

**Department of Veterans Affairs
Veterans' Family, Caregiver and Survivor Advisory Committee
June 3, 2024
Virtual Meeting**

Advisory Committee Members

Dr. Rebecca Porter, Chair (Excused)	Jennifer Koget- Ex-officio
Maggie Hall Walsh, Acting Chair	Linda Kreter
Meredith Beck	Shawn Lopez
Caira Benson	Mary Chi Michael (Excused)
Melissa Comeau	Laura Monk
Jill Debord – Ex-officio	Johnathan Pruden
Holly Ferrell	Rafiq Raza – Ex-officio (Excused)
Gregory Gadson (Excused)	Andrea Sawyer
Stacy Greathouse	Tori Seals
Dr. Scotte Hartronft – Ex-officio	Chelsey Simoni (Excused)
Lisa Hallett	Robert Thomas (Excused)
Dr. Catherine Kelso – Ex-officio	Lauren Trosclair Duncan

VA Staff

Dr. Colleen Richardson, Executive Sponsor	Erika Jacobson
Dr. Betty Moseley Brown, DFO	Timothy Jobin
Michelle Buethe	Joni Morin
Jelessa Burney	James Pond (ESD)
Cindy Featherly-Lavelle	Anna Rasmussen
Joy Finkleson	Patricia Sele
Heather Hess-Chatterjee	Sara Simbric
Stephen Gonce	Allison Williams

Public

Note: This meeting was virtual. The public names were used to register for the meeting (only the first initial and last names are noted for these minutes).

Bassaw, M.	James, E.
Bathan, N.	Johnson, M.
Benson, S.	Kaplan, T.
Bonfrancesco, L.	Krahe, A.
Butler, R.	Lee, A.
Campos, R.	Mansell, J.
Candler, D.	Mullikin, V.
Drinkwalter, D.	Odom, C.
Dunaway, R.	Orlemann, K.
Fisher, C.	Passabet, J.
Fletcher, D.	Pellito, J.
Frederickson, K.	Peterson, H.
Gaddy, B.	Powell, J.

Gibson, K.	Re, N.
Greathouse, A.	Seaman, B.
Guisby, S.	Smith, D.
Hanson, H.	Stanton, N.
Hedgepeth, M.	Stitt, R.
Hickerson, L.	Stracco, K.
Holt, J.	Victorino, D.
Howard, J.	Webber, D.
Hyatt, W.	Webster, H.

Others (unable to categorize individuals who called in only by phone numbers)

Call-in User_2 (+1267262****)
 Call-in User_3 (+1912349****)
 Call-in User_4 (+1813362****)
 Call-in User_5 (+1813501****)
 Call-in User_6 (+1813362****)
 Call-in User_7 (+1910638****)

Note: Some questions and answers have been paraphrased and included for informational purposes.

Monday, June 3, 2024	
Call to Order and Pledge of Allegiance Betty Moseley Brown, Ed.D., Designated Federal Officer	Call to Order, Pledge of Allegiance <ul style="list-style-type: none"> - Announced Dr. Allison Williams, Acting Alternate Designated Federal Officer. - Rules of behavior for the meeting were reviewed. - Public comments will be a part of the minutes and were shared with the Committee prior to this meeting. - All committee members completed their ethics training. - There was a quorum to conduct business.
Welcome and Opening Remarks - Colleen Richardson, Psy.D., Executive Director, Caregiver Support Program (CSP), Veterans Health Administration (VHA)	Welcomed VA staff, committee members, members of the public, for being online. Reminded the audience this is a follow on to our 1 May meeting. <ul style="list-style-type: none"> - Through after-action discussions from the May meeting it was determined that additional time was needed on the recommendations. - Introduction of Maggie Walsh who is Acting Chair in Dr. Porter’s absence.
Opening Remarks & Committee Introductions –	Opening remarks included:

<p>Maggie Walsh, Acting Chair, Veterans' Family, Caregiver and Survivor (VFCS) Advisory Committee</p>	<ul style="list-style-type: none"> - Honored to serve as Acting Chair in Dr. Porter's absence. There were many rich discussions following the May 1 hybrid meeting. - Committee members introduced themselves. Those excused were introduced (along with Ex-officio Members).
<p>Recommendation Discussion 1-3 Family Focus – Meredith Beck, Chair, Family Subcommittee</p>	<p>Meredith Beck, Chair, Family Subcommittee:</p> <ul style="list-style-type: none"> - Reiterated how helpful it has been to have the members and ex-officios as part of this conversation. They were able to answer questions in real time and offer information that was important to help us as we were developing these proposed recommendations. - The caregiver portfolio is important that we distinguish between family members and recognized caregivers because veterans want to allow their designated support person, whomever that maybe, to be a person who can help interface with the VA. <p>Proposed Recommendation 1: The VA should facilitate the process for authorized family members or other designated support individuals to communicate with the VA on behalf of the Veteran.</p> <p>Rationale: The committee has understood from numerous families that communicating with the VA on behalf of the Veteran is often needlessly difficult and frustrating. Due to lost paperwork, outdated communication methods including faxing, varying information technology security practices, and a lack of a standardized location within the Veteran's record to note authorized individuals, family members are often told that staff cannot find the required documentation and, therefore, cannot communicate with them. This makes it more difficult for Veterans and family members to participate in care decisions even when requested by the Veteran, assist in the coordination of the Veteran's care and services, make appointments, or discuss necessary and relevant health information. These obstacles to communication increase the day-to-day stress, anxiety and burden felt by family members and Veterans when interacting with the VA. A challenge both in person and telephonically, the VA should develop a standard process to identify family members with whom the Veteran authorizes communication and a standard location within the electronic health record, easily identifiable by staff, to note that information.</p> <p>Ms. Walsh: Is there any discussion?</p> <p>Ms. Hallett: Inquired about timelines with the proposed recommendations.</p> <p>Dr. Moseley Brown: Shared that the Report can do that holistically and updates will be included with the Recommendation Package and added as a part of future meeting agendas.</p>

Ms. Beck: Shared that in her world there are a lot of policy discussions that sometimes it is forgotten about the most practical challenges and problems that cause the frustrations and headaches every day, and this was one that came up very quickly, and among the family discussion.

Proposed Recommendation 2:

The VA should seek all opportunities, including congressional authority, to reasonably expand mental health services to immediate family members (as defined in existing policy) beyond those enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC).

Rationale:

While it is understood that this recommendation may require legislation, the VA should seek to honor its promise “to care for those who have served in our nation’s military and for their families, caregivers, and survivors,” by working with the Office of Management and Budget and Congress to expand the availability of mental health services to family members unable to access care through other insurance.

The Committee notes that this recommendation was also made in 2020, and while some progress has been made, additional steps need to be taken. The Committee also notes that during the COVID-19 pandemic, the VA was able to use emergency authority to expand access to mental health care and services. Given the current mental health crisis facing our nation, the suicide rate among veterans, and the documented positive impact of well-supported family members, the VA should consider using emergency authority to ensure the agency is doing everything possible to support this vulnerable population.

As the nation has come to appreciate that military families serve too, it is important to understand that the Veteran’s service can also impact the family. The committee understands that the lingering impact of prolonged absences while on active duty, the stress of navigating the large bureaucracy of the VA, financial concerns, and the impact of a Veteran’s injuries and potential mental health disorders, among other things, can prove to be overwhelming/devastating for family members, especially children.

Anecdotally, increasing divorce rates and compelling accounts of struggling children in Veteran families demonstrate the need for access to care. Increased access to mental health services for family members can help to mitigate any potential negative impact of the Veteran’s service on the family as well as strengthen the family unit, including the Veteran. (end of proposed recommendation)

Ms. Beck: It should be noted to the survivor subcommittee that there was discussion that included the most important thing was that we wanted to make sure that the survivor focus was separated from that of the family focus.

Ms. Walsh: Any discussion on recommendation two?

Ms. Comeau: Agreed with what Meredith said regarding the survivor mental health. The subcommittee wanted to make the point very strong especially for our bereavement needs, which is mental health care, but different mental health care.

Ms. Beck: Recommendation number three is another specific one, but it came from the benefit of having that ex-officio expertise during the discussions.

Proposed Recommendation 3:

The VA should prioritize seeking the implementation of the Veteran Family Resource Program in each VA medical center.

Rationale:

Individual VA medical centers and surrounding communities are often flooded with resources that can help to support Veteran families. Clinical support services, financial resources, programs for children, mental health resources, and employment programs are just a few of the locally and nationally available services. Unfortunately, due to a lack of knowledge and time, overwhelmed social workers and family members are unable to identify, navigate, and utilize those resources. Especially during the “moments that matter” as identified by the VA, family members feel unsupported, frustrated, and depressed, and already budgeted resources, both inside the VA and out, are often left unused. Family members are exhausted from scrambling needlessly to find resources for themselves and their loved ones, if they even know to look, and those who are unaware continue to suffer in silence. Some family members equate the situation to an Easter egg hunt—the VA and communities have some very pretty eggs, but they only matter if you can find them. In addition, it is the committee’s understanding that recent VA listening sessions conducted with family members and Veterans identified the following challenges:

- A lack of information regarding resources to support family members who are not Veterans
- A lack of VA employee knowledge in this space
- A lack of clarity of family member eligibility for VA programs
- A lack of VA knowledge of community resources focused on the needs of Veteran families
- Need for a liaison that can facilitate an accountable transition between the Veteran/family and a connected resource.

After documenting these challenges, the VA considered the establishment of Veteran Family Resource Program Coordinators (VFRPC) at each VA medical center. The VFRPC would help to enhance the resilience, health, and well-being of Veterans by addressing Social Drivers of Health/social needs experienced in their family unit through person-centered clinical integrations, connection to VA benefits, and community resource engagement. The VFRPC would help family members make timely connections to much-needed resources both inside and outside of the VA for their own benefit and that of the Veteran.

Unfortunately, due to budget constraints, the new position was not approved. Instead of a dedicated position, the VA will be implementing a national strategy to

	<p>address these needs with existing resources rather than hiring new employees. However, given the VA's already overwhelmed and understaffed social work program, currently with a deficit of almost 4,000 social workers, adding another collateral duty will only further weaken an overburdened system leading to frustrated staff and inadequately supported families. The Committee believes the full implementation of this position would help to strengthen the VA and community partnerships to better meet the needs of Veterans and their families. Therefore, the Committee recommends that the VA reconsider its previous decision and prioritize the establishment of the VFRPC with a dedicated, full-time employee to proactively recognize and address the needs of all who have served, including the family.</p> <p>Ms. Walsh: Thanks Meredith. Any discussion?</p> <p>Dr. Moseley Brown: It should be noted that unfortunately due to limited time this meeting is unable to entertain questions and comments from the public.</p> <p>Ms. Beck: It may be helpful for the public to know these recommendations have been discussed at previous meetings and conversations, which is why there is less discussion among the committee members.</p> <p>Ms. Walsh: Thanks for the clarification,</p>
<p>Recommendation Discussion 4-6 Caregiver Focus – Andrea Sawyer, Chair, Caregiver Subcommittee</p>	<p>Proposed Recommendation 4: Recognize that certain Veterans' condition(s) will not improve and find a way to recognize that within the CSP evaluation process to reduce the frequency and the redundancy of reassessment items.</p> <p>Rationale: Many Veterans have debilitating conditions, some of which are permanent and either stable or degenerative, such as some types of MS, ALS, traumatic brain injuries, quadriplegia, dementia, etc. It is medically understood that these conditions are irreversible and will not improve with time and will likely cause the Veteran progressively to decline. A training component emphasizing that many Veterans have conditions that are unlikely to improve should be integrated into the education of CEAT and CSP staff.</p> <p>Current PCAFC regulations (38 CFR § 71.30) state that reassessments may occur on a less than annual basis if a determination is made and documented by VA that an annual re-assessment is unnecessary, Recognizing that PCAFC has a reassessment component for the Veteran and caregiver, but acknowledging the impact this process has on the physical and mental health of the Veteran and caregiver, the committee requests that the CSP develop a more streamlined, efficient reassessment protocol to reduce the frequency of reassessments and eliminate the duplicative nature of some items aiming to solicit the same information in multiple ways. Furthermore, the change in a Veteran's primary caregiver should not result in the cessation of the Veteran's participation in the program, requiring re-application, but</p>

should focus on the eligibility of the new primary caregiver, especially if a secondary caregiver is documented and has already been trained and certified by the VA.

Ms. Walsh: Any discussion? Seeing none we shall move on to recommendation five.

Proposed Recommendation 5:

Enhance collaboration with a Veteran's providers within the PCAFC application and re-evaluation process and enhance collaboration between caregivers and the Veteran's providers in general across VHA.

Rationale:

Acknowledging that Veterans within the PCAFC and PGCSS programs are Veterans with high needs for assistance and that caregivers of those Veterans are more apt to interact with the Veterans' health care providers, it is imperative that those Veterans' caregivers are able to collaborate with the providers. If a Veteran is assigned a treatment that the caregiver has to monitor or help administer, it is necessary for the provider to have provided instruction to the caregiver on the administration of that treatment. Far too many times, caregivers are assigned a duty or task by a physician for the facilitation of a treatment plan when the caregivers have had no direct explanation from the provider of how to carry out the activity or administer the treatment. In trying to reach a provider, caregivers can face many barriers.

In many cases, when caregivers call the VA, despite having a caregiver designation and possibly a Healthcare Power of Attorney, caregivers cannot access the information which they seek. As such, one solution to facilitate caregivers' access to information across VA facilities nationwide, would be to create a notification system in the Veteran's chart that documents the name of the caregiver and their designation as a participant in PCAFC/PGCSS and/or the Veteran's Healthcare Power of Attorney (POA). This notification should be nationwide as many Veterans may travel (older Veterans may be snowbirds) and/or use multiple facilities for their needs.

The notifications should be visible throughout the entirety of and outside of a Veteran's home VISN, as many small clinics require Veterans to be seen in multiple different facilities throughout the nation. This information should not be in a clinical warning, as many people within the VA do not have access to view clinical warnings. Hiding an important note such as this in clinical warnings does not allow the personnel who need to interact with this information, i.e. appointment clerks, easy access to view it, thus creating an unnecessary delay in what may be a time-sensitive matter.

Additionally, since caregivers do administer care on a daily basis, they are the experts in a Veteran's changing needs. Their input on the care and case management of a Veteran should be considered by the Veteran's care provider. They should have access to providers for assistance and collaboration. When caregivers have to manage multiple high care needs and conditions, it may require interaction with multiple providers. Assigning case management that can reach across clinical disciplines to get the healthcare and assistance needed in the home, to the

population of Veterans with multiple serious conditions, who have caregivers managing those conditions, would improve outcomes for Veterans and take some case management burdens off those caregivers. Having Veterans and caregivers in PCAFC evaluated for inclusion in Care Coordination and Integrated Case Management should be considered for Level II PCAFC caregivers.

Lastly, caregivers have routinely noted that the information providers are asked to document differs drastically from the information evaluated in the assessments for PCAFC. As such, there may be little documentation from providers that describes the true clinical needs of the Veteran for purposes of ADL assistance and SPI when applying. Involvement and more detailed input from a Veteran's providers through assessments and notes that document the true care needs, ADL's and SPI's, should be visible in a Veteran's records annually, especially for Veterans enrolled in and applying to PCAFC. For instance, one way of achieving this would be by incorporating a form for Veteran's primary care provider that would gather essential information on ADL and SPI care needs. This would also assist with recommendation number four.

Ms. Walsh: Thank you, Andrea. Conversation, questions?

Ms. Beck: For the rationale purposes are you asking that they automatically be evaluated by definition of being a PCAFC that they automatically be evaluated for CC and ICM, which I. I agree with I'm just curious if that's what you're asking for?

Ms. Sawyer: I'd ask my team members to look at this. I don't think we had the discussion that it'd be mandatory just that it should happen.

Ms. Beck: Got it. I was just curious cause it makes a lot of sense because obviously you have overlapping people just like in the first part where you talk about people with permanent disabilities. There are certain things that if they're automatically done, 1) I think they take the burden off the caregiver and veteran and 2) hopefully helps to streamline the process for the staff.

Ms. Sawyer: That's so, that's ok. So in order for that to happen, CC and ICM would have to be rolled out everywhere and it would have to have the staff available to do it. So, in some cases that that staff and the understanding of the program would have to.

Ms. Beck: To which it's not a program, it's an initiative.

Ms. Sawyer: It is a process, but it would have to be available.

Ms. Beck: And I agree. Okay, thank you. I just was I was curious about the intent.

Ms. Walsh: Ms. Debord?

Ms. Debord: I would typically not jump into this, but I wanted to make sure we use the correct verbiage, so it's care coordination and integrated case management is, is CCICM, just making sure we have that notated correctly.

Ms. Walsh: Thank you.

Ms. Walsh: Ms. Comeau.

Ms. Comeau: This is more of a comment for recommendation number four, and I don't know if this is helpful, but we did make a similar recommendation on this committee back in 2018, that indicated perhaps a clinical indicator. I believe at that time the VA was saying that they couldn't create a separate reevaluation because it was a clinical program and the clinical program made it need to have those annual reassessments. And so, the language back in 2018 alluded to a clinical indicator to perhaps lessen the reassessments. In Andrea's language it is very thorough in recommendation four about what our intent is with this. But I just wanted to note that it might be helpful to say this recommendation was made in 2018 with either concur or concur-in-principle.

Ms. Walsh: It was a 2018 recommendation.

Ms. Comeau: Question four.

Ms. Walsh: Yes ma'am. Do, do we want to go back?

Ms. Sawyer: Okay, Dr. Richardson correct me if I'm wrong, in recommendation four, we discussed that it doesn't have to be annual. It has to be if it's clinically indicated. Is that, correct?

Dr. Richardson: So, to Melissa's point the statute reads, that the Secretary has to ensure that people meet qualification or eligibility requirements to be in the program, which in statutes says essentially as clinically indicated, and that's not something that our program has historically done. So, the subcommittee recommending you look at that and make consideration for clinically, looking at whether or not the veteran caregiver need a real assessment at that time.

Ms. Sawyer: This recommendation is specifically for those folks who have already met that criteria and who have debilitating conditions that are not expected to get better. This does not apply certainly to every veteran and caregiver within the program, just those that we know aren't going to improve by nature of their diagnoses.

Dr. Richardson: Right, and something to keep in mind is that PCHC doesn't just evaluate the veteran for appropriateness to evaluate the caregiver, so there's a little nuance to what you just said because we're not just looking at the veteran, but we're also looking at the veteran and the caregiver. Sometimes our caregivers

end up not being able to provide those services especially for some of our elderly caregivers who become institutionalized have strokes of their own etc. So, we look at both pieces, but yes ma'am, that is that the principle of what you're saying from a clinical perspective is.

Ms. Comeau: Yes, apologies. I had a little bit of Wi Fi issues there. So I'm not sure if this was just said, Dr. Richardson I think you are again getting at the heart and the intent of this recommendation. One area I don't see.

Ms. Walsh: Yeah. Melissa, you, you froze. Can you, can you back.

Ms. Comeau: Yes, so I'll start with Dr. Richardson talking about the heart and the intent of this recommendation. And I do think it's important to call out that clinical piece, which Andrea has done. One group that I see missing in this recommendation is those caregivers who are caring for someone through end of life perhaps in hospice. And we have heard from some caregiver survivors that they were expected to do a caregiver reevaluation during that time. And so we just want to make sure that we're mindful of that take. The end-of-life journey and that caregiver assessments are not done in that clinical situation as well.

Ms. Sawyer: My concern about that Melissa, would be if you have a person in an end-of-life state that is a level one that all of a sudden requires level two care. That if you didn't do the evaluation, they may be missing out on those extra benefits, and the purpose of this also is to say that we want to reduce the frequency if you're in that situation, but the duplicative nature of those items. So, the hope would be that if they did, if there was a need for reevaluation which certainly could be to increase the supports for the caregiver during that time period was that there would be less of a nature of that redundancy and duplicative nature of so many items that it would be a modified assessment, but certainly, you know, we don't want a caregiver in a situation where they need more supports and they don't do a reassessment that would, would then allow them to have extra supports in place.

I think that probably needs to be a discussion. Maybe Dr. Richardson a training discussion with caregiver support coordinators around what caregivers and veterans want maybe in that situation. I mean, certainly they would have the ability to, to say, I don't want to do another assessment even if it would increase my level of supports but there will be some caregivers who want that increase in support.

Ms. Walsh: Sean Lopez.

Mr. Lopez: I think that's a great point Melissa, and I think the intent maybe is to give caregivers and veterans the option to say

undergo a reassessment, if you feel like you're, you're stuck at tier one, you're probably going to be there because of these conditions that are, you know, ongoing. Maybe you say that we're not going to automatically reassess you given your condition, but you have the option if you feel like it's degenerating or getting worse, you can voluntarily undergo a reassessment.

Ms. Ferrell: Comments or thoughts. You have another problem as well because there comes a time when end of life at some point requires more care than can be provided by a non-medical professional. And in those cases, if the veteran requires skilled care and needs to be in a medical facility, they will not qualify for this program. So, in those cases, they wouldn't qualify under recommendation four. So, we can't say at end of life would not be able to be reassessed. Also, in situations of where the caregiver wouldn't meet criteria, that would require a reassessment. So, end of life wouldn't really be fair. We've also had some who were at end of life and made a complete turnaround, which very rare.

Ms. Beck: I was just going to say to address all of these different various scenarios, could you just add the words at the end of your recommendation when appropriate? And redundancy of re reassessment items when appropriate?

Ms. Walsh: Okay.

Ms. Benson: Dr. Richards, my understanding is that a caregiver who feels that level of care has changed may trigger a reassessment by talking to their caregiver support coordinator to say we need a reassessment, the level of care has drastically changed. And, I mean, correct me if I'm wrong, but that's my understanding. So having an end-of-life situation where you needed an adjustment of care would be a call your caregiver support coordinator and say we need reassessment. And I'm not sure that that's where we were going with this recommendation more so to delay not delay. Intentionally utilize the statutory language of less than.

Dr. Richardson: Annual. Correct. A caregiver and veteran today could request a reassessment at any time in the process. Should they feel that their level of care needs et cetera, have changed. That is accurate. Today, the way statute reads is not how we've been applying it consistently and reassessments are on pause anyways, right? So, no one's receiving a clinical reassessment unless they state my level of needs have changed. I'd like a reassessment, then we'll be doing those, but you are correct Caira.

Ms. Benson: I want to address that end-of-life situation, I think this recommendation actually would cover degeneration even into end of life because that need for reassessment we can trigger as caregivers any time. What we're intentionally doing here is leveraging that statutory language that if care needs are degenerative or stable in a sense that we're not getting better, we're not getting worse, they don't have to go undergo that yearly reassessment.

Ms. Sawyer: Well, it's not necessary but frequency also.

Ms. Benson: So as instead of (*inaudible*)?

Ms. Sawyer: For reassessment. It was correct. It may still be annual, it just might not be as in depth as it normally would and I not sure that I would agree with the when appropriate, just because I feel like the when appropriate would add, too much.

Ms. Beck: Interpretation. Caira's question and comment, actually I think rids the need for saying when appropriate anyway.

Ms. Ferrell: What she clarified got rid of that. I agree with that.

Ms. Benson: As well.

Mr. Pruden: I agree as well. I was I was actually going to agree with the as appropriate but Caira's comment did help me understand that a little better. I'm comfortable with that and so I think we're in a good place with this one.

Ms. Walsh: Okay, I don't see any other hands. Are we good with four and five? Okay, let's move on to recommendation six.

Ms. Sawyer: Yeah. This one came after a lot of discussion of how we discovered caregivers' medical records were created, including their mental health records and we discovered that it could happen in multiple different ways depending on their eligibility.

Proposed Recommendation 6:

Create a standardized method for the creation of electronic medical records for caregivers.

Rationale:

Due to the many ways a caregiver may have an electronic medical record created for them within the VA system— PCAFC, Health Eligibility Office, etc., —and the many ways that a caregiver may access resources, caregivers report that sometimes their mental and physical health records are co-mingled in their Veterans' electronic health records. As such, some caregivers avoid using the VA physical and mental health resources that are available to them. To avoid this, VA should create a standardized process for the creation and management of electronic medical records for caregivers. In the event that a caregiver may have a counseling session with a mental health professional where a collateral health record is not indicated, there should be a process that alerts the caregiver that such information will be in the Veteran's health record, such as in counseling through HBPC where the mandate to talk with the caregiver is based on the Veteran's eligibility and not the caregiver's eligibility.

Caregivers should be encouraged to use mental health resources within and outside of the VA, and care should be taken to ensure that Caregivers' health records, including mental health records, do not become part of the Veteran's Electronic Medical Record, throughout all VHA programs. Caregivers of Veterans face mental and physical health issues in relation to caring for their Veterans and in the transition of their relationships from friends, spouses, and/or parent/child to caregiver/care-receiver dyads. During the process of caregiving, caregivers may find counseling beneficial. Additionally, some caregivers have reported having their mental health counseling records placed in the Veteran's health record so that a Veteran can read the thoughts that a caregiver has expressed to their providers. We would ask that whether it be through PCAFC, PGCSS, VDC, HBPC, etc., that a caregiver receives mental health counseling, that a caregiver have a collateral mental health record and not have their counseling notes placed in the Veteran's health record.

A caregiver's time with their therapist and the thoughts expressed in such a session should be confidential and no less confidential because the records are created due to counseling accessed through a VA program.

Putting a caregiver's mental health records in a Veteran's records allows all the Veteran's providers and the Veteran themselves to read the struggles a caregiver may be experiencing in their caregiving role. This may cause issues if the Veteran has access to these notes. If a Veteran's provider brings up the information about a caregiver to a Veteran during an appointment, a caregiver may feel a profound sense of betrayal. The mental health records of a caregiver should not be able to be accessed by the Veteran or the veteran's providers. The need for confidentiality of a caregiver's mental health records is especially true if the Veteran is also a VA patient due to the caregiver's own status as a Veteran. Due to many Veterans marrying Veterans and dual parent/child Veteran status, it is not uncommon for one Veteran to be the primary care provider of another Veteran.

As such, it is imperative that a Veteran who is a caregiver has the same protections receiving VA mental health services as the caregiver of a Veteran who might receive mental health services outside of the VA. It is the intent of this recommendation, that the provider/caregiver relationship be sacrosanct unless the caregiver or veteran's wellbeing is in question. VA should advertise its mental health support programs to the caregivers. Many caregivers within VA may be hesitant to access mental health counseling through VA or may not know that it exists.

VA should make an effort to advertise the sacredness of the Caregiver/Therapist relationship and advertise the mental health services available to caregivers through any VHA/VA programs where it exists (counseling options through HBPC, PCAFC, and in some cases the Vet Centers.)

While the Committee applauds the creation of counseling resources for caregivers of PCAFC, there are many more caregivers that may need access to counseling options under VHA Patient Care Services. While SecVA does not have a legislated mandate to

provide counseling resources to those outside of PCAFC, it is important to acknowledge that other caregivers are experiencing similar transitions into and out of caregiving and likely need the same supports.

Ms. Walsh: I just had a quick question. We alternated in the slide before the last one between what I heard was VHA and then VA, and I just wanted to clarify if we meant VHA or we're using the universal VA. VA then of course to leave it.

Ms. Sawyer: You said VHA? I think it can, so VHA and VA programs, to flip those back and forth specifically where we are talking about patient care.

Ms. Walsh: For services that needs to be under VHA. I think it's the next slide.

Ms. Sawyer: Or the one before that. Well, actually, it's in that slide also, so if you go in and we started with VA at the top and then VHA.

Ms. Hallett: A VA program. So, would you like all of them to be hyphenated VHA/VA.

Ms. Sawyer: No, they don't need to, I think it's understood.

Ms. Walsh: Lisa. Okay, thank you. Jonathan?

Mr. Pruden: Yeah, this is a semantic thing, but on the first slide where we say every caution because it's right at the front there, that wordings a little funny to me, recommendation six and I thought maybe instead of every caution we could say care should be taken to ensure.

Ms. Sawyer: Is this the 1st slide?

Ms. Beck: Recommendations.

Mr. Pruden: I think it might be the 2nd slide. Maybe it is. There we go. And every caution should be changed and instead of saying every caution should be taken because we say care should be taken to ensure, somehow.

Ms. Walsh: Every caution should be taken as a I feel like we had that originally and it got changed in, in the discussion back and forth in the last week. Yeah.

Ms. Sawyer: Makes sense.

Ms. Beck: Specifically, for PGCSS I'm wondering though because looking at the overlap between you've got caregivers who are family members, family members who are caregivers, some of whom are in PGCSS or some of whom are not.

Well, I'm just trying to figure out how to make the two make sense together. So, we make this recommendation for mental health care and services. What if we said, in the caregiver subcommittee's

recommendation in accordance with that sentence that it would be beneficial for the VA to collect data on seeking the expansion?

Ms. Sawyer: To understand the changing mental health needs.

Ms. Beck: You said it would be helpful to understand these counseling and I don't know if anybody else has any.

That's the two recommendations cause it's not going to be broken down by caregiver and family subcommittees that we're asking and one to have mental health care increased and we're asking the other to determine if it makes sense to have mental health care increase. So, I don't know if that's a concern of anybody else, but they just jumped out at me.

Ms. Walsh: Log in my computer. Linda?

Ms. Kreter: My question was whether we should strike that last sentence completely because you're going down with a full recommendation and then you're asking for more information. And I think it dilutes the message of what you're trying to say about confidentiality of the therapist caregiver relationship. And I think in the first with the family support.

I think that one was very clear. The comment that was just made about collecting data that raises the hair on the back of my neck because too many of our programs have collected data that wasn't uniformly gathered and caused people to be very suspect of where this data was going. What was being identified? So, I am uneasy with the thought of collecting more data on people we are already collecting enormous amounts of data on and we don't know where it's going. There are multiple programs at VA that go to dead ends. But the data is collected, and data is information and power, and that concerns me.

Ms. Walsh: Okay.

Mr. Pruden: Jonathan? Oh, I was just going to say I believe it makes sense given what Meredith and Linda just said you strike that last sentence from the.

Ms. Walsh: Recommendation...Ms. Benson?

Ms. Benson: I was just going to second that I'm fine striking that last sentence from the recommendation giving the family's recommendation about...

Ms. Walsh: Expansion of mental health?

Ms. Hallett: Yes, but Dr. Moseley Brown I have an inserted sentence from that last set of recommendations that we shared. Do you want me to read the inserted sentence that is not captured on this slide or do you want me to read the slide and then.

	<p>Dr. Moseley Brown: Please, read it.</p> <p>Note: There was editing of the slide used prior to the discussion. The below is the corrected narrative.</p>
<p>Recommendation Discussion 7-8 Survivor Focus – Lisa Hallett, Chair, Caregiver Subcommittee</p>	<p>Proposed Recommendation 7: The VA should establish access to mental health services for family members who lose a loved one in the Department of Defense or VA care, in line with the 13-month standard of care for bereaved individuals established by Centers for Medicare and Medicaid Services (CMS).</p> <p>Rationale: Bereavement is complicated and can be long-lasting. Survivors, including parents, spouses, siblings, and children, should have access to the mental health care they need, especially in the vulnerable first year after a loss. While the CMS, Centers for Medicare & Medicaid Services, currently establishes a standard of care for bereaved individuals at 13 months, those who lose a family member in VHA care do not have access to bereavement counseling, creating an urgent need.</p> <p>Every year, 500,000-600,000 Veteran deaths occur generating thousands of calls for assistance to VA Medical Centers. In FY2023 approximately 21,000 Veterans passed away in VA medical care, including in hospitals, nursing homes, and contracting facilities. 67% of surveyed survivors said they needed “more help” during these moments that matter (Bereaved Family Survey Q3 FY 2023). Surviving family members, including elderly partners, adult children, minor children, and siblings often are left to process the death of their loved one with no support from VA.</p> <p>Across the nation, there are approximately 400,000 Survivors who are recipients of Dependency and Indemnity Compensation (DIC). While some Survivors benefit from bereavement services through Vet Centers - their services are limited to Survivors of Service Member Deaths while on Active Duty, family members and caregivers of a current/former client or family members, and caregivers of Veterans who die by suicide. The vast majority of VA’s Survivors are not eligible for bereavement counseling through the VHA. Offering access to bereavement counseling for immediate family members shortly after, and for an extended period after their Veteran dies, would help military and Veteran Families heal and honor the sacrifices of their Veterans.</p> <p>Ms. Walsh: Any discussion? Stacey,</p> <p>Ms. Greathouse: Oh, is that from before? Okay. Yeah, sorry. No worries.</p> <p>Ms. Sawyer: Okay. Can you go to the second slide, please?</p>

Ms. Walsh: Okay discussion? Okay, shall we move on to recommendation eight?

Ms. Walsh: Laura Monk had her hand up. Oh, I'm sorry Laura, I didn't see it Laura.

Ms. Monk: So, we can hear her. Hi, I just wanted to let you know that I was here, and I've been able to listen in on the whole time. I do not have any recommendations for, this, but I just want to let you know that I was here, and I have been listening.

Ms. Walsh: Thank you Laura,

Proposed Recommendation 8: The Committee recommends timely, expanded, and standardized support of the Survivors Assistance and Memorial Support (SAMS) Program, to ensure that survivors of deceased Veterans (within the VHA system) and anticipatory survivors* have accessible and dedicated in-person support within VA facilities, in addition to virtual support, to assist Survivors with the navigation of administrative tasks associated with the passing of a Veteran.

Rationale: The Committee was encouraged to learn VHA is taking steps to support Survivors through the Survivor Assistance and Memorial Support Program (SAMS) but believes there is a gap in transitional support from Caregiver to Survivor. Survivors have earned compassionate and dedicated support in the education and navigation of survivor benefits to include, but not limited to, bereavement counseling, burial benefits, healthcare, education and training, employment, home loan programs and/or financial counseling, life insurance options, survivor pension, and DIC. We are deeply concerned by the Survivor-to-Staff ratio at the Office of Survivors Assistance (OSA) and an extremely small leadership staff, as well as no field staff, in the SAMS program. We recommend an increase in the number of dedicated staff directly supporting our Survivors. The Committee also highlights the unique needs of our helpless and incapacitated dependents who would urgently benefit from dedicated support.

Specifically, the Committee recommends the implementation of SAMS throughout the 170+ points of care staffed with dedicated specialists who can focus on supporting Survivors through the complicated VA system. These specialists should be trained and resourced consistently to ensure Survivors receive consistent and standardized support, moving the VHA away from pockets of excellence and towards a pursuit of excellence regardless of locations.

After their Veteran passes away, it appears that VHA closes Survivor access to the system that previously supported them. Providing access to bereavement support through VHA is a well-reported need from Survivors, which can be found on Veterans Benefits Administration (VBA's) Survivor Journey Maps, Tragedy Assistance Program for Survivors (TAPS) Journey Maps, and Bereaved Family Surveys.

The Committee has reviewed feedback from Survivors that includes “feeling lost in the system,” waiting to meet with minimally trained clerks who rush them through their questions, the inability of a VA representative to answer relevant questions, and realizing long after their Veteran has died that there were benefits of which they could have taken advantage (financial, housing, education, and so forth). For many of our families in VHA, death is complicated and prolonged. Many military families navigate complicated grief, which persists after the normal grief window of 2-3 years post-loss. This complicated grief underscores the importance of focused guidance to ensure that these survivors are able to adequately access their earned benefits.

While it is the responsibility of Decedent Affairs to support new Survivors, there is no national oversight and care is inconsistent, only available immediately in the aftermath of losing a loved one.

In addition, the Committee recommends an agency-wide training campaign to ensure consistency in awareness of bereavement care, services, and benefits available to our surviving population across VA departments. VHA should ensure that its workforce is sensitive to the Survivor journey, familiar with Survivor resources, and proactive in directing Survivors within a VA facility so they feel welcomed and supported throughout their grief journey.

Ms. Walsh: Okay or discussions? Jonathan, do you have your hand up?

Mr. Pruden: Yeah, I do not, but on the last page of the recommendation on the last sentence, there was a grammar question I had. We go to the last page, I'm sure that all of its workforce is familiar with survivor benefits and a proactive not.

Ms. Hallett: It's fine. So we're good. Good job Lisa. Jonathan, if we're catching grammar over grammar edits though, that first sentence on that page while it is the responsibility of decedent affairs to support new survivors. There's NO national oversight. Take away that comma.

Ms. Beck: I have a quick question though on the last slide that we're on right now where it says, VHA should ensure that all of its workforce is familiar with survivor benefits and proactive and directing. I pride myself on knowing the people to call, not necessarily knowing all of the benefits, and asking the whole workforce to know those benefits might be a bridge too far, even though it would be ideal.

The workforce is familiar with potentially familiar with the SAMS program, so that they are, they know where to direct people or do you want to say the entire workforce familiar with survivor benefits?

Ms. Hallett: No, I think, one of the sensitivities to a survivor's journey,

and to know where to direct a Survivor, but right now we need to have that person and that team in place to be able to support is such a valid point.

Ms. Beck: I don't know if you're an expert in everything, you're an expert in nothing, so, I mean you could say VHA should ensure that all of its workforce is sensitive to the survivor journey and familiar with the resources.

Ms. Hallett: For survivors and where to direct them, is sensitive to the survivor journey.

Ms. Beck: It's familiar with the resources available, and where to send survivors in need or might have.

Ms. Seals: Okay.

Ms. Walsh: I would put it as with those resources instead of with survivor benefits because the resources are not always going to be just VA, based benefits. I have gotten some very unusual resource assistance through others...hey, did you know this?

Ms. Monk: I was going to say I can't view the slide because my eyes were dilated this morning, but I would say definitely direct the survivors to get those resources would be definitely the best way instead of just saying the benefit, so I do agree with that change.

Ms. Hallett: So the committee recommends an agency wide training campaign to ensure consistency and awareness of bereavement care services and benefits available to our surviving population across VA departments. VA should ensure that its workforce is sensitive to the survivor journey and as familiar with survivor resources and where to direct them.

Ms. Beck: No, actually you can just get rid of that. If you say it's familiar with survivor resources, get rid of the rest of that sentence and proactive in directing survivors within a VA facility so they feel welcomed throughout their grief journey.

Ms. Hallett: Does that make sense? Does that work? So, VA should ensure that all of its works force is sensitive to the survivor journey and is familiar with survivor resources and proactive in directing survivors within a VA facility so they feel welcomed and supported throughout.

Mr. Pruden: Their great Journey. And we're cutting.

Ms. Kreter: I would concur with what Jonathan just said. When you put the word all in there, you're putting a big onus on a lot of people. If you say would ensure its workforce is sensitive, I think that's broader, gets the point across and doesn't.

Ms. Hallett: So VA should ensure that its workforce, is sensitive to this survivor journey, comma.

Ms. Beck: Remove the and.

Ms. Hallett: There you go. Remove that and right there. Yep. You're doing great. Okay so we've got VA should ensure that its workforce is sensitive to the survivor journey, is familiar with survivor resources comma. Oh, well, I guess we can remove that too, so we're sensitive to the survivor journey is, well, we already have the is, so familiar with survivor resources comma, and proactive and directing survivors within VA facilities they feel welcome and supported throughout their care.

Ms. Sawyer: Okay, so in this, if you're deeply concerned about the, basically, lack of or deeply concerned by the survivor to staff ratio, like the understood request there is that you increase that survivor to staff ratio.

Ms. Hallett: To directly request that that survivor to staff ratio be increased. So just flip to a positive, right? We rather than we're deeply concerned.

Ms. Walsh: Caira?

Ms. Benson: Andrea hit on some of the points or the questions I had because that last paragraph went to generalities versus just really focusing in on direct staff relations. So, my suggestion is on that last paragraph on slide 19 that we say, in addition, the committee recommends an agency wide training campaign, and the rationale being that the meat of this recommendation is increasing direct support. A training campaign agency wide isn't increasing director support, so that would be my recommendation as we say in addition, but that we really do what you just did, which is that focus on that increased to staff ratio.

Ms. Hallett: No, great catch on that thank you any other thoughts on this? Meredith and holly.

Ms. Beck: When SAMS gave their update, I know we didn't

have a lot of opportunity to ask questions. I'm just curious, was, there clearly a path forward to increase that staff within the SAMS program.

Ms. Debord: Thank you Meredith. Rafiq is on a very well-deserved vacation this week. So, we did go before VHA governance week before last. Because we had to pivot, I think we all talked about this because of the staffing constraints and budgetary constraints on our initial ask for an additional staffing person at each facility, but instead to realign staff that are currently doing into the affairs work under care management and social work to stand up the SAMS program, with an enhanced role on PD that was endorsed. So, we are strategizing a progressive deployment to move it out.

It's, it's more challenging just to be really. We're just going to be working really hard with each facility to try to support them rolling it out.

Ms. Beck: Depending upon their current staff. Does that make sense? It does so it's in a similar situation as the family support resource coordinator and the way we phrased it on that one was reprioritize that particular position. But I guess what you're saying is that rather than create a new Position, it is offering those decedent affairs individuals a collateral duty or is it redesigning their role overall?

Ms. Debord: The plan would be you've got existing staff doing the work and maybe it's a collateral there. With the new SAMS program, which the directive is under review we're going to be publishing a notice this summer. There will be an expanded expectation of that role. We really need a full time staff. It's aligning a full-time person, at least one, if, if not multiple at some sites under management and social work to operationalize this program, but because there are NO new resources, NO new people, we're having to really adjust how roll it out to make sure they can be successful. I mean we've got so many great resources that we're ready to roll out, but we must be sensitive to what they're experiencing at the facility level to make sure we do it in a successful way. Does that make sense?

Ms. Beck: Yes, and it does. And Lisa, where you're saying we are deeply concerned by the survivor of staff ratio at OSA and one employee at SAMS, that's not one employee per VA medical center, that's literally Rafiq, correct?

Ms. Walsh: I just want to make sure because hands up for a while now and I want to make sure we're hitting up everybody's hand. I was just going to jump in. Holly, I know you have had your hand up. Is it specifically with regard to this?

Ms. Ferrell: Yeah, I was gonna ask about this and ask

does SAMS have a website or a hub where the families can go or survivors can go to check on the resources available for the care services and benefit. Benefits for self-service instead of going directly to someone.

Ms. Debord: And I will take that Holly. So, they are building that out. They currently have piloted a standardized bereavement package which at six sites across the country, where.

We're going to be getting all that feedback back within this month, and then, you know, adjusting with that, which includes some of those what you're talking about, you know, those, links to all the resources, but what we're saying is that it's such a complex.

System of care that we feel that you need to have somebody that has specialized knowledge in this space to help survivors navigate. What I'm hearing you say is in the meantime, is there something, some place to go? And what I'm basically saying is that we're building that out still.

Ms. Walsh: But that would be the end state. One thing we were considering.

Mr. Pruden: No, I, agree, but you can only squeeze so much juice from a single orange and I am concerned if we don't add additional staff to that SAMS portfolio, they won't have additional bandwidth because the decedent affairs folks I assume already have full time jobs that are keeping them gainfully employed and adding additional responsibilities and new tasks doesn't necessarily increase that bandwidth.

Ms. Debord: That would look like for you guys that might be helpful. Jonathan, thank you for asking. I think what I would say is that we recognize this and it's just the current state.

We want to make sure that work continues to progress and move forward and be better for our survivors in this current environment with such limited resources. So absolutely, it's going to take at least one SAM specialist at every facility because the of the expanded role of

coordinating the clinical staff that'll be involved in it, making sure that we're proactively reaching to every survive, you know, all of that, it's going to be an expanded role. It's just that this was a way to keep it moving forward until we can kind of get out.

Mr. Pruden: From under this current budgetary constraint.

Ms. Debord: Does that makes sense? Yeah, so bottom line perfect world, additional staff would be helpful. Absolutely.

Ms. Walsh: Okay committee, we have about 10 min left. I see four hands up.

Ms. Benson: Thank you Maggie. Really quickly Lisa, just verifying that if our, our, if the goal of the recommendation here is physical staff, do we want to under the recommendations say dedicated in person staff within the facilities comma in addition with virtual support comma to assist instead of saying and or virtual support?.

Ms. Hallett: I would say yes, it's something that every time I read it, we, we want to make sure that those virtual support, whether it's it's the hub or that I can zoom with, I want to be able to zoom with somebody. We know many of our families live in rural areas, so we want them to be able to zoom or have an electronic process.

Ms. Benson: So, in person, dedicated in person support within the facilities, comma.

Ms. Walsh: In addition to virtual support.

Ms. Walsh: Linda.

Ms. Kreter: Thank you. I thought I had unmuted. It's back in that same sentence. We are deeply concerned by the survivor to staff ratio at the OSA and one employee at the Sam's and recommend and carry on. I I think it would make it clearer and more urgent if we changed and.

A single employee in the SAMS program, because we already had questions about is that one employee, is it one per VA, et cetera, a single employee in, instead of at the SAMS program?

Ms. Debord: Just wanting to add one piece to this because I keep coming back to this. In current state Rafiq is the only person. However, we are in the process of hiring his three associate directors, so literally by the time this would be released, it's going to look different than it

does currently, so I just would be afraid to put that out there.

Ms. Hallett: Okay

Ms. Walsh: Yeah Lisa, is it too ambiguous to say staff ratio at the OSA and the.

Ms. Debord: Extremely limited leadership team in the SAMS program. Absolutely.

Ms. Beck: Yeah Jill, is it?

Ms. Debord: Fair to say that there are NO currently field staff?

	<p>Note: more discussion on grammar correction and punctuation.</p> <p>Ms. Walsh: Okay, we have completed our comment and conversation on each of the eight recommendations, and it's now a time for committee members to vote on the recommendations that will be forwarded to the VA Secretary. I will read each recommendation and once the recommendation has been read, I will ask the committee members to unmute and voice either approval.</p> <p>Yay or disapproval nay, for moving the recommendation forward. Are we ready to take the vote? Okay, seeing NO hands, we'll begin.</p> <p>Ms. Walsh asked the Committee to vote on each Potential Recommendation. They passed unanimously.</p>
<p>Overview of Recommendation Process</p> <p>Colleen Richardson, Psy.D., Executive Sponsor for the Federal Advisory Committee</p>	<p>Thank you, Maggie, and thank you Subcommittee Chairs and committee members. I think we've got a lot of good recommendations going forward to the secretary. Next that will happen is Dr. Moseley Brown will package these together and they will go forward. They are due on 1 July, so we are ahead of schedule and ready to rock and roll.</p> <p>Our next meeting will be sometime here in the fall. Then with the full committee, probably around the September October timeframe, an exact date will be determined here in the next couple of months, but really appreciate everybody's work. And again, we're going to try to meet quarterly if we can. I think that that's keeping things very transparent and allows for really good discussion as we move forward for a new committee and new committee members.</p>
<p>Maggie Walsh, Acting Chair, Veterans' Family, Caregiver and Survivor (VFCS) Advisory Committee</p>	<p>We'll head it, hand it back over to you ma'am to officially close out.</p> <p>Thank you so much and I'd especially like to thank you, Dr. Richardson for your leadership. This has been a great experience and we appreciate your expertise and your kindness in your leadership. Dr. Betty, thank you and your team so much for making it all.</p> <p>Okay, if I had a gavel, I'd be hitting at thank you. This meeting is adjourned.</p>
	<p>Adjournment</p>

Approved on August 28, 2024
/s/Dr. Colleen Richardson, Executive Sponsor

Approved
/s/Maggie Walsh, Acting Chair

Approved on August 16, 2024
/s/Dr. Betty Moseley Brown, DFO