregivers, were 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 were being added to the program each month. 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.⁵

- 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 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. Program officials also expressed concern about the reliability of the system's data, which they must take steps to validate. 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. This is inconsistent with federal standards for internal control, which state that agencies should identify, capture, and distribute information that permits officials to perform their duties efficiently.⁶ 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. 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.⁷ Program officials told us 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

⁵See [GAO/AIMD-00-21.3.1](#).

⁶See [GAO/AIMD-00-21.3.1](#).

⁷See [GAO/AIMD-00-21.3.1](#).

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.

In conclusion, 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 that would allow it to more fully understand the program's workload and its effect on VAMCs, CSCs, and caregivers. 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.

To ensure that the Family Caregiver Program is able to meet caregivers' demand for its services, we recommended 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. We also recommended that the Secretary of the Department of Veterans Affairs direct the Undersecretary for Health to (1) 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 (2) 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 so that caregivers can receive the services they need in a timely manner.

VA concurred with our recommendations and identified actions planned or underway to address them. However, in concurring with our last recommendation to use data from the IT system, once implemented, 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. 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 its response based on actions it knew it 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.

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you or other members of the subcommittee may have at this time.

For questions about this statement, please contact Randall B. Williamson 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 this statement. Individuals making key contributions to this testimony include Bonnie Anderson, Assistant Director; Fred Caison; Jacquelyn Hamilton; and Giao Nguyen.

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