Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00991-255

Healthcare Inspection

Deficiencies in the Caregiver Support Program Ralph H. Johnson VA Medical Center Charleston, South Carolina

August 21, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations that the Caregiver Support Program (CSP) at the Ralph H. Johnson VA Medical Center (facility), Charleston, SC, does not operate in accordance with Public Law or VA guidelines.

We substantiated the allegation that an interdisciplinary team had not appropriately assessed many veterans during the application process. Facility leadership did not designate an interdisciplinary CSP team or develop a comprehensive assessment process until February 2014.

We substantiated the allegation that more than 100 applications were awaiting initial CSP screening, and many were beyond the 45-day requirement. We found that the facility had placed a hold on all new applications while they addressed the care and monitoring of active participants in the program. As of January 27, 2014, more than 200 patients were awaiting CSP eligibility screening, with 164 of them waiting longer than 45 days. However, as of February 14, the facility had conducted a review of all applications and processed them appropriately.

We substantiated the allegation that CSP staff did not conduct 90-day and annual follow-up visits. We reviewed 60 electronic health records of currently enrolled patients and found that 57 percent had not received the initial in-home visit within 10 business days of their caregiver completing the education-training course, 75 percent had not received the 90-day in-home monitoring visits, and 89 percent had not received the annual in-home assessment. Furthermore, none of the seven patients who were due for their second annual assessment had been reassessed.

We confirmed that the Chief of Social Work Service and facility leadership did not assure sufficient staffing in a timely manner to conduct CSP follow-up visits. While facility managers hired a second Caregiver Support Coordinator (CSC) to assist with workload demands, this staffing was not sufficient to address the existing volume of home visits. The facility was in the process of hiring two nurses to conduct CSP in-home monitoring and assessments. We did not substantiate the allegation that a CSC did not possess the knowledge, skills, and abilities to perform the job.

We substantiated the allegation that caregivers received “hundreds of thousands of stipend dollars” without confirmation that the patients and caregivers met program requirements. We found that caregivers were paid even though the facility had not documented required annual reassessments.

We recommended that the Facility Director ensure that the CSP’s Clinical Eligibility Committee meets regularly, CSP applications are processed timely, currently enrolled patients are monitored and assessed as required, adequate staffing is available to meet the minimum in-home monitoring and caregiver assessment requirements, and reassessments supporting continued eligibility and stipend payments are documented, as required.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B pages 8–12 for the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspection

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to allegations that the Caregiver Support Program (CSP) at the Ralph H. Johnson VA Medical Center (facility), Charleston, SC, does not operate in accordance with Public Law (PL) or VA guidelines.

Background

The facility is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. It is part of Veterans Integrated Services Network (VISN) 7 and serves veterans throughout South Carolina and parts of Georgia. The facility has 79 hospital beds, 20 community living center beds, and 18 mental health (MH) beds and is the parent facility for community based outpatient clinics in Beaufort, Goose Creek, Myrtle Beach, and Trident, SC, and Hinesville and Savannah, GA.

PL 111-163, *Caregivers and Veterans Omnibus Health Services Act of 2010*, authorized the CSP and was signed into law on May 5, 2010. The purpose of the CSP is to provide medical, MH, travel, training, and financial benefits to caregivers of eligible veterans and service members injured in the line of duty on or after September 11, 2001. The Veterans Health Administration (VHA) CSP guidebook, issued on April 20, 2012, and updated on June 11, 2013, prescribes requirements for eligibility, screening, caregiver education, and clinical follow-up. Although the CSP guidebook was in draft form at the time of our inspection, VHA considers it mandatory guidance.

In May 2011, the facility began enrolling patients and caregivers into the CSP. At that time, the facility had one Caregiver Support Coordinator (CSC-1) overseeing the program. CSC-1 was responsible for screening applications for administrative eligibility, coordinating with primary care and/or MH providers to determine clinical eligibility, referring and monitoring caregivers' completion of the training and education course, arranging with VA resources to conduct initial in-home assessments, and providing ongoing in-home monitoring every 90 days. A second CSC (CSC-2) was hired part-time in November 2012 and became full-time in April 2013.

Since initiation, the facility's CSP has grown steadily. As of our site visit, 191 caregivers were enrolled in the program and 204 applications were pending review.

In November 2013, the OIG Hotline Division received a complaint alleging clinical and administrative deficiencies in the CSP. Specifically, the complainant alleged that:

- An interdisciplinary team had not appropriately assessed veterans, as required.
- More than 100 applications were awaiting initial CSP screening, many of them beyond the 45-day requirement.

- CSP staff had not conducted 90-day and annual home visit evaluations, as required.
- The Chief of Social Work Service (SWS) did not provide dedicated staff to conduct CSP follow-up.
- A CSC, who is a registered nurse (RN), does not possess the knowledge, skills, and abilities to perform the job.
- VA is paying "hundreds of thousands" of stipend dollars to caregivers without confirmation [via follow-up visits] that the patients and caregivers meet program requirements.

Scope and Methodology

We conducted a telephone interview with VA Central Office CSP officials in December 2013 and with the complainant in January 2014. We conducted our site visit February 18–19, 2014. We interviewed the Director, Chief of Staff, Chief of SWS, Associate Director for Patient Care Services, Associate Deputy of Nursing and Patient Care Services, and Primary Care Director, both CSCs, the current and former CSP supervisors, an RN case manager, and the CSP administrative support assistant. In addition, we interviewed staff at the Health Administration Center (HAC) located in Denver, CO.[1] We also reviewed PL 111-163; VHA's Plan for Implementation of PL 111-163; the *Caregiver Support Program Guidebook* (draft, issued April 20, 2012, and updated June 11, 2013); and materials on VHA's CSP website.

We reviewed the electronic health records (EHRs) of 60 randomized patients enrolled in the CSP program as well as those awaiting screening. We reviewed documents related to patient and caregiver training, CSC functional statements, Clinical Eligibility Assessment and scoring information, Issue Briefs, and the status report and process improvement plan from the facility. We also evaluated stipend payments to specified caregivers from July 2011 through January 2014.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency

[1] The HAC is responsible for the disbursement of caregiver stipend payments.

Inspection Results

Issue 1: CSP Assessments and Monitoring

Initial Assessments

We substantiated that an interdisciplinary team had not appropriately assessed veterans during the application process.

PL 111-163 requires that an independent provider, in collaboration with the interdisciplinary care team, complete a Clinical Eligibility Assessment to determine the veteran's eligibility to participate in the program and the amount and level of stipend payment the primary family caregiver will receive.

From May 2011 to October 2013, the facility did not have an interdisciplinary care team designated to evaluate CSP applicants. During this time, the CSC would collaborate with the primary care and/or MH provider to determine clinical eligibility and estimate the stipend level based on the clinical assessment. In response to a facility CSP internal audit conducted in August 2013, an interdisciplinary team met once in October to review the clinical eligibility status of active participants. During that meeting, the team determined that they could not make clinical eligibility decisions based solely on limited chart reviews. The interdisciplinary team relayed this information to the Chief of SWS, and the team disbanded.

Initial Screening

We substantiated that more than 100 applications were awaiting initial CSP screening and that many of them exceeded the 45-day processing requirement.[2]

We confirmed that as of January 27, 2014, more than 200 patients were awaiting CSP eligibility screening, with 164 of them waiting longer than 45 days. We found limited documentation that CSCs were communicating with the patients or caregivers awaiting screening during this period. The facility told us that in October 2013, the new CSP applications were placed on hold pending review of the eligibility of, and service delivery to, the current CSP patients and caregivers. An Issue Brief tracking the status showed that as of February 14, 2014, facility staff had reviewed the EHRs of all veterans awaiting screening and had taken the next step in the process to refer caregivers of clinically eligible veterans to the training and education program. Veterans whose eligibility was not clear based on the EHR review were referred for further clinical evaluation.

Ongoing Monitoring

We substantiated that CSP staff had not conducted 90-day and annual follow-up visits, as required.

[2] VHA, *Caregiver Support Program Guidebook (Draft),* issued April 20, 2012; updated June 11, 2013.

The CSP guidebook requires that: (1) VA personnel complete the initial in-home assessment within 10 business days after official notification that the caregiver completed training; (2) applications be processed and approved or disapproved within 45 days; (3) monitoring occurs every 90 days through an in-home assessment to determine the well-being of both the veteran and the caregiver; and (4) an annual in-home full reassessment of the primary caregiver's competence be conducted as a stipulation for continued stipend payments and other benefits.

Our EHR review of 60 active patients (and their caregivers) from August 8, 2011, through September 20, 2013, found that the facility did not comply with requirements, as follows:

- 57 percent of initial in-home assessments had not been completed
- 50 percent of applications were not processed within 45 days; it took an average of 54 days for application approval with a range of 15–191 days
- 25 percent of the households were visited but not every 90 days as required
- 75 percent of the households were not monitored following their initial in-home assessment
- 89 percent of the 35 households due for their first annual in-home reassessment were not reassessed
- None of the seven households due for their second annual in-home reassessment were reassessed

The August 2013 CSP internal audit identified similar deficiencies. At the time of our visit, CSP staff had revised the screening process and instituted an interdisciplinary team for application review, which met for the first time in February 2014.

Issue 2: Staffing

Dedicated Staff

We confirmed that the Chief of SWS and facility leadership did not assure sufficient staffing in a timely manner to conduct CSP follow-up visits. However, the guidance on CSP staffing is vague, and it does not appear that the facility was *required* to provide dedicated staffing for CSP follow-up activities.

VHA guidance suggests that staff from VA programs such as Home Based Primary Care, community health programs, Spinal Cord Injury and Disorders Home Care, MH Intensive Case Management, or a contract Home Health Care Agency provide in-home monitoring.[3] This suggestion does not take into account whether these programs have the ability to include additional patients in their caseloads, nor does it require them to do so. CSC-1 conducted some home visits and developed verbal,

[3] VHA, *Plan for Implementation PL 111-163 "Caregivers and Veterans Omnibus Health Services Act of 2010," Title 1 Caregiver Support, Section 101, Assistance and Support Services for Caregivers.*

informal agreements with Home Based Primary Care and a MH nurse practitioner to assist with the home assessments as time and resources permitted. However, CSC-1 was not empowered to mandate staff to assist with the home visits.

While facility managers hired CSC-2 (who started in November 2012) to assist with workload demands, it would have been difficult for CSCs 1 and 2 to address the volume of applications and the existing backlog of home visits without other clinical staff to support the effort. Facility leaders learned of the growing backlog in October 2013, but did not promptly take actions to assure the necessary human resources were available to meet 90-day and annual home visit requirements. At the time of our onsite inspection, CSP managers were interviewing applicants for two full-time RN positions to help address the backlog of 90-day in-home monitoring and annual reassessments.

Position Competence

We did not substantiate that CSC-1, who is an RN, did not possess the knowledge, skills, and abilities to perform the job. The complainant did not offer specific examples to support the allegation.

The CSP guidebook states that the CSC may be an advanced practice social worker, psychologist, or RN whose primary responsibility is local administration of the CSP. The CSP guidebook also states the expectation that CSCs participate in scheduled national calls on a regular basis.

As an RN, CSC-1 met qualification standards for the position. CSC-1 also attended multiple VISN and national training programs related to the implementation of the CSP and participated on national calls as required. We found no documentary evidence, nor did we hear testimonial evidence, that CSC-1 failed to adequately perform in the role.

Issue 3: Stipend Payments

We substantiated the allegation that caregivers received stipends without confirmation via follow-up visits that the patients and caregivers met program requirements. The purpose of the in-home assessment is to evaluate whether the patient is still in need of the care and whether caregivers are still able and competent to deliver the care. Caregiver competence to deliver the needed care appropriately and consistently is a key component in optimizing a veteran's health and functional status in the community. PL 111-163 stipulates that, at a minimum, VHA is required to initially evaluate caregiver competence, followed by annual competency reassessments, in order for caregivers to receive stipend payments and other benefits. VHA's HAC disburses stipend payments directly to caregivers regardless of whether the necessary 90-day and annual home visits have occurred.

Between July 2011 and January 2014, CSP 191 caregivers collectively received 2,927 stipend payments totaling approximately $5.4 million. Of those payments, 675 (23 percent), totaling nearly $1.2 million, were made to caregivers; although, the

facility had no documentation to support that annual reassessments occurred as of March 15, 2014.[4]

Conclusions

We substantiated the allegation that an interdisciplinary team has not appropriately assessed veterans during the application process. The facility had not designated an interdisciplinary CSP team or developed a comprehensive assessment process until February 2014.

We substantiated the allegation that more than 100 applications were awaiting initial CSP screening, and many were beyond the 45-day requirement. We found that the facility had placed a hold on all new applications while they addressed the care and monitoring of active participants in the program. As of January 27, 2014, more than 200 patients were awaiting CSP eligibility screening with 164 of them waiting longer than 45 days. However, as of February 14, the facility had conducted a review of all applications and referred the cases as appropriate.

We substantiated the allegation that CSP staff had not conducted 90-day and annual follow-up visits. We found that 57 percent of the cases we reviewed had not received the initial in-home visit within 10 business days of completing the caregiver education-training course; 75 percent had not received 90-day in-home monitoring visits; 89 percent did not have a documented annual in-home assessment; and none of the seven patients who were due for their second annual assessment received it.

We confirmed that the Chief of SWS and facility leadership did not assure sufficient staffing in a timely manner to conduct CSP follow-up visits. While facility managers hired a second CSC to assist with workload demands, this staffing was not sufficient to address the existing volume of home visits. The facility is in the process of hiring two nurses to conduct CSP in-home monitoring and assessments.

We did not substantiate the allegation that CSC-1, who is an RN, did not possess the knowledge, skills, and abilities to perform the job.

We substantiated the allegation that caregivers received "hundreds of thousands of stipend dollars" without confirmation that the patients and caregivers met program requirements. We found that caregivers were paid even though the facility had not documented required annual reassessments.

Recommendations

1. We recommended that the Facility Director ensure that the Caregiver Support Program's Clinical Eligibility Committee meets regularly to review and discuss the clinical eligibility of current and future participants in the program.

[4] We used a cutoff date of March 15, 2014, for reviewing payment received and completion of the annual reassessment.

2. We recommended that the Facility Director ensure that Caregiver Support Program applications are processed timely.

3. We recommended that the Facility Director continue efforts to ensure currently enrolled patients are monitored and assessed as required.

4. We recommended that the Facility Director ensure that adequate staffing is available to meet the minimum in-home monitoring and caregiver assessment requirements.

5. We recommended that the Facility Director ensure that reassessments supporting continued eligibility and stipend payments are documented, as required.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 4, 2014

From: Director, VA Southeast Network (10N7)

Subject: **Draft Report**—Healthcare Inspection - Deficiencies in the Caregiver Support Program, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

To: Director, Atlanta Regional Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for the opportunity to respond to your findings and recommendations contained in the OIG draft report noted above.
2. I concur with all the recommendations identified as well as the action plans contained within this document.
3. Should you have questions or require additional information, please contact Judy Finley at (678)924-5700.

Charles E. Sepich, FACHE

Charles E. Sepich, FACHE
Director, VA Southeast Network, VISN 7

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 1, 2014

From: Facility Director (534/00)

Subject: **Draft Report**—Healthcare Inspection – Deficiencies in the Caregiver Support Program, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

To: Director, VA Southeast Network (10N7)

1. I have reviewed the draft report of the Inspector General's Healthcare Inspection of the Ralph H. Johnson VA Medical Center. There were five (5) recommendations.

2. I concurred with all of the recommendations. One of the recommendations is completed and will be sustained. Actions are currently in process to resolve the remaining recommendations.

3. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

Scott R. Isaacks, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that the Caregiver Support Program's Clinical Eligibility Committee meets regularly to review and discuss the clinical eligibility of current and future participants in the program.

Concur

Target date for completion: Completed and ongoing

Facility response: The Caregiver Support Clinical Eligibility Committee has met 20 times since February 10, 2014, with the majority of meetings (12) held in February and March to expedite processing the backlog. The committee is meeting a minimum of monthly with documented minutes.

Recommendation 2. We recommended that the Facility Director ensure that Caregiver Support Program applications are processed timely.

Concur

Target date for completion: November 1, 2014

Facility response: Of the applications reviewed by the OIG, 95 percent have been processed. The initial review for the remaining 5 percent has been completed and applications are pending determination of clinical eligibility. Due to the large number of older and new applications being processed, completion within 45 days has not been consistently occurring. Clinical leadership has identified an additional provider to assist full time to expedite the remaining clinical evaluations. The Caregiver Support Program Manager is working with Quality Management to develop a tracking mechanism to track and measure real-time progress as new applications are received.

Recommendation 3. We recommended that the Facility Director continue efforts to ensure currently enrolled patients are monitored and assessed as required.

Concur

Target date for completion: November 1, 2014

Facility response: Currently, 89.5 percent of enrolled Veterans have completed the required 90-day and/or annual evaluation. Evaluation visits for the remaining Veterans have been scheduled. Leadership approved the request for recruitment of 2 registered nurses RNs) on January 9, 2014, to bring the FTEE from 2 to 4. These new RNs entered on duty May 18, 2014, to support in-home monitoring and caregiver

assessments. The program did suffer another staff member loss recently and recruitment to fill the vacancy has already begun. Once the vacancy is filled, it is expected that the 4 staff members will be able to sustain the compliance for timeliness of monitoring and assessments to $\geq$ 95 percent.

Recommendation 4. We recommended that the Facility Director ensure that adequate staffing is available to meet the minimum in-home monitoring and caregiver assessment requirements.

Concur

Target date for completion: November 1, 2014

Facility response: Leadership approved the request for recruitment of 2 RNs on January 9, 2014, to bring the FTEE from 2 to 4. These new RNs entered on duty May 18, 2014, to support in-home monitoring and caregiver assessments. The program did suffer another staff member loss recently and recruitment to fill the vacancy has already begun. Once the vacancy is filled, it is expected that the 4 staff members will be able to manage the current workload for assessments and reassessments.

Recommendation 5. We recommended that the Facility Director ensure that reassessments supporting continued eligibility and stipend payments are documented, as required.

Concur

Target date for completion: December 1, 2014

Facility response: As reassessments are completed, cases are documented in the Clinical Eligibility Committee and the Veteran's electronic medical record. The Committee determines the appropriate Tier level of participation; however, the Health Eligibility Center (HEC) determines the stipend.

Identified through detailed reassessment and review by the Clinical Eligibility Committee, Charleston currently has 148 Veterans enrolled and receiving stipends that no longer meet the eligibility criteria for caregiver services. As the Program is a therapeutic modality versus a benefit, Veterans are required to meet specific clinical criteria. The goal of the program is to assist Veterans until those support needs are no longer required. It is not intended as a long term support. These 148 Veterans are now eligible for graduation from the Caregiver Support Program, and the process of disenrolling them is beginning. Education on other supportive activities and community services will be provided to these Veterans and caregivers to assist them with their transition and continued improvement in their physical and mental health.

It is anticipated that disenrollment from the program will cause an increase volume in communications and requests for appeals which could impact timeliness of processing new applications. To manage the volume, the timing of Veteran notification will be

structured accordingly and include both verbal and written notification and information regarding the appeal process.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Joanne Wasko, LCSW, Team Leader Victoria Coates, LICSW, MBA Matt Frazier, MPH, MBA Michael Shepherd, MD Toni Woodard, BS

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southeast Network (10N7)
Director, Ralph H. Johnson VA Medical Center (534/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Saxby Chambliss, Lindsey Graham, Johnny Isakson, Tim Scott
U.S. House of Representatives: John Barrow, Jeff Duncan, Jack Kingston, Mark Sanford, Joe Wilson

This report is available on our web site at www.va.gov/oig