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IMPLEMENTATION OF CAREGIVER ASSISTANCE: ARE WE GETTING IT RIGHT?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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IMPLEMENTATION OF CAREGIVER ASSISTANCE: ARE WE GETTING IT RIGHT?

FRIDAY, MARCH 11, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Stearns, Bilirakis, Roe, Runyan, Michaud, Carnahan, and Donnelly.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. I want to begin by thanking all of you in attendance this morning for joining us for the very first hearing of the Subcommittee on Health of the Committee on Veterans' Affairs.

I also want to take the opportunity to say thank you on behalf of our Nation to all of the veterans in this room. We live in the greatest Nation in the history of mankind because of the service and the sacrifice of our veterans. Please allow me, on behalf of a grateful Nation, to say thank you to all of you this morning.

I am honored to have been chosen to be the Chairwoman of the Health Subcommittee. And I am very pleased that my colleague, Mr. Michaud, has been selected to be the Ranking Member.

Mr. Michaud has a distinguished history of service and support to our veterans, and I look forward to closely working with him to ensure that those who have so honorably served our country receive the highest quality care that they so much deserve. I know he shares my conviction that the very least we can do for our veterans who put themselves in harm's way is to ensure that they have excellent health care.

We are joined on the Health Subcommittee, and I will go through the whole list of Members. I will mention those who were here first, Mr. David Roe from Tennessee, and Mr. Cliff Stearns from Florida. We have Ms. Corrine Brown of Florida and Mr. Michaud from Maine.

Not here yet is Mr. Gus Bilirakis from Florida, Dr. Dan Benishek from Michigan, Mr. Jeff Denham from California, Mr. Jon Runyan from New Jersey, Mr. Russ Carnahan from Missouri, and Mr. Joe Donnelly from Indiana.

I am so pleased with the wealth and the diversity of knowledge and the experience that they all bring to this Subcommittee. I am confident that the work we are going to do will be in the best inter-

est of veterans and have a real and positive impact on the daily lives of our brave veteran heroes and their loved ones, which brings us to the matter that we are here to discuss morning.

Each one of us serves on this Committee because of a deep respect and admiration for the service and sacrifice of American veterans. Each of us serves on this Subcommittee, because we recognize the importance of ensuring that our veterans have access to high quality medical care to help them cope with the wounds of war and readjust to civilian life. Each of us here has a respect for the U.S. Department of Veterans Affairs (VA) health care system as it stands and a fervent desire to make the system even better.

At the same time, we recognize that no matter how good a health care system is, it can only go so far. We can and we must provide the highest quality of care for our veterans. But regardless of how hard we try, nothing, can equal the love and support given by a family member.

Some family members are with us this morning. In our audience is Sarah Wade and Patty Horan. Sarah is the full-time caregiver for her husband, Ted, who was injured in Iraq when his Humvee was hit by an improvised explosive device (IED). Patty is a full-time caregiver for her husband, Pat, who suffered from a gunshot wound during his service in Iraq.

If I could ask you to stand, we would like to acknowledge you and thank you for making the trip here this morning. Sarah and Patty have been there for their husbands day in and day out through every up and every down in the course of their recovery. Because of their commitment to their husbands, they have sacrificed jobs, hobbies, and personal free time.

Last year, Congress passed Public Law 111–163 to ensure that family caregivers like Sarah and Patty wouldn't also have to sacrifice their financial stability or their own health.

Congress intended for these benefits to be available by January 30th of this year. However, the Department of Veterans Affairs has failed to comply with the law and has yet to implement the caregiver assistance program.

Even more unfortunate, when the VA finally released its initial implementation plan on February 9th, it was immediately met with consternation by lawmakers and stakeholders who raised serious concerns about strict eligibility criteria and other issues, including the provision for respite care, mental health coverage, and in-home monitoring requirements.

It is my fervent hope that this morning we will bring these issues to light and uncover the necessary changes, and those changes will be made by the VA to ensure that the benefits Congress intended and veteran and family members expected and so deserve are provided without further delay.

Again, I thank you all for being here this morning. I look forward to a very positive and productive discussion.

At this time, I now recognize my colleague and Ranking Member, Mr. Michaud.

[The prepared statement of Chairwoman Buerkle appears on p. 28.]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Madam Chair. I want to congratulate you for being elected to your position as Chair of the Subcommittee, and I think it is definitely a very good bipartisan Committee. We work very well together to make sure that what we do in the Committee that we ultimately take care of the veterans and the caregivers. And I think you will find over the next 2 years, that the Committee staff, both on the Republican side and Democratic side, work very well together. So congratulations. I look forward to working with you.

And I also want to thank you for holding this hearing today. The goals of today's hearing is to identify the gaps in the implementation of Public Law 111–163, the Caregivers and Veterans Omnibus Health Service Act of 2010. We also seek a better understanding of the VA's current efforts to meet the needs of the family caregivers of our veterans.

Public Law 111–163 provides immediate support to the mothers, fathers, husbands, and wives and other family members caring for the warrior for the current conflict, as well as previous conflicts. Today, we have an opportunity to recognize their tremendous sacrifice and share the heavy burden that the caregivers give.

As you heard earlier, we do have a couple of caregivers in the audience. And Patty and Sarah have demonstrated each and every day that family caregivers are the true backbone of the U.S. long-term care system. There are more than 50 million people who provide informal caregiving for chronically ill, disabled, or aged family members or friends in any given year, so they are to be commended.

Clearly, the family caregivers of our veterans have made great sacrifices. We have heard from family caregivers who gave up their jobs, delayed their schooling, or made other sacrifices in their own lives to take care of their loved ones.

This hearing raises questions about the VA's current efforts to help these family caregivers and whether or not there are sufficient support services available.

Today's hearing will give the Subcommittee the opportunity to better understand VA's implementation plan as required by Public Law 111–163.

Madam Chair, I would ask unanimous consent that my full statement be entered into the record and I think it is very important and look forward to hearing the panelists today as we move forward with this hearing.

Ms. BUERKLE. Thank you, Mr. Michaud, without objection.

Mr. MICHAUD. Thank you. I yield back.

[The prepared statement of Congressman Michaud appears on p. 29.]

Ms. BUERKLE. At this time I would ask our first group of panelists to come to the table.

Thank you all very much. It is my honor to introduce the four panelists this morning. Starting from my left is Adrian Atizado, who is the Assistant National Legislative Director from the Disabled American Veterans (DAV). Good morning and welcome.

Next to Mr. Atizado is Ralph Ibson, the National Policy Director for the Wounded Warrior Project (WWP). Good morning.

Next to Mr. Ibson is Tom Tarantino, who is the Senior Legislative Associate for Iraq and Afghanistan Veterans of America (IAVA). Good morning.

And next to him is Barbara Cohoon, Deputy Director of Government Relations for the National Military Family Association (NMFA). Good morning, and welcome to all of you.

Thank you all for appearing this morning to lend your knowledge and your expertise on all of these issues. I know that many of you have been working on these issues for a long time behind the scenes. I want you to know that the veterans, caregivers, and the Members of Congress appreciate all that you have done.

I would ask that you would limit your opening statements to 5 minutes and we will enter into the record your complete testimony. That way we will ensure that everyone has time to ask their questions.

We will start with Mr. Atizado.

STATEMENTS OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RALPH IBSON, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT; TOM TARANTINO, SENIOR LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND BARBARA COHOON, PH.D., R.N., GOVERNMENT RELATIONS DEPUTY DIRECTOR, NATIONAL MILITARY FAMILY ASSOCIATION

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Madam Chairwoman and Members of the Subcommittee, I would like to thank you for inviting the Disabled American Veterans, an organization of about 1.2 million members whose sole mission is to build better lives for America's disabled veterans, their families, and dependents.

We are pleased to testify on VA's implementation plan for the caregiver assistance program and whether it meets Congressional intent embodied in Title I of the Public Law.

First and foremost DAV would like to thank the 111th Congress and this Committee's staff for your hard work in passing this law. It is historic legislation, because for the first time, support benefits and services will be provided and are being tailored directly for veteran's caregivers.

Second, while eligibility is a core concern, as was mentioned, there are other concerns in the implementation plan that our organization has, and these concerns are in components as well as gateway provisions. Further detail on these matters are included in my testimony and I am sure my colleagues on this panel will speak to those specifically.

It does appear to many that VA's implementation plan does not fully comport to Congressional intent but rather misappropriates it. Now in that context, the question becomes why in VA's desire to provide a clear and consistent guideline to its front line personnel, did the Department decide to engender what appears to be a more restrictive standard across these benefits?

This question is a critical one that requires thoughtful consideration. This is to be able to foster a collaborative approach and not

create an adversarial and divisive environment to solve this very big problem in front of us today.

DAV would like to acknowledge that VA and the administration have had to its credit open communications with veteran service organizations (VSOs) and undoubtedly with other parties as well interested in this matter.

As it stands now, our concern over VA's implementation plan only serves as a reference. This is because we have turned our attention to the anticipated Interim Final Rule, the IFR.

Madam Chairwoman, the natural tendency for Federal agencies in rulemaking is to be intolerant and at times defensive once it makes a formal rule determination. However, VA has testified before the Senate that it considers the IFR to be a good start and that VA is open to suggestions.

The DAV remains cautiously optimistic that the Department will adjust accordingly to Congressional oversight, especially in light of its implementation plan and the broad concerns it raised when it was made public.

We urge this Subcommittee to ensure that VA carries out the required good faith and serious consideration of post-promulgation comments from the public on the proposed IFR. Congressional oversight is critical in this instance to ensure the IFR is not perceived as and is not allowed to become an autocratic decision.

Finally, DAV would like to take this opportunity to address three overarching concerns. One, the original legislation the law is derived from proposed to fragment and rank the veteran population. This kind of divisive provision works against the leave no one behind. This is a principle, a core belief that defines both military service and veteran's benefits.

DAV has a resolution from our membership calling for comprehensive caregiver support based on needs of injured and ill veterans of any war. Nevertheless, DAV ultimately supported the compromised legislation knowing that it would benefit the newest generation, but also allow the VA to expand the eligibility to caregivers of veterans from previous wars.

Two, VA's budget request for this program for fiscal year 2012 and 2013 is inadequate to meet Congressional intent. As we look to VA to correct regulatory inadequacies, we also look to Congress to appropriate the necessary funds for the VA to successfully implement this program.

Three, ensuring benefits provided by either VA or U.S. Department of Defense (DoD) that are aimed at assisting caregivers and families of severely disabled servicemembers or veterans are not duplicative, unequal, or otherwise unavailable.

If done properly, a thoughtful inspection followed by a well-structured alignment of current benefits and support services into a cohesive set of benefits could provide the much needed stability during an otherwise overwhelming and turbulent time.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions you or other Members may have.

[The prepared statement of Mr. Atizado appears on p. 31.]

Ms. BUERKLE. Thank you very much. Mr. Ibson.

STATEMENT OF RALPH IBSON

Mr. IBSON. Thank you. Chairman Buerkle, Ranking Member Michaud, Members of the Subcommittee, we greatly appreciate you holding this hearing and inviting WWP to testify this morning.

And we are very, very pleased that the Wades and Horans could be here, and I am honored to attempt to speak for them and for the many, many more who had placed such hope in the Caregiver Act.

Successful implementation of the caregiver assistance program and the law is our highest priority this year. But VA's implementation plan in our view is deeply flawed.

We view the restrictive eligibility criteria to be simply unlawful and to disqualify caregivers of as many as several thousand veterans, many with severe cognitive and other impairments due to traumatic brain injury (TBI).

The provisions of the Caregiver Act, indeed Title I of the Act, some 27 pages long are very detailed, very explicit as to who is eligible.

We, therefore, expect via its implementation plan to closely track the law. But its criteria not only bear no resemblance to the law, they are all together inconsistent with it. And let me offer an example. A veteran who has sustained a severe TBI in Iraq can now carry out all activities of daily living but is simply unable to live independently because of cognitive impairment, impaired judgement, and anxiety when alone in the community. His condition requires that his wife accompany him at all times and manage virtually all of the household affairs, finances, telephoning, medication management, and other activities. Without a caregiver, the veteran would need to live in a supervised setting.

But under the VA plan, this veteran would not be eligible, because the VA criteria require that a veteran be so impaired as to need hospitalization or nursing home care to be eligible under this law. As a result under the plan, the spouse would not qualify for caregiver supports.

Let me stress this is not a difficult law in terms of its eligibility. The eligibility language is plain on its face. Congress directed VA to provide specific services to the primary caregiver of the veteran who sustained a serious injury on or after 9/11, and who needs personal care services, a defined term, either because of an inability to perform one or more activities of daily living like toileting or bathing, or because the veteran needs supervision or protection based on symptoms of neurological injury or other impairment.

Congress made two specific references in this eligibility section to traumatic brain injury. First, as an example of what it meant by the terms "serious injury" and secondly to clarify the kind of condition that would give rise to a need for supervision or protection.

Notwithstanding that, VA has proposed additional restrictive requirements that would render most veterans with a severe TBI ineligible. This is profoundly troubling, since TBI is not only a signature wound of this war, it is a signature wound under this law.

Given that VA's criteria would disqualify a high percentage of families who should be eligible in our view under the law, we have particularly focused on those eligibility issues.

But the plan raises other serious problems, as well. In summary, it sets unreasonable limits on the scope of covered mental health services. It goes far too far in our view in requiring routine home visits every 90 days without regard to whether the caregiver or veteran have had any problems.

And particularly for longstanding devoted caregivers, this kind of monitoring through frequent home visits is inherently intrusive and unwarranted. At very least, a reasonable plan would provide for tapering off the frequency of that monitoring in the absence of any problems.

Finally, the plan relies on flawed criteria, which fail to take account of traumatic brain injury for determining the amount of a stipend.

Madam Chairwoman, the Caregiver Act represents a solemn promise to spouses, parents, and other family members who devotedly care for their seriously wounded loved ones. The plan in our view would break that promise.

The Administration must not speed through a regulation that covers only a fraction of those eligible. It must not abandon vulnerable veterans who cannot live independently because of cognitive or other deficits due to TBI. It must be faithful, both to the warriors and to the law.

Thank you for your attention to these deep concerns.

[The prepared statement of Mr. Ibson appears on p. 37.]

Ms. BUERKLE. Thank you, Mr. Ibson. Mr. Tarantino.

STATEMENT OF TOM TARANTINO

Mr. TARANTINO. Madam Chairwoman, Ranking Member, and Members of this Subcommittee, on behalf of Iraq and Afghanistan Veterans of America's 200,000 members and supporters, I thank you for the opportunity to testify here on implementation of the Caregivers and Veterans Omnibus Health Services Act of 2010.

My name is Tom Tarantino, and I am the Senior Legislative Associate with IAVA. I proudly served 10 years in the Army beginning my career as an enlisted reservist and leaving service as an active duty officer. During these 10 years, my family served along with me. Because of the nature of the wars in Iraq and Afghanistan, many families like mine are continuing to serve long after veterans have left service.

Wounded servicemembers are coming home to the prospect of having someone care for them for the rest of their lives. And all across this country family members are stepping up, putting aside their own lives and plans to take care of these wounded warriors.

Like IAVA supporter Natalie Cobb, she is an example of the selflessness displayed by military families across the country. Her husband, Steve, who served in Iraq in 2004, was severely wounded when a mortar exploded less than 50 feet from his patrol.

Following his deployment, Natalie immediately noticed a change in his behavior. Natalie remained by his side throughout his long recovery, and now, over 6 years later, still serves as Steve's primary caregiver.

Natalie had to learn to take care of Steve on her own. She navigated the VA by herself. Today, she manages their household while

taking care of Steve 24 hours a day, and she has not had any respite in over 6 years.

The veterans' community came together 2 years ago to help Natalie, Steve, and military families like them across the country. IAVA and all of the veteran service organizations worked closely with Congress, military families, and the caregiver community to craft a law that would meet the needs of these selfless caregivers.

And at the time, we believed that we had accomplished our mission. The Caregivers Bill was written specifically to apply to more, rather than fewer caregivers in need of support. Ralph very accurately outlined that it was extremely explicit in the law.

Now we understand the complexity of regulating this program. We also appreciate that the VA has moved forward on aspects of the law that didn't require a lot of regulation. The creation of a hotline and a Web site for caregivers that provides them with information and assistance in accessing benefits is absolutely critical. Nonetheless, we are seriously disappointed by the regulations for eligibility.

Along with representatives of our fellow veteran service organizations, I spent 2 days at the VA this past October discussing how to make sure that the law was regulated appropriately.

Now at the time, we made it clear that the goal was to ensure that all caregivers who needed help received it. In real numbers, we are really not talking about a lot of people here. We are talking roughly 3,000.

These men and women have given up everything to take care of their wounded veterans. And it is absolutely unacceptable to shortchange heroes like Natalie at a time when they need our help.

The regulations proposed by the VA are far more limiting than the bill intended. To be eligible for caregiver benefits, a veteran would have to be hospitalized if there is no caregiver present.

Now many veterans coming home from Iraq and Afghanistan might well need constant care. However, they don't need institutionalization. I want to be clear. Injuries that require caregivers and hospital care are not necessarily synonymous. And making the need for institutionalization the threshold for eligibility completely misses the goal of this legislation.

We told the VA that if they relied on specific definitions of severely injured and the need for institutionalizations as their threshold for eligibility, then far too many veterans and their families would simply not get the support their country promised them.

And the VA's explanation of why they did not take this feedback into account is simply insufficient. The VA argues that we, being the VSOs, "stated repeatedly that the intent of the law was 'to avoid having to place a veterans in institutions when home care was not a viable option.'"

And was indeed part of the intent. The main goal, however, was and remains to support a population of caregivers who are living in some places with no regular income, no health insurance just so that they can take care of veterans who can no longer take care of themselves.

Now is it hard to come up with eligibility criteria and regulate this law? Yes, it is hard. Does it mean that the only solution is to

take the easy way out and settle on restrictive criteria? Absolutely not.

IAVA and our fellow veteran service organizations are more than willing to work with officials to identify the best criteria. But as it is now the regulation should not stand.

We would like to see the law implemented properly in order to give our veteran caregivers the overdue support that they deserve. But before any part of the law is enforced, regulations on eligibility must be changed to accurately reflect the intent of the law and to ensure that we are not as a county leaving anyone behind.

Madam Chairwoman, I am grateful for this opportunity to share the thoughts of Iraq and Afghanistan veterans with this Subcommittee. And we look forward working together to solve this problem. Thank you for your time and attention. I will be happy to answer questions.

[The prepared statement of Mr. Tarantino appears on p. 44.]

Ms. BUERKLE. Thank you, Mr. Tarantino.

Dr. Cohoon.

STATEMENT OF BARBARA COHOON, PH.D., R.N.

Dr. COHOON. Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of this Subcommittee, the National Military Family Association would like to thank you for the opportunity to present testimony.

Our Association asserts that behind every wounded servicemember and veteran is a wounded family. Family members along with the caregiver are an integral part of the health care team, and their presence has been shown to improve the servicemember and veterans quality of life in aid recovery.

We are pleased with the passage of the Caregivers and Veterans Omnibus Health care Service Act of 2010 that will provide for training, compensation, and other needed benefits for caregivers. This law places the VA in an active role in recognizing caregivers' important contributions and enabling them to become better caregivers to their loved ones. It is a win-win for everyone involved.

While our Association is extremely appreciative of Members of Congress for the passage of this landmark legislation, we have some concerns regarding the VA's implementation plan not meeting the intent of Congress or the needs of the caregivers.

The VA has not met the implementation timeline for the caregiver portion of the law. Every day the VA waits to implement the caregiver provision means those who care for our wounded, ill, and injured are going without valuable resources that were intended to improve the quality of the caregiver's life and of the life they care for. It places additional stress on an already strained population. We cannot afford to put this off one more day.

The VA's eligibility establishes a much more stringent criteria than the law dictates. Many of our wounded servicemembers and veterans have mild to moderate cognitive impairment that requires caregiver support. But they certainly do not need hospitalization. The law's language was intended to capture this population. However, the VA will exclude them and subsequently their caregiver.

The plan states a servicemember and the caregiver cannot begin the application process until they receive a date of separation. We

believe this may not provide enough time for the completion of all the VA's eligibility criteria before the servicemember and the caregiver enter veteran status. More importantly, we are concerned this may impact the seamless transition of programs and services of the caregiver.

Currently, the DoD is providing a caregiver compensation benefit to the servicemember. The law states DoD's compensation stops 3 months after the servicemember has been medically retired. However, the VA's caregiver benefits do not begin until training is completed and validated by the VA. Therefore, this scenario has the potential to create a gap in monetary compensation and impact the family's financial stability.

Waiting until after the receipt of a separation date will prevent caregivers from being able to obtain benefits early enough in the recovery process to make a difference. Waiting also impacts the ability to obtain time sensitive needed benefits. This especially impacts our non-spouse caregivers.

The VA has decided to begin all of the benefits at the same time. They could very easily begin some benefits much earlier in the process.

The VA's decision to delay access to valuable training may force each Service to begin their own training program. This may cause each Service's training program to vary in its scope and practice. Therefore, it may not meet VA's training objectives. This could force the caregiver to undergo two different training programs.

Our Association appreciates VA's compensating caregivers for providing direct hands-on medical care. However, the compensation should also recognize non-medical care.

The plan states it will not include medication to caregivers for mental health. Therefore, we wonder how the coordination between the caregiver's medical provider and the person or entity providing mental health services will be accomplished.

Caregivers have enough on their plate without having to navigate the travel benefit and the burden of submitting forms. We recommend the VA should assist caregivers with this benefit.

The VA is not meeting the intent of the law regarding respite care. The intent was to add more respite care hours to the current VA policy, not keep the status quo.

The VA also needs to focus on the well being of the caregiver, making sure they are physically, mentally, and financially stable. We recommend the VA take a holistic approach to care and include the caregiver and family when monitoring the veteran. Everyone's health and well being is linked together.

The goal is for a seamless transition of caregiver benefits between DoD and VA. We ask this Subcommittee to assist in meeting that responsibility.

Our Association would like to thank you for the opportunity to present testimony today. We look forward to working with you to improve the quality of life of our veterans, their caregivers, and their families.

Thank you and I await your questions.

[The prepared statement of Dr. Cohoon appears on p. 46.]

Ms. BUERKLE. Thank you very much. We will begin questions now. Each Member will have 5 minutes. I will begin by yielding myself 5 minutes.

This question is for each of the members on the panel. Based on your expertise and all of the investigation and work you have put into looking at this law and its implementation, could each one of you identify for me what it is that you see as the single most serious deficit in the implementation of this law? And what your solution would be for that deficit. And if you just could limit your remarks so everyone would have a chance to respond, I would appreciate it.

We will start with Mr. Atizado.

Mr. ATIZADO. Chairman Buerkle, I appreciate that question. But, again, I have to caution the Committee that eligibility is only one of a number of gateway provisions in this law.

Certainly if a servicemember and their caregiver or veteran and their caregiver are deemed eligible and meet other gateway provisions that don't allow them the appropriate services, then being eligible becomes a moot point in the end.

As the other panelists have mentioned, it appears that VA's eligibility criteria does raise the bar that a caregiver and veteran must meet to be entitled or at least considered eligible. And my testimony has a specific example of that.

But I think in all—in all fairness, I believe VA has—VA clinicians know what they need to do. And I think we know what they—we know what we want them to do. And I think there seem—there may have been a little bit of misinterpretation I think on both sides.

My point is is that we all have to step back a little bit from this very emotionally charged situation, reassess ourselves, and come together on equal grounds, because I fear that no matter what we say today, if we continue down this path, we will not come to a very amicable solution.

Ms. BUERKLE. Thank you. Mr. Ibson.

Mr. IBSON. I share my colleague's view that it is difficult to isolate a single factor, because there really are a great many flaws.

But honoring your question, I do think that the imposition of very, very restrictive eligibility criteria, that are inconsistent with the law and have the affect of disqualifying three of every four caregivers who probably should be covered under this law, is the most profound of the many problems we have discussed this morning.

Ms. BUERKLE. Thank you. Mr. Tarantino.

Mr. TARANTINO. I associate myself with the comments of Adrian and Ralph. I think they are absolutely correct. You know, there are multiple issues with the regulation of this law.

But if we needed to start somewhere, we have to start at eligibility, because that is the first gateway. And, you know, if you want to look at how to do it I would suggest that they read the law, because it is pretty explicit. It is, in fact, probably the most explicit piece of legislation that I have read since I started working in this field 3 years ago.

But I actually do—and I share Adrian's term, we need to caution ourselves that we don't just stop there. That we have to actually

look at how this program—how this program is implemented holistically.

And that once if the eligibility criteria is fixed, that we don't just stop and say, great, put a win on the board and move on. This is a very complicated program, and we have to keep looking at it until we get it right.

Ms. BUERKLE. Thank you.

Dr. COHOON. Our Association feels it has to do with when you are actually going to be starting the benefits. If it is not started until all these other requirements are met, it pushes eligibility to all these benefits until further down the road. And, well maybe, several months or maybe years into veteran status.

And, we would like to see that started earlier, because our caregivers need these benefits much earlier in the process than when they will possibly be getting them.

The VA is also rolling out all the benefits at the same time. So, we feel that they should be able to start some of the benefits earlier in the process, interjecting them at the time when the caregiver actually needs them. So, that they have the resources that they need, have the right skills to be able to provide the care that they need, and, therefore, the veteran gets the care or the servicemember is getting the care that they need.

So, our concern is the fact that they are waiting until all the wickets are met before they start any of the benefits. And one of the major wickets has to be that the veteran has to be receiving care 100 percent in the home. And many of our servicemembers are still going through the recovery phases where they might be having wound revisions or maybe they are having their burns grafts taken care of.

And, so if we are waiting until 100 percent in-home care, then that could also delay either of them starting these particular benefits. That would be our concern.

Eligibility also, but starting the benefit is the biggest for us.

Ms. BUERKLE. Thank you very much.

I now yield 5 minutes to the gentleman from Maine, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair. I have a question for each of the panelists.

If you look at—I know Mr. Atizado mentioned that he doesn't feel that it is properly funded. Actually when you look at fiscal year 2010 and fiscal year 2011 there is actually no money appropriated for the Caregiver Act, and I know the VA requested $166 million. *The Independent Budget* actually recommended that just for the caregiver's piece that it is $385 million for that provision for fiscal year 2012. And I believe the Department requested $208 million for the caregiver legislation. So there is a huge gap between the two.

My question I guess for each of the panelists is why do you think that gap is so large? I know the criteria is narrowed under the VA's proposed rule. But do you have any idea why that significant gap in the proposal?

And my second part of that question is as the VA went through this process, I know the VSOs have been involved; to what extent has the VSOs been involved? And do you feel that the VA actually

listened to any of your concerns or were you just brought in at the end of the process and made a few comments?

Mr. ATIZADO. Chairman Michaud, thank you for that question. As far as answering the first part of your question with regards to the gap between both the appropriated amount or I should say the amounts dedicated to this program, as you—as all the Members here know, in the law the authorized appropriation for the law under Congress's intent was $60 million for implementation, $1.5 roughly billion, $1.54 billion over 5 years.

VA's budget request intimates that they estimated about $20 million for implementation. They also request $66 million for sections 101 through 104 for fiscal year 2012 and then about $70.6 million for 2013.

You know, we have talked about these numbers and these budgets as kind of like a bell weather of where everybody is going. But what is still unclear to our organization is that 840 or otherwise 850 individuals that the Department of Veterans Affairs has testified that their implementation plan would provide, we are not really certain whether we are comparing apples to apples as opposed to apples to oranges. It would be definitely a question that should be clarified with the Administration when they come up with the next panel.

With regard to listening to our concerns, I believe that they did. The DAV is aware that the VA operates in a different environment than all of us, all the rest of us do. Just as here today they may be listening to us and you may be listening to us, but who knows what the VA is going to end up with in their interim final rule. And we don't know what Congress is going to appropriate for this program.

So, yes, I believe they listen to us and they continue to listen to us today. In fact, it has been pretty constant throughout this process, maybe not publicly, but certainly there has been communication.

Mr. IBSON. Thank you as well for the question, Mr. Michaud.

With respect to that gap, the sense I have is that by having set such restrictive criteria, VA could cover only a relatively limited number of caregivers and projected only some 840 for next year. That is striking odds to the projections that were at play when your two Committees reached a compromise agreement and targeted a number closer to 3,500. So that gap I think accounts for the enormous disparity in budget figures.

With respect to the dialogue we have had with VA, this law is really remarkable in many respects. I think as we have said, it is remarkable for its detail, for the very careful discussion of eligibility, but also for the degree to which stakeholders were to be brought in to that process.

And from my perspective it has been somewhat disappointing. We were consulted somewhat last-minute toward the end of VA's process. We indeed did have robust discussions for several hours over the course of 2 days.

Unfortunately, we never had a template with which to work. We did not have a draft VA implementation plan against which to comment. We did not see a final proposed implementation plan before it went to the Office of Management and Budget (OMB). We re-

main in the dark with respect to the content of interim final regulations.

I, and I think my colleagues, have offered advice to VA, to include middle ground proposals. But is as though we had shouted into a forest. There has been no return to that conversation.

And were this a more transparent process, aligned with what I think the intent of the law was, we probably would not have the kind of disparity that we face today. And so I am personally disappointed at that.

Thank you.

Ms. BUERKLE. Thank you.

Mr. Stearns from Florida.

Mr. STEARNS. Thank you, Madam Chair.

Dr. Cohoon, the questions I have are for you. What, if any, services does the Department of Defense provide to caregivers? And do you anticipate the caregiver assistance program in Public Law 111–163 will have any affect on these benefits?

Dr. COHOON. The DoD does offer a lot of benefits for the servicemember and for the family member. It depends upon if the family member is a spouse, therefore, qualifies for benefits, because they are married, or if they—are a non-spouse, as mom or dad or a sibling as what sort of benefits they have access to.

Currently, in the military treatment facilities, those that are on invitational travel orders up to three are provided on a space available basis care within a military treatment facility. And, so they are allowed to get free health care through DoD.

They are also allowed to be able to have the same care through the VA. So, if the servicemember was getting care in a polytrauma center, they themselves would also have access to the same care. We are under the impression that the VA has not implemented this particular program.

The National Defense Authorization Act 2 years ago included a caregiver compensation that is paid directly to the servicemember if they have a caregiver. And, the definition is catastrophically ill and injured. The amount was originally tied to aid and attendance.

Last year, the National Defense Authorization Act made some changes to that particular law where it is still tied to the aid and attendance until the VA comes forward with their particular eligibility criteria and the stipend that they are going to be being paid. Therefore, they would align a little bit better.

There are several places in which there are some disparities, the definition within the National Defense Authorization Act as far as the servicemember qualifying versus the VA. It is injured and ill and it is catastrophic in DoD. Where the VA it is not clear if illness is even included. Also too as far as the health care piece, which I described. Training, if we look at training, the VA is going to be providing training. But, currently right now DoD is not providing any training. And, where and when will that start. The stipend will be the same as far as what the caregiver would be receiving directly through the servicemember regarding the compensation piece now the VA has come out with their implementation. There is some issue as far as mental health services as well, sir.

Mr. STEARNS. Let me follow up. I think in your opening statement you said, "It appears the VA is focused exclusively on the

care and well being of the veteran rather than making sure the caregiver is also physically, mentally, and financially stable."

So I guess the question is this in-home monitoring, is that not also a benefit to the caregiver who will have many opportunities to interact with the VA regarding additional needs, and concerns, and success? And I guess is there a balance that we have to strike here between, you know, assuring that you have proper and appropriate care as provided to the veteran and at the same time opportunity to check on the well being of the caregiver?

Dr. COHOON. Yes, sir. Our organization is asking that the VA, while they are doing all of this monitoring on the veteran, they should also be making sure that they are monitoring how well the caregiver is doing, because it is often shown that the caregiver will be the last person they will look at as far as taking care of themselves, and to look internally when you are the caregiver.

So it is important when the VA is monitoring the veteran they also have an opportunity to put eyes on the caregiver to see how they are doing and also making sure that they make recommendations if they need to go see a doctor or asking are they utilizing enough respite care.

And, when you read the implementation plan, it dictates as far as what they are looking for in the veteran. But there isn't anything in there as far as what they are going to be looking at as far as the caregiver's well being.

Mr. STEARNS. For how long of a period is this monitoring by the VA on the caregiver?

Dr. COHOON. Well the monitoring doesn't start until the caregiver qualifies for the benefits. And then they monitor on three different bases. And I think Ralph alluded to that as far as the amount of times.

Mr. STEARNS. Okay. Thank you, Madam Chair.

Ms. BUERKLE. Thank you. I yield 5 minutes to the gentleman from Indiana, Mr. Donnelly.

Mr. DONNELLY. Thank you very much, Madam Chair.

This question is for everyone. In regards to traumatic brain injury or TBI, which is often considered the signature wound of the Afghanistan and Iraq wars, do you believe the current criteria in this implementation plan sufficiently understands the nature of that injury and will enable coverage for our vets who have suffered this injury?

Mr. Atizado, if you would lead off.

Mr. ATIZADO. Thank you, Mr. Donnelly.

In my testimony, I outline a number of issues with regards to the VA's implementation plan in making sure that veterans, I am sorry, caregivers of veterans who suffer from traumatic brain injury are provided the appropriate services and support that they need.

Generally this is determined by assessing not only the veteran's need as well as the caregiver's need. And it appears that there is—there was no such tool included in the plan. In fact, the plan talks about two specific assessment instruments, the Katz Scale and something called patient behavioral scale. I think anybody who has worked around this issue is well aware of what the Katz Scale is. I am not familiar with the patient behavioral scale.

But there is certainly nothing that would otherwise be able to capture the needs of the veteran and thus the needs of the caregiver who is suffering from traumatic brain injury. This is a very different injury and has very different needs assessment requirements from one that is suffering from a physical disability or that that is suffering from mental health disability.

And I would urge the VA to take this into consideration, because this is a prevalent injury that servicemembers are suffering from from wars in Iraq and Afghanistan.

Mr. DONNELLY. Thank you. Mr. Ibson.

Mr. IBSON. Thank you for the question, Mr. Donnelly. I happen to have spoken the day before yesterday with a single mom in Texas who has been caring for her son who sustained a gunshot wound, very like the wound that Representative Giffords sustained.

This young man has regained most of his capacity to carry out activities of daily living. He can walk; he can bathe himself, toilet, et cetera. But he cannot be left alone. He cannot be left alone. Now if this young man were assessed under VA's criteria, clinicians would likely conclude that he would not require hospitalization or nursing home care. So, he would be ineligible.

His mom, 4 years ago, gave up her job, moved from Pennsylvania—well, actually flew from Pennsylvania to Germany to be at his bedside, relocated to Tampa, Florida, subsequently relocated to Texas where her health is failing in the strain of caregiving. She has no income whatsoever.

Mr. DONNELLY. Is the relocation to Texas, because that is the closest facility that can provide assistance to him as well in the VA world?

Mr. IBSON. I think she was unhappy with the care that he was receiving in Florida and moved to Texas in order to get better care.

You know, the concern that I had for her situation and the concern she, of course, has is that under the criteria in terms of need for nursing home care, as well as the criterion that speaks to the individual being at high risk for personal safety, which is a pretty high threshold, he would be deemed ineligible and she would not qualify for comprehensive supports.

This young man may not be at that high a risk. But he is certainly well within the meaning of the law, which as I indicated earlier, twice speaks to traumatic brain injury as a point of reference to make it crystal clear that young men and women as badly injured as he is who have regained physical capacities but cannot live independently should be covered under the law yet would not be under VA's plan.

Mr. DONNELLY. Thank you. I apologize, Mr. Tarantino and Dr. Cohoon, I am out of time. But we appreciate your answers to that question. Thank you.

Ms. BUERKLE. Thank you. I yield now to the gentleman from Tennessee, Mr. Roe.

Mr. ROE. Thank you for yielding. Well, first I want to introduce a guest I have with me today, Ann Reuschel. Ann, if you would stand. Ann does my VA work back in the district. Her husband was a victim of Agent Orange from the Vietnam War, and so she has been a caregiver herself.

Ann, thank you for being here, the intent of this law in Congress was to aid people who are assisting wounded warriors. That was the intent of the law. Not to make it so complicated that nobody could possibly figure out how to get this help.

I am going to tell you a story, just a brief story, about an encounter and I said this the other day, a little less in detail, about a veteran's wife that I saw who was 64 years old. Her husband was shot through the chest in Vietnam in 1966. This woman, 19 years old with one child, has taken care of him for 40 years. And this man would have died, no doubt in my mind about it, had he been left to an institution or whatever.

I looked at the ten things that she had to go through, medication management, vital signs, pain control, infection control, nutrition, and on, and on, and on. She took care of him without any of this training.

He was told by physicians that his life expectancy probably was 7 years at that time, and I certainly believe it would have—as a physician I believe this was true, were it not for the unbelievable care that this caregiver gave.

Now she is 64 years old and is not eligible for Social Security, because she didn't have a job during that time. She was taking care of her family, her husband and her child; and her husband got to watch their child grow up. So we as a Nation can never repay her for what she has done. I don't know how we are going to. But we are going to try.

I just looked at the minimal amount of money that the caregivers are given. And it is not a lot of money. Just her caregiving, not the institutional, the time that he would have been in a hospital that would have paid for it, is over $1 million. This woman has given her husband over $1 million in care.

And I say this to these young families out there, because I want you to understand that there were a group of veterans and their families who were left alone after the Vietnam War, after World War II, and quite frankly every war up until today.

It is now time to get this right. And I honestly believe we can. And I know that is the intent of this Congress, both the Democrats and Republicans, is to get this right.

I could go on about her, because I think she is one of the true American heroes of this country. I really believe it. I am getting a little emotional, but I believe that. I truly do.

So the questions I have, and we can get them answered later in writing, is how long, and how, and who has to do this training? I want to know how much of the resources go to the trainers and to the clipboard carriers and not to the actual caregivers. That will be for a later panel.

No one visited her home every 90 days. And yet she gave wonderful care. Why? Because she loved her husband. That is why. She loved her family. And that is why most of these family members, as Mr. Donnelly pointed out do this. They do this because they love their families. And it is time we stopped piddling around, and get this right, and get these resources to these families who give up their Social Security, their jobs, and their careers.

Two years ago we had the folks in for the Veterans Integrated Service Network (VISN). One young woman was at Duke University and gave up her career to take care of her blinded husband.

I don't know how much to go into the administration of this. The absolute majority of this money needs to go to the caregivers, to the folks out there every day. And this is hard work. I mean the work that this woman did was bowel evacuation, wound care, and on and on. Stuff that is really not a lot of fun every day was done because they love their families.

And I didn't mean to use all my time giving a speech. But it meant a lot to me to meet this family. And I see these young family members out here who are doing exactly that to their families. And thank you every single day from this veteran to you for what you do.

And if you have any comments fine or otherwise I will yield back my time.

Mr. ATIZADO. Mr. Roe, I can certainly appreciate your comments. And I want to thank you, ma'am, for what you do. Our membership is predominantly, just by virtue of reality, Vietnam veterans, Korean, Persian Gulf, other conflicts, and now Iraq and Afghanistan veterans.

But I have to say we are deeply concerned about the stance that has been taken on monitoring. I can tell you, sir, ma'am, that monitoring is not intended as a punitive nature. It is not intended to—it is not intended as a safeguard against those that are well meaning or doing a good job.

In fact, if you look at advocacy groups, grass root advocacy groups, of caregivers, both of the disability and the aging movement, are very well aware of the necessary—of the need for monitoring, for the need for self-assessment. Some of these caregivers who are extremely committed forget that they have to take care of themselves. There have to be fresh eyes to make sure that the caregiver's well being is attended to. That they themselves don't forget about themselves, much less the veterans.

And I can tell you—I can tell you that if there is a proposal to remove the monitoring aspect of this, which is not only a safeguard for the veteran and the caregiver, but the credibility of this program, I think that would be a very poor choice.

Ms. BUERKLE. Thank you, Mr. Atizado.

Mr. ROE. I yield back.

Ms. BUERKLE. Thank you. I yield to the gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. Thank you, Madam Chair.

You kind of just talked where I wanted to go. I have had some personal experiences in my life with care. I had a grandmother who suffered from Alzheimer's for 13 years. We went through much of the same issues, which led me directly to becoming very involved in the Alzheimer's Association.

In dealing with that, we talk about monitoring. It is necessary. But with that, I think we have to be very conscious of the support aspect to the caregiver. We did talk about being financially stable, being mentally stable. It is a strain dealing with Alzheimer's disease.

And it relates to what my colleague, Mr. Donnelly, was talking about and myself in my past career dealing with TBI, with concussive incidents. There is a direct correlation between concussive incidents, dementia, Alzheimer's, which these are long-term issues.

And ultimately, yes, we did—we did ultimately have to put my grandmother into a home, because our family could not do it anymore. But we did everything we possibly could to keep her out of that situation, because quite frankly she spent her life savings. We spent her life savings putting her in a home.

And we really have to tackle this and be up front about it, because it is—the direction I think we are going here in health care in general, we talk about wellness. We talk about keeping people in the home, keeping them with loved ones. We don't talk about the psychological aspects of having the loved ones home, being in home, and not being in those clinical situations and quality of life.

And I am going to sit here and tell you that I have experienced it. I have lived it. I understand it. And we need to fight for it. But, you know, with the monitoring aspect, there is—it has to correlate with the training. And the training does adapt, because as we grow older, our issues change. And I think that is a huge part of it.

And I would like any of you to address how we actually would go about the training and retraining on a yearly basis to make sure that our warriors are getting the long-term treatment they need, because they are going to have a better quality of life being at home.

Anybody have a comment on how we basically improve our care that our loved ones are giving our warriors?

Dr. COHOON. As I have mentioned before, the way the VA's implementation plan is set, none of this starts until after they have been to the training and then all the benefits start.

When the servicemember is initially injured, the caregiving starts at that particular point in time. They will cycle in and out of the hospital. As far as going home for recovery, then the caregiver at that particular point is going to be giving care at that juncture as well. So, training is going to be taking place all across the recovery phases of the servicemember and then into veteran status.

So, that is why our Association brought up the concern and the fact as when do you start the training? And let us make sure that whatever training is put into place that it is consistent across both DoD and VA.

So if they are still on active duty that the training is still happening at that particular point. But whatever they are trained and given at that point, it is acceptable to the VA when they enter veteran status.

And, how do you go about reevaluating? Our Association asked that as well, because when you look at the implementation plan, even though they are monitoring on a regular basis, it doesn't tell you how often the caregiver and the veteran are reevaluated for their activities of daily living and basically the care that the caregiver is giving to determine if the stipend is then reassessed at that particular point or stays the same.

Mr. RUNYAN. You really addressed it. And I think it's—I think the oversight is more, you know, just checking in to make sure that

the money—the money is the issue. That is not the issue. The care is the issue.

And how the warrior actually either progresses or regresses in their disability, I think really needs to be addressed. And with that I yield back.

Ms. BUERKLE. Thank you, Mr. Runyan.

At this time, we will ask our second panel to join us. I would like to thank panel number one for all of your answers and your willingness to testify today. Thank you very much.

Joining us on the second panel is Dr. Petzel, who is Under Secretary for Health for the Veterans Health Administration. Dr. Petzel is accompanied by Mr. Walter Hall, who is the Assistant General Counsel from the Office of General Counsel, as well as Ms. Deborah Amdur, who is the Chief Consultant for Care Management and Social Work at the Veterans Health Administration.

Thank you all for joining us today. I know we are all anxious to get and to hear your testimony, so we will begin. We have been advised that we are going to have a vote in about 15 minutes.

So, Dr. Petzel, if I could ask your indulgence and maybe keep your comments brief, so we could at least get to some of our questions. Any questions we don't get to we will submit to you in writing. Thank you very much. And thank you for being here.

STATEMENT OF HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; DEBORAH AMDUR, LCSW, CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. PETZEL. Chairman Buerkle, Ranking Member Michaud, and now sitting in for him, Congressman Donnelly, before I begin I do want to recognize the presence of the Wades and Horans, two couples who really symbolize why it is very important that we get this piece of legislation correct from the very beginning.

Members of the Committee, I want to thank you for the opportunity to discuss VA's implementation plan for the family caregiver program required by the Caregivers and Veterans Omnibus Services Act of 2010.

I am accompanied by, as mentioned, Mr. Walt Hall, the Assistant General Counsel, and Ms. Deborah Amdur who is Chief Consultant for Care Management and Social Work. I ask that my written comments be introduced into the record.

Ms. BUERKLE. Without objection. Thank you.

Dr. PETZEL. Servicemembers injured today are surviving injuries that would have been fatal in past conflicts. We understand how critical family caregivers are for these veterans. And we know veterans are best served if they can live their lives as independently as possible, surrounded by those people that they love and who love them.

The Caregivers Act enhances VA's existing authority to provide for these services for caregivers and will allow VA to provide com-

prehensive—a rather comprehensive set of benefits and services to certain caregivers of eligible veterans.

We are fully committed to ensuring that injured veterans and their families receive these benefits and the support that they need. There is no better way to express my and all of VA's commitment than the title of this hearing.

VA must get the implementation of these new caregiver provisions right. We understand very clearly the concerns expressed here today. Dialogue between VA and Congress is important. And it is especially important in the context of this legislation.

We have had good discussions with Committee staff this week—during this week—on the most acute concerns about eligibility and other issues and we look forward to a continuing exchange with you and with your staff, again so that we get this legislation right.

My written statement provides a thorough account of our efforts to develop VA's implementation plan and I won't go into the details therein.

Completing the remaining detailed steps of implementation in a way that makes the program practicable and clear is no easy task. But the challenge before us is nothing compared to the challenges that these caregivers, as symbolized by the Wades and the Horans, face on a daily basis.

I second the Secretary's regret that our plan was not submitted on plan and also that the implementation date set in the law was not met. This process has taken longer than any of us would have liked.

As you know, VA submitted on February 28 a proposed interim final rule to the Office of Management and Budget. And this procedure will result in faster implementation than had been earlier expected.

The Secretary has set the mark for getting the program operational by early summer. But we must not lose sight of what is most important and that is, again, to reiterate, to get it right.

The success of this effort depends on putting forward standards that will secure those additional benefits for caregivers of seriously injured veterans who are in greatest need. These standards must be able to be applied consistently by our front-line clinicians. And we have an obligation to be able to explain to an injured veteran why he or she would or would not qualify for these benefits. Making sure these additional benefits are focused on the right caregivers who are giving so much that is so vital to them.

Our highest priority is delivering world-class health care services and benefits to our seriously injured veterans, and servicemembers, and their caregivers.

We look forward to working with Congress, the veterans service organizations, and all of you, again, to ensure that we get this right.

Thank you for inviting me to testify today about this incredibly important and new groundbreaking program. My colleagues and I are prepared now to answer your questions.

[The prepared statement of Dr. Petzel appears on p. 56.]

Ms. BUERKLE. Thank you, Dr. Petzel.

I am going to yield 5 minutes to Dr. Roe.

Mr. ROE. Thank you, Madam Chairman.

Quickly, I have watched this now for the third year. It seems that all the programs that we see are slow, and glacial to get going.

And I know that it is a very complicated program. But as you clearly pointed out, it is not nearly as complicated as having no arms or legs, and getting around in your home, or with a traumatic brain injury where you can't balance a checkbook and someone has to be there for you to do that. That is a lot harder as you just pointed out. I could not agree more.

So why is it taking so long? And, I mean, this doesn't—this program doesn't seem as complicated to me as many of the programs that the VA has.

Dr. PETZEL. Thank you, Congressman Roe. I will turn to Debbie Amdur in a minute to elaborate on this.

But I think the biggest aspect of this is that it is a completely new concept for us. We have never been engaged in the business of providing a stipend to somebody who is providing caregiving services.

And developing the regulations for this, getting all of the correct input before the regulations are actually in place, takes a long time. I apologize as I had before for the fact that we are so late in doing this. But I think the fact that this was new and it required relatively complex regulations is part at least of the explanation.

Mr. ROE. We have regulations now for home health care people that go in. It looks to me like it would have been fairly simple to look at those and say there is some criteria there that would have been pretty easy.

I think we micromanage this down to what if, I think the intent of Congress was to provide this to as many families. And I think right now, just like in the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD–VASH) Voucher Program, we found out we have 11,000 vouchers out there and yet still have homeless veterans.

So I think what you are going to find out with this is that there is going to be a lot more need than we thought. But we don't even know what that is now, because it is so hard for people to get in.

As Mr. Tarantino pointed out, the gateway is eligibility. But that is just the first step. So we really don't know right now how many people. And do you know how many people have applied or how many have to date?

Dr. PETZEL. Of course, there hasn't been an application period yet, Congressman. But we have an estimate of somewhere between 750 and 1,000 people would probably be applying or would be eligible under the way the criteria are presently delineated.

Mr. ROE. Well I guess that seems like an awfully small number to me in a country with millions of veterans. It seems to me like—I bet it will be 10, or 20, or 30 times that many.

Dr. PETZEL. Well—

Mr. ROE. Unless the criteria is so narrow that they don't qualify.

Dr. PETZEL. But first of all we have defined this as people—the result of the present conflict. So all of the other era veterans would not be considered in that group to begin with.

And I will ask Mr. Amdur if she can elaborate briefly on the eligibility criteria and perhaps the number of people.

Ms. AMDUR. Thank you. As a clinician who has many years of experience in the field working directly with disabled veterans and their family caregivers, I would like to say firsthand that I do recognize that the kinds of incredible sacrifices that these family members make. And it is really an honor to be here with Sarah Wade and Patty Horan who are two examples of this.

I can tell you also that VA is fully committed to ensuring that this important benefit gets to the families of our most seriously injured servicemembers and was very concerned to hear the interpretation that we would not be covering veterans with traumatic brain injury.

When we put together the eligibility criteria, we brought forward subject matter experts from across VA, including leadership of our Federal Recovery Coordination Program, our polytrauma programs, traumatic brain injury programs, and so forth. And there was significant recognition of the challenges that are faced by family members caring for individuals with traumatic brain injury.

And so without a doubt, our intention is that those individuals will be included and eligible if you have an individual who requires supervision to remain at home.

I would like to also say that the eligibility criteria were created in a context really of VA's wide range of existing in-home services that are designed specifically to support veterans and families, keeping them at home, and avoiding at all costs the possibility of institutionalization, because we know that—

Mr. ROE. Not to interrupt, but my time is about up. In July if we have this same Health Subcommittee meeting again, will there be families getting help?

Ms. AMDUR. Our intention is that we are fully operational early summer. Yes, sir.

Mr. ROE. So we are going to be able to have resources going out to family members who take care of wounded warriors this summer?

Ms. AMDUR. That is our intention, yes.

Mr. ROE. Guaranteed?

Ms. AMDUR. We know how important—

Mr. ROE. Which will be 6 months later than it was supposed to be. But if we can get it done then so they will have some time certain, that would be good.

And my time is up. So I will finish by just saying that no institution, I have practiced medicine for—I have been a doctor for 40 years. No one will give you better care, loving care, than your family.

Ms. AMDUR. I agree wholeheartedly, sir. Thank you.

Ms. BUERKLE. Thank you, Doctor. I will yield now to Mr. Donnelly.

Mr. DONNELLY. Thank you, Madam Chair.

Dr. Petzel, the VA plan calls for routine home visits about every 90 days. And so after a while, you know, three, four visits, you see there is a pattern, everything is the same time after time.

Do you think that there could be a framework put in place to perhaps make it every 4 months after that or every 6 months after that, or do you think it is necessary to stay on the 3-month visit schedule?

Dr. PETZEL. Congressman Donnelly, I certainly think that that can all be looked at. The purpose of those visits are primarily as sort of training and checkup if you will, episodes. They are not meant to be punitive. They are not meant to be, you know, looking out for trouble particularly. We really would like to have them be an opportunity to talk with the caregiver, talk with the patient about how things are going. See if there are new and other things that need to be done.

Certainly after a period of time it may not be necessary to do it four times a year. I think we would want to periodically have a system to ensure that there isn't deterioration in the patient that needs further and other kinds of training on the part of the caregiver but absolutely. We don't necessarily have to stick forever to four times a year.

Mr. DONNELLY. Yes. And that is where I was going to go next was what you had just mentioned, which is in between visits. What kind of support structure are we going to put in place so the caregiver can call and say, I am really struggling this month?

Dr. PETZEL. Let me turn to Ms. Amdur, and she can go I think briefly again through what other supports are available.

Ms. AMDUR. We do think that a—

Mr. DONNELLY. I can't hear you.

Ms. AMDUR. We think that a key component of the program is direct support to caregivers. That is really what this is all about.

So VA has put a full-time caregiver support coordinator position at every VA medical center and their role will be to ensure that the caregivers have a direct line to someone who is able to respond immediately to their needs, link them to the appropriate resources, and so forth.

In addition, we are instituting through these caregiver support coordinators, support groups, education and training that will happen in group formats, all of which are geared directly at providing support to the caregiver.

In the training that will be part of the overall program, we have included modules in the core curriculum that focus on stress management, self care for caregivers, and also things like advocacy, legal issues, and so forth, because we know how very challenging those can be for caregivers.

Mr. DONNELLY. Dr. Petzel, getting back to the TBI issue. It is so tricky to know exactly how they are going to turn out or where it is going to go. How will you determine in cases where you are not sure whether or not they will be included in providing this assistance?

As was heard in the first panel, the fellow was talking about the mom taking care of her son and that physically it didn't look all that different, but that he couldn't be alone. How are we going to make those calls?

Dr. PETZEL. Well, thank you, Congressman. In the implementation plan, we talk about the concept of if someone cannot live safely by themselves, and that is a fundamental you are in, you are eligible. If you cannot be safely left home alone, that in and of itself is going to be—make you fundamentally eligible for the program.

I am not quite sure where the misinterpretation of what is in the interpretation plan. But we anticipate that large numbers of TBI patients are indeed going to be eligible for this program.

Mr. DONNELLY. Because it is my expectation that what you see on first blush is obviously not going to be always where a lot of our veterans who are struggling with TBI will be the next day, or the next week, or the next month.

Dr. PETZEL. Correct.

Mr. DONNELLY. So if we could just keep an open mind on that, I would appreciate it.

Thank you very much, Doctor. And thank you for all you have done for our veterans over the years. I have met with you many times. And I know the veterans of my district and all our districts are appreciative of the hard work of all of you folks.

Dr. PETZEL. Thank you.

Ms. BUERKLE. Thank you, Mr. Donnelly. I am going to yield 5 minutes to Mr. Roe.

Mr. ROE. Just one question, did you say that there was a caregiver at every VA medical center?

Ms. AMDUR. We have instituted a caregiver support coordinator position at every VA medical center.

Mr. ROE. Okay. Let me stop right there—

Ms. AMDUR. Yes, sir.

Mr. ROE [continuing]. And then do some math. There are 154 of those in the country?

Ms. AMDUR. That is correct.

Mr. ROE. You have 1,000 people. That is one for every six people we are going to have in this program?

Ms. AMDUR. One of the things that we feel very committed to is that we provide services to all era veteran's caregivers. And so these positions will not only be assisting directly those who are eligible for this particular benefit, but will be doing support, education, and training activities for the caregivers of all era veterans. So we anticipate they will have actually a very busy schedule doing so.

Mr. ROE. Okay, thank you. I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

I will yield myself 5 minutes just for some questions since they haven't called the vote yet.

As we chatted when you first entered and I came to the meeting this morning, we mentioned that I am a registered nurse and I have been involved in health care for many years. And I too, like Members of the Committee, have lived up close and personal with a family member. I had a sister who was quadriplegic for 25 years. My mother cared for her at home. So I know up close and personal—the immense sacrifice that the family makes to make that decision, the benefits that the patient derives from it, and the fact that it affects the entire family.

So I am sitting here this morning, and I am so concerned that we are talking so much and we are not going to get this done. Time is of the essence.

When a family is frustrated or overwhelmed with the prospect of what they need to give—to keep that patient at home, to keep their loved one at home, and the ramifications of the decision to keep

them home, they need us then. They don't need us talking about early summer.

So I guess my question to you is what assurance can you give us? We heard early summer. But what assurance can you give us that we will make this a priority, will figure this out, and will get it done?

Because as was mentioned by the Committee Members earlier, home health care is not new for the VA. But giving assistance to home health care members, and home care assistants, and the whole theory of home health care is not new. It is not like we have to reinvent the wheel. We just need to apply it to our veterans who need this care, and this help, and assistance so dramatically.

So what assurance can you give us that we are going to proceed with the utmost pace and get this done by early summer so we can begin getting family members into this system? And we can do for our veterans to get this thing done.

Dr. PETZEL. Well, Madam Chairwoman, you have my absolute promise and assurance that we will get this done by summer. That we will by early summer be paying people to provide care in the communities.

This is part of the reason why I think it is very important that right now we get this right. About 95 percent of what we need is already done. And I think people generally agree on most of those points.

There are three or four areas where we need to develop a consensus as to how we should move forward. If we can get those things cleared and if they entail some change to the interim final rule, we can get that done and meet that timeline.

So I absolutely hear your angst about the time, and we share it. We want to get this done as quickly as possible as well, and we will.

Ms. BUERKLE. Thank you. Do you have any idea when you will get the findings of the interim rule?

Mr. HALL. The plan is 60 days from the time. OMB had 60 days from the time that we provided them with the draft rule, which would be about May 1st. And it would go into effect 30 days later.

[Mr. Hall subsequently submitted the following information:]

> Mr. Hall would like to amend that statement to convey that if OMB approves the regulation for publication as an interim final rule, it will go into effect on the date specified in the regulation, expected to be on the date of publication.

Ms. BUERKLE. Thank you. Anyone else on the Committee have any questions?

We also discussed this morning my visit to our veterans hospital in Syracuse. And I was so impressed with the satisfaction of the patients there and the commitment that the staff had during our meeting.

I mentioned to Secretary Shinseki that it was apparent to me that for the veterans and for all of the health care providers in the medical center, it was a mission and not just a job to them.

I hope that as a result of this hearing we will make this our mission to get this bill done, to do what is right for our veterans, and for their families.

So I thank you all very much for being here today, for you taking the time and giving us your testimony. I will allow 5 days for the Members of the Committee to submit any questions or opening statements for the record.

And with that, thank you again for appearing here today. This hearing is adjourned.

[Whereupon, at 11:27 a.m. the hearing was adjourned.]

APPENDIX

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman, Subcommittee on Health

The Subcommittee will come to order.

Good morning. I want to begin by thanking all of those in attendance for joining us today at the first Subcommittee on Health hearing of the 112th Congress.

I am honored to have been selected to serve as Chairwoman of this important Subcommittee and I am pleased that my friend, Mr. Mike Michaud of Maine was designated by his colleagues to serve as the Ranking Member.

Mr. Michaud has a distinguished history of support for our veterans and I look forward to working closely with him to ensure that those who have honorably served our Nation receive the highest quality care. I know he shares my conviction that that is the least we can do for those who willingly put themselves in harm's way to protect our freedoms.

We are joined on the Health Subcommittee by:

Mr. Cliff Stearns of Florida,
Mr. Gus Bilirakis of Florida,
Mr. David Roe of Tennessee,
Dr. Dan Benishek of Michigan,
Mr. Jeff Denham of California,
Mr. Jon Runyan of New Jersey,
Ms. Corrine Brown of Florida,
Mr. Silvestre Reyes of Texas,
Mr. Russ Carnahan of Missouri, and
Mr. Joe Donnelly of Indiana.

I am heartened by the wealth of diversity, knowledge, and experience we have among us and I am confident that the work we do here will have a very real and positive impact of the daily lives of America's brave veteran heroes and their loved ones—which brings us to the crux of the matter before us this morning.

Each of us serves on this Committee because of our deep respect and heartfelt admiration for the service and sacrifices of American veterans. Each of us serves on this Subcommittee because we recognize the importance of ensuring that those same veterans have access to high quality medical care to help them cope with the wounds of war and readjust to civilian life. Each of us has respect for the VA health care system as it stands and a desire to make the system even better.

At the same time, we recognize that no matter how good a health care system is, it can only go so far. We can—and should—provide the highest quality care by the highest quality physicians and therapists in the highest quality facilities. But nothing can equal the support provided by a loving and loyal family member.

Some of those family members are with us this morning. In our audience is Sarah Wade and Patty Horan. Sarah is a full time caregiver for her husband, Ted, who was injured in Iraq when his Humvee was hit by an Improvised Explosive Device. Patty is a full time caregiver for her husband, Pat, who suffered from a gunshot wound during his service in Iraq.

Sarah and Patty has been there for their husbands day in and day out through every up and every down. Because of their commitment, they have sacrificed jobs, hobbies, and free time.

Last year, Congress passed Public Law 111–163 to ensure that family caregivers like Sarah and Patty wouldn't also have to sacrifice their financial stability or their own health.

Congress intended for these benefits to be available by January 30th of this year. However, the Department of Veterans Affairs (VA) has failed to comply with the law and has yet to implement the caregiver assistance program.

Even more unfortunate, when VA finally released its initial implementation plan on February 9th, it was immediately met with consternation by lawmakers and stakeholders who raised serious concerns about the strict eligibility criteria and

other issues, including the provision for respite care, mental health coverage, and in-home monitoring requirements.

It is my hope that during today's hearing we will bring these issues to light and the necessary changes will be made by VA to ensure that the benefits Congress intended and veteran and family members expected are provided without further delay.

Again, I thank you all for being with us this morning. I look forward to a very productive discussion.

Mr. Michaud you are now recognized for any opening statement you may have.

Prepared Statement of Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health

Thank you, Madam Chair.

I would like to thank you for holding today's hearing. The goal of today's hearing is to identify the gaps in the implementation of Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010. We also seek a better understanding of the VA's current efforts to meet the needs of family caregivers of veterans.

P.L. 111–163 provides immediate support to the mothers, fathers, husbands, and wives and other family members caring for warriors from the current conflicts, as well as previous conflicts. Today, we have the opportunity to recognize their tremendous sacrifice and share their heavy burden.

I would like to recognize in attendance today Ted and Sarah Wade, as well as Pat and Patty Horan. Army Captain Pat Horan is from Springfield, VA, and was part of the Stryker Brigade at Ft. Lewis in Washington State. Over 4 years ago, Pat sustained a gunshot wound to the head in Iraq, leaving him completely and totally disabled. Pat has made major strides in his rehabilitation, and all along, his wife Patty has been by his side.

For the last 6 years, Sarah Wade has acted as her husband's primary caregiver and case manager. In February 2004, her husband, Army Sergeant Ted Wade, was in Iraq when his Humvee was hit by an improvised explosive device (IED). Ted was one of the first major explosive blast polytrauma cases from Operation Iraqi Freedom, and Sarah suspended her studies to serve as an advocate and caregiver for her husband.

Thank you all for your service and sacrifice to this Nation.

As Patty and Sarah demonstrate each and every day, family caregivers are the true back-bone of the U.S. long-term care system. There are more than 50 million people who provide informal caregiving for a chronically ill, disabled, or aged family member or friend in any given year.

Studies of the general family caregiver population show the real adverse financial and physical toll that caregiving has on these individuals. For example, women family caregivers are more than twice as likely to live in poverty. Also, family caregivers report having a chronic health condition at twice the rate of their non-caregiver counterparts and those who provide 36 or more hours of weekly caregiving are more likely to experience symptoms of depression and anxiety than non-caregivers. In the end, this has serious implications for our veterans. In order to ensure that our country's heroes receive the highest quality of care from their family caregivers, it is important that we arm them with the right tools and offer appropriate supportive services so that they are less apt to be overwhelmed by the difficult day-to-day realities of being a caregiver.

Clearly, the family caregivers of our veterans have made great sacrifices. I have heard from family members who gave up their jobs, delayed their schooling, or made other significant life-changing sacrifices in order to be by their loved one's side. This raises questions about the VA's current efforts to help these family caregivers and whether there are sufficient supportive services in place.

Today's hearing will give the Subcommittee the opportunity to better understand the VA's implementation plan as required by Public Law 111–163. As many of you may be aware, there are numerous concerns, including:

- **The delays in the rollout of the implementation plan.** This law required a plan for implementation that was due to the Committee in November 2010, with full implementation of the program in January 2011. However, the VA is only now preparing regulations—which will have to undergo a lengthy public comment and approval process—and there is still no definitive date when veterans and caregivers will begin receiving the services required by P.L. 111–163.

- **Second, the narrowing of criteria for eligibility of these benefits.** VA has put forth in the regulations, criteria that would seriously limit access to the stipend and health care benefits for caregivers that the law was intended to include. The law was written in a way to allow for about 3,500 caregivers who would be eligible for the program, while the regulations narrow the eligibility to about 800 to 1,000. Specifically it outlines as one of the "clinical eligibility requirements" that without ongoing caregiver support, the veteran would require hospitalization, nursing home, or other institutional care.
- **Finally, moving forward.** These setbacks increase my apprehension towards VA's capabilities to successfully implement the caregivers program. This is a major concern, and we will continue to actively engage VA as we move forward with a plan that is more in line with the intent of Congress.

Madam Chair, the implementation of the Caregivers and Veterans Omnibus Health Services Act of 2010 demands our immediate attention. I hope that it is clear to our panelists before us today that by making this our first hearing of 2011, we demonstrate the importance of the subject at hand.

This hearing provides the VA with an opportunity to present clear details to our Subcommittee about where the VA currently stands with regard to the implementation of the new caregiver requirements. Our goal continues to be that veterans and their caregivers are ensured these critical benefits.

Prepared Statement of Hon. Gus M. Bilirakis

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee: I want to thank you for calling this hearing today to learn more about and evaluate the implementation plan for the caregiver-assistance program established in Public Law 111–163 (the Caregivers Act).

When family members, loved ones and friends willingly put the needs of a wounded veteran above their own by becoming a primary caregiver, it is clear that the wounded and disabled veterans are not the only ones who suffer. Veteran caregivers often sacrifice careers, social lives, and responsibilities in order to ensure that their loved one can receive care and recover at home. The men and women who selflessly support our wounded soldiers in this manner are as heroic to me as our men and women in uniform, and I am grateful to them for their service.

Congress recognized the myriad sacrifices that veteran caregivers make by passing the Caregivers Act into law in 2010. This legislation was originally designed to provide supportive services and comprehensive assistance for family caregivers of veterans. However, the VA's implementation plan for the law contains troubling new criteria that could limit the scope and inclusiveness of the program. It is very worrisome that the VA would seek to restrict a program customized to support our veterans and their caregivers. Additionally, the VA's continued delay in the roll-out of the caregiver assistance program is extremely frustrating. Veteran caregivers have waited long enough; to ask them to wait longer for the benefits we promised them, which will help them provide better care to our wounded veterans, is simply unacceptable.

I look forward to hearing from the witnesses today on how we can ensure that this legislation retains its Congressional intent. Thank you.

Prepared Statement of Hon. Silvestre Reyes

Thank you Chairwoman Buerkle and Ranking Member Michaud for bringing this issue before the Committee today. And thank you to the members of the panel for your service to our veterans and for being here today. It is always the goal of the members of this Committee to ensure that our Nation's veterans receive the finest care possible once they leave the service. With that goal in mind, we passed the Caregiver's Assistance Act. We intended to extend the benefit provided by the Department of Defense to our military's brave men and women who sustained injuries serving this great Nation. These injuries include not only external physical wounds, but also internal and psychological ailments that can result from military service.

It is a great concern to me and my colleagues that 9 months after enactment of this law, the program has not been implemented. I understand this is a complex program with many considerations, but this is not a new program in military health care. In fact this is simply meant to ensure soldiers, sailors, airmen and marines receive the same level of care and compensation they received will under Depart-

ment of Defense medical care. For this reason, I am in disbelief that the VA could not create a plan to extend this care in less than 9 months.

Like many new programs, the legislation governing this initiative is not perfect. Many people for whom we intended to provide support to have been excluded from the benefits they deserve. I hope today's dialogue will give us a clear path to correcting the shortcomings of the current Caregivers Legislation.

Thank you Madam Chairwoman and I yield back the balance of my time.

Prepared Statement of Russ Carnahan

Chairwoman Buerkle and Ranking Member Michaud, thank you for holding this needed hearing to address the Implementation plan of the Caregivers Assistance Program.

As you know more than 50 million people in the U.S. provide some type of care giving for a chronically ill, disabled or aging family member or friend. Our Nation's caregivers typically provide financial support and physical care for those who have severe chronic health conditions.

Included in the group of individuals that rely on caregivers to help them with their day-to-day functions are our some of our most severely wounded veterans. That's why it is important that during this implementation stage of the caregiver assistance program, we must work in tandem with each other to get it right.

Caregivers are depending on us to develop a concrete and cohesive plan that will meet their needs by providing financial/physical assistance but also keep them in a position to continue providing the best care to their loved ones. Caregivers not only play a critical role in recovery and maintaining quality of life for the veterans but without them the VA could face a tremendous burden in providing direct care to those many veterans that depend on family caregivers. It is my hope that through implementation of the caregivers assistance program, we can begin to payback our debt to the individuals who are committed to a lifelong responsibility of providing care to those so desperately in need.

To all the witnesses and panelist with us—thank you for taking time out of your busy schedules to appear before us. I look forward to hearing your testimony.

Prepared Statement of Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans

Madam Chairwoman and Members of the Subcommittee:

On behalf of the more than 1.2 million members of the Disabled American Veterans (DAV) and its Auxiliary, thank you for inviting our organization to submit testimony for this important oversight hearing. We appreciate the opportunity to offer our views on the Department of Veterans Affairs (VA) implementation plan for the caregiver assistance program and whether it meets Congressional intent embodied in Title I of Public Law (P.L.) 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010.

As this Committee is aware, Title I, which was enacted on May 5, 2010, contains reporting requirements for VA with prescribed timelines to include the following:

1. Not later than 180 days after the date of enactment (November 1, 2010), VA was required to submit a report to the House and Senate Veterans Affairs' Committees an implementation plan for subsection 1720G(a)(1), as amended by the Act.[1]
2. Within 270 days of enactment (January 30, 2011), VA was required to initiate the programs required by (a) and (b) of section 1720G of Title 38, United States Code, as amended.[2]
3. Not later than 2 years after the effective date (January 30, 2013), two reports must be submitted to the House and Senate Veterans Affairs' Committees:
   a. A comprehensive annual evaluation on implementation;[3]
   b. A report on the feasibility and advisability of expanding the provision of caregiver assistance under section 1720G(a) of title 38, United States Code,

[1] P.L. 111–163, Section 101(b).
[2] P.L. 111–163, Section 101(a)(3).
[3] P.L. 111–163, Section 101(c).

to caregivers of veterans seriously injured in the line of duty prior to September 11, 2001.[4]

Unfortunately, VA did not meet timeliness requirements for either submission of an implementation plan or the commencement of assistance and support services for caregivers. The annual evaluation report and the report on expansion of caregiver assistance, however, can be submitted at any time prior to January 30, 2013.

While the caregiver assistance program's date of prescribed implementation could be viewed by some as optimistic, caregivers of severely disabled veterans largely view this timeline as appropriate considering how long they have willingly cared for their loved ones with little to no relief from VA.

On February 28, 2011, VA submitted to the Office of Management and Budget an Interim Final Rule (IFR) to speed the Federal rulemaking process to implement, not all, but certain provisions of P.L. 111–163 by early this summer. Madam Chairwoman, the natural tendency for Federal agencies in rulemaking is to be close-minded and defensive once they have made a "final" rule determination. Although VA considers the IFR as a good start and has indicated it is open to suggestions as to the scope of the benefit to be provided,[5] DAV is cautiously optimistic the Department will adjust accordingly to Congress' intent, in light of its initial interpretation contained in the VA's implementation plan, and the broad concerns raised by that plan.

In this matter, we urge this Subcommittee to ensure that VA exhibits the required good faith and seriously considers post-promulgation comments from the public, including the concerns of our community. Congressional oversight is critical in this particular instance to ensure the IFR is not perceived as and is not allowed to become, an autocratic action.

Before addressing our organization's evaluation of VA's implementation plan, DAV wishes to highlight four items that best describe the wide gulf that exists between the intent of Congress and VA in this program.

Assuming VA's budget request for Sections 101 through 104 of P.L. 111–163 is based on the cost of its caregiver implementation plan, VA requests $65.9 million for Fiscal Year (FY) 2012 and $70.6 million for FY 2013. Even by any reasonable estimation of growth in VA's version of the caregiver assistance program, this funding request falls well short of Congress' authorized appropriation of $60 million for the first year and $1.542 billion for the subsequent 5 years.[6] In addition, VA also recently testified the implementation plan would serve only 840 caregivers as opposed to the 3,500 caregivers Congress intended to cover with this legislation.

DAV is concerned that in its zeal, VA has developed a plan that may well abandon most of those caregivers the law was intended to aid and support.

Eligibility:

P.L. 111–163 prescribes eligibility criteria that a veteran or servicemember must meet before support and services can be provided to primary caregivers (their supporting family caregivers) and general caregivers under § 1720G. The criteria also provides VA the authority to consider, "such other matters as the [Department] considers appropriate," in making eligibility determinations.[7]

We believe this last criterion was intended by Congress to give VA the flexibility to act responsibly by ensuring caregivers and veterans who would benefit from this program but are not otherwise considered in the prescribed eligibility criteria, would still be made eligible for primary and family caregiver assistance. However, it appears the Department has ignored this authority took a strict interpretation of the intent of the law—to avoid institutional care placements—to develop and propose a complex and restrictive eligibility criteria that will serve to deny these benefits to thousands of service-disabled veterans.

In its implementation plan, VA indicates a veteran must meet P.L. 111–163 eligibility criteria *and all* items in the following conditions to be eligible for Primary Caregiver benefits:[8,9]

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[4] P.L. 111–163, Section 101(d).

[5] United States Senate Committee on Veterans' Affairs, Hearing on the President's Budget, March 2, 2011.

[6] Congressional Record, page S2567.

[7] 38 U.S.C. § 1720G(a)(2)(C)(iii) and (b)(2)(C).

[8] Plan for Implementation Public Law 111–163 "Caregivers and Veterans Omnibus Health Services Act of 2010," Title I Caregiver Support Section 101 Assistance and Support Services for Caregivers; Page 16.

[9] Additional criteria for veterans/servicemember undergoing military medical discharge: "Meet the clinical eligibility criteria (listed below) based on VA aid and attendance and compensation benefits (based on 38 U.S.C. § 1114 and implementing regulations)." Ibid. Page 34.

1. Require continuing medical management or be at high risk for personal safety and cannot live independently in the community without caregiver support.
2. Without caregiver support providing personal care services at home in an ongoing manner, would require hospitalization, nursing home, or other institutional care.
3. Require at a minimum 6 months of continuous and approved caregiver support.[10]
4. Receive care at home once caregiver training is complete.
5. Receive ongoing care from a VA Patient Aligned Care Team (PACT) or other VA health care team due to VA's responsibility, as outlined in the statute, to monitor the well-being of each eligible Veteran receiving personal care services under the program.
6. Services provided by the primary family caregiver will not be simultaneously provided by another entity.

If the veteran or servicemember is undergoing military medical discharge, an additional criterion must be met:

7. Meet clinical eligibility criteria based on VA aid and attendance and compensation benefits (based on 38 U.S.C. § 1114 and implementing regulations).

DAV appreciates VA's desires for a clear and consistent clinical guideline for VA personnel to apply. Such a guideline could ensure equity in light of the various injuries veterans have sustained from the wars in Iraq and Afghanistan and the subjective nature of eligibility determinations. However, the eligibility criteria outlined in P.L. 111–163 can be considered open to misinterpretation or misapplication. We believe the language in VA's proposed criteria contains similar qualities that require interpretations and subjective judgments, even as it proposes criteria more restrictive than Congress intended.

In the law, Congress specified an eligible veteran or servicemember must be, among other deficits, unable to perform one or more activities of daily living (ADL) *or* be in need of supervision or protection based on symptoms or residuals of neurological or other impairment or injury. VA combined these two discretionary requirements (be at high risk for personal safety *and* show inability to live independently in the community without caregiver support).

DAV appreciates VA's desire for a clear and consistent clinical guideline for the purposes of determining eligibility for caregiver assistance under 38 U.S.C. § 1720G. However, using the example of the underlying problem causing the Department's disability claims backlog to grow, standard application of any guideline is most influenced by proper training and education as it is by avoiding ill-defined words such as "continuing medical management" or "high risk." In addition, we recommend VA develop retrospective root cause analyses to identify the cause of, and improve upon variability of, eligibility determinations on families denied these services.

With regard to the additional criteria for veterans or servicemembers undergoing military medical discharge, it appears VA intended this additional criterion to be in line with the special compensation for severely injured military servicemembers under Section 603(a) of P.L. 111–84, the National Defense Authorization Act for Fiscal Year 2010 (NDAA).[11]

However, the purpose of this special compensation benefit is for both the Department of Defense (DoD) and VA to ensure the seamless transition of care of all servicemembers retiring for medical disability. This NDAA provision would recognize that family members are making life-altering sacrifices in order to care for servicemembers at home. The provision would cap the amount of special compensation at the amount authorized for aid and attendance compensation for veterans under section 1114(r)(2) of title 38, United States Code. By aligning the NDAA authority with the authority to provide aid and attendance compensation for veterans under section 1114 of title 38, United States Code, the conferees expected to close gaps in coverage and care for catastrophically injured servicemembers transitioning from DoD to VA.[12]

If VA has concerns with aligning the eligibility criteria for caregiver assistance under 38 U.S.C. § 1720G to the special monthly compensation rates, we suggest VA look to the eligibility criteria for the special compensation under 37 U.S.C. § 439 (b).

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[10] In addition, the fourth requirement listed above that the veteran must need, at a minimum, 6 months of continuous and approved caregiver support is based on the premise that their family members may be able to utilize 26 weeks of unpaid leave under the Family and Medical Leave Act (FMLA). However, this condition assumes that the family member will not have used any of the 26 weeks at the time this requirement will be applied.

[11] 37 U.S.C. § 439

[12] Conference Report 111–288 to accompany H.R. 2647, Page 755–756.

Since this DoD special compensation is primarily a financial benefit, we believe it is more appropriate to remove VA's proposed eligibility that references 38 U.S.C. § 1114 and address its alignment concerns under the stipend provisions of P.L. 111–163.

We have testified many times and written in *The Independent Budget* our concerns with respect to transition of active duty servicemembers to civilian veteran status. Numerous reports have revealed great weaknesses between VA and DoD in effectively promoting a seamless transition even in cases where the individuals concerned are severely wounded and in need of an array of health and benefits services from both agencies. In this implementation plan, VA may have failed to coordinate its decisions with DoD with respect to severely injured active duty and veterans. Lack of coordination will exacerbate existing issues that hamper a seamless transition and could result in caregiver support services being unnecessarily duplicated, unequal, or unavailable across both systems at the detriment of caregivers and the quality of care and rehabilitation of the individuals concerned. As VA reviews its implementation plan for caregiver support services as a result of strong Congressional oversight and involvement of this community, we urge VA to work closely with DoD counterparts in fashioning change.

Stipend:

Due to the number of concerns DAV has identified about the potential caregiver stipend, we believe a closer inspection is needed to determine if this benefit as proposed by VA is both appropriate and valid in light of Congress's intent.

First, the amount of personal caregiver services that will be required of a caregiver may include skilled nursing care (wound care, bowel and bladder care, tracheostomy or ostomy care, etc.), physical and occupational therapy, home health aide care and homemaker duties. As amended by P.L. 111–163, title 38, United States Code, § 1720G(a)(3)(C)(ii)(V), recognizes this potential and States the stipend be, "*not less than* the monthly amount a commercial home health care entity would pay an individual in the geographic area of the eligible veteran to provide equivalent personal care services to the eligible veteran." (Emphasis added.)

However, VA proposes to take the intended minimum monthly stipend amount and convert it to the maximum amount payable. The Department proposes to base the stipend payment on the Department of Labor's Bureau of Labor Statistics (BLS) wage rate for a home health aide, with no other option. In doing so, VA may not fully recognize all the personal care services a primary caregiver will provide.

Second and subsequent to the previously mentioned proposal, VA incorporates an especially grievous proposal that sets a bar caregivers must overcome but is not recognized by the stipend benefit despite VA's statement that, "[t]he stipend is an acknowledgement of the sacrifices that families are making to care for seriously injured eligible Veterans."[13] This situation is evident in two forms:

1. VA proposes that in order for the caregiver to be eligible for the monthly stipend, the caregiver must be able to provide personal care services that include any additional care requirements prescribed by the PACT or veteran's primary care team[14]—that is, other personal care services such as skilled nursing care that a home health aide would not or could not otherwise provide. Yet, VA proposes to limit the stipend amount to that paid to a home health aide; and
2. In another set of requirements VA's implementation plan includes a standardized veteran/caregiver assessment tool (Appendix B) that will be used to evaluate and validate caregiver competence, which is required for the primary caregiver to begin receiving the stipend and other benefits.[15] Part of the assessment tool includes whether the caregiver furnished needed Instrumental Activities of Daily Living (IADL).[16] In calculating the hours of work that VA estimates a primary caregiver will need to—provide required personal care services, it appears that no weight is given to the hours of care needed to perform IADLs in calculating the monthly stipend.

Third, DAV is also concerned about the calculation of hours of care VA estimates a primary caregiver will need to perform the required personal care services.

VA states that nothing in § 1720G, as added by section 101 of P.L. 111–163, shall be construed to create "an employment relationship between VA and an individual

[13] Plan for Implementation, Public Law 111–163, "Caregivers and Veterans Omnibus Health Services Act of 2010," Title I, Caregiver Support, Section 101, Assistance and Support Services for Caregivers, Department of Veterans Affairs. Page 23.
[14] Ibid. Page 13
[15] Ibid. Page 28.
[16] Ibid. Page 56.

in receipt of assistance or support," to include primary family caregivers. However, VA's implementation plan uses a 40-hour work week as a standard and proposes a maximum 40 hours of care without consideration for the time needed to provide personal care services during evenings, weekends, or holidays.[17] This restriction is proposed despite VA's eligibility requirement that a veteran must need "continuous and approved personal care services."

Fourth, according to VA, behavior points from the Patient Behavior Scale assessment will be subtracted from the ADL points from the Katz ADL Scale. Combined results of these scales are given a numeric value to determine the level of the stipend payment:

- VA's implementation plan assumes behavior points are equal to ADL points without explanation or validating evidence to support this assumption.
- VA's implementation plan lacks explanation of how the combination of ADL and behavior points relate to the amount of hours-of-care needed.
- VA's implementation plan does not conform to Section 101, P.L. 111–163, where IADLs are not specified as a tool to be used in the evaluation and calculation of stipend amounts.

Assessment Instruments:

Determining the type of ADL and IADL care that a patient needs permits a clear idea of whether or not living at home with care is an option. Further, recognizing a person's functioning level as it relates to ADL and IADL is the first step in developing a care plan (or making a referral for care) to provide the appropriate type and level of assistance. This is also recognized in Appendix B (page 56), the Veteran/Caregiver Assessment Tool, which evaluates both ADL and IADL limitations.

VA's implementation plan proposes to use the Katz Index of Independence in Activities of Daily Living, a patient behavior scale to determine the levels of the caregiver stipend payable. The Katz Index uses a dichotomous rating (0 = independent; 2 = dependent) for each activity; Alternatively, VA proposes a trichotomous rating (1 = high dependence; 2 = medium dependence; 3 = low dependence). These three levels of dependency are ill-defined and will most certainly lead to wide variations in scoring among health care providers, and will fail to meet VA's stated goal for a clear and consistent guideline.

We recommend VA consider a rating scale with each item assigned points according to a defined decision rule (e.g., 0 = no help needed; 1 = uses a device; 2 = needs human assistance; 3 = completely dependent). Alternatively, the Lawton IADL scale developed by Lawton and Brody in 1969 assesses the more complex ADLs necessary for independent living in the community where competence in skills such as shopping, cooking, and managing finances are necessary tasks. VA could consider using the trichotomous rating used in the Lawton IADL instrument (1 = unable; 2 = needs assistance; 3 = independent). In any case, VA provides no evidence about the validity of using other than the dichotomous rating of a patient as either dependent or independent for an ADL in conjunction with the Katz Index.

DAV is also concerned VA's implementation plan does not propose to use an IADL instrument to assess the personal care needs a veteran or servicemember may require, which the primary caregiver will undoubtedly perform. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning but it is not referenced in the implementation plan.

Of equal concern is the lack of information in VA's implementation plan on whether the proposed Patient Behavioral Scale is a valid instrument in determining veterans' needs and amounts of personal care services that primary caregivers must provide.

Madam Chairwoman, DAV would like to highlight a missing yet critically important component in VA's implementation plan—any instrument to assess the personal care needs of a veteran or servicemember suffering from neurological or cognitive impairment due to traumatic brain injury (TBI).

Although impairment in cognitive function is a recognized concern in P.L. 111–163 (§ 1720G(a)(2)), VA did not propose to assess veterans' or servicemembers' executive functions (planning, organizing, problem solving, sequencing, self-monitoring and controlling behavior). Deficits in executive functions may be devastating to someone's ability to cope with everyday life, work, and relationships. Executive functions are assumed to be located in the frontal lobes of a human brain. These are particularly vulnerable to damage after TBI because they sit on bony projections in the skull, and thus are at greater risk of injury and damage. Although the Katz

[17] Ibid. Page 23–24.

ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of improvements seen in the rehabilitation of patients.

It is not clear from VA's implementation plan whether the proposed Katz Scale or the Patient Behavioral scale will be used to assess cognitive, neurological impairment, and other residuals of TBI. Notwithstanding there is no assessment instrument proposed for veterans suffering from TBI, we appreciate VA's not intimating the use of the Global Assessment of Functioning (GAF) Scale as a proxy. GAF scores are used in conjunction with a multiaxial evaluation of a psychological disorder, whereas severe TBI can result in not only psychological, but physical, cognitive, and psychosocial impairments and functional disabilities.

For example, damage to the frontal lobes is often associated with good recovery of motor, sensory, and linguistic functions as seen on neuropsychological testing. Thus, the person with frontal lobe or executive functioning damage may appear normal in testing, or in the context of a highly structured and routine environment. On the other hand, executive dysfunction can cause many problems despite good recovery in the aforementioned areas, and debilitating complications can be seen with managing cognitive, social and communicative functioning, and behaviors. It can result in difficulty in executive functions such as attending, planning, organizing, learning, problem-solving, and reasoning in the unstructured reality of life tasks even though these individuals may show good performance on highly structured neuropsychological tests.

Research has generally supported hierarchical arrangement of functional skills by demonstrating IADLs are affected earlier in the course of cognitive impairment,[18] whereas ADLs are preserved until relatively late.[19] There is robust discussion on subdividing IADLs or higher level functional skills to reflect relevant underlying cognitive abilities. In essence, there is a need to establish a tool or series of tools that has a proven ability to link domains of daily function to particular domains of cognitive function. This would improve VA's ability to make meaningful predictions about which specific functional impairment might result from specific cognitive impairment.

There are three general approaches to measuring everyday function: Self-report, Informant report and Performance based measuring. Self-report has been shown to be problematic in individuals with cognitive impairment.[20] Performance based measuring is argued to be the most valid and reliable method of assessing functional abilities of patients with cognitive impairment, but a caveat must be stressed. That is, all reasonable effort must be made to ensure the measurement is not administered under artificial conditions in which the individual is "prompted" to engage in a task and provided all the materials he or she requires in completing the task.

Critics cite performance based measuring as time consuming and requires extensive equipment, thus making it impractical for routine use. More practical would be the use of the caregiver or similar individual—who knows the patient best—as a proxy rater.

Respite Care:

A significant new array of respite services is also authorize under P.L. 111–163, that are intended to be provided in a flexible and helpful way to caregivers of severely wounded veterans. Research has shown that providing respite for caregivers can have a positive effect on the health of the caregiver as it provides the much needed temporary break from the often exhausting challenge imposed by constant attendance of a severely disabled person.

Currently, VA's system for providing respite care is fragmented and inflexible, governed by local policies for Community Living Center (formerly VA Nursing Homes) and Adult Day Care programs. Moreover, the Government Accountability Office and other independent reviewers have cited a series of weaknesses in VA existing respite program.

In previous testimony, DAV indicated a significant majority of veterans do not avail themselves of such services due to lack of knowledge of such a benefit or the services are simply not available in the veteran's community. The majority of in-home respite care is purchased by VA from community agencies that may not provide weekend or overnight respite services. Furthermore, trust and privacy remain significant barriers when an individual who is to provide in-home respite, homemaker and home health programs, is perceived as a stranger.

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[18] Kemp et al., 2002; Richardson, Nadler and Malloy, 1995; Tomaszewski et al., 2005

[19] Sclan and Reisber, 1992; Suurmeijer et al., 1994

[20] Debettignies, Mahurin, and Pirossolo, 1990; Seltzer et al., 2001

Despite VA's recognition of the importance of respite care for caregivers of disabled veterans, DAV is deeply concerned the implementation plan contains no discussion to address any of these existing issues in its current respite care program. At the very least, DAV had hoped VA would have proposed establishing clearer policies regarding in-home respite and that such policies would also include an expectation that every Community Living Center and Adult Day Care Program to provide priority for age-appropriate respite care for severely injured veterans. We urge VA to have a more deliberate plan to implement a robust and flexible respite program.

Conclusion:

Madam Chairwoman, in the absence of family caregivers, an even greater burden of direct care would fall to VA at significantly higher cost to the government and reduced quality of life for these veterans who have sacrificed so much. They play a critical role in facilitating recovery and maintaining the veteran's independence and quality of life while residing in their community, and are an important component in the delivery of health care by the VA. These family members, relatives, or friends are motivated by empathy and love, but the very touchstones that have defined their lives—careers, love relationships, friendships, and their own personal goals and dreams—have been sacrificed, and they face a daunting lifelong duty as caregivers.

Along with other veterans service organizations, DAV has been working for years with the Administration and VA to address these lapses. DAV is concerned that VA's implementation plan will not result in actions rooted in Congress' intent when in passing P.L. 111–163. We are keenly aware of VA's ability to do what is right by veterans and their caregivers. VA recently issued a news release on the topic, "Resources for Enhancing Alzheimer's Caregivers Health (REACH) VA." REACH VA is an initiative translated from a VA randomized control trial. The clinical trial showed significant improvement in caregiver burden, depression, health/self-care, social support, and management of patient behaviors. The goal of REACH VA is to implement nationally an effective intervention to decrease stress among caregivers who typically provide the majority of care for those with dementia, on average 16–20 hours per day, and improve the management of patient behaviors throughout the VHA system.

VA is indeed capable of administering a caregiver assistance program envisioned by caregivers of disabled veterans, the veteran community, and Congress. In time, we will know if VA has listened to the concerns, considered them, and adjusted its position when the IFR and subsequent amendments are issued, and when a final regulation is published.

Again, we thank you for the opportunity to present our views on VA's implementation plan for Title I of P.L. 111–163. The DAV is committed to working constructively with Congress, VA and the Administration to ensure family caregivers do not remain undertrained, underpaid, underappreciated, undervalued, and exhausted by their duties.

Prepared Statement of Ralph Ibson, National Policy Director, Wounded Warrior Project

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project (WWP) to testify on the Department of Veterans Affairs' (VA) implementation plan for the caregiver-assistance program established in Public Law 111–163 (the Caregivers Act). VA's implementation plan has profoundly concerned and disappointed us, and we greatly appreciate your holding this early hearing.

With our mission of honoring and empowering wounded warriors, WWP's vision is to foster the most successful, well-adjusted generation of veterans in our Nation's history. WWP's highest legislative priority during the last Congress was the enactment of legislation requiring the Department of Veterans Affairs to establish a program of comprehensive supports for family caregivers of those seriously wounded in Operation Enduring Freedom and Operation Iraqi Freedom. In light of Congress' decisive action last year in passing a very strong Caregivers Act, successful implementation of that program is now our top priority. But VA's implementation plan falls far short of our goal. More importantly it falls far short of what the law requires. Among its most egregious flaws are rigid clinical eligibility criteria that have no foundation in the law and would disenfranchise several thousand veterans intended

to be covered under the Act, many of whom have severe cognitive and other impairments resulting from traumatic brain injury.

Background: VA's Fierce Opposition to Caregiver Legislation

In attempting to understand why VA has submitted a plan that is so fundamentally flawed, it is worth noting VA's longstanding, deep opposition to caregiver-assistance legislation. From the perspective of an organization that saw the profound need for caregiver assistance and advocated hard for it, VA's position during the period of this law's development and consideration was deeply disappointing.

Over a period of several years during which caregiver-assistance legislation was under consideration in Congress, VA seemingly struggled to identify a rationale for its consistent opposition to the concept. In 2008, VA testified before this Subcommittee that such legislation was unnecessary because "VA already has a program in place that accomplishes [its] goals more efficiently and effectively."[1] The following year, it advised the Senate Veterans Affairs Committee at a legislative hearing that it "strongly opposes" the then-pending caregiver-assistance bill,[2] which it characterized as "divert[ing] VA from its primary mission of treating veterans and training clinicians." VA's testimony also stated that such legislation was premature in that Congress should not mount a program of this complexity without piloting it first; yet VA also expressed the contradictory view that any caregiver-support initiative should not be limited by date of service.[3] At a subsequent hearing before this Subcommittee, VA expressed "recogni[tion] that some veterans, particularly young veterans, will need care for the rest of their lives" and stated that it was "currently undertaking a comprehensive reassessment of caregiver programs . . . and look forward to working with Congress to identify the most feasible and effective caregiver program improvements."[4] VA's strongest point of opposition appeared to have been aimed at providing modest financial assistance to any caregivers. As VA Secretary Shinseki testified recently in acknowledging the Department's efforts to strip the stipend from any caregiver legislation, "[o]ur proposal . . . was to use an existing mechanism . . . called Aid & Attendance [which already provides special monthly compensation to the veteran] . . . , [but] our position didn't prevail."[5]

The bottom line is that from the outset of the legislative process VA balked at the notion of providing caregivers with vitally needed supports and, despite a clear statutory mandate in the Caregivers Act, VA's very restrictive eligibility criteria continue to evidence that opposition.

VA Caregiver-Assistance Implementation Plan

The Caregivers Act directed VA to develop a plan, in consultation with stakeholders, for implementing the comprehensive assistance program, and to submit that plan to the Senate and House Veterans Affairs Committees not later than 180 days after enactment. The Act further directed VA to implement the program 90 days later.

The provisions of the Caregivers Act are noteworthy in several respects. First, the law is detailed and prescriptive, and is quite explicit as to who is an eligible veteran.[6] Second, it provides a very robust role for stakeholders like WWP. Specifically, the law directs VA to consult with stakeholders in the development of an implemen-

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[1] Statement of Gerald Cross, MD; Department of Veterans Affairs, before the Subcommittee on Health, House Committee on Veterans Affairs, September 9, 2008.

[2] S. 801, 111th Cong., established the framework for what became the comprehensive caregiver-assistance program.

[3] Statement of Gerald Cross, MD; Department of Veterans Affairs, before the Senate Committee on Veterans Affairs, April 22, 2009.

[4] Statement of Madhulika Agarwal, MD; Department of Veterans Affairs, before the Subcommittee on Health, House Committee on Veterans Affairs, June 4, 2009.

[5] Testimony of Secretary Eric Shinseki before the House Committee on Veterans Affairs on VA's budget for FY 2012, February 17, 2011. Indeed even *after* both the Senate and House had passed caregiver bills that both included a stipend provision, senior VA staff sought unsuccessfully in a meeting on December 1, 2009, to negotiate for an alternative that would scale back the legislation to eliminate provision of a stipend.

[6] Contrast the Act with H.R. 3051, 110th Congress, a similar-purpose measure which in pertinent part provided simply that "The Secretary of Veterans Affairs shall establish a program on training and certification of family caregivers of veterans and members of the Armed Forces with traumatic brain injury as personal care attendants of such veterans and members . . . . [and] shall determine the eligibility of a family member of a veteran or member of the Armed Forces for participation in the program required by subsection (a) . . . based on the clinical needs of the veteran or member of the Armed Forces concerned, as determined by the physician of such veteran or member . . . A family caregiver of a veteran or member of the Armed Forces who receives certification as a personal care attendant under this section shall be eligible for compensation from the Department of Veterans Affairs for care provided to such veteran or member." Accessed at http://www.thomas.gov/cgi-bin/query/D?c110:1:./temp/~c110wUzrc0::

tation plan and to report to Congress on the recommendations stakeholders offer and, where such recommendations are not adopted, to provide the rationale for that decision. Finally, the law sets critical due dates: VA was to develop and submit an implementation plan to Congress 6 months after enactment (which fell on November 1st, 2010) and was to implement the law 9 months after enactment, January 30th, 2011.

Based on those requirements of the Act, WWP had three general expectations. First, we had every reason to expect that VA would develop an implementation plan for the comprehensive-assistance program that honored the plain meaning of the law. We expected, therefore, that it would closely track the law and cover caregivers of those who in line of duty on or after 9/11 had sustained a serious injury—including "traumatic brain injury, psychological trauma, or other mental disorder"[7]—and were "in need of personal care services because of (i) an inability to perform one or more activities of daily living; [or] (ii) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury."[8] Our second expectation was that VA would work diligently and in coordination with the Administration to ensure that the deadlines set in the law were met. And our third expectation, based on the consultation provision of the law, was that there would be open dialogue and transparency vis à vis stakeholders in the program's development and implementation.

None of these expectations has been met. As you know, VA has failed to meet the deadlines set in the law. Communication with stakeholders has been decidedly one-sided. VA staff solicited stakeholders views only very late in the process. At no time were stakeholders given a glimpse of a preliminary implementation plan, or a basis for believing that our recommendations were even being seriously considered. VA's deliberation and decision-making regarding implementation has been marked by a level of secrecy more appropriate to a military combat operation than to an effort to help families. But most tragic, the substance of VA's implementation plan falls far short of the requirements of the law; indeed with respect to the question of who would be eligible for comprehensive caregiver support, the plan bears almost no resemblance to the law.

VA Clinical Eligibility Criteria: Who Will Be Hurt and Why

WWP was given no inkling of the contents of the VA implementation plan prior to its submission to the House and Senate Committees, but we have since presented VA officials with a detailed critique of their plan. Most recently, in response to the suggestion that the Administration was moving to expedite its implementation, we presented VA a paper entitled "Caregiver Law Implementation: Accelerated Start Is Less Vital than Getting the Plan Right." Among the problems we highlighted were the plan's unreasonably rigid "clinical eligibility criteria." It is critical to appreciate that these criteria are fundamentally inconsistent with those set in the law; in fact, a core requirement of the VA plan was considered and rejected during the course of development of the legislation itself. To underscore the implications of these criteria, we offered the following examples of the impact these criteria would have on wounded warriors and their caregivers, drawing on our direct experience with these families.

Case 1: A veteran sustained a severe traumatic brain injury. Five years post-injury, he lives with his wife, and while he can carry out all activities of daily living he cannot live independently due to residual cognitive impairment, impaired judgment, and anxiety when in the community. His condition requires that his wife manage all household affairs, finances, telephoning, etc., and accompany him when traveling. While the veteran cannot live independently, he could live in another supervised setting, but because he is not so impaired as to need nursing home care he would not be deemed an "eligible veteran" under the VA implementation plan, and his wife would not be eligible for caregiver supports. Even if that were not an obstacle, coverage would likely be denied under the VA plan's definition of "serious injury" based on its requirement that the veteran be "at high risk for personal safety"—a particularly high threshold this veteran might not meet.

Case 2: A veteran has sustained polytraumatic injuries that have resulted in blindness and cognitive deficits. Because of his cognitive impairment he has not achieved maximum benefit of blind rehabilitation and needs regular assistance with food preparation, shopping, laundry, finances, housekeeping and transportation. His mother provides this assistance on a daily basis. But because his con-

[7] 38 U.S.C. sec. 1720G(a)(2)(B).

[8] 38 U.S.C. sec. 1720G(a)(2)(C); the term "personal care services" is defined at U.S.C. sec. 1720G(d)(4).

dition is stable, he does not require "continual medical management;" and although there are some issues of personal safety, he is not "at high risk for personal safety"—he does not meet one of the VA's required clinical eligibility criteria (or the definitions of the term "serious injury" or "personal care services").

WWP sees no need for VA to establish clinical eligibility criteria beyond those set forth in the law itself. But we also see absolutely no basis in law for VA to superimpose the following requirements, which have the effect of severely limiting eligibility, particularly for those with one of the signature wounds of this war, traumatic brain injury:

a. *Requiring that without caregiver support, the veteran would require institutional care:* The language of the law provides no credible basis for inserting this criterion. It sets an unreasonably high bar, and is fundamentally inconsistent with the explicit criteria in the law. Under the law, the critical issue in determining whether an individual is an "eligible veteran," for purposes of the comprehensive caregiver assistance program, is whether the veteran "is in need of personal care services because of . . . an inability to perform one or more activities of daily living . . . [or] a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury." But VA, by imposing the much higher requirement—need for institutional care—would deem ineligible many veterans who cannot live independently and need the full-time supervision or protection afforded by a family member because of residuals of traumatic brain injury, but are not so profoundly impaired as to need institutional care. VA is saying in effect that even though a veteran needs personal care services, the caregiver who provides those needed services would not be deemed eligible for support. Under this bizarre construct, VA tells a single mother who has left the workforce to care for her son, that she's not eligible for the modest stipend and other support because—although her son can't live independently, he doesn't need nursing home care. What makes this strange reading of the law even more disturbing is that the "need for institutional care" criterion was considered in the development of this legislation and rejected, as discussed in the Explanatory Statement describing the compromise agreement on the Caregivers Act developed by the Senate and House Veterans Affairs Committees.[9] It is unreasonable for VA to revive this rejected standard, and in so doing dramatically restrict eligibility.

b. *Requiring that the veteran must either need "continuing medical management" or be "at high risk for personal safety:"* In creating this criterion, VA again goes too far. Requiring "continuing medical management" has nothing to do with a need for personal care. A veteran's condition can be medically stable, yet make it impossible for the individual to live independently. The plan provides an alternative—a finding that the veteran is "at high risk for personal safety." But such a requirement sets an artificially high threshold: to require that a veteran be at "high risk for personal safety" is to say that a young mother with a brain-injured spouse who poses "only" a moderately high risk of leaving the stove unattended or crossing the street unaware of cars does not merit caregiver support. This high threshold also reads the phrase "need for supervision" out of the statute. The law clearly is not focused solely on safety, but also on behaviors often associated with traumatic brain injury or severe behavioral health problems, either of which could require a caregiving attendant to provide needed supervision.

c. *Defining the term "serious injury" so narrowly that it frustrates the purposes of the law*: VA's plan defines the term "serious injury" by stating that an individual with a serious injury is one who, due to that injury, (i) "require[s] ongoing care," (ii) exhibits impaired ability to function independently, (iii) is vulnerable, (iv) is "at high risk for personal safety," and (v) requires at least 6 months of continuous caregiver support to enable them to live outside an institutional care setting. This definition would artificially create a far higher eligibility standard than the criteria expressly set forth in the law: need for personal care services because of an inability to perform one or more activities of daily living or a need for supervision or protection based on symptoms or residuals of neu-

[9] As noted in the Joint Explanatory Statement accompanying the amendment of the House of Representatives to S. 1963, enacted as Pub. L. No. 111–163, under the earlier House-passed caregiver-assistance bill, H.R. 3155, "[e]ligible OEF or OIF veterans are defined as those . . . in need of caregiver services without which the veteran would be hospitalized, or placed in nursing home care or other residential institutional care . . . ", but "[t]he Compromise Agreement contains the Senate provision" and only "follows the House bill in creating a separate program of general family caregiver support services for . . . caregivers of veterans of any era."

rological or other impairment or injury.[10] The language of the law[11] is consistent with VA policy,[12] and expressly identifies specific kinds of trauma and injury as encompassed by the term "serious injury." As made clear in the Joint Explanatory Statement, seriously injured veterans are those who need personal care services under the criteria specified in the law.[13] VA, in utterly distorting the term "serious injury," has not only ignored the plain meaning of the law, but ignored its own recent definition. VHA Directive 2009–018 defines virtually the same term, "seriously injured or ill Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) Veteran," as one who has "one or more of the following diagnoses or medical conditions . . . : (a) Burns; (b) Spinal Cord Injury; (c) Amputation or loss of function of arm, leg, hand, or foot; (d) Post-traumatic Stress Disorder; (e) Visual impairment; or (f) Traumatic brain injury."[14]

d. *Defining the term "personal care services" in a manner inconsistent with law:* The VA plan defines the term in pertinent part, as a need for assistance "to prevent harm to self or others . . . ." while the law employs very different terminology specifying "a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury" (38 U.S.C. sec. 1720G(a)(2)(C)(ii)). The plan definition not only reads the word "supervision" out of the statute, but inappropriately substitutes a test that comes closer to the strict standard applied to involuntary civil commitment.

VA's Rationale for Setting Eligibility Requirements Far Stricter than Those Set in Law:

VA's Office of General Counsel recently provided the Senate Veterans Affairs Committee a "white paper"[15] which responded to the suggestion that it was not lawful for VA to condition eligibility on a requirement that "without caregiver support providing personal care services at home in an ongoing manner, [the Veteran] would require hospitalization, nursing home, or other institutional care." The General Counsel's paper offered a thin rationale for its conclusion that "there would be a 'rational basis' for including such a criterion . . . such that it would likely withstand any legal challenge." We respectfully differ with that view. But more importantly, the white paper raises the question whether the Secretary of Veterans Affairs, who "is responsible for the proper execution and administration of all laws administered by the Department,"[16] or any officer of the Department acting in his behalf on this matter, ever asked the Office of General Counsel a question such as, "What IS the Secretary's responsibility to caregivers of wounded warriors and to Congress and the American people under the Caregivers Act?" Had that question been posed and the opinion followed, we are confident VA's implementation plan would have looked markedly different. But, rather than attempting to carry out the clear intent of a law it had opposed from the outset, we believe VA sought to impose the strictest-conceivable limitations on who would be eligible.

Thus, in its recent white paper, VA's Office of General Counsel suggests that because the phrase "serious injury"[17] is not defined in the Caregivers Act, implementing regulations "must" supply an appropriate definition to promote consistency of application. Counsel offers no support for the proposition that "consistency of application" trumps conformity to the plain language of the statute. Even more troubling, Counsel makes no effort to explain how the phrase "serious injury" could be read to be synonymous with the phrase "catastrophic injury." Congress defined the term "catastrophic injury or illness" in the context of injured or ill servicemembers as "a permanent, severely disabling injury, disorder, or illness that . . . com-

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[10] 38 U.S.C. sec. 1720G(a)(2)(C).

[11] ". . . an eligible veteran is any individual who . . . has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) . . . ", 38 U.S.C. sec. 1720G(a)(2)(B).

[12] VHA Directive 2009–018, *Tracking Severely Injured or Ill Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans Using the Non-primary Care Team Function in the Primary Care Management Module (PCMM),* March 24, 2009. Sec. 2.c.(1), Accessed at http://www.va.gov/vhapublications/ViewPublication.asp?pub__ID=1863.

[13] Joint Explanatory Statement, ibid.

[14] VHA Directive 2009–018, *Tracking Severely Injured or Ill Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans Using the Non-primary Care Team Function in the Primary Care Management Module (PCMM),* March 24, 2009. Sec. 2.c.(1), Accessed at http://www.va.gov/vhapublications/ViewPublication.asp?pub__ID=1863.

[15] VA Office of General Counsel, *"Family Caregiver Program Implementation Plan: Question on Proposed Eligibility Requirements,"* February 22, 2011.

[16] 38 U.S.C. sec. 303.

[17] ". . . an eligible veteran is any individual who . . . has a *serious injury* (including traumatic brain injury, psychological trauma, or other mental disorder) . . . [who] is in need of personal care services . . . ." 38 U.S.C. sec. 1720G(a)(2) (emphasis added).

promises the ability of the afflicted person to carry out the activities of daily living to such a degree that the person requires personal or mechanical assistance to leave home or bed, or constant supervision to avoid physical harm to self or others."[18] Counsel further conflated scattered provisions of the law that are neither structurally nor logically related to the eligibility language,[19] together with phrasing *deleted* from earlier legislation,[20] to arrive at a richly imagined "implied intention."

Having studied the VA plan, we were frankly mystified by VA's perplexing misreading of the Caregivers Act. Finally, Madam Chairwoman, your questioning of the Secretary at the Committee's recent hearing on the VA budget for FY 12 provided the catalyst to better understanding what was at play. Responding to your question, Secretary Shinseki attempted to defend the Administration's budget for the new comprehensive caregiver-assistance program, which he admitted would cover only 840 families. He acknowledged that in developing eligibility criteria, the goal was "to write a regulation that meets the immediate requirement . . . to Iraq and Afghanistan vets and caregivers—and yet keep the opportunity open" to expand the law to other populations. "So, it's an issue of fairness,"[21] he asserted. In short, he as much as stated that VA's eligibility criteria were set very narrowly, and exclude many OEF/OIF veterans covered under the law, and particularly those with severe traumatic brain injury—so that these criteria might at some future date be applied to other era-veterans.

Such a position is fundamentally at odds with the law, which directs VA to establish parallel programs of caregiver support—a comprehensive program for caregivers of warriors wounded on or after 9/11 as well as a "program of general caregiver support services" (codified at 38 U.S.C. sec. 1720G(b)) for caregivers of all veterans enrolled in the VA health care system who need personal care services.[22] Under the general program, VA is to provide counseling, respite care, and educational support to eligible caregivers. The law further directs the Secretary, within 2 years after the law's implementation, to report on the feasibility and advisability of expanding the comprehensive program to caregivers of veterans injured prior to 9/11.

In short, Congress established a very deliberate framework in the Act—to assist caregivers of all eras of service—while requiring more comprehensive supports for those caring for veterans with recent injuries—an approach that could be viewed as initially limiting the scope of the comprehensive program to those in most immediate and compelling need.[23] While offering real help for all-era caregivers, the law recognizes not only the prevalence of unique kinds of wounds this war's veterans have survived—wounds so profound they would likely have been mortal in earlier wars—but the fact that those with recent injuries are in most instances still undergoing rehabilitation from those injuries. As such, it is altogether understandable that Congress would provide more robust supports for those warriors to help assure the fullest and greatest possible rehabilitation.

With all due respect, for Secretary Shinseki, representing the Administration before Congress, to imply that eligibility rules for the Caregivers Act's comprehensive program should be tightly restricted to enable some future Congress to extend the Act's provisions to other populations is to suggest that the Administration's idea of good policy should trump Congress's. Sadly, arising in the context of the Administration's efforts to trim the FY 12 budget, the fact that only very limited numbers would likely receive comprehensive supports under the plan's cramped eligibility requirements invites speculation as to whether fiscal considerations—rather than "fairness"—have trumped compliance with law and keeping faith with brain-injured warriors.

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[18] National Defense Authorization Act of 2010, Pub. L. No. 110–84, sec. 603 (2010).

[19] Counsel places heavy reliance on two provisions of the law relating to respite care benefits as supporting its reading. But surely VA social workers, if not its lawyers, would appreciate that a family caregiver would need periodic respite whether or not the veteran was so impaired as to require nursing home care.

[20] Counsel would have it both ways. It assigns significance to a statement of purpose dropped from an earlier Senate bill, while rejecting the notion that there is any significance to be attached to the fact that the compromise agreement did not adopt the pertinent provisions of House-passed H.R. 3155, which had included the phrase "without such services, the veteran would require hospitalization, nursing home care, or other residential institutional care."

[21] Testimony of Secretary Eric Shinseki before the House Committee on Veterans Affairs on VA's budget for FY 2012, February 17, 2011.

[22] Under the Caregivers Act the criteria employed in describing what constitutes a "need for personal care services" for purposes of the program of general caregiver support services are the same as for the program of comprehensive assistance; cf. 38 U.S.C. sec. 1720G(a)(2)(C) and 38 U.S.C. sec. 1720G(b)(2).

[23] Limiting the scope of the comprehensive program in this manner, Congress was arguably drawing lines consistent with VA's earlier testimony counseling that caregiver assistance be approached in phases, beginning as VA proposed with a pilot effort.

Other Serious Flaws in the VA Plan:

While eligibility issues have been the principal focus of controversy, VA's plan raises other serious issues. Let me summarize:

1. *Unreasonable limits on the scope of covered mental health services:* The law calls for providing needed mental health services to a primary-caregiver under the comprehensive services program. But VA's plan would provide that caregiver only the very limited coverage afforded under the law's program of general caregiver support. That coverage is expressly limited (under 38 U.S.C. sec. 1782) to circumstances where providing services is necessary to the veteran's treatment. So if a warrior's condition were stable and did not require ongoing treatment, a caregiver who, for example, was experiencing severe anxiety associated with caregiving might not be covered—defeating the very purpose of the benefit. And, under the plan, a caregiver experiencing a bout of depression associated with the stresses of caregiving, for example, would likely not be covered for drug therapy under the plan's strictures. In sum, this limited coverage falls far short of the law's intent as well as short of the kind of support contemplated in the White House's "Strengthening Our Military Families" program.
2. *Ongoing monitoring through routine home-visits at least every 90 days*: The VA plan calls for ongoing monitoring at least every 90 days. Yet as noted in the Joint Explanatory Statement, the compromise agreement contains the Senate provision which was modified to delete a provision that called for "mak[ing] home visits every 6 months."[24] Having successfully pressed the point that routine home visits are inherently intrusive and unwarranted as applied to longstanding, devoted caregivers, WWP finds it very troubling that VA's plan requires routine home-visits twice as frequently as earlier proposed. The intrusiveness of such monitoring is heightened for the many caregivers who also serve as the veteran's fiduciary. As such, they are subject to periodic home visits to check on the veteran's well-being. While the monitoring requirements are highly problematic, the plan is still more objectionable for its failure to address these overlapping inspections. A reasonable plan would at least provide for tapering off the frequency of any monitoring in the absence of problems, and for eliminating the dual intrusion posed for many caregivers by fiduciary-oversight visits.
3. *Flawed Criteria for Determining Stipend Amount*: Under the law, an individual's stipend is to be based on "the amount and degree of personal care services provided." The term "personal care services" is defined in the law to mean "assistance with one or more independent activities of daily living" (as well as any other non-institutional extended care). (Independent activities of daily living (IADL's) include the ability to use the telephone, shopping, food preparation, housekeeping, laundry, ability to travel, responsibility for one's medication, and handling finances.) But VA's plan—rather than determining stipend amount by reference to IADL's, as required by the law—does so principally by reference to activities of daily living (ADL's). The implications of this misapplication of the law are all too apparent to families caring for a loved one with cognitive and other impairments associated with traumatic brain injury, since IADL's take account of such impairments while ADL's do not. The following example illustrates the point:

   > A veteran sustained severe traumatic brain injury as a result of an IED blast in Iraq. While he also suffered a below-the-knee amputation, he is able to perform all the activities of daily living. But he cannot live independently because significant cognitive impairment, markedly impaired judgment and impulsivity create a very serious risk for safety. His father, who has left the workforce, is with him almost constantly, providing for his safety, and also attends to a wide range of the veteran's needs, including telephoning, food preparation, laundry, housekeeping, finances, and transportation. While the veteran meets the VA plan's eligibility criteria, the father would receive only a very nominal stipend under the VA plan because it bases the magnitude of the stipend on the extent of deficits in activities of daily living (feeding, toileting, etc.)—which the veteran can do—rather than independent activities of daily living—which the veteran cannot, and which render him highly dependent.

Madam Chairwoman, the Caregivers Act is not only historic legislation; it represents a solemn promise to spouses, parents, and other family members who devot-

[24] Joint Explanatory Statement, ibid.

edly care for their seriously wounded loved ones. The VA plan would break that promise, and we urge you to stand firm and join us in voicing strong objection. The Administration must not speed through a regulation that covers only a fraction of those eligible under the law. It must not abandon those vulnerable veterans who cannot live independently because of cognitive or other deficits due to traumatic brain injuries.

Thank you for your attention to these deep concerns.

Prepared Statement of Tom Tarantino, Senior Legislative Associate, Iraq and Afghanistan Veterans of America

Madam Chairwoman, Ranking Member and Members of the Committee, on behalf of *Iraq and Afghanistan of America's* 200,000 Member Veterans and supporters, thank you for the opportunity to testify here today on the critical issue of the implementation of the Caregivers and Veterans Omnibus Health Services Act of 2010 (S. 1963) and specifically caregivers' assistance.

My name is Tom Tarantino and I am a Senior Legislative Associate with IAVA. I proudly served 10 years in the Army beginning my career as an enlisted Reservist, and leaving the service as an Active Duty Cavalry Officer. During these 10 years, my family served along with me. They experienced every deployment as well as the challenges of every transition home. Because of the nature of the wars in Iraq and Afghanistan, many families like mine continue to serve long after their veterans have returned home.

The wars in Iraq and Afghanistan are unique. In the last 10 years, improvements in medical technology have decreased the overall number of combat deaths. But while more servicemembers are returning home, thousands are coming back with injuries that will require a lifetime of care. Since the start of the wars, the Department of Defense has counted more than 40,000 servicemembers wounded in action.

Soldiers, Marines, Airmen and Sailors, as young as eighteen, are coming home to the prospect of having someone feed, clothe and care for them for the rest of their lives. All across the country, mothers and fathers, husbands and wives, brothers and sisters, and boyfriends and girlfriends are stepping up, putting aside their own lives and plans to take care of these wounded warriors.

Many caregivers have had to leave their full-time jobs, losing income and benefits. A recent study by the *National Alliance for Caregiving (NAC)* found that 62 percent of veteran caregivers reduced their job hours and half quit their jobs or opted for early retirement—compared to only 10 percent of caregivers nationally. Moreover, half of veteran caregivers reported that they experienced a high degree of financial hardship.[i] Even though helping their veteran is now their full-time job, veteran caregivers right now do not receive the necessary financial support to do so without financial risk.

Far too many are also working without any formal instruction, training or support to care for their veteran. As a result, the *NAC* study found that 88 percent of veteran caregivers reported increased stress or anxiety. Only 15 percent of them received respite care from the VA or another community support service in the past 12 months.[ii]

Natalie Cobb is an example of the selflessness displayed by military families across the country. Her husband Steve, who served in Iraq in 2004, received a concussion in a vehicle accident and then later was severely wounded during patrol when a mortar exploded less than 50 feet away. Following his deployment, Natalie immediately noticed a difference in his behavior. A CT scan revealed an ambiguous spot in his brain and he was sent to Walter Reed Army Medical Center. Steve spent 13 months receiving care there after doctors diagnosed him with Traumatic Brain Injury and Post-Traumatic Stress Disorder. A short time after his release, Steve suffered a heart attack as a result of his anxiety. Natalie remained by his side throughout his long recovery and now, over 6 years later, still serves as Steve's primary caregiver.

Natalie had to learn to take care of Steve on her own. She navigated the VA paperwork by herself. Today, she manages their household while taking care of Steve 24 hours a day. Since she doesn't trust anyone to replace her as his caregiver, she has not had any respite in over 6 years.

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[i] Caregivers of Veterans—Serving on the Homefront, National Alliance for Caregiving, November 2010, p. 17: http://www.unitedhealthfoundation.org/download/cov__*exec.pdf*.

[ii] Ibid., p. 18.

The veterans' community came together 2 years ago to help Natalie and Steve and the many families like them across America. IAVA and all of the veterans' service organizations worked closely with Congress, military families and the caregiver community to craft a law that would meet the needs of these selfless caregivers.

This Committee and its counterpart in the Senate worked tirelessly to ensure that families like the Cobb's would get the support that they needed, including health care, mental health care, respite care and living stipends. Our goal was to make caregivers' lives easier, so that they could devote more time to their wounded warriors without wearing themselves out both physically and financially.

At the time, we believed that we had accomplished our mission. The Caregivers and Veterans Omnibus Health Services Act of 2010 (S. 1963) outlined the law we expected to see from the VA. It was written specifically to apply to more, rather than less, veterans in need of caregivers. It also was intended to cover veterans with Traumatic Brain Injury and Post-Traumatic Stress Disorder, the signature wounds of this war.

We expected to see the implementation plan from the VA within 180 days of enactment of the law on May 5, 2010, and we hoped that caregivers would start receiving much-needed support within 270 days as was stated in the law. But October 2010 came and went without the implementation plan and benefits did not start flowing to caregivers in January as required.

We understand the complexity of regulating S. 1963. This will be the first time that the VA provides direct benefits to family members, outside of a small group of family members who qualify for CHAMPVA. Moreover, the VA must come up with equitable definitions of eligibility for wounded veterans, which is undoubtedly complicated.

We also appreciate that the VA has moved forward on aspects of the law that did not require regulation. The creation of a hotline and Web site for caregivers that provides them with information and assistance in accessing benefits is critical. One of the main challenges caregivers face is a lack of understanding of the benefits available to them. Aggregating these resources and making it easier to find and access them is a big step forward.

Nonetheless, we are disappointed by the delay in implementing the law and specifically in the regulations for eligibility. Since the regulatory process is finally moving forward, I will state that we believe it should continue to move forward quickly. We need to ensure that caregivers do not have to wait any longer for the help that we promised them almost a year ago.

But urgency should not lead us to make more mistakes. The current eligibility requirement is a significant mistake that, if it stands, will gut the spirit of the legislation that we worked so hard to push forward and that this Committee put so much time into crafting.

The law states that eligibility for personal care services will hinge on: one, "an inability to perform one or more activities of daily living," and two, "a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury."[iii] The law also specifically mentions "traumatic brain injury, psychological trauma, or other mental disorder" as serious injuries that would make a veteran eligible.[iv]

Along with representatives of our fellow Veterans Service Organizations, I spent 2 days at the VA this past October discussing how to make sure that the law was regulated appropriately. At the time, we made it clear that the goal was to ensure that all caregivers who needed help received it. In real numbers, we are not talking about a huge segment of the American population—roughly only 3,000 caregivers. These men and women have given up everything to take care of their wounded veterans. It is unacceptable to shortchange this small population at a time when they need our help. Congress made sure this would not be the case by appropriating $1.5 billion from 2011–2015 for support of primary and non-primary family caregivers.[v]

Yet, the regulations proposed by the VA are far more limiting than S. 1963 intended when it comes to eligibility for the critical services that primary caregivers need. The VA's proposed regulations specifically require that the veteran "without caregiver support providing personal care services at home in an ongoing manner, would require hospitalization, nursing home, or other institutional care."[vi] Many

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[ii] Ibid., p. 18.

[iii] Caregivers and Veterans Omnibus Health Services Act of 2010, S. 1963, 111th Congress, § 1720G.

[iv] Ibid.

[v] Ibid.

[vi] Plan for Implementation, Public Law 111–163, "Caregivers and Veterans Omnibus Health

veterans coming home from Iraq and Afghanistan with TBI or post-traumatic stress disorder (PTSD) might well need constant care; however, they don't necessarily need institutionalization. These injuries and hospital care are not synonymous, and making the need for institutionalization the threshold for eligibility misses the goal of S. 1963.

In addition, the definition that the VA uses in the S.1963 regulations for "serious injury" is very specific: "Individuals with a serious injury are individuals who, due to their injury, psychological trauma, or mental disorder, require ongoing medical care, exhibit impaired ability to function independently in their community, are vulnerable and at high risk for personal safety, and for whom at least 6 months of continuous and approved caregiver support is required to enable them to live outside of an institutional care setting."[vii] Yet, the definition of "seriously injured or ill OEF or OIF veteran" according to a directive by the Veterans Health Administration from 2009 is defined as "having one or more of the following diagnoses of medical conditions . . . (a) Burns; (b) Spinal Cord Injury (SCI); (c) Amputation or loss of function of arm, leg, hand or, foot; (d) post-traumatic stress disorder (PTSD); (e) visual impairment, or (f) Traumatic Brain Injury."[viii] In this case, the more restrictive definition used by the VA unnecessarily limits which caregivers will be eligible to act as primary caregivers and receive stipends and support.

The VA has acknowledged that in the VSO meetings some participants "verbalized concern that this [reliance on specific definitions of 'severely injured' and reference to prevention of institutionalization as criteria to assess eligibility] could lead to a 'restrictive' interpretation of eligibility."[ix] Those of us who voiced that opinion were speaking from the experience of our members and their families—and we were right. This regulation is too restrictive. As a consequence, far too many veterans and their families will simply not get the support our country promised them.

The VA's explanation of why it did not take this feedback into account in regulation has so far been insufficient. It ultimately argues that VSO representatives "stated repeatedly that the intent [of the law] was 'to avoid having to place veterans in institutions.'"[x] That, indeed, was part of the intent. The main goal, however, was and remains to support a population of caregivers who had to change their lives to care for their wounded warrior; women and men who are living in some cases with no regular income and no health insurance, just so that they can take care of veterans who can no longer take care of themselves.

Is it hard to come up with the right eligibility criteria? Yes. Does this mean that the only solution is to settle on restrictive criteria? No. To the extent it will help the VA, IAVA and our fellow Veteran Service Organizations are more than willing to work with officials to identify the best criteria. But as it is now the regulation should not stand.

Madam Chairwoman, we are grateful for this opportunity to share the thoughts of Iraq and Afghanistan veterans and their families on the implementation of S. 1963. We also appreciate the VA's efforts to regulate this complicated law and expedite its enforcement. We would like to see it implemented as quickly as possible to give our veteran caregivers the overdue support they deserve. Before any part of the law is enforced, however, regulations on eligibility as they were submitted to the Office of Management and Budget must be changed. We look forward to working with you to ensure this happens swiftly.

Prepared Statement of Barbara Cohoon, Ph.D., R.N., Government Relations Deputy Director, National Military Family Association

Chairwoman Buerkle and Distinguished Members of this Subcommittee, the National Military Family Association would like to thank you for the opportunity to present testimony on *"Implementation of Caregiver Assistance: Are we getting it right?"* The National Military Family Association will take the opportunity to discuss our concerns regarding the Department of Veterans Affairs' Caregiver Implementation Plan and several issues of importance to family caregivers of the wounded, ill, and injured servicemembers, veterans, their families, and caregivers in the following subject areas:

[vii] Ibid., p. 4–5.

[viii] "Tracking Severely Injured or Ill operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans Using the Non-Primary Care Team Function in the Primary Care Management Module (PCMM), VHA Directive 2009–018, March 24, 2009.

[ix] VA Plan for Implementation, p. 34.

[x] Ibid.

I. Wounded Servicemembers Have Wounded Families
II. Caregivers
III. VA Caregiver Implementation Plan
IV. Budget
V. Additional Caregiver Compensation
VI. Senior Oversight Committee

Wounded Servicemembers Have Wounded Families

The National Military Family Association asserts that behind every wounded servicemember and veteran is a wounded family. Spouses, children, parents, and siblings of servicemembers injured defending our country experience many uncertainties. Fear of the unknown and what lies ahead in future weeks, months, and even years, weighs heavily on their minds.

Transitions can be especially problematic for wounded, ill, and injured servicemembers, veterans, and their families. The Department of Veterans Affairs (VA) and the Department of Defense (DoD) health care systems, along with State agency involvement, should alleviate, not heighten these concerns. Our Association believes the government must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded servicemember and veteran must also consider the needs of the spouse, children, parents of single servicemembers, siblings, and especially the caregivers.

Who are the Families of Wounded Servicemembers?

In the past, the VA and DoD have generally focused their benefit packages for a servicemember's family on his/her spouse and children. Now, however, it is not unusual to see the parents and siblings of a single servicemember presented as part of the servicemember's family unit since they offer primary support. Almost 50 percent of the members are single in the active duty, National Guard, and Reserve. Having a wounded servicemember is new territory for family units. Whether the servicemember is married or single, their families will be affected in some way by the injury. As more single servicemembers are wounded, more parents and siblings must take on the role as caregiver helping their son, daughter, or sibling through the recovery process. Family members are an integral part of the health care team. Their presence has been shown to improve the servicemember and veteran's quality of life and aid in a speedy recovery.

Our Association gathered information about issues affecting our wounded servicemembers, veterans, and their families through numerous encounters with families, including a focus group held 2008 at Camp Lejeune and our *Operation Purple®* Healing Adventures Family Retreats in 2008, 2009, and 2010. Families said they find themselves having to redefine their roles following the injury. They must learn how to parent and become a spouse/lover with an injury. Spouses talked about the stress their new role as caregiver has placed on them and their families. Often overwhelmed, they feel as if they have no place to turn to for help. We found many have put their own lives on hold while caring 24/7 for their loved one. Even with all of the additional support by the individual Services and corrective legislative action by Members of Congress, caregivers of the wounded, ill, and injured still find their responsibilities to be overwhelming.

Caregivers

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded, ill, and injured servicemembers and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to VA and DoD health care providers because they tend to the needs of the servicemembers and the veterans on a regular basis. Their daily involvement saves VA, DoD, and State agency health care dollars in the long run.

Caregivers of the severely wounded, ill, and injured servicemembers and veterans have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. The National Military Family Association is pleased with the passage of the *Caregivers and Veterans Omnibus Health Services Act of 2010* (P.L. 111–163) that will provide for the training and compensation for caregivers of wounded, ill, and injured, servicemembers undergoing medical separation and veterans. This law places the VA in an active role in recognizing caregivers' important contributions and enabling them to become better caregivers to their loved ones. It is a "win-win" for everyone involved.

VA Caregiver Implementation Plan

While our Association is extremely appreciative of Members of Congress for the passage of this landmark legislation, we have some concerns regarding the VA's im-

plementation plan. These concerns include a delay in implementation and the interpretation of the law's intent by the VA regarding veteran and caregiver eligibility requirements and available benefits.

Delay

The VA has not met the implementation timeline for the caregiver portion of P.L. 111–163. The bill was signed into law by President Barack Obama on May 5, 2010, with an implementation plan date no longer than 180 days and the commencement of programs no longer than 270 days after enactment of the Act. This required the VA to provide a caregiver implementation plan no later than November 2010 and begin providing the benefit by January 31, 2011. The VA just submitted an Interim Final Rule to the Office of Management and Budget on March 1, 2011 and has posted information about its caregiver implementation plan. The VA is now late in implementing the law. Every day the VA waits to implement the caregiver provision means those who care for our wounded, ill, and injured are going without valuable resources that were intended to improve the quality of the caregiver's life and of the life of those they care for. Our Association acknowledges the VA has not implemented other provisions provided in the law as well. These include: women veteran's health care; rural health improvements; mental health services for veterans; and other health care matters. These provisions must also be implemented as quickly as possible.

Our Association, along with other Veteran and Military Service Organizations, frequently states how important this piece of legislation is for our Nation's caregivers. Every day the VA delays its implementation only places additional stress on an already strained population. We really cannot afford to put this off even one more day. The least the VA could do in order to compensate for its delay is to provide retroactive stipend payments to caregivers from the original date of implementation required by law.

Congressional Intent

Our Association, along with several others, was involved with the careful drafting of the caregiver legislation. We all worked hard ensuring the language included important provisions to provide valuable support to the caregivers of our wounded, ill, and injured servicemembers and veterans. We feel very fortunate to have played such an important role in the development of the legislation. We are also thankful to the VA for inviting us to participate in the VA's roundtable discussion and provide our input on the caregiver program's implementation. However, we have concerns with the VA's interpretation of the caregiver provision in P.L. 111–163 in two areas: veteran and caregiver eligibility and available benefits. We feel the VA is not meeting the intent of Congress or the needs of caregivers the law was intended to help.

Eligibility

The VA's eligibility establishes a much more stringent criteria then the law dictates. According to the VA's caregiver implementation plan, the veteran's eligibility is tied to:

- the veteran's inability to live independently in their community without the support from a caregiver;
- the caregiver providing personal care services at home continuously; and
- the veteran being hospitalized, placed in a nursing home, or in other institutional care settings without the support of the caregiver.

It appears the VA chose not to incorporate the law and the intent of Congress and to capture a larger less medically disabled population. The inclusion of language, "has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder)" and "a need for supervision" was intended to allow for wounded, ill, and injured servicemembers and veterans to be included without the requirement of a catastrophic medical condition or the need for institutional level of care. Many of our wounded, ill, and injured servicemembers and veterans have mild to moderate cognitive impairment that require caregiver support, but they certainly do not need hospitalization or to be institutionalized. The law's language was intended to capture this population and allow their caregivers to be eligible to receive benefits. However, the VA's interpretation will exclude this population. More importantly, the VA's interpretation will now cause a much smaller number of caregivers to qualify. Original estimates stated the law would have assisted 3,500 caregivers; however, during recent testimony the VA stated only 840 caregivers would qualify under these criteria.

The application process cannot begin until after the servicemember has completed the DoD disability evaluation process, has been found unfit for duty due to their

medical condition, and received a date of separation. According to the Army's MILPER Message #09–067 regarding the Army Transition Center Policy and Procedures for Disability Evaluation System (DES) Separation Processing, a soldier found unfit for duty by the physical evaluation board will be assigned a separation date not later than 90 days. The VA's implementation plan state the servicemember and the caregiver cannot begin the application process until they receive a date of separation. Our Association believes this may not provide enough time for the completion of all of the VA's eligibility criteria before the servicemember and their caregiver enter veteran status. Our Association is concerned this may impact the seamless transition of programs and services for the servicemember, but more importantly for the caregiver.

Currently, the DoD is providing a caregiver compensation benefit to the servicemember for services provided by their caregiver. The law states DoD's compensation stops 3 months (90 days) after the servicemember has been medically retired. However, the VA's caregiver benefits do not begin until training and pre-defined competencies have been successfully completed by the caregiver, in the home, and validated by the VA. Ninety days until the servicemember medically retires, along with DoD's additional 90 days following medical retirement to receive caregiver compensation, may not provide enough time for:

- the VA's caregiver application process to be completed;
- the VA to determine the servicemember and caregiver are eligible; and
- the caregiver to successfully complete the required caregiver training.

This scenario has the potential to create a gap in monetary compensation and impact the family's financial stability because the DoD's caregiver compensation benefit has stopped and the VA caregiver stipend benefit has not started.

Eligibility dictates that the servicemember and veteran will receive care at home once caregiver training is complete. This means that even if a servicemember has a date of medical separation the caregiver will still not qualify if the servicemember/veteran is still receiving care from a hospital. Therefore, the servicemember would need to be finished with all treatment and ready to be cared for solely at home in order to qualify for this program. This would also delay the servicemember's ability to submit the application and for the VA to begin caregiver benefits.

There is a strong possibility given the eligibility criteria that some servicemembers with multiple injuries, such as a mild or moderate TBI, a loss of an extremity, PTS or PTSD, and 10 percent burn, may not qualify for this program. Multiple injuries are commonly seen in our returning servicemembers from war. The potential disqualifying criteria states, "incapacity, physical or mental which requires care or assistance on a regular basis to protect the veteran from hazards or dangers incident to his or her daily environment." It is the word "incapacity" that will most likely disqualify them and subsequently the caregiver from receiving any benefits. Again, this was not the intent of the law. Co-morbid injuries may require the servicemember and veteran to need the assistance and support of a caregiver; therefore, they should be included in these benefits.

The inclusion of the language "has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder)" and "a need for supervision" was intended to allow for wounded, ill, and injured servicemembers and veterans to be eligible. Illness was one condition that was intended to be included. It is unclear whether or not illness is considered an eligible medical condition for the VA caregiver benefit. If illness is not included, then there is the potential for DoD's caregiver compensation benefit and the VA's caregiver benefit to apply to different sets of servicemembers and veterans. DoD's would include illness and the VA's would not. This could potentially create a disparity in benefits and a lack of a seamless transition regarding compensation. Therefore, our Association recommends that illness be included as an eligibility requirement by the VA. Maintaining financial compensation will be key in ensuring these families' financial situations stay stable during transition from active duty to veteran status.

The time to acknowledge the caregiver's important role and to implement a standardized, certified program, and begin compensation is while the wounded, ill, and injured servicemember is still on active duty status. The self-selection process of a caregiver occurs during the early phase of the recovery process. All branches of the Services are holding onto their wounded, ill, and injured servicemembers much longer than previous wars. Years may have passed before the caregiver and the wounded, ill, and injured servicemember reach eligibility and can benefit from the VA's important programs and services. Therefore, we recommend that the designation and education of caregivers be established while they are still upstream on active-duty, rather than wait until they have transitioned to veteran status.

Benefits

Waiting until after the receipt of a medical separation date will prevent caregivers from being able to receive training and obtain benefits early enough in the recovery phase to make a difference in their quality of life and in the quality of care they provide. Servicemembers often receive care in a military hospital and/or VA Polytrauma Center and then recover at home, and then return to the hospital for follow on care/surgeries. This training requirement will prevent eligible caregivers from receiving any advance training for in-home care until the servicemember is being medically retired from the military. Our Association finds this troubling because a recent survey by the National Alliance for Caregiving, *"Caregivers of Veterans—Serving on the Homefront,"* found a top challenge faced by veteran caregivers was not knowing what to expect medically with the veteran's condition and not knowing how to address post-traumatic stress disorder or mental illness. Caregivers have frequently stated they did not know how to care for a servicemember and veteran when they were discharged from the hospital and went home during their recovery phase. This can cause increased stress on an already anxious caregiver. Our Association believes the sooner you provide caregivers with the skills they need to perform their duties, the sooner they will be able to provide a higher quality of care to the wounded, ill, and injured servicemember and veteran. The VA's decision to wait until the servicemember is medically retired from the military and getting care only at home before beginning the application process will certainly prevent this valuable training opportunity from occurring at the appropriate time to make a difference in the quality of care of the wounded, ill, and injured servicemember.

The delay in eligibility also impacts the ability to obtain time sensitive needed benefits, such as access to mental health counseling, health care benefits, and financial compensation. This especially impacts non-spouse caregivers who would greatly benefit from these services. According to the recent survey, *"Caregivers of Veterans—Serving on the Homefront"* one in four respondents were parents caring for Operation Enduring Freedom and Operation Iraqi Freedom veterans. Also, a larger proportion of veteran caregivers compared to their National (civilian) counterparts reported mental illness, such as depression or anxiety (70 percent) or PTSD (60 percent) compared to their National counterparts (28 percent). Veteran caregivers also reported their situation to be highly stressful (68 percent versus 31 percent Nationally) and 75 percent stated it placed a stress on their marriage (74 percent).

According to this recent survey, there are widespread impacts on the caregiver's health, such as increased levels of stress and anxiety (77 percent) and not sleeping (77 percent), and a decrease in the utilization of healthy behaviors, such as seeing their medical provider. Our Association is hearing that caregivers are reaching the stage of burnout and many are deciding to walk away from their roles as caregivers. The longer the VA waits to begin benefits, the more opportunity there is for the caregiver's quality of life to worsen and for the caregiver to reach the stage of burnout. The caregiver survey highlighted the increased stress our veteran caregivers are under compared to their National counterparts. The law and Congressional intent were to allow the VA to provide assistance through value-added benefits to the caregiver early enough in the process to make a difference and prevent the development of physical health, mental health, and/or financial problems. Caregivers of our wounded, ill, and injured need these services now, and sooner in the recovery process than later.

The VA has decided to begin all of the benefits at the same time. They could very easily make training information and access to valuable VA and DoD resources available much earlier in the process than their proposed timeline. Again, the earlier access to pertinent resources and information related to VA and DoD benefits for the servicemember, veteran, and themselves, will only be a win-win for everyone involved. Allowing early access to information validates the important role caregivers provide. Plus, an educated caregiver will only provide better care in the long run. Our Association recommends the VA begin caregiver benefits as early as possible while the servicemember is still on active duty status and not wait until they have received a final determination.

We acknowledge and applaud VA's recent launch of a caregiver section on their Web site. However, the outreach to potential recipients was not included in their caregiver implementation plan. How will caregivers of our wounded, ill, and injured servicemembers and veterans of all eras be made aware of this valuable resource?

Training

The VA's decision to delay access to valuable training may force each Service to begin their own training program in order to compensate for this delay. Most likely, this may cause each Service's training program to vary in its scope and practice; therefore, it may not meet VA's training objectives. This could force the caregiver

to undergo two different training programs in order to provide care and receive needed benefits.

Stipend

Many caregivers have given up their jobs. Therefore, the family has less money to make ends meet. The caregiver stipend will most likely not equal the caregiver's lost wages, but it will be better than not having any additional income. Our Association appreciates VA's acknowledging the need to compensate caregivers for providing direct hands-on medical care. We support the VA's decision to use a stipend matrix applying the U.S. Department of Labor's Bureau of Labor Statistics (BLS) hourly wage index in the geographic market times the number of hours/Full Time Equivalent (FTE) required to perform a determined number(s) of Activities of Daily Living in determining the caregiver's stipend. However, we notice that the VA did not include a provision to pay caregivers for performing non-medical care services.

Our Association has always proposed that financial compensation should recognize the types of medical and non-medical care services provided by the caregiver. We have also advocated for this compensation to begin while the hospitalized servicemember is still on active duty, continue throughout transition, and into veteran status.

Our Association's proposal for a non-medical compensation for caregivers would be on a sliding scale with a minimum and maximum amount allowed under this provision. The payment would reflect the amount of services the caregiver was providing, such as traveling to appointments or making appointments. The amount would increase as the demand for services increased, such as following a surgery, and decrease as the need dissipated after recovery. This need would have to be assessed quickly without delay in order to provide the correct amount of compensation. The compensation could begin with the level determined during the initial evaluation and could increase, but not decrease, until the servicemember enters veteran status and establishes a permanent residence. The amount should remain the same regardless of where the caregiver resides from the time of eligibility until they reach veteran status and establish a permanent residence.

The reason for wanting to include a non-medical compensation benefit is because there are many hours in a day spent performing these activities that play an integral part in maintaining the servicemember and veteran's quality of life yet are not captured by the VA's BLS stipend matrix. Plus, Section 1115 of title 38 of the United States Code provides compensation to the veteran only when the spouse cannot perform the duties of a caregiver. This same level of stipend should be applied to non-medical care services provided by caregivers to servicemembers and veterans.

The VA's stipend is paid directly to the caregiver for their services, which we appreciate. We are concerned over the VA's statement that the caregiver stipend may be considered taxable income. This was certainly not an intended consequence. Our Association looks forward to working with the VA and Members of Congress on addressing this potential issue.

CHAMPVA

Our Association is pleased caregivers will have the opportunity to benefit from the Civilian Health and Medical Program of the Department of Veterans Affairs, known as CHAMPVA. We appreciate caregivers being allowed to access health care through community based CHAMPVA providers or on a space available basis at VA Medical Centers. The population most likely to use this benefit will be the veteran's parent. They will at some point become eligible for Medicare. Therefore, we would recommend the VA include a provision to help guide them during this transition process to ensure continuity of health care services.

Mental Health Services

The VA caregiver implementation plan states, "Primary family caregivers will be covered . . . for mental health services in connection with the treatment of the Veteran" and "mental health services needed by the primary family caregiver but *not related to the treatment of the Veteran.*" The implementation plan states further, "but not medication." We wonder if medication will be provided by the caregiver's medical provider. If so, how will the coordination between the caregiver's medical provider and the person/entity providing mental health services be accomplished? We recommend VA provide coordination of mental health services and appropriate medication when indicated by the caregiver's primary health care provider to ensure the caregiver is receiving a holistic approach to mental health care. Also, the caregiver implementation plan does not explain what the VA means by expanded "counseling" services under the law. We would appreciate it if the VA would clarify what these counseling services for family caregivers will include.

Travel, Lodging, and Per Diem

Our Association is concerned over the reimbursement process. Being paid after the event may cause an unwarranted financial burden on the family. We would recommend the VA evaluate the financial impact on the caregiver before granting travel and offer advance travel compensation if warranted. What does the VA mean they will provide reimbursement "when appropriate" and determine costs based on "any other extenuating circumstance?" These are vague and open-ended statements that need further clarification. The implementation plan is not clear on who submits the request for travel authorization, the caregiver, veteran, or the case manager? Our Association would recommend the case manager or a VA employee be assigned to provide this service. Caregivers have enough on their plate without the added burden of submitting forms.

Respite Care

The VA currently has authority to provide respite care and says it does not require additional authority to expand respite care services under the new law. The VA policy currently allows up to 30 days annually and states additional days may be offered due to unforeseen circumstances. And, they say they will assess the veteran and caregiver for appropriate respite care services. The VA is not meeting the intent of the law regarding this benefit. The intent was to add more respite care hours to the current VA policy, not keep the status quo. Caregivers of our wounded, ill, and injured veterans are experiencing tremendous stress and strain. This fact has been validated in the recent caregiver survey where veteran caregivers experienced higher burden of care (65 percent) compared to National caregivers (31 percent). We recommend caregivers have immediate access to these additional hours on top of the hours already provided in VA's current policy without the need to be "assessed" by the VA to determine if they are eligible for additional hours.

Monitoring

The intent of the law is for the VA to be as unobtrusive as possible when monitoring the caregiver's performance. The plan's statement that "on-going monitoring will include home visits . . . at least every 90 days," means to us that this could occur more frequently. If so, how frequent and what would trigger the visit? It appears the VA is constantly monitoring and will collect data during three separate occasions: in-home visits, ongoing visits, and well-being visits. Where is this information going and who is coordinating all of the data? How often will the veteran's activities of daily living and the caregiver's hours be re-evaluated? What does the VA mean by "the initial validation of caregiver competence will be done in a timely manner?" What does the VA consider timely?

It appears the VA is focused exclusively on the care and well-being of the veteran rather than making sure the caregiver is also physically, mentally, and financially stable. We recommend the VA take a holistic approach to care and include the caregiver and the family when assessing the veteran. Everyone's health and well-being is linked together, especially when caring for the wounded, ill, and injured servicemember and veteran. This would require the VA to assess the primary caregiver and their family's well-being during each of their visits and make appropriate referrals for care and/or services to address the issue(s). Timely intervention is key in making sure caregivers get the right care at the right time and the issue is quickly resolved. The VA must also look for abuse of the caregiver by the veteran and provide appropriate mediation when necessary.

Revocation of Primary Family Caregiver

Our Association is pleased the VA provided an implementation plan if the primary caregiver decides to no longer provide the required personal care services. The VA states all benefits for the primary caregiver will end once their role ends. We appreciate the VA offering to work with the primary caregiver during transition; however, we would request the VA provide a definite timeline and criteria required to be met prior to the stopping of the stipend. We hope the potential financial impact on the caregiver and family is also taken into consideration before discontinuing the stipend and the impact of ending any benefits on the veteran, caregiver, and their family.

The VA needs to clarify additional revocation concerns. What if the veteran is mentally unable to make the decision to revoke the caregiver's benefit? How does the legal guardian fit into this scenario? What if the primary caregiver is also the veteran's legal guardian and/or medical power of attorney? What if the veteran has difficulty controlling their anger related to their medical condition and this is the underlying reason for the revocation request(s)? The caregiver implementation plan does not provide any insight on how these matters will be dealt with by the VA.

Budget

The VA budget will provide $208 million for the implementation of the *Caregivers and Veterans Omnibus Health Service Act of 2010* (P.L. 111–163) for Fiscal Year 2012 (FY 2012). The money will be used to provide: specialized caregiver training for individualized veteran health care needs; a stipend payment paid directly to caregivers for care provided; and health care and mental health care services for caregivers. *The Independent Budget for the Department of Veterans Affairs Fiscal Year 2012* recommended the VA will need approximately $385 million to fund the provisions in P.L. 111–163 in FY 2012. They further state the advance appropriations for FY 2011 will be insufficient to meet the increased workload placed on the VA by the P.L. 111–163, which may require supplemental funding. We encourage Members of Congress to make sure the law is sufficiently funded to meet all of its requirements.

Additional Compensation for the Caregiver

Our Association is appreciative of the generous benefits included in the *Caregivers and Veterans Omnibus Health Service Act of 2010.* However, there were some areas not addressed. Our Association would like to take the opportunity to present recommendations.

A report by the Center for Naval Analysis determined 85 percent of caregivers left employment or took a leave of absence from work or school while performing their caregiver duties. They found that the average loss of earnings per caregiver was approximately $3,200 per month. The financial strain placed on the family of our wounded, ill, and injured servicemember and veteran by the caregiver leaving outside employment has a trickle down affect. Caregivers who have been saving for retirement now find they are ineligible for their employers' 401(k)s. We believe a mechanism should be established to assist caregivers to save for their retirements, for example, through the Federal Thrift Savings Plan.

Once the recovery process is finished and the veteran's care has stabilized, the caregiver may decide to work outside the home in order to help make financial ends meet. These caregivers may need the ability to learn new skills in order to compete in today's workforce. We recommend VA offer these caregivers the opportunity to participate in VA's vocational rehabilitation programs and help retool the caregiver's resume. We must also find innovative ways to encourage civilian and government employers to hire these caregivers, especially when the veteran is unable to work.

According to the Center of Naval Analysis, wounded, ill, and injured servicemembers and veterans, their families, and caregivers are assisted by many non-governmental organizations (NGOs) and charities. This assistance is important with the overall financial stability of these families during the recovery phase. Our Association's concern, as we continue into another year of economic downturn, is that we may find many of these NGOs and charities no longer able to assist in the manner they have previously. We believe the availability of outside assistance by others will need to be monitored closely by both the VA and DoD to make sure these families are still being helped. If they are no longer being assisted, we believe the VA and DoD may need to begin providing assistance in those areas previously done by NGOs and charities.

Relocation Allowance

Active duty servicemembers and their spouses qualify through the DoD for military orders to move their household goods (known as a Permanent Change of Station (PCS)) when they leave the military service. Medically retired servicemembers are given a final PCS move. Medically retired married servicemembers are allowed to move their family; however, medically retired single servicemembers only qualify for moving their own personal goods.

The National Military Family Association suggests medically retired single servicemembers be allowed the opportunity to have their caregiver's household goods moved as a part of the medically retired single servicemember's PCS move. This should be allowed for the eligible primary caregiver and their family. The reason for the move is to allow the medically retired single servicemember the opportunity to relocate with their caregiver to an area offering the best medical care, rather than the current option that only allows for the medically retired single servicemember to move their belongings to where the caregiver currently resides. The current option may not be ideal because the area in which the caregiver lives may not be able to provide all the health care services required for treating and caring for the medically retired servicemember. Instead of trying to create the services in the area, a better solution may be to allow the medically retired servicemember, their caregiver, and the caregiver's family to relocate to an area where services already exist, such as a VA Polytrauma Center.

The decision on where to relocate for optimum care should be made with the help of the Federal Recovery Coordinator (case manager), the servicemember's physician, the servicemember, and the caregiver. All aspects of care for the medically retired servicemember and their caregiver shall be considered. These include a holistic examination of the medically retired servicemember, the caregiver, and the caregiver's family for, but not limited to, their needs and opportunities for health care, employment, transportation, and education. The priority for the relocation should be where the best quality of services is readily available for the medically retired servicemember and his/her caregiver.

Veteran Housing

Many of our wounded, ill, and injured servicemembers and veterans from this current conflict are being cared for by their parents. Also, many adult children of our senior veterans are experiencing firsthand trying to juggle the needs of the parents along with the needs of their children, and are referred to as the "sandwich" generation. Parent caregivers worry about who will care for their wounded son or daughter as they age and are unable to fulfill the role of caregiver. Caregivers may reach burnout and will need alternative solutions for providing care. The VA needs to be cognizant of the ever changing landscape and needs of their veteran population and those who care for them. The VA needs to offer alternative housing arrangements, such as assisted living facilities and family/retirement villages, which allow a diversified population to live together in harmony. This will go a long way in allowing for family units to stay together, foster independent living, and maintain dignity for the veteran.

Brooke Army Medical Center (BAMC) has recognized a need to support our wounded, ill, and injured families by expanding the number of guesthouses co-located within the hospital grounds and providing a family reintegration program for their Warrior Transition Unit. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in guest housing serves as a sanctuary for family members. VA medical facilities could benefit from looking at successful programs like BAMC's that embrace the family unit and commit to building family friendly environments of care for our wounded, ill, and injured servicemembers, veterans, and their families. We recommend the development of alternative housing and living arrangements for veterans, their families, and those who care for them.

Mental Health

The need for mental health services will remain high for some time even after military operations scale down and servicemembers and their families transition to veteran status. Veterans' families and caregiver requirements for a full spectrum of mental health services—from preventative care and stress reduction techniques, to individual or family counseling, to medical mental health services—will continue to grow. It is also important to note if DoD has not been effective in the prevention and treatment of mental health issues, the residual will spill over into the VA health care system. The VA must be ready. They must partner with DoD and State agencies in order to address mental health issues early on in the process and provide transitional mental health programs. They must maintain robust rehabilitation and reintegration programs for veterans, their families, and caregivers that will require VA's attention over the long-term.

The National Military Family Association is especially concerned with the scarcity of services available to the veterans' families and caregivers as they leave the military following the end of their activation or enlistment. Military families will no longer qualify for many of the Services' family support programs and DoD's Military OneSource. Our Association recommends the VA increase outreach to veterans, their families and caregivers, and the communities they live in about available mental health resources to help them deal with the residual effects of long frequent deployments.

Children of the Veteran and Caregiver

The impact of the wounded, ill, and injured veteran on their children is often overlooked and underestimated. These children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating Military Treatment Facility (MTF) or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded, ill, and injured spouse. Children get shuffled from place to place until they can be reunited with their par-

ents. Once reunited, they must adapt to the parent's new injury and living with the "new normal." We must remember the caregiver may not be the veteran's spouse. They may be the wounded veteran's parent, sibling, or friend. These children are also affected and Congress and the VA must be cognizant of their potential psychological needs as well.

We encourage partnerships between government agencies, VA, DoD, and State agencies and recommend they reach out to those private and non-governmental organizations who are experts on children and adolescents. They could identify and incorporate best practices in the prevention and treatment of mental health issues affecting these children. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as they head into the veteran phase of their lives. VA, DoD, State, and our local communities must become more involved in establishing and providing supportive services for our Nation's children.

Expansion of Caregiver Pilot Programs

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. These pilot programs are important; however, there is a strong need for 24-hour in-home respite care, 24-hour supervision, emotional support for caregivers living in rural areas, and coping skills to manage both the veteran's and caregiver's stress. We are appreciative that P.L. 111–163 will provide for increased respite care hours, along with counseling and mental health services for caregivers, but neither addresses the 24-hour supervision. We recommend if these pilot programs are found successful, they should be implemented by the VA as soon as possible and fully funded by Congress. Another program not addressed is the need for adequate child care. The caregiver may have non-school aged children of their own or the wounded, ill, and injured veteran may be a single parent. The availability of child care is needed in order to attend their medical appointments, especially mental health appointments. Our Association encourages the VA to create a drop-in child care program for medical appointments on their premises or partner with other organizations to provide this valuable service.

Senior Oversight Committee

Our Association is appreciative of the provision in the National Defense Authorization Act for Fiscal Year 2009 (NDAA FY09) continuing the DoD and VA Senior Oversight Committee (SOC) until December 2010. The DoD established the Office of Wounded Warrior Care and Transition Policy to take over the SOC responsibilities. The office has seen frequent leadership and staff changes and a narrowing of their mission. We urge Congress to put a mechanism in place to continue to monitor this Office for its responsibilities in maintaining VA and DoD's partnership and making sure joint initiatives create a seamless transition of services and benefits for our wounded, ill, and injured servicemembers, veterans, their families, and caregivers.

Recommendations

- ***Broaden eligibility criteria to meet Congressional intent;***
- ***Clarify eligibility requirements and benefits provided by the VA;***
- ***Provide retroactive stipend payments to the original date of implementation required by law;***
- ***Begin caregiver benefits as early as possible while the servicemember is still on active duty status and not wait until they have received a final determination;***
- ***Provide extra respite care as required by law;***
- ***Provide adequate funding to implement caregiver benefits;***
- ***Maintain seamless transition of benefits and programs;***
- ***Coordinate and collaborate health care and behavioral health care services between the VA, DoD, and State and governmental agencies in sharing of resources;***
- ***Approve relocation allowances and provide alternative housing and living arrangements;***
- ***Increase outreach to veterans, their families, and the communities they live in about available benefits;***
- ***Provide opportunities for the entire family to reconnect and bond as a family again;***
- ***Provide a holistic approach to care that incorporates the impact of the wound, illness, or injury on the family unit;***

- ***Expand all of the VA's caregiver pilot programs; and***
- ***Continue oversight of the SOC by Members of Congress.***

The National Military Family Association would like to thank you again for the opportunity to provide testimony on the VA's caregiver implementation plan for P.L. 111–163. Military families support the Nation's military missions. The least their country can do is make sure servicemembers, veterans, their families, and caregivers have consistent access to high quality health and behavioral care. Wounded servicemembers and veterans have wounded families. The system should provide coordination of care, and VA and DoD need to work together to create a seamless transition. We ask this Subcommittee to assist in meeting that responsibility. We look forward to working with you to improve the quality of life for servicemembers, veterans, their families and caregivers, and survivors.

Prepared Statement of Robert A. Petzel, M.D.,
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Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of the Committee: thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Implementation Plan (the Plan) for the provisions of title I of Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010 (the Act). I am accompanied today by Mr. Walt Hall, Assistant General Counsel, and Ms. Deborah Amdur, Chief Consultant for Care Management and Social Work, VHA.

VA has provided support to caregivers of veterans for almost eight decades. We understand how critical family caregivers are for the veterans they support with such dedication. Veterans are best served when they can live their lives as independently as possible and when surrounded by their loved ones. VA remains committed to ensuring veterans receive the care they need in the least restrictive environment possible. The Act enhances VA's existing authority to provide services for caregivers of veterans and will allow VA to provide groundbreaking new benefits and services to certain caregivers of eligible veterans whose serious injuries were incurred or aggravated in the line of duty on or after September 11, 2001.

This is an historic law that provides unprecedented benefits to caregivers of certain seriously injured veterans and servicemembers. Many veterans and caregivers, Veterans Service Organizations, and community partners have worked to enact this legislation and have provided input into VA's Implementation Plan. VA is working as quickly and responsibly as possible to deliver the enhanced benefits authorized by the Act to eligible veterans and their caregivers and will keep the Committee closely apprised of its progress.

Servicemembers injured in Afghanistan and Iraq are surviving injuries that would have been fatal in past conflicts, due in part to advanced protective equipment and medical treatment. VA and the Department of Defense see the full range—and countless combinations—of injuries suffered by these returning veterans and servicemembers.

My testimony today discusses what VA is doing to support veterans and servicemembers and their caregivers, and what assistance and support services VA will provide under the new law. I will begin by briefly summarizing the law; describing VA's comprehensive efforts to develop the programs required by this law and draft the Plan; detailing VA's existing programs for supporting caregivers; providing VA's recommendation for benefits and enhancements to these programs; and then present a path forward for full implementation.

About the Law

The Caregivers and Veterans Omnibus Health Services Act of 2010 (the Act) was signed into law by President Obama on May 5, 2010. Title I of the Act authorizes VA to provide specified new benefits to the approved primary and family caregivers of eligible veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. VA distinguishes between three categories of caregivers who may receive assistance and support under the new law:

1. *General Caregiver*: Any person who provides personal care services to an enrolled Veteran, regardless of era or injury, under the program of support services for caregivers of covered veterans.
2. *Family Caregiver*: A person designated by the eligible veteran who is approved as a provider of personal care services for an eligible veteran who supports the

primary family caregiver in meeting the veteran's daily needs, under the program of comprehensive assistance for family caregivers. This person can be a family member or someone who lives with the eligible veteran full time.

3. *Primary Family Caregiver*: This person is designated by the eligible veteran and is designated by VA as the primary provider of personal care services for an eligible Veteran. This will be the person primarily responsible for the veteran's daily care and assistance, under the program of comprehensive assistance for family caregivers. This person can be a family member or someone who lives with the eligible Veteran full time.

Caregivers of qualifying veterans will receive educational sessions made available in person and online; access to telehealth services and other available technologies; techniques, strategies and skills for caring for a disabled veteran; counseling, training and other services necessary for the veteran's treatment; respite care that is medically and age appropriate for the veteran; and referral services to community and other support programs. It is important to emphasize that these are programs and services currently available within VA, but these are being expanded as a result of the Act.

Approved family caregivers of eligible veterans may receive tailored instruction and training for the veteran's care; travel, lodging and per diem while undergoing training; respite care for the veteran while the caregiver receives training; lodging and subsistence during travel to and from, and for the duration of medical examinations, treatments or care for the veteran; ongoing technical support; and counseling.

Designated primary family caregivers may receive a monthly stipend paid directly to the caregiver; health care coverage under the Civilian Health and Medical Program of VA (CHAMPVA), if the caregiver is not already entitled to care or services under a health plan contract; mental health services; and at least 30 days of respite care per year, which can include in-home care. Stipend amounts will be based on the amount and degree of personal care services provided. Under the Implementation Plan submitted to the Committee in February, VA would ensure that stipend amounts are comparable to the earnings of a Home Health Aide in the veteran's local community. The actual amounts and other details of the stipend will be defined through regulations and are still in development.

Primary and family caregivers will be chosen by the veteran through a joint application process with the assistance of a local VA caregiver support coordinator. VA will assess the eligibility of the veteran for the family caregiver program and the capacity for the veteran's selected caregiver(s) to provide the personal care services required by the veteran.

Implementation Plan

Even before the Act was signed by the President, VA had begun work to identify resources and develop plans to put these enhancements and new benefits in place. VA established a Steering Committee to oversee the implementation process. The Committee reviewed the law, recommended staff resources necessary for full implementation, and established four Workgroups that analyzed and developed recommendations for different aspects of the Caregiver Support Program: benefits, clinical issues, eligibility and information technology. The Committee consisted of more than 50 subject matter experts from across the country with expertise in polytrauma care, care management, mental health, administration, law, business processes, information technology, contracts, and other specialties. The Department of Defense also participated in these sessions. The Workgroups conducted face-to-face meetings and held regular conference calls to address issues associated with implementation, answer questions critical for VA's Implementation Plan and develop effective processes that could be put in place across the system.

VA held a Caregiver Conference in Washington, D.C. in July 2010 and conducted a series of meetings and round table discussions with veterans, caregivers, national non-governmental organizations (NGO) with expertise in caregiving, and Veterans Service Organizations (VSO) to solicit their input and identify concerns. VA staff met with VSOs on October 5, 2010 and October 13, 2010. These meetings included representatives from the American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Iraq and Afghanistan Veterans of America, Military Officers Association of America, National Military Family Association, Paralyzed Veterans of America, Veterans of Foreign Wars, Veterans of Modern Warfare, and Wounded Warrior Project. On October 7, 2010, VA met with NGOs possessing expertise in caregiving, including American Red Cross, Easter Seals, National Alliance for Caregiving, National Family Caregivers Association, Family Caregiver Alliance, Rosalynn Carter Institute for Caregiving, National Association of Area Agencies on Aging, National Council on Independent Living, and ARCH National Respite Network and Resource Center.

The Implementation Plan was delivered and briefed to staff of the House and Senate Veterans' Affairs Committees on February 9, 2011. This Plan can be accessed electronically on VA's Caregiver Web site at: http://www.caregiver.va.gov/docs/Caregivers_part1.pdf. It is important to note that the Plan comprises VA's recommendations; the final word on eligibility criteria, as well as the other details of implementation, will come only after completion of the rulemaking process, which includes Office of Management and Budget (OMB) review and a period for public comment, which can also result in adjustments to the rules governing the program.

Existing Services Available to Caregivers and Veterans through VA

As noted earlier, VA has offered support and benefits to the caregivers of veterans since before World War II. VA has provided aid and attendance benefits for decades as part of certain veterans' direct benefits, and depending upon the nature of disability. VA can provide up to $4,977 per month in special monthly compensation (in addition to the $2,673 in disability compensation for 100 percent service-connected condition) for eligible veterans in need of aid and attendance to allow them to pay caregivers. The amount varies depending on the level of aid and attendance needed.

For example, VA routinely offers in-person educational support for caregivers of veterans undergoing discharge from an inpatient stay at a VA facility and teaches techniques, strategies, and skills for caring for a disabled veteran. This includes instruction and specialized training in specialty areas such as traumatic brain injury (TBI), spinal cord injury/disorders, and blind rehabilitation. VA has a caregiver assistance healthy living center on My Health*e*Vet (*www.myhealth.va.gov*) and hosts a caregiver Web site (*www.caregiver.va.gov*). Both of these sites include information on VA and community resources and caregiver health and wellness.

VA offers a number of programs and services to support veteran care at home. VA purchases personal care services to assist veterans in their homes with activities of daily living. These benefits are available to veterans who, without these services, would require nursing home or other institutional placement and are provided using public and private agencies. VA also offers purchased skilled home care through contract agencies for veterans who are homebound and in need of skilled services such as nursing, social services, or physical, occupational or speech therapy. Home-based primary care is a unique program that provides comprehensive long-term primary care through an interdisciplinary team that visits the homes of veterans with complex, chronic disabling diseases or injuries for which routine clinic-based care is ineffective.

The Veteran-Directed Home and Community-Based Care program provides veterans of all eras the opportunity to receive services in a veteran-centered manner that allows them to avoid institutional placement while continuing to live in their homes and communities. VA operates this program in collaboration with the Administration on Aging under the Department of Health and Human Services. In-home hospice care is also available for veterans who are in the advanced stages of incurable disease. Care includes comfort-oriented and supportive services that are provided by an interdisciplinary team of providers and volunteers. Community Home Hospice services are available 24 hours a day, 7 days a week. Veterans and their caregivers who are in need of close monitoring of vital signs or frequent communication with a health care team can benefit from home telehealth services. Telehealth offers the possibility of treating chronic conditions cost effectively while contributing to patient satisfaction.

Specialty care services, such as for blind rehabilitation, polytrauma, spinal cord injury, and a range of modifications or adaptations are also provided to Veterans and caregivers in need. Family training programs at Blind Rehabilitation Centers provide family members and caregivers with education about blindness in general, and specific information about their family member's vision loss. In VA's Polytrauma System of Care, caregiver and family education and training are provided as part of the rehabilitation process through meetings with the care team, written and web-based information, and other forums. This education includes rehabilitation techniques to facilitate adaptation, safe and effective use of prosthetic or other devices, skill development to meet the needs of the veteran, behavioral management training, and information on how to access community resources. Specialized information on TBI is also available if the Veteran has this condition. During initial rehabilitation of a veteran with a new spinal cord injury, VA trains the veteran to guide a caregiver in meeting the veteran's personal care needs. Caregiver support is also provided directly by VA staff and through referral to community support services where needed. Home care services for bowel and bladder care are also available, and VA can pay for these services through a professional home health agency. VA provides patient lifts to help caregivers move veterans with limited mobility, ramps to facilitate ingress and egress from a home, vehicular and home modifica-

tions and adaptations, attendant controls on any power wheelchair, and specially adaptive housing modifications to provide a barrier-free, wheelchair accessible living environment for the veteran and the caregiver.

VA offers a range of family support initiatives. Family counseling, spiritual and pastoral care, and temporary lodging at Fisher Houses are all currently available. Counseling for family members under 38 United States Code (U.S.C.) 1782 may also be available. Respite care, either at home or in an institutional setting, provides the caregivers of Veterans with a needed break to relieve the demands of caring for a chronically ill, injured, or disabled family member and to prevent caregiver burnout. Adult Day Health Care Centers also provides respite care in a safe environment with constant supervision.

VA launched a Caregiver Support Line (1–855–260–3274) that is providing counsel on issues related to non-institutional care, benefits, the law, and other questions. Since its activation on February 1, 2011, the line received more than 3,000 calls. This Support Line, staffed by clinical social workers, provides immediate and highly responsive access to information for caregivers. Each VA medical center has designated a Caregiver Support Point of Contact to coordinate caregiver activities and serve as a resource expert for Veterans, their families and VA providers to assist them in locating and accessing non-VA resources.

VA's Plan for Benefits and Enhancements to Caregivers

The Plan outlines VA's proposal for providing enhanced benefits for family caregivers of eligible veterans and servicemembers. The Plan includes recommendations concerning eligibility, application, training, monitoring and implementation, stipend amounts, health care benefit coverage, mental health services, and travel, lodging and per diem. As noted above, the recommendations that comprise the plan are just that—recommendations—and there are steps remaining in the rulemaking review process (including a period for public comment) that provide an opportunity for adjustments in the rules and processes that will be followed by VA in carrying out the provisions of the Act.

Following are some of the areas that received concentrated attention and discussion in the Implementation Plan. They are treated in full detail in the Plan, but we would like to highlight some of the prominent areas here.

Eligibility for Family Caregiver Program

VA's Implementation Plan outlines proposed clinical eligibility criteria that would be used by VA clinical providers to determine a Veteran's eligibility to participate in the family caregiver program (i.e. whether family caregiver(s) of the Veteran may be approved and/or designated to receive support under the family caregiver program), and to help determine the amount and level of the stipend the primary family caregiver would receive. These clinical eligibility criteria would be applied, along with other eligibly criteria (such as whether the Servicemember is "undergoing medical discharge," and whether the serious injury was incurred or aggravated on or after September 11, 2001) to determine which veterans and servicemembers are eligible to participate in the family caregiver program.

The clinical eligibility assessment would consist of two parts. The first part would include evaluation based on clear clinical criteria to determine the appropriateness of the Veteran for the program, and VA's proposal for those standards can be found at pages 13 and 14 of the Plan. This has proven to be the most challenging aspect of VA's implementation planning—to ensure that VA can put forward eligibility standards that fulfill the aims of the law, while setting out criteria that can be applied consistently by clinicians and understood by veterans and their families.

The second part of the proposed assessment would determine the base level of the stipend to be provided to the primary family caregiver, based upon the complexity of the Veteran's functional limitations and the assistance required, as defined by activities of daily living (ADL) and required hours of care. Pages 16 and 17 of the Plan provide greater detail of how this assessment would be conducted.

The Act defines "family member" as a member of the family of the Veteran (parent, spouse, child, step-family member, or extended family member) or someone who lives with the Veteran but is not a family member. The definition establishes eligibility requirements for family caregivers seeking to participate in the program. In the Plan at page 18, VA proposes standards aimed at ensuring the caregiver meets minimum competency requirements, and that VA performs its due diligence to prevent, whenever possible, potentially abusive situations.

The Application for Family Caregivers

The Act provides that Veterans and caregivers seeking participation in the program will submit a joint application to VA. VA proposes an application process that would be managed nationally to take advantage of VA's existing infrastructure and

ensure a quick and accurate review. The application would be based on existing elements of the CHAMPVA application, VA's Geriatric and Extended Care Referral Form, and newly developed portions in response to the Act.

VA clinicians will be trained in the specific program eligibly criteria to assess the needs of the Veteran and confirm his or her need for caregiver support. VA clinical providers will determine whether the care the veteran needs can be provided at home and whether a family member(s) on the application will be capable of providing such care. VA will evaluate the family member(s) to determine the amount of instruction, preparation and training the family member requires to provide the personal care service the veteran needs.

VA aimed in the Plan to design the application process to be as simple as possible for the Veteran, the proposed family caregivers, and VA staff. VA will also incorporate the application into the Veteran's electronic health record. We will offer a paper application and an online version of the application as well. The Caregiver Support Coordinator or designated case manager at each VA medical center will work with the Veteran and the proposed family caregiver to determine the appropriateness of each caregiver and the educational needs of each participating family member.

Education and Training

Education and training for family caregivers would include two parts under VA's Plan: first, a basic caregiver curriculum that will be available in standard classrooms or self study through books, DVD, or online media. It will include training on the standard information applicable to all caregivers and Veterans and will allow the family caregivers to choose the mode of training that is most convenient for them. It will cover material every family caregiver must understand and will include ten core competencies: medication management, vital signs and pain control, infection control, nutrition, functional activities, activities of daily living, communication and cognition skills, behavior management skills, skin care, and caregiver self-care.

The second part of the training will be specific to the individual Veteran's care needs. It will emphasize care related to the Veteran's condition, such as traumatic brain injury, post-traumatic stress disorder, impulse control, suicide risk and prevention, substance use disorders, dementia, depression and anger.

Both parts of the training would require that the caregiver demonstrate their competence to provide personal care services to the veteran in the home. This is an important factor because VA has heard from caregivers about the difficulty they have experienced in transferring skills learned in a clinical setting to the home environment. VA proposes to conduct home visits in a supportive manner to provide additional onsite training, to facilitate successful completion of the training, to validate the family caregivers' competence, and to provide additional support or problem solving as necessary. Appendix B of the Implementation Plan includes a standard assessment tool VA proposes to use during the home visit to ensure a consistent approach across the country.

Under VA's Plan, within 10 business days of the family caregivers' completion of education and training, VA would conduct a home visit to assess the family caregivers' understanding and competence in providing the care needed by the veteran. During the initial visit, VA will review core competencies and the family caregiver will be required to demonstrate their understanding of these competencies and those related to the veteran's specific care needs. Our goal is to support and provide additional training as necessary to ensure the caregiver and veteran have what they need.

VA heard from NGOs and others regarding the training and education requirements established in the Act. The NGOs recommended that VA use training materials based on a nationally recognized program that could be modified slightly to address the needs of veterans and servicemembers eligible to participate in the family caregiver program. We support this concept and are looking for partners to develop this material. Some VSOs and caregivers recommended that family members with experience in caregiving should be exempt from the required training, but VA in its Plan recognized the importance of establishing clinically demonstrated competency to provide care, which is a requirement of the Act.

Training would extend beyond just care delivery for the veteran to include segments on self-care and stress management, important skills which caregivers may not have learned before. Moreover, training sessions provide opportunities for caregivers to connect with one another, to develop peer support networks and to exchange ideas that can benefit caregivers and veterans alike.

Monitoring and Implementation

The Act is very clear that VA ". . . shall monitor the well-being of each eligible veteran receiving personal care services under the program . . ." (38 U.S.C. 1720G(a)(9)(A)). VA monitoring as outlined in the Plan would include evaluation of the Veteran and caregiver's physical and emotional state, including any signs of abuse and neglect, the adequacy of care and supervision being provided by the family caregivers, the veteran and family caregivers overall adjustment to care at home, and signs of caregiver stress. Home visits would be completed with a supportive and educational approach to ensure the caregiver is equipped to succeed in their role. VA would focus on the veteran or legal guardian and caregiver's perception of the optimal social, emotional, and physical state of welfare in a safe and nurturing environment.

In addition to the in-home competence review after the caregiver has completed training, VA in its Plan proposes follow-up well-being checks at least once each quarter, and more often if there are significant changes in the Veteran's condition or in home dynamics as noted by the Patient Aligned Care Team (PACT) or primary care team. VA saw annual in-home full reassessment of the primary family caregiver's competence as necessary for continued receipt of the stipend and other benefits. The initial assessment and the quarterly follow-up checks would be conducted by a member of the interdisciplinary health team, such as a registered nurse, social worker, physical therapist, or others. Ongoing monitoring would be provided by VA staff through programs such as Home-Based Primary Care, Community Health, Spinal Cord Injury and Disorders Home Care, or Mental Health Intensive Case Management. The Caregiver Support Coordinator or designated case manager would be responsible for ensuring the ongoing monitoring of primary and family caregiver competencies.

Changes in the level of care noted during home evaluation visits would be reported back to the facility Caregiver Support Coordinator or designated case manager and the PACT or primary care team. If there are concerns about caregiver competence that do not pose an immediate safety concern for the veteran, VA would conduct an assessment to determine what additional training the caregiver requires, and VA would make the necessary arrangements for the caregiver to receive this training in a timely manner. If, during the initial assessment or follow-up home visits, there is evidence of abuse or neglect (or other immediate concerns for the safety of the veteran), VA will make immediate arrangements for alternate care. Suspected abuse or neglect must be reported in compliance with law and VA policy.

VA has heard the concerns raised by VSOs, NGOs, veterans and caregivers alike that, while monitoring is essential to ensuring the well-being of the veteran, it must be done in a supportive manner. VA agrees with this principle entirely and in its Plan noted it would train those conducting in-home visits and assessments to provide support compassionately to the Veteran and caregiver's specific situation and needs.

The veteran or legal guardian or the primary family caregiver can request that the designation of primary family caregiver be revoked. VA can initiate revocation for cause or due to the permanent institutionalization or death of the veteran. Further information about VA's proposed revocation process can be found on pages 29–31 of VA's Implementation Plan.

Stipend

VA will issue stipends directly to the designated primary family caregiver under this program. The stipend is made in recognition of the sacrifices that families make when caring for a seriously injured eligible veteran, and is based on the amount and degree of personal care services provided. As specifically provided in the Act, this stipend is not an entitlement. The stipend is not intended to replace career earnings, and a primary family caregiver does not become a VA employee based on receipt of the monthly caregiver stipend. Details of VA's proposal for implementing the stipend payments can be found at page 23 of the Plan.

The stipend payments to primary family caregivers constitute "payments [of benefits] made to, or on account of, a beneficiary" that are exempt from taxation under 38 U.S.C. 5301(a)(1).

Health Care Benefit Coverage

Primary family caregivers of eligible veterans may receive medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) if they are not entitled to care or services under a health plan contract (including Medicare, Medicaid, worker's compensation, insurance policies or contracts, etc.). CHAMPVA is a comprehensive health care benefit program in which VA shares the cost of certain health care services with eligible beneficiaries.

Mental Health Services

VA recognizes that caregivers can experience stress that may result in depression, anger, interpersonal conflict, anxiety, substance use, sleep disturbance, social isolation, or other conditions. Caregiving can also place stress upon the marital or family relationship as well. VA has heard from caregivers that they need and want access to mental health services. As a result, VA's Plan would include mental health and counseling services to ensure that the primary family caregiver can access support and services to alleviate stress, burnout, and other complications.

In accordance with 38 U.S.C. 1782, general caregivers, as well as family caregivers, would have access to consultation, professional counseling, marriage and family counseling, training and mental health services as necessary in connection with the treatment of the Veteran.

VA would offer mental health and counseling services needed by family caregivers but unrelated to the treatment of the Veteran by providing individual and group therapy and counseling and peer support groups. Under the proposal outlined in the Plan, VA would not provide medication or other medical procedures related to mental health treatment or inpatient psychiatric care. If a primary family caregiver has CHAMPVA or other coverage, such care could be provided by those plans, subject to the health plan's particular terms.

Travel, Lodging and Per Diem

Travel, lodging and per diem expenses would be provided to family caregivers when family caregivers are undergoing needed training. In addition, family caregivers may be provided the expenses of travel, including lodging and subsistence, when the eligible veteran is traveling to and from, and throughout the duration of, a medical examination, treatment or care episode.

Respite Care

Caregiving, as noted earlier, places significant demands on those who provide personal care services for a seriously injured eligible veteran. Respite care is designed to offer family caregivers temporary relief from the demands of daily care, thereby supporting the veteran's desire to remain in his or her home. VA may provide respite care for the veteran during the family caregivers' training if needed. Respite care for the primary family caregiver will be available for at least 30 days annually under the Act, and VA proposes including 24-hour care commensurate with the care provided by the family caregiver. The VA Caregiver Support Coordinator or designated case manager, in collaboration with the Patient Aligned Care Team (PACT) or primary care team would assess the veteran and caregiver for appropriate respite services. VA is committed to delivering clinically and age appropriate respite care services through VA and non-VA programs.

VA's Path Forward for Implementation

The Act is a tremendous step forward for this country in supporting those who have made significant sacrifices on its behalf. It represents the hard work and efforts of Congress, Veterans Service Organizations, VA, and most importantly, our seriously injured veterans and their caregivers. We understand the frustration many have experienced with the pace of implementation, and we share that frustration. We regret the delay in transmitting the Implementation Plan to the Committee. The Act also identified January 30, 2011 as the date on which caregiver benefits would commence. Given the complexity of these programs, the need for stakeholder input, and the need for regulations, VA was not able to meet that date.

But let me assure our veterans, their families, and the Committee that we have been working tirelessly to implement this program and begin delivering the benefits established in law. On February 28, 2011, VA transmitted a draft Interim Final Rule to the Office of Management and Budget. We believe this measure will expedite the rulemaking process and set the path to begin delivering caregiver benefits as early as this summer.

VA has been active on a myriad of other fronts that do not require the publication of regulations to accomplish other implementation milestones. We released a request for proposals in January to assist the Department in creating a national program of caregiver training. This curriculum will serve as the basis for establishing the competencies of family caregivers participating in the program and will promote effective care for our seriously injured veterans. We launched a new Caregiver Support Line on February 1, 2011 out of awareness of the urgent need to provide information and additional support to caregivers. We are planning to hire at least one full time Caregiver Support Coordinator at every VA medical center by the end of April 2011. We are working now on a new, state-of-the-art Web site that will be launched in May 2011. We are already planning to add additional staff on a tem-

porary basis to manage the creation of these programs and to handle the initial wave of applications from veterans and caregivers.

VA will also employ a comprehensive outreach program so that veterans and their caregivers are aware of these services and can easily apply. Our Caregiver Support Coordinators will assist them in this process and will make every effort to expedite our review and the delivery of benefits.

VA understands the concerns that have been expressed on the scope of the benefit, as outlined in our Plan. The Secretary appreciates that VA has an important obligation to get this benefit right. That means making sure those clinicians can consistently apply—and Veterans and their families can understand—our eligibility criteria, as we evaluate the myriad types and combinations of circumstances that injured Veterans and their families face.

Conclusion

There is no higher priority than delivering world class health care services and benefits to our seriously injured veterans and servicemembers and their caregivers. We again appreciate the efforts of Congress, the Veterans Service Organizations, and all of our stakeholders in making this Act a reality. It is important for VA as it moves ahead in implementing all parts of the caregiver provisions of the Act to keep the Committee apprised and to hear and respond to your concerns. Thank you for inviting me here to testify today to do that. My colleagues and I are prepared to answer your questions at this time.

Statement of the Paralyzed Veterans of America

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the implementation of the caregiver provisions of P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act." The Subcommittee proposes to answer the question, "Are we getting it right?" Simply put, the VA is not getting it right, and we hope that the Administration will review the steps it has taken so far and revise them appropriately. Likewise, we urge Congress to continue to conduct oversight of the VA's implementation plan to ensure that its full intent is being met.

PVA and its partners worked extremely hard to get comprehensive caregiver legislation enacted during the 111th Congress. Fortunately, on May 5, 2010, the President signed into law P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act." This legislation created an innovative new caregiver program to be administered by the Department of Veterans Affairs (VA). The law called for the VA to begin implementation of this important new program within 270 days of enactment of the bill. This placed the deadline for implementation of this legislation in February of this year. However, the VA's efforts have fallen flat, to say the least.

As you know, the VA recently published its interim final rules regarding the implementation of the caregiver provisions of P.L. 111–163. PVA was very disappointed to see that the VA tailored its eligibility criteria very narrowly to provide for services for a much smaller number of veterans than Congress intended. The VA essentially explained that it will base eligibility for the new caregiver provisions on whether or not the veteran being cared for would otherwise be kept in an institutional setting. This simply ignores the call for more home and community-based care settings, particularly for the newest generation of veterans. Moreover, it ensures the narrowest scope of eligibility for the caregiver benefits. This is totally unacceptable.

We were already concerned about the fact that the original legislation divided the levels of services provided between Pre-9/11 and Post-9/11 service-connected disabled veterans. And yet, we ultimately supported the final legislation because it will do a great deal of good for the newest generation of severely disabled veterans while allowing for the VA to expand the broad range of caregiver services to Pre-9/11 veterans in the future.

PVA is also seriously concerned about the VA's lack of commitment in its FY 2012 budget request and FY 2013 advance appropriation estimate. For FY 2012, the VA requested approximately $65.9 million for the implementation of the caregiver provisions of P.L. 111–163 and an additional $70.6 million for FY 2013. This is especially troublesome in light of the fact that during consideration of the legislation, the costs were estimated to be approximately $1.6 billion between FY 2010 and FY 2015. This included approximately $60 million identified for FY 2010 and approximately $1.54 billion between FY 2011 and FY 2015. However, no funding was provided in FY 2010 or FY 2011 to address this need. Moreover, Secretary Shinseki clearly identi-

fied a shortfall in funding for the provisions of P.L. 111–163 in a letter he sent to Congress on July 30, 2010. As a result, the VA will have an even greater need for funding to support P.L. 111–163 between FY 2012 and FY 2015 in order to fully implement the provisions of the law based on the full intent of Congress. With this in mind, *The Independent Budget* for FY 2012—co-authored by AMVETS, Disabled American Veterans, PVA, and the Veterans of Foreign Wars—included a recommendation of approximately $385 to fund the caregiver provisions of P.L. 111–163.

PVA has over 60 years of experience understanding the complex needs of spouses, family members, friends, and personal care attendants that love and care for veterans with life-long medical conditions. The aspects of personal independence and quality care are of particular importance to veterans with spinal cord injury/dysfunction. As a result of today's technological and medical advances, veterans are withstanding combat injuries and returning home in need of medical care on a consistent basis. Such advances are also prolonging and enhancing the lives and physical capabilities of injured veterans from previous conflicts. No matter the progress of modern science, these veterans need the health-care expertise and care from a health team comprised of medical professionals, mental health professionals, and caregivers. As a part of the health care team, caregivers must receive ongoing support to provide quality care to the veteran. It is for this reason, that we strongly urge VA to develop support and educational programs by conducting caregiver assessments that identify the needs and problems of caregivers currently caring for veterans.

PVA members have more direct interaction with caregivers than any other individual group of disabled veterans. As such, PVA has developed educational materials over the years to benefit the disabled veteran, his or her family, and the caregiver on the best practices for dealing with the myriad of challenges they will face. I would like to highlight two publications in particular that PVA developed that address these challenges and issues.

One very important publication that PVA developed many years ago is "Yes, You Can! A Guide to Self-Care for Persons with Spinal Cord Injury." The fourth edition of this book is available through PVA's Web site. The book serves as a self-help resource for severely disabled veterans, their families and their caregivers, as well as all people with disabilities, with a focus on individuals who have incurred a spinal cord injury or disorder. The book is written expressly for new spinal cord injured individuals providing them with a lifelong reference guide.

For over two decades, "Yes, You Can!" has been compiled and edited by Dr. Stephen P. Burns, a practicing VA SCI physician, and Dr. Margaret C. Hammond, Chief Consultant for VA's SCI Service, as well as more than 40 experts from the Seattle VA Health Care System. Having answers to the myriad of challenges that SCI veterans and their families might face is central to personal care and independence for people who have SCI. Additionally, "Yes, You Can!" includes a list of print, online and community resources for obtaining additional information. The book equips people with disabilities with essential information on how they can lead healthy, productive lives and reintegrate fully into the community.

The second publication that PVA developed is a consumer guide called "Managing Personal Assistants." This important book provides critical information on how to best determine your personal assistant or caregiver needs. It offers advice on how to recruit, hire, properly train and retain, and when necessary, fire, a personal assistant or caregiver. It allows a severely disabled veteran and his or her family to be well-informed when making the caregiving decisions that are best for him or her.

Our experience has shown that when the veteran's family unit is left out of the treatment plan the veteran suffers with long reoccurring medical and social problems. However, when family is included in the health plan through services such as VA counseling and education services, veterans are more apt to become healthy, independent, and productive members of society.

With regard to family caregiver services, we ask that VA continue its effort to enhance the support and educational services provided to family members caring for veterans. Moreover, as the VA begins full implementation of the caregiver provisions of P.L. 111–163, we believe that it will be essential to incorporate medical professionals or clinicians into the training. Due to the unique health care challenges often associated with the catastrophic disabilities of those veterans who need caregiver support services, only clinicians can provide the broadest scope of medical care support in training.

As the veteran community is aware, family caregivers also provide mental health support for veterans dealing with the emotional, psychological, and physical effects of combat. Many PVA members with spinal cord injury also have a range of co-morbid mental illnesses, therefore, we know that family counseling, and condition spe-

cific education is fundamental to the successful reintegration of the veteran into society. Combat exposure coupled with long and frequent deployments are associated with an increased risk for post-traumatic stress disorder and other forms of mental illness. In fact, the VA reports that Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans have sought care for a wide array of possible comorbid medical and psychological conditions.

We believe that Vet Centers should increase coordination with VA medical centers to accept referrals for family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation; improve reintegration of combat veterans who are returning from deployment; and provide information on identifying warning signs of suicidal ideation so veterans and their families can seek help with readjustment issues. PVA believes that an effective mental illness family counseling and education program can improve treatment outcomes for veterans, facilitate family communication, increase understanding of mental illness, and increase the use of effective problem solving and reduce family tension.

There are approximately 44 million individuals across the United States that serve as caregivers on a daily basis. The contributions of caregivers in today's society are invaluable economically as they obviate the rising costs of traditional institutional care.

PVA would like to thank this Subcommittee for the opportunity to express our views relating to the implementation of the VA's new caregiver program. We hope that the Subcommittee and Congress will take an active role to ensure that the VA is actually implementing the provisions of P.L. 111–163 as intended. Failure to comply with the intent of Congress is simply not an option in this case. The most severely disabled veterans and their families are depending on the VA to get it right.

We look forward to working with the Subcommittee as it continues addressing these issues. We will gladly respond to any questions. Thank you.

Statement of Heather L. Ansley, Esq., MSW, Director of Veterans Policy, VetsFirst, a Program of United Spinal Association

Chairwoman Buerkle, Ranking Member Michaud, and other distinguished Members of the Committee, thank you for the opportunity to submit for the record our concerns about the Department of Veterans Affairs' (VA) implementation of the caregiver assistance program established in Title I of Public Law 111–163.

VetsFirst represents the culmination of 60 years of service to veterans and their families. United Spinal Association, through its veterans service program, VetsFirst, maintains a nationwide network of veterans service officers who provide representation for veterans, their dependents and survivors in their pursuit of VA benefits and health care before the VA and in the Federal courts. Today, United Spinal Association is not only a VA-recognized national veterans service organization, but is also the leader in advocacy for all people with disabilities.

VetsFirst fully supports the caregiver services that were included in the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163). VetsFirst believes that caregivers are vital to ensuring that veterans with disabilities are able to be independent. Under Public Law 111–163, caregivers for all eligible veterans who are enrolled in the VA's health care system will have access to education sessions, support services, counseling, mental health services, and respite care. The law also provides certain caregivers of veterans who have a serious injury, such as a traumatic brain injury, that was incurred or aggravated in the line of duty on or after September 11, 2001, with a monthly stipend and access to medical care.

For the family members of veterans with disabilities, the battle to ensure that their loved ones receive the support and services that they need to reintegrate into their families and communities never ends. In order to ensure that veterans with disabilities are able to receive the care they need, VetsFirst believes that our Nation must fully support the dedicated caregivers of our Nation's veterans.

Many families of veterans with disabilities play a crucial role in providing needed services and supports that allow veterans to return to, and remain in, their homes. The sacrifice of family caregivers not only supports veterans, but also supports the VA in its mission. These individuals often endure significant life changes as they seek to assist their husbands, wives, and adult children in their efforts to rehabilitate and reintegrate into their communities.

In the aftermath of a veteran receiving a severe injury and resulting long-term disability, many family caregivers are forced to either quit their jobs or seek flexible employment in order to care for their loved ones. As a result, many caregivers must

balance the strains of caregiving for someone who has significant disabilities with lost income and cancellation of employer-provided health care coverage and other benefits. The longer-term impacts on leaving the traditional workforce include the loss of retirement benefits, which may lead to financial shortfalls as the caregiver ages.

Although the commitment of the caregivers of our Nation's veterans has been evident for many decades, a study released in November 2010 by the National Alliance for Caregiving provides statistical evidence supporting the depth of the commitment that these caregivers have made to our veterans. For instance, the study report titled, "Caregivers of Veterans—Serving on the Homefront," noted that 70 percent of caregivers for our Nation's veterans are spouses. For all populations, only 6 percent of caregivers are spouses. Clearly, immediate family members have an important role in caregiving for our Nation's veterans.

An even higher number of caregivers, 80 percent, live with the veteran for whom they are providing care. Nationwide, only 23 percent of caregivers of all adults live with the care receiver. Consequently, 68 percent of caregivers of veterans report a high level of emotional stress due to caregiving which is more than double the level of stress endured by caregivers of all adults.

The lifelong commitment made by caregivers of our Nation's veterans is clearly represented by the 26 percent of parents who are providing care for their sons and daughters who are veterans of Operation Iraqi Freedom or Operation Enduring Freedom (Afghanistan). The long-term caregiving relationship of our Nation's veterans with disabilities and their caregivers exceeds that of other caregiving relationships. According to the National Alliance for Caregiving, 30 percent of caregivers of veterans from all eras give care for 10 years or longer, as opposed to only 15 percent of caregivers nationwide.

Intensive caregiving provides many challenges for caregivers. Some of the challenges identified by the study include lack of awareness about helpful VA services, lack of information about how to receive financial assistance, and lack of knowledge regarding the medical aspects of the veteran's disability. Of note, the resource for most caregivers for the services and supports available to them as caregivers was through "word of mouth."

To address some of the identified issues, the report makes seven specific recommendations. Those recommendations included the following: harnessing the "word of mouth" by providing caregivers with avenues to learn from each other, assisting caregivers with finding needed respite services, and making training and information about conditions such as post-traumatic stress disorder more accessible to caregivers.

The expansive services provided through Title I of Public Law 111–163 provided hope for many caregivers who as the National Alliance for Caregiving study demonstrates provide care for a longer period of time and have a higher stress level than other types of caregivers. As established by Congress, the caregiver programs discussed in Title I directly address some of the key areas of concern for many caregivers. The law provides caregivers for all eligible veterans enrolled in the VA's health care system with general supports. The law also includes a more comprehensive program of assistance for family caregivers of veterans who have a serious injury, such as a traumatic brain injury, that was incurred or aggravated in the line of duty on or after September 11, 2001.

In order to receive assistance under the program of comprehensive assistance for family caregivers, a caregiver must be providing care to an "eligible veteran." According to 38 U.S.C. § 1720G(a)(1)(B)(2),

> "an eligible veteran is any individual who (A) is a veteran or member of the Armed Forces undergoing medical discharge from the Armed Forces; (B) has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001; and (C) is in need of personal care services because of (i) an inability to perform one or more activities of daily living; (ii) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or (iii) such other matters as the Secretary considers appropriate."

Under the comprehensive program, family caregivers are eligible to receive training, technical support, counseling, and lodging and subsistence. For the family caregiver who is chosen as the primary provider of personal care services additional benefits are available. These benefits include mental health services, respite care of not less than 30 days annually, medical care, and a monthly personal caregiver stipend. As identified by the National Alliance for Caregiving, these benefits will be extremely beneficial to the caregivers of eligible veterans.

Unfortunately, the caregiver program implementation plan released by VA in February 2011 fails to provide the promised benefits that many caregivers believed would be available to them. VA's implementation plan, which focuses on the comprehensive caregiver program, seeks to place limits on eligible veterans beyond those intended by Congress. Specifically, VA appears to rely on 38 U.S.C. § 1720G(a)(1)(B), which allows the Secretary to provide support "to a family caregiver of an eligible veteran if the Secretary determines it is in the best interest of the eligible veteran to do so," to add seven clinical eligibility criteria.

The cumulative result of these clinical criteria, however, is to limit the number of eligible veterans and thus family caregivers who can benefit from this comprehensive program beyond that intended by Congress. One of the clinical criterion states that, "Without caregiver support providing personal care services at home in an ongoing manner, would require hospitalization, nursing home, or other institutional care." Another clinical criterion states that the veteran must "Require continuing medical management or be at high risk for personal safety and cannot live independently in the community without caregiver support." Based on the "eligible veteran" criteria outlined in the law, Congress did not intend for VA to place these types of strictures on eligibility.

In the proposed implementation plan, VA also imposed specific aspects of these clinical criteria into its definition of "serious injury." In the law, Congress noted only certain types of injuries, such as traumatic brain injury, psychological trauma, or other mental disorder, in its explanation of this term. The VA defines serious injury as follows: "Individuals with a serious injury are individuals who, due to their injury, psychological trauma, or mental disorder, require ongoing medical care, exhibit impaired ability to function independently in their community, are vulnerable and at high risk for personal safety, and for whom at least 6 months of continuous and approved caregiver support is required to enable them to live outside of an institutional care setting." Based on Congressional intent, VetsFirst believes that VA's definition of serious injury incorporates restrictions on eligibility beyond those intended by the law.

If the VA is allowed to move forward with the outlined implementation plan, the number of eligible family caregivers providing needed services and supports for veterans with serious injuries due to their service will be limited to less than one-third the number Congress intended would be eligible for the program. Furthermore, veterans with certain types of injures that are specifically stated in the law may be left out due to the development of overly stringent criteria.

Aside from Congressional intent, expansion of caregiver programs to veterans who are not eligible for an institutional level of care but for whom caregiving is likely to extend their ability to live in the community is extremely effective in the long-term. Specifically, delaying or preventing institutional placements through quality caregiving not only fulfills the desire of many individuals to remain in their homes but also saves money due to decreased utilization of institutional placements. Thus, VA must not unnecessarily limit the comprehensive caregiver program due to fears that the program will be too costly.

In addition, VA must ensure that the process veterans with disabilities and their family caregivers must follow to participate in the comprehensive caregiver program is not overly bureaucratic. Instead, the process should be veteran-centered with the goal of helping eligible family caregivers to complete the process in a timely, successful manner.

In order to ensure that the role of the family caregiver and the needs of the veteran are at the center of the process, VetsFirst believes that VA must ensure that the caregiver education and training outlined in the implementation plan recognizes the different skill sets and educational backgrounds of the caregivers. As outlined by VA, the caregiver education and training component will be divided into two sections. The first section provides general training on caregiving through a variety of educational methods (self-study, DVD, classroom, online). VetsFirst believes that this training should also include aspects that can speak to those who have attained knowledge through other caregiver training and those who have learned through the process of actually providing care to their loved one. If the goal of training is to develop the caregiving skills of family caregivers, then it must meet the caregiver's level of knowledge and experience.

Although caregivers must be approved and receive adequate training, VetsFirst hopes that VA will make every effort to ensure that the process of final certification is expeditious. Many family caregivers have waited through great personal difficulty for the types of benefits available through the comprehensive caregiver program. VA must ensure that the certification process is conducted in a manner that encourages eligible veterans with disabilities and their family caregivers to participate in and receive the benefits of this critical program.

Finally, VA must not limit eligibility beyond that which Congress intended due to fears about the consequences if the program is later expanded for caregivers of veterans of all eras. Based on the need outlined in the study by the National Alliance for Caregiving, VetsFirst will continue to advocate for increased services and supports for caregivers of veterans of all eras to make sure that these caregivers can continue to support our Nation's veterans with disabilities. Specifically, VetsFirst believes that these benefits must be able to not only veterans with service-connected disabilities of all eras but also veterans who receive VA health care services due to a catastrophic disability acquired outside the veteran's service. Otherwise, unnecessary inequality in the system of health care benefits may result.

VetsFirst believes that veterans with disabilities have the right to receive their services and supports in the least restrictive environment. Most people with disabilities want to live in their homes and have the opportunity to be a part of their communities. Although funding services for caregivers requires an upfront investment, the long-term gains that result from assisting veterans with disabilities in their efforts to reintegrate into their communities are significant.

Thank you for the opportunity to submit for the record VetsFirst's concerns with VA's implementation plan for the comprehensive caregiver program. We appreciate your leadership on behalf of our Nation's veterans with disabilities and their families and survivors. VetsFirst stands ready to work in partnership to ensure that all veterans are able to reintegrate in to their communities and remain valued, contributing members of society.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
March 17, 2011

Tom Tarantino
Senior Legislative Associate
Iraq and Afghanistan Veterans of America
777 North Capitol Street NE, Suite 403
Washington, DC 20002

Dear Tom:

In reference to our Subcommittee on Health Committee hearing entitled "Implementation of Caregiver Assistance: Are We Getting It Right?" that took place on March 11, 2011. I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 17, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Jian Zapata by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

Michael H. Michaud
Ranking Democratic Member

CW:jz

Questions for the Record
HVAC Hearing on "Implementation of Caregiver Assistance: Are We Getting It Right?"
March 11, 2011
Response by Tom Tarantino
Senior Legislative Associate, IAVA

Question 1: Please tell this Committee what was the extent of your organizations' involvement in the development of the implementation plan?

Answer: Along with several other VSOs that were instrumental in passing the caregivers law, IAVA participated in two focus groups held by the VA at VA Head-

quarters. These meetings were held on October 5, 2010 and October 23, 2011. Both lasted several hours. The stated goal of those meeting was for the VA to receive the VSO community's views and ideas on Eligibility, DoD to VA transition, training, benefits, and monitoring. While the topics were structured, the conversation was free form with all of the recommendations coming from the VSOs to the VA. The VA provided no information on where they were on any given issue. When asked questions by the group, the frequent response was "What do you think we should do?" While this provided a forum to address issues of concern from the VSO community, there was very little feedback from the VA. We left each meeting unsure where the VA was in the process.

This was the extent of IAVA's involvement with the implementation plan. The VSOs and the Congressional offices that worked on the bill went to great lengths to make the legislative text as explicit as possible, in order to curb poor regulation. IAVA feels that despite the two focus groups, the VA regulated this law without effectively tapping the knowledge and experience of the VSO community that represents the veterans that they are trying to serve.

Question 2: Traumatic Brain Injury or TBI is considered the signature wound of these wars. Given that, do you believe that the current criteria in the implementation plan would unnecessarily exclude many veterans who have a TBI?

Answer: The National Military Family Association frequently says, "Wounded servicemembers have wounded families." If we are to treat and cure the wounds of a servicemember, we must also care for the wounds of the families, or in this case, the caregiver. This was clearly Congress' intent when crafting this law.

We feel that the narrow eligibility criteria proposed by the VA will exclude many veterans and their caregivers from receiving the care and benefits that they need. The intent of this law was to provide assistance to the caregivers who have put their lives on hold to care for their wounded warrior. It was not meant to replace hospital care. TBI is the staunchest example of an injury that will be left behind by the VA's proposed criteria. While the most severely wounded cases of TBI will surely qualify, the criteria set out by the VA does not account for the moderate cases of TBI that may not require hospitalization, but still will require constant care and monitoring if they are to recover.

A veteran suffering from a severe TBI who would require hospitalization would definitely be eligible for the caregiver program. However, injuries like TBI aren't that simple. There are levels of severity that while not requiring institutionalization, still require constant care to both ensure the safety of the veteran and promote a healthy recovery. Based on numerous accounts from our members and supporters, IAVA believes that the majority of those who would benefit from the caregivers program fall in the former category. Under current VA regulations, this larger group of caregivers will not be eligible for support. Given that this program was designed to help those caregivers, the VA's failure to include these caregivers shows that the VA is fundamentally missing the point of this program. While the caregiver program is meant to help facilitate the care and recovery of the veteran, it is designed to support the caregiver who is sacrificing to care for their wounded warrior.

We understand the VA's need to establish clinical metrics in determining eligibility. IAVA feels that adding clinical criteria into the equation is necessary. However, it is not sufficient if we are to remedy the problem that the caregiver program is meant to solve. The VA must factor the needs of the caregivers who are providing a critical service in the veteran's care and recovery. In this respect, the VA has failed to meet the goals set forth by Congress.

Question 3: Several of the testimonies raised concerns with the mental health services and the coverage for the caregivers in the implementation plan. I would like each of you to expound on your concerns.

Answer: IAVA is cautiously optimistic about the mental health services that caregivers will be eligible for under this program. According to the implementation plan "Primary family caregivers will be covered . . . for mental health services in connection with the treatment of the Veteran" and "mental health services needed by the primary family caregiver but *not related to the treatment of the Veteran.*" While is seems that this does cover the range of mental health care that a caregiver would require, we are concerned about what the VA will determine as "services in connection with the treatment of the veteran." Based on the VA's narrow view of criteria for the rest of the caregivers program, we are not confident that the VA will adopt an interpretation of "connected" that reflects the needs of the caregivers that this program is meant to support. Unfortunately, we will have to see how the VA handles this in practice to assess its effectiveness.

Committee on Veterans' Affairs
Washington, DC.
March 17, 2011

Barbara Cohoon, Ph.D., R.N.
Government Relations Deputy Director
National Military Family Association
2500 North Dorn Street, Suite 102
Alexandria, VA 22302

Dear Barbara:

In reference to our Subcommittee on Health Committee hearing entitled "Implementation of Caregiver Assistance: Are We Getting It Right?" that took place on March 11, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 17, 2011.

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Due to the delay in receiving mail, please provide your response to Jian Zapata by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

Michael H. Michaud
Ranking Democratic Member

CW:jz

National Military Families Association
Washington, DC.
April 8, 2011

Congressman Michael H. Michaud
Ranking Democratic Member
Subcommittee on Health
Committee on Veterans' Affairs

Dear Congressman Michaud:

Question 1: Please tell this Committee what was the extent of your organization's involvement in the development of the implementation plan?

Answer: The Department of Veterans Affairs extended two invitations to the National Military Family Association to participate in a half-day roundtable discussion on the implementation of the caregiver provision in P.L. 111–163. I participated in both discussions. We were given plenty of opportunity to discuss our vision on how certain aspects of the caregiver provisions should be implemented. The four organizations that had worked on the drafting of the law were included along with a variety of other Veteran Service Organizations. The National Military Family Association also submitted a white paper outlining our Association's recommendations for implementation, which I have provided.

Question 2: Traumatic Brain Injury or TBI is considered the signature wound of these wars. Given that, do you believe that the current criteria in the implementation plan would unnecessarily exclude many veterans who have a Traumatic Brain Injury?

Answer: The National Military Family Association believes the current criteria in the implementation plan would unnecessarily exclude many veterans who have a Traumatic Brain Injury (TBI). There are two references included in the VA's implementation plan that could adversely affect eligibility. The inclusion of the "need for 'institutional' level of care without the support of a caregiver" will disqualify many servicemembers and veterans with TBI. Many of our wounded servicemembers and veterans have mild to moderate cognitive impairment that require caregiver support, but they certainly do not need hospitalization or to be institutionalized. The criteria, "incapacity, physical or mental which requires care or assistance on a regular basis to protect the veteran from hazards or dangers incident

to his or her daily environment," is concerning. The word "incapacity" details the level of severity of the wound that needs to be met in order to qualify. Servicemembers and veterans with just mild or moderate TBI will most likely be disqualified under this criterion. There is a strong possibility that some servicemembers with multiple injuries, such as a mild or moderate TBI, a loss of an extremity, PTS or PTSD, and 10 percent burn, may not qualify for this program. Multiple injuries are commonly seen in our returning servicemembers from war. Co-morbid injuries may require the servicemember and veteran to need the assistance and support of a caregiver, but not seen as being at the level of incapacitated. Again, this was not the intent of the law. Both of these criteria, "institutional" and "incapacity" provide a level of severity that would make these servicemembers and veterans along with their caregivers ineligible for the caregiver benefits.

Question 3: Several of the testimonies raised concerns with the mental health services and the coverage for the caregivers in the implementation plan.

Answer: The National Military Family Association's concerns regarding the mental health services and the coverage for the caregivers in the implementation plan involve several areas.

The first is the delay in eligibility until the servicemember is entering veteran status. This delay will impact the ability for the caregiver to obtain time sensitive needed benefits, such as access to mental health counseling and health care benefits. This especially impacts non-spouse caregivers who would greatly benefit from these services. As we mentioned in our testimony, the recent survey, *"Caregivers of Veterans—Serving on the Homefront"* one in four respondents were parents caring for Operation Enduring Freedom and Operation Iraqi Freedom veterans. Also, a larger proportion of veteran caregivers compared to their National (civilian) counterparts reported mental illness, such as depression or anxiety (70 percent) or PTSD (60 percent) compared to their National counterparts (28 percent). Veteran caregivers also reported their situation to be highly stressful (68 percent versus 31 percent Nationally) and 75 percent stated it placed a stress on their marriage (74 percent). Also, they found there were widespread impacts on the caregiver's health, such as increased levels of stress and anxiety (77 percent) and not sleeping (77 percent), and a decrease in the utilization of healthy behaviors, such as seeing their medical provider.

Our Association is hearing that caregivers are reaching the stage of burnout and many are deciding to walk away from their roles as caregivers. The longer the VA waits to begin benefits, the more opportunity there is for the caregiver's quality of life to worsen and for the caregiver to reach the stage of burnout. The caregiver survey highlighted the increased stress our veteran caregivers are under compared to their National counterparts. The law and Congressional intent were to allow the VA to provide assistance through value-added benefits to the caregiver early enough in the process to make a difference and prevent the development of physical health, mental health, and/or financial problems. Caregivers of our wounded, ill, and injured need these services now, and sooner in the recovery process than later.

The second involves the decision not to provide medication for mental health treatment. The VA caregiver implementation plan stated, "Primary family caregivers will be covered . . . for mental health services in connection with the treatment of the Veteran" and "mental health services needed by the primary family caregiver but *not related to the treatment of the Veteran."* The implementation plan further stated, "but not medication." Our Association is concerned with the coordination of care between the mental health provider and the health care provider. The VA stated they will not provide medication for mental health treatment. However, the caregiver's health care insurance program, which could be CHAMPVA, would provide the medication. Our Association was wondering how this would be coordinated to ensure the caregiver received the mental health benefit entitled in the caregiver law from the VA and the medication needed to effectively treat the mental health condition from the caregiver's health care plan. We recommend VA provide coordination of VA mental health services and the appropriate type and dosage of medication is provided by the caregiver's primary health care provider to ensure the caregiver is receiving a holistic approach to mental health care.

Finally, our Association requests the VA to clarify what they meant by providing expanded "counseling" services to caregivers under the law. We would appreciate if the VA would provide a definition of what these expanded counseling services for family caregivers will include.

Caregiver Compensation Discussion

Deborah, Per your request, I have taken a look at the slides and have some suggestions.

Eligibility:

Definition

The definition needs to be set by the VA, but not so different from the DoD and the various Services to allow for the Services' Recovery Care Coordinators to be able to recognize the caregiver's eligibility for the VA Caregiver provisions. There will need to be several mechanisms in place to assure these families are recognized as qualifying for this important benefit. It should be encouraged for all who think they qualify to be recommended to apply, similar to the FRC program. Better to err on the side of receiving more requests than for the Service case managers to not even bring up the potential qualification for the program. Also, this will allow for those already medically discharged and receiving care in the community to be identified by the various Service's case managers.

Start time

The different provisions could start at separate times. For example, educational material should be readily available to access even though you have not qualified for the program. Access to Web site and pamphlet material at the earliest phase of recovery will also be important. Access to mental health services should be started prior to the eligibility being finalized. Access to mental health information (i.e. self assessment exams online, PTS and TBI assessment exams online), and available resources, (i.e. Military OneSource, TRICARE face to face or TRIAP, Vet Centers, etc.), will be very important to start this as soon as possible. The caregiver could either self identify or providers could recommend these services. Access should not be restricted to only those who have already been determined eligible because of the time from identifying the caregiver eligibility and determination of qualification. The need for formal training or behavioral health services may be the trigger that helps identify the caregiver as potential candidates for this program.

There has been some discussion that the program's benefits should start immediately upon the injury/illness. As mentioned earlier, some of the provisions should be allowed to start earlier in the process and not wait for a formal determination of eligibility. Our Association would support the entire benefit starting around the time frame of the MEB process, once the Services have determined the servicemember will be evaluated for fit-for-duty. Wounded, ill, and injured servicemembers are usually triaged to determine their acuity level and they are assigned to a RCC accordingly. A discussion with the various Services to ensure caregivers are then vectored to the VA for evaluation for the caregiver provision during this same time period will need to take place by the VA. The evaluation could be done similar to the DES process using key factors related to the caregiver's role/responsibilities in their care with the wounded/ill/injured servicemembers/veterans. As we have discussed, there will need to be continued evaluation as the need for the caregiver provisions may change over time. Health care provision may not be needed initially, but arise later on.

Training:

There should be formal and informal training. Some caregivers will need to learn more of the hands on medical care needed to care for the veteran (i.e. drawing up medications, changing dressings, dissimpactions, etc.). Paying for them to attend Medical Assistant training or a higher level (LPN/RN) could be allowed depending on the desire of the caregiver to become an expert at that level of care. Again, if this is identified earlier, they may qualify for DoD's MyCAA that provides money for training. VA could maybe start a similar program for these caregivers. As intended certain level of social work training so they may be better able to handle stress in the family and the servicemember/veteran. Any training that requires the caregiver to be away from the servicemember/veteran, care will still needed to be provided. The VA should provide all those services during that time frame.

Informal training would involve advocating for your servicemember/veteran, how to care for yourself, benefits and resources available to you and your family, what it is like to be a caregiver, and making doctor's appointments. This can be done in many different forms, such as internet, pamphlets, and actual face to face training.

Financial compensation:

Compensation Type A

It is for services rendered nonmedical care. Only the primary caregiver would qualify. It would be on a sliding scale with a minimum and maximum amount al-

lowed under this provision. The payment would reflect the amount of services the caregiver was providing, such as traveling to appointments, making appointments, etc. The amount would increase as the demand for services increased, such as following a surgery; and decrease as the need dissipated after recovery. This need would have to be assessed quickly without any or little time delay in order to provide the correct amount of compensation. You could start out with the level determined during the initial evaluation with the ability for this to increase, not decrease until the servicemember enters veteran status and is permanently located. Amount should be the same no matter where you reside during the determination phase through entering veteran status and permanent residence is established. If you were looking at the rate being tied to a geographical location, this would be applied only after permanent residence was established after becoming receiving veteran status.

Compensation Type B

It is for actual home health, hands on care provided to the servicemember/veteran by the caregiver. The payment would be hourly, reflect the region's payment scale, and geared toward the level of care provided. The caregiver will be provided training by either the VA or a pre-accredited civilian program. The caregiver will be certified after completing the training program. This certification must be recognized and transferable to the civilian sector. The training and certification will be paid for by the VA. This will be offered to no more than two caregivers. This would allow for more than one person to provide hands on care, such as mom and dad to share the physical care responsibility. Caregivers will be provided continued training opportunities paid for by the VA. A system needs to be in place to assure quality care is being provided by the caregiver. The caregiver is paid directly for their services.

Competence:

This should be done by someone the caregiver and servicemember/veteran trust. This can be accomplished by someone they already know, or trust could be built by the evaluation team set up by the VA. Same as a DES board, but on a much friendlier compassionate basis, so as not to create the feeling as though you are just going through "the process of determination." Since you are looking for continuity in determination of eligibility, it would be best to set up teams with special training on how to deal with this delicate determination. Competence would be assessed during the eligibility time. Competence must also be evaluated on a regular basis. If they are seeing health care providers on a regular basis, this will be easier, then if they are using non-VA health care providers or no longer using health care providers. This population will most likely be assigned a FRC. It will be this person who will stay attached overseeing holistic care until death of the veteran. Evaluation for competence will need to be part of the "care plan" for the veteran and the family. There will be a need for an appeal process if the caregiver is found not competent.

Mental Health:

All providers must be familiar with military culture, not just mental health providers. Access to therapy should be through telemental health, online chat, and face to face individual, family, and group sessions. As mentioned earlier, access needs to be available as soon as possible. Knowing how to self assess and identify resources to available behavioral health support will be key in addressing the issue early enough in the process to make effective change. The VA needs make sure these services are available in Military Treatment Facilities, on military installations that are housing wounded, ill, and injured servicemembers and their families in order to start these important services "upstream," while still on active duty status. They should also have access in the community through Vet Centers regardless of meeting the "combat" criteria for services, at the various VA facilities and community-based outpatient clinics (CBOCs), and purchased provider services if behavioral health support is not available through other means.

Monitoring:

Competence and eligibility for the various support services and programs must be evaluated on a regular basis. If they are seeing health care providers on a regular basis, this will be easier, then if they are using non-VA health care providers or no longer using health care providers. This population will most likely be assigned a FRC. It will be this person who will stay attached overseeing holistic care until death of the veteran. Evaluation for competence and the requirement for support services will need to be part of the "care plan" for the veteran and the family. The caregiver may not recognize their need for health care services, respite care, or mental health counseling. Having regular interaction either by phone or in person, should help the FRC evaluate how the caregiver is fairing. Asking questions, like when was the last time they went to the dentist, had a physical, took time off, and

visited a relative. They should also be monitoring the family for how well they are coping. And, recommend support programs and services to the family as well.

Suspension of Stipend/Provisions:

There must be a provision for transition for the caregiver. If the caregiver's services are no longer needed, chooses to no longer participate, or is asked by the veteran to no longer provide services. The caregiver will still be able to maintain health care for 1 year. The Stipend could be changed to reflect the sliding scale of non-medical services Compensation A as discussed earlier, to reflect the amount of care they are still providing while the veteran is hospitalized. Compensation B would stop if the caregiver was no longer providing hands on medical care while hospitalized. Medicare ties their reimbursement to the 100-day rule. TRICARE for Life begins their evaluation for eligibility for reimbursement at the 80-day time frame with a determination made prior to the 100-day mark. The VA could use a similar rule of starting an evaluation process. Depending on the VA's definition of eligible veteran, they may be using Medicare already. Compensation would discontinue following the end of all services/care provided by the caregiver determined by the VA.

Investment opportunities:

All caregivers would be TSP eligible.

Final Question:

Don't wait too long to start these Caregiver support services and programs. Allow them to be flexible enough to allow the caregiver to initiate well upstream (while the servicemember is on active duty) in order to make a difference in their quality of life.

Committee on Veterans' Affairs
Washington, DC.
March 17, 2011

The Honorable Robert A. Petzel, M.D.
Under Secretary for Health
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Petzel:

In reference to our Subcommittee on Health Committee hearing entitled "Implementation of Caregiver Assistance: Are We Getting It Right?" that took place on March 11, 2011. I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 17, 2011.

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Due to the delay in receiving mail, please provide your response to Jian Zapata by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

Michael H. Michaud
Ranking Democratic Member

CW:jz

Questions for the Record
Ranking Member Michael Michaud
House Committee on Veterans' Affairs
Subcommittee on Health
"Implementation of Caregiver Assistance: Are We Getting It Right?"
March 11, 2011

Question 1: In their testimony, the Wounded Warrior Project states that they were "given no inkling of the contents of the VA implementation plan prior to its submission to the House and Senate Committees". Did you engage the VSOs in meaningful dialogue during the process of putting together the implementation plan that you eventually submitted to the Committee? If you did, when in the process did you do this and were their suggestions given due consideration?

Response: The Department of Veterans Affairs (VA) met with representatives from several of the Veterans Service Organizations (VSO) on October 5 and October 13, 2010. These meetings included representatives from American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Iraq and Afghanistan Veterans of America, Military Officers Association of America, National Military Family Association, Paralyzed Veterans of America, Veterans of Foreign Wars, Veterans of Modern Warfare, and Wounded Warrior Project.

In addition to these formal sessions, VA maintained regular contact with our VSO colleagues since the law was enacted. During the meetings in October, VA listened to the concerns raised by the VSOs on a number of issues including eligibility, the primary family caregiver stipend, education and training requirements for family caregivers, and regular in-home monitoring of the Veteran and the caregiver. VA adopted many of the recommendations offered by the VSOs, including the need for multiple methods of application to the program, and the importance of integrating the new programs into existing systems and services. Further information about these discussions, the recommendations put forward by the VSOs, and VA's response to the proposals that were not included in the Implementation Plan can be found on pages 34–37 of VA's Implementation Plan, available online at *http://www.caregiver.va.gov/docs/Caregivers*__part1.pdf.

The VSO meetings were held in early October to allow enough time for robust discussion and to cover all relevant topics. Potential aspects of eligibility criteria were discussed at least in concept. VA, however, did not have a formal position on the elements of the Implementation Plan in October, and it was premature to have provided, in technical detail, specific language that was still being deliberated. VA felt that a series of listening sessions would allow Department officials to hear the concerns and recommendations of the VSOs in an environment that would allow VA to then incorporate those recommendations into the larger plan.

Question 2: Is there anything that the first panel testified on that you would like to address?

Response: Some of the VSOs seemed to suggest that Veterans with traumatic brain injuries (TBI) would not be covered under the eligibility criteria outlined in VA's Implementation Plan. VA disagreed with that assessment in exchanges at the March 11 hearing, and is confident Veterans with TBI would qualify under the standards put forth in the Implementation Plan. Many of the clinical criteria describe functional impairments that are associated with TBI, including "incapacity, physical or mental, which requires care or assistance on a regular basis to protect the Veteran from hazards or dangers incident to his or her daily environment."

When VA experts were drafting the eligibility criteria, professionals with expertise in the Federal Recovery Coordination Program, our Polytrauma programs, and TBI programs were consulted for input. There was significant recognition of the challenges that are faced by family members caring for individuals with TBI, and it is VA's intention that those individuals be included and be eligible if the Veteran requires supervision to remain at home. VA anticipates that significant numbers of severely injured TBI patients will be eligible for this program.

Budget

Question 1: Concern has been raised to this Committee on the adequacy of the budget resources for implementation of the Caregivers legislation. Could you give us some detail as to the amounts of the requests for FY 2011, 2012, and 2013 and what that request reflects? Please start with the budget for FY 2011. It is my understanding that the Secretary submitted a letter in July of 2010 requesting an additional $166 million for P.L. 111–163. I would also like to know if you believe these requests are adequate to adequately implement the plan.

Response: VA cannot finalize the cost estimates while the Interim Final Rule is pending. VA will continue to keep the Committee informed, including providing our final estimate, once the process is completed.

In response to your concern about the July 2010 letter, VA submitted to the House and Senate Committees on Appropriations and Veterans Affairs a report on the sufficiency of funds in FY 2011 on July 30, 2010. The FY 2011 budget was presented in February 2010, but Public Law 111–163 was not signed into law until May 5, 2010. As a result, the July letter only states that the 2011 budget did not include funds for these programs because these programs did not exist at the time the budget was proposed. VA has identified resources to support these initiatives in FY 2011 and has included in its 2012 and 2013 request additional support.

Eligibility

Question 1: Many of the VSOs take issue with the eligibility criteria contained in the implementation plan and subsequently in the regulations. Would you explain to the Committee why VA decided to "narrow the pool of eligible caregivers" with the addition of the criteria-clearly this was not the intent of the law.

Response: VA does not believe it is an accurate characterization to say that the eligibility criteria identified in the Implementation Plan were designed to "narrow the pool of eligible caregivers." The clinical experts consulted in developing these criteria are dedicated to helping injured Veterans and were exercising their professional judgment in developing criteria that would define those Veterans and caregivers in greatest need so as to be able to provide them with the additional support they require. It is important that VA has clear clinical guidelines to be consistently applied by clinicians across the country. We know that many Members of Congress and Veterans' advocates disagree with the criteria outlined in the Plan. VA and the Administration take these concerns seriously, and they are being considered during the subsequent deliberations on the content of the pending Interim Final Rule.

Question 2: Why was it necessary for the VA to establish clinical eligibility criteria beyond those in the law?

Response: Several key terms in the law were undefined, including "serious injury" and others. VA cannot implement the program without defining clear criteria that can be consistently applied by clinicians across the country. The criteria in the Plan attempts to provide that consistency. VA and the Administration are taking the criticism of the policy issue of eligibility and other aspects of the program very seriously.

Question 3: Wounded Warrior Project testified that the VA plan defines the term "personal care services" in a manner inconsistent with the law. Would you agree with that?

Response: VA does not agree that the Implementation Plan defines the term "personal care services" in a manner inconsistent with the law. The rationale for applicable program definitions, including the definition of the term "personal care services," will be included in the Interim Final Regulations.

Mental Health

Question 1: In the case of a Veteran injured after 9/11, the law directs VA to provide mental health services needed by the primary caregiver. But the VA plan imposes restrictions not required by law. Under VA's plan, if the caregiver needed mental health care for anxiety or depression due to the stresses of caregiving (rather than care *related to the Veteran's treatment*) but was not eligible for CHAMPVA, VA would apparently not provide any mental health services. Under those circumstances, a caregiver might have to rely on other coverage that might have very limited mental health benefits. Why is that a good policy, given the goal of maintaining the caregiver's mental and emotional health?

Response: VA recognizes that caregivers can experience stress that may result in depression, anger, interpersonal conflict, anxiety, substance use, sleep disturbance, social isolation, or other conditions. Caregiving can also place stress upon the marital or family relationship as well. In these circumstances, in accordance with 38 United States Code (U.S.C.) 1782, general caregivers, as well as family caregivers, would have access to consultation, professional counseling, marriage and family counseling, training, and mental health services as necessary in the connection with the treatment of the Veteran.

VA would offer mental health and counseling services needed by family caregivers but unrelated to the treatment of the Veteran by providing individual and group therapy and counseling and peer support groups. This provision in Public Law 111–

163 (as it is proposed in the Implementation Plan) would ensure that mental health services would be provided to primary family caregivers whether the care is related to the treatment of the Veteran (where care could be provided under 38 U.S.C. 1782) or whether they were unrelated (where care could be provided under 38 U.S.C. 1720G(a)(3)(A)(ii)(II). This would cover most mental health needs of primary family caregivers.

VA's Implementation Plan stated that VA would not provide medication or other medical procedures related to mental health treatment or provide inpatient psychiatric care. This provision was included because VA believed that caregivers requiring this type of intensive treatment should seek it within the context of a comprehensive treatment setting that addresses all elements of the caregiver's well-being, not just his or her mental health care. This philosophy underlies VA's approach to care, which is to treat all of the Veteran's health care needs, because mental or physical health conditions can create complications beyond the immediate diagnosis.

In the event that a caregiver needed care in the private sector, the law provides access to health care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) for certain primary family caregivers who are not otherwise entitled to care or services under a health-plan or contract. In addition, the local VA facility's Caregiver Support Coordinator would assist him or her in locating a provider and ensuring that care and services meet the caregiver's needs.