



Department of Veteran Affairs
Office of Care Coordination

Supporting Veterans' Caregivers: A Frequently Asked Questions Guide



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SECTION 1: INTRODUCTION

Our mission is to provide the right care to our veterans in the right place and at the right time and the caregiver's role in this mission is certainly significant. In many instances, the caregiver serves as **the** vital link between the VA and the veteran, who may be seen in variety of programs and settings and present with a variety of needs. Without a caregiver, many veterans would not have the continuity of care or the quality of life they desire. It is our responsibility as clinicians to assure that we are aware of all influences that may impact the veteran's treatment and to insure that the veteran and their caregiver(s) are full participants in their care planning.

Caregivers may be labeled as either a "formal" caregiver or an "informal" caregiver. Formal caregivers such as nurses and home health aides are professionally trained and are paid to provide health care for a certain length of time. Informal caregivers are people such as a spouse or significant other or partner, family member, neighbor or friend who generously gives their time and energy to provide whatever assistance is needed to the veteran.

We all recognize the benefits to our veterans when their informal caregivers are healthy, engaged and coping well. However, we must also recognize the impact on the veteran when caregivers are struggling because of their limitations. As clinicians, it is our responsibility to support caregivers when possible and permissible within existing VHA rules, regulations, resources and capacity.

This guide will help answer questions and discuss various ways clinicians can work more effectively with informal caregivers. In the sections that follow, the clinician will learn how to assess the strain and burden on the caregiver and why this is important in the care of veterans, explore various programs available to provide help and support to the caregiver, as well as describe educational and training resources that are available to both the clinician and the caregiver. Guidance will be provided in how to document and code interventions pertaining to caregivers and accurately capture the amount of workload involved. Caregiver issues related to privacy, confidentiality and client-to-clinician professional boundaries will also be discussed.

"Supporting Veterans' Caregivers: A Frequently Asked Questions Guide" is meant to be a useful tool as you strive to increase the frequency and quality of your interactions with caregivers. Remember - whatever assistance you are able to provide to the caregiver stands to be of great benefit to the veteran. Without a strong informal caregiver presence, many of our veterans with compromised medical, physical, psycho-social and mental health needs would certainly have diminished independence and quality of life.

SECTION 2: THE ROLE OF THE CARE COORDINATOR

The clinician's primary responsibility is to meet the health care needs of the veteran. Caregivers often have a great deal of information about their veterans' concerns, values, preferences, habits, and lifestyle. Therefore caregivers can be an invaluable resource to clinicians as they gain understanding regarding how to better serve veterans and help them to achieve their self-determined goals. The following questions will address important information regarding the role of the care coordinator in supporting the caregiver as a valuable resource.

Frequently Asked Questions

What is my role and responsibility in supporting the veteran and his/her caregiver?

It is often difficult to separate and address the needs of the veteran without acknowledging the needs of the caregiver, as their lives are so intertwined and interdependent. For that reason, it is important to ask how we can assist both of them. It is recognized that it may take extra time and effort to develop a relationship with the caregiver. However, once they feel their voice is heard, and feel that they are being provided with the necessary knowledge, skills, and support, they will be better able to continue in their job of care giving. The caregiver may not be our patient, but their stress and burden are our concern.

What types of support should be offered to the caregiver?

Here are some ways that you as a care coordinator can support the caregiver:

Screening/Assessment

By asking the caregiver a few questions, it is possible to ascertain how well they are coping. If they're stressed and having difficulties in their attempts to assist the veteran, we want to know about it as soon as possible so that we can begin supporting them.

Education

We can take the time to educate them about their veteran's illnesses including how to provide hands-on-care, the expected course of illness progression, and signs and symptoms to look for that may require professional help.

Referrals to community resources

There are many wonderful resources available to assist caregivers in most communities, but they may not know about them. By helping caregivers locate and take advantage of community services like transportation, adult day care, or in-home health care services, we can enable the caregiver to do more for the veteran, while also easing their burden.

Support

We can be an engaged listener to caregiver's stories. We can encourage them to seek the support of other family, clergy, friends and neighbors. Caregivers should not feel that they must do it all alone.

Caregivers also need to be encouraged to take care of themselves, and to not feel guilty when they do. It can be very helpful to remind them that they might not be able to continue taking care of their veteran unless they take care of themselves. Eating healthy, exercising, praying/meditating, and making time for activities they enjoy, whether it is shopping, going to a movie or book club, are all very good ways for a caregiver to reduce stress.

Helping caregivers cognitively reframe the way they perceive their situation can also be useful. We know that caregivers who feel they have no choice or control regarding their situation tend to fare worse. While encouraging acceptance of changes that cannot be controlled, providers can also help caregivers think differently about what remains within their control. At the very least, they can work on controlling how they feel or will respond to the situations in which they find themselves. Sometimes the expectations caregivers have of themselves can be very unrealistic. Again, helping them find new ways to think about what is reasonable, and what isn't, can alleviate stressful thoughts.

It is important that caregivers are given credit and validation for all the support they are able to provide, and not made to feel guilty for the things that cannot do. For many caregivers, they help out of a feeling of commitment/love towards their care recipient, and try to do as much as they can, within their own constraints and limitations.

Advocacy

Clinicians often perceive one of their major roles as being advocates for veterans and their caregivers. An advocate is one who speaks out, pleads, or argues a cause. An advocate can also be one who pleads on another's behalf, being an intercessor. This can be extremely helpful in making veterans' and caregivers' needs known, and helping them make smooth transitions within and between VHA and community resources. It is also important to encourage caregivers to become more active advocates for their veterans.

What is my responsibility in protecting veterans' and caregivers' privacy and confidentiality concerns?

The Health Information Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 established national standards for protecting the privacy of individuals' health information. It is intended to provide guidance for the use and disclosure of health information to ensure quality care while protecting individual privacy rights. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities (OCR).

The Privacy Rule defines protected health information (PHI) as "individually identifiable health information held or transmitted by a covered entity or its business association in any form or media, whether electronic, paper or oral." Examples of individually identifiable health information include:

- Demographic data including name, address, birth date, Social Security number
- Past, present, or future physical or mental health conditions
- Provision of health care to the individual

There are two situations in which protected health information must be disclosed:

- When the individual (or their personal representative) specifically requests it. The individual can also provide formal permission to disclose information to the individual's family, friends, or other persons identified by the individual.
- When Health and Human Services requests it during a compliance investigation, review, or enforcement action

The privacy rules do permit use and disclosure of protected health information without an individual's authorization or permission for 12 national priority purposes, listed below. For each priority purpose specific conditions or limitations apply.

- Required by law
- Public health activities
- Victims of abuse, neglect, or domestic violence
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Decedents
- Cadaver organ, eye, or tissue donation
- Research
- Serious threat to health and safety
- Essential government functions
- Workers compensation

Another major aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. This requires a reasonable effort be made to provide only the minimum amount of protected information needed for the purpose. As a clinician, every effort should be made to protect health information. If you are ever in doubt about what to do in this regard, please discuss your concerns with your supervisor. Further discussion may also be necessary with your privacy officer and/or local ethics committee.

What if the caregiver is a designated Surrogate or Personal Representative? What information can I share with them?

The HIPAA privacy rule does recognize that there are instances when an individual is unable to exercise their rights and may choose someone to act on their behalf. The person authorized under applicable law to make healthcare decisions on the behalf of another is referred to as the "personal representative" (PR) or surrogate. Examples of personal representatives or surrogates for an adult include health care powers of attorney, court appointed legal guardians, and general powers of attorney. If the individual is deceased then the executor of the estate is the PR.

HIPAA requires that the PR be treated as if they were the individual. The law defines the scope of the PR's authority. If the authority to act for the individual is limited to specific situations then the PR is to be treated as the individual only in those circumstances.

If you, the care provider, believe that an individual (child or adult) has been or may be the victim of abuse, neglect, or domestic violence at the hands of the personal representative or that treating a person as the personal representative would endanger the individual or would not be in the individual's best interests, you are permitted to decline to disclose information.

What if the caregiver is not a designated Surrogate or Personal Representative? Do I need a Release of Information to speak to them about the veterans' condition?

When talking with a family member who is NOT a designated Personal Rep, one should always ask the veteran's permission, and then just note the veteran's concurrence in the progress note. It is not necessary to request that the vet sign a Release of Information. The information is being used for health care planning purposes, and therefore it is permissible to share it with the individual providing the care.

In protecting the veteran's privacy, is there any information I can't disclose?

In addition to HIPAA, the VA further protects private health information by limiting disclosure of sensitive conditions that may result in discrimination against the individual: "Statute 38 U.S.C. 7332 prohibits VA clinicians from disclosing patient information related to drug or alcohol abuse, sickle cell anemia, or HIV with few exceptions."

What if the veteran is not able to give consent for disclosure? What can be shared with the caregiver?

In situations where the identified patient lacks capacity to give consent for disclosure of 7332-protected information, clinicians who deem it necessary to disclose this information must seek assistance from the court for appointment of a legal guardian or an order authorizing disclosure of the protected information to the surrogate.

Policy dictates that the clinician must consider several factors when determining whether to disclose information and how much to disclose:

- The patient's prior statements:
 - Did the patient ever indicate a preference that the information be withheld from a particular individual? E.g., "Don't tell ___ I have HIV."
 - Or give oral permission for disclosure? "If I get really sick, I guess its okay for _____ to know about my drug use."
 - Did the patient previously express an opinion about a specific treatment or procedure?
- The patient's behavior:
 - Did the person regularly include the surrogate?
 - Did they ask that person to leave when certain issues were discussed?

It is also important to consider whether having the information would reasonably lead the surrogate to make a different decision than they would without it.

In these situations the clinician may experience conflict between their professional ethics and their legal responsibilities. These are often difficult to resolve and may require consultation with the facilities' Privacy Officer or Ethics Committee. Several VHA publications are available to offer guidance on these issues.

How involved should the caregiver be in the informed consent process?

Veterans are encouraged to name surrogates or personal representatives who can serve as an agent of the patient. VHA grants the surrogate "the same authority and responsibilities as the patient in the informed consent process."

If there has been no official designation of an individual as a surrogate or PI, and consent is needed for a procedure which the patient is unable to give, there should be consultation with the Chief of Staff and General Counsel. If the family member has been involved and present, their input will probably be solicited.

What should I do if I suspect the caregiver is abusing or neglecting the veteran? What information can I share?

In cases where abuse and neglect are suspected, all VA medical centers, VA Outpatient Clinics (OPCs), and Vet Centers must comply with state law in reporting abuse and neglect. VA employees are expected to follow relevant state statutes for identification, evaluation, treatment, referral, and or reporting. You should notify your supervisor of any suspicions of neglect or abuse to make the appropriate reports.

SECTION 3: SCREENING AND ASSESSMENT

The following section will describe the screening and assessment process to determine caregiver stress and burden and why this process is important to the clinician in the care of veterans.

Frequently Asked Questions:

What is caregiver high risk screening?

A caregiver high risk screening includes the use of a reliable and validated tool that helps the clinician identify a caregiver who is experiencing a great deal of stress and/or burden and who requires the need for a more in-depth assessment of the issues that are contributing to their high level of risk. The caregiver high-risk screening instrument used within Care Coordination Home Telehealth (CCHT) and Home Based Primary Care (HBPC) programs is the Zarit Burden Inventory or ZBI. A zero to four Likert scale is used to screen for burden. If the score is eight or greater, further assessment is indicated. The shortened version consists of only four questions. They are listed below:

- Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?
- Do you feel stressed between caring for your relative and trying to meet other responsibilities (work/families)?
- Do you feel strained when you are around your relative?
- Do you feel uncertain about what to do about your relative?

What is caregiver assessment?

A caregiver assessment is a systematic process of gathering information that describes a care giving situation, and identifies the particular problems, needs, strengths and available resources of the family caregiver. It approaches issues from the caregiver's perspective and culture, focuses on what assistance the caregiver may need and takes into consideration outcomes the caregiver wants to achieve in order to continue supporting the veteran. An important component to the assessment includes maintaining the caregiver's health and well-being.

There are several fundamental principles for caregiver assessment. They include the importance of recognizing, respecting, assessing and addressing caregiver needs. The assessment should also embrace a family-centered perspective, inclusive of the needs and preferences of both the care recipient and the family caregiver. The assessment should result in a care plan, developed collaboratively with the caregiver that indicates the provision of services and intended measurable outcomes. The caregiver assessment should be multi-dimensional in approach and periodically updated, and reflect culturally competent practice.

What are some guidelines of practice to be considered when screening and assessing caregivers?

The following list describes practical guidelines to consider when screening and assessing caregivers for stress and/or burden:

- The unit of care embraces both the veteran and the caregiver
- The caregiver is an arm of the treatment team and the care plan
- Services should be consumer directed and veteran and family focused

- The assessment of the caregiver and subsequent support provided improves the quality of care, veteran and caregiver quality of health and lifestyle, and contributes to reduced utilization while improving continuity of care for the veteran
- The rationale for conducting the assessment needs to be made clear to both the veteran and the caregiver. Reasons may include:
 - Identification of the primary caregiver and other informal caregivers who will help the healthcare team support the veteran's health care
 - Educating and improving the caregiver's understanding of their role and responsibility to carry out tasks through their better understanding of the care giving situation
 - Identification of other support needs and unresolved problems so that appropriate and timely referrals for these additional support services can be made
- Assessment should occur as early as possible
- Re-assessments should be built into the process
- Numerous entry points are needed

Who should be screened and/or assessed?

It is important to ask the veteran who he considers to be his/her primary caregiver. This may require an explanation of the caregiver role. You may need to provide examples of this role such as a spouse, adult child, sibling, neighbor, church member or friend, so the veteran knows how to answer your question.

Anyone who self-identifies as a family caregiver should be offered a screening, leading to an assessment as deemed appropriate. Multiple caregivers within a family may require a group interview, and at times, may result in the need for conflict resolution if there are differences of opinion among members.

Do I need the veterans' permission to screen his caregiver?

An explanation should be given to the veteran as to why you would like to speak to the caregiver and the possible benefits to be gained by both the veteran and caregiver. Of course, the veteran can refuse to allow you to have such a conversation. If the veteran does not give permission for this discussion then a note should be made in the veteran's medical record.

How do I perform a caregiver high risk screening?

The four questions from the Zarit Burden Inventory can be asked in person, over the phone, or by mail. Screening should be conducted on a regular basis. Just because a caregiver might be doing well at one particular point in time doesn't mean this will always be the case as circumstances are always changing.

What if the results show that the caregiver is at high risk?

A high score would be an indicator of the need for a more in-depth assessment of the care giving situation, to be done either by the care coordinator, or by the social worker assigned to your program.

If you need help in getting this assessment done because you don't feel comfortable doing it yourself and/or there is not a social worker available in your program, the Social Work Executive at your facility should be contacted.

Why is it necessary to conduct caregiver high risk screens and assessments?

There are several reasons why caregiver assessments should be completed. In clinical practice, caregiver assessments are necessary to determine caregiver needs, and eligibility for appropriate caregiver support services so ways of assisting them can be incorporated into the veteran's care plan.

In helping the family feel heard and better understood, we can build and strengthen the therapeutic alliance. By making family and caregivers an essential component of the treatment team, we can empower these key individuals to continue in their care giving role by reinforcing that their contributions are recognized, supported, valued and needed by both the veteran and the healthcare team.

From a systems perspective, these caregiver assessments will enable clinicians to develop a better sense of collective caregiver needs across all levels of staff, programs and sites. It can help engage care coordinators in discussions about what they are doing to address these needs, and to share and develop good resources and best practices across programs and facilities.

In the research and policy arena, assessment can be used to describe the population being served, review changes over time, identify new directions for service and/or policy development, evaluate the effectiveness of existing programs or a specific service, contribute to and assure quality of care and examine related veteran and caregiver outcomes.

SECTION 4: CAREGIVER REFERRALS

This section describes what type of information should be included in the referral process and how to make a referral to VA and/or community support services for the caregiver. Also discussed are privacy issues to keep in mind when disclosing information to entities outside VA.

Frequently Asked Questions:

What information should be included in the referral process?

Key to making an appropriate and helpful referral for assistance from a support service or agency is accurate identification of the caregivers' needs as determined by the high risk screening and more in-depth assessment. These needs may be directly related to the veteran him/herself, such as the need for personal hygiene care. The indicated needs may also be indirectly related, such as the caregivers' lack of knowledge or skill in managing a particular chronic health problem or difficulties with decision making. The caregiver may need assistance with financial management issues. Stress management concerns also are important whereby the caregiver may require some type of support or respite services.

Once the needs of the veteran and caregiver are correctly identified, a plan can be developed to effectively match the need with the appropriate resource. When making a referral, it is important to know the following things:

- Age of the veteran and the caregiver
- Physical and emotional health
- Cognitive abilities
- Support systems and resources available
- Financial concerns
- Stress and strain
- Skills and abilities to provide necessary care
- Educational needs

How do I make a referral to a community support service or agency for caregiver support?

Referral for additional resources and services will be driven by the identified needs of the caregiver. Once the decision has been made to make a referral, there are three directions the clinician involved may take:

1. Collaborate with the service social worker, interdisciplinary team and/or primary care provider to complete the referral
2. Call the service agency yourself, depending on the nature of the referral
3. Provide the community agency information to the caregiver for their self referral

Utilizing the documentation template for your screening results will describe the status of the caregiver and the need for further follow up so other health professionals are aware of the situation. Section 5 provides a short list of both internal VA and external community resources to consider. Please refer to Section 6 for a review of how to document the referrals made.

What should I know about VHA privacy policies and practices with regard to releasing patient /caregiver information to community agencies?

Individually identifiable information is personal information on an individual that identifies that person. Protected health information (PHI) is individually identifiable health information maintained in any form or media. All identifiable veteran information maintained by VHA is PHI.

Any information that is not de-identified in accordance with VHA Handbook 1605.1 Appendix B will be considered protected health information (PHI) and can only used and disclosed in accordance with policy.

Use of Information

All VHA staff including contractors will only use PHI in the performance of their official duties relating to treatment, payment or health care operations.

VHA staff will not discuss individually identifiable information except in the performance of their job duties and will ensure that others who have no need to hear the information do not overhear it.

Disclosure of Information

Section 24 of Handbook 1605.1 pertains to disclosure of information to non-VA health care providers such as physicians, other hospitals, nursing homes and community agencies. It states that:

- a. VHA may disclose individually-identifiable health information, excluding 38 U.S.C. 7332-protected information, to a non-VA health care provider for the purposes of VA paying for services.
- b. VHA may disclose individually-identifiable health information, excluding 38 U.S.C. 7332- protected information, to a non-VA health care provider without the prior written authorization of the individual to whom the information pertains for treatment of such individual, including a veteran, veteran beneficiary, member of the armed forces, or any other person who has received care from VA.
- c. VHA may disclose individually-identifiable health information, excluding 38 U.S.C. 7332, to resident care homes, assisted living facilities, and home health services for the purposes of health care referrals without the written authorization of the individual to whom the information pertains.
- d. VHA may disclose 38 U.S.C.7332-protected information to a non-VA health care provider including home health services, resident care homes, and assisted living facilities only with the written authorization of the individual to whom the information pertains.
- e. VHA may disclose individually-identifiable information, including health information, to a non-VA health care provider caring for an individual under emergent conditions. A notification of the disclosure must be mailed to the patient at the last known address (see 5 U.S.C. 552a(b)(8)).
- f. VHA may disclose individually-identifiable information, including relevant health information excluding 38 U.S.C. 7332-protected information, to welfare agencies, housing

resources, and utility companies in situations where VHA needs to act quickly to prevent the discontinuation of services that are critical to the health and care of the individual.

Any written requests for PHI or aggregate data from an entity outside of VA must be processed in accordance with all applicable Federal laws including the Freedom of Information Act (FOIA) and Privacy Act. VHA Handbook 1605.1 provides guidance on the legal authorities for disclosing PHI.

All disclosures of PHI to entities outside of VA must be tracked for accounting purposes. The following must be maintained for the accounting: date and purpose of disclosure, to whom disclosure was made and what information was disclosed. The accounting may be maintained in a log or spreadsheet. Contact your local VHA Privacy Officer or Chief of HIMS for any questions or assistance you may need with privacy issues.

Safeguarding Information

VHA staff including contractors will not transmit information containing PHI using electronic mail, mailing through US mail or other packaging companies or other unsecured means unless the data is encrypted or password protected.

VHA staff must ensure that any paper containing PHI is thoroughly protected until destroyed. Appropriate protections include immediately shredding the documents or placing the documents in a located recycling bin.

If PHI is compromised through loss, theft or an inappropriate disclosure, the incident needs to be reported to the VHA Privacy Office so it may be entered in the Privacy Violation Tracking System (PVTS). Guidance on how to notify the affected veterans may be obtained from the VHA Privacy Office.

SECTION 5: AVAILABLE CAREGIVER SUPPORT RESOURCES

There are many internal resources within Veterans Health Administration (VHA) that are available for veterans, their families and caregivers. Some of these resources are structured programs. Or they may be activities such as patient advocacy, individual or group counseling, or support groups. What is not available within VHA may be found in the community, under federal, state or local auspices. This section helps you identify what some of the possibilities are.

Frequently Asked Questions:

What are some resources within the VHA that can provide assistance to veterans and their caregivers?

Non- Institutional Long Term Care Programs within the VA

The Department of Veterans Affairs (VA) offers a spectrum of geriatric and extended care services to veterans enrolled in its health care system. More than 90 percent of VA's medical centers provide Home and Community-Based outpatient long-term care programs. This veteran-focused approach supports the wishes of most veterans to live at home in their own communities for as long as possible. In addition, nearly 65,000 veterans will receive inpatient long-term care this year through programs provided by the VA or state Veterans homes. [VA Fact Sheet January 2005](#)

Veterans can receive Home-Based Primary Care, Contract Home Health Care, Adult Day Health Care, Homemaker/Home Health Aide Services, In-Home Respite Care, Home Hospice Care and Community Residential Care. In fiscal year 2003, 50 percent of VA's total extended care veteran population received care in non-institutional settings.

Adult Day Health Care (ADHC)

In 1985, Adult Day Health Care programs were developed to provide health maintenance and rehabilitative services to veterans in a group setting during daytime hours. This service also provides relief to the veteran's spouse or caregiver. In 2004, VA operated 21 programs directly and provided contract ADHC services at 112 VA medical centers. Two State Homes in the nation have received recognition from VA to provide ADHC, which has recently been authorized under the State Home Per Diem Program.

Care Coordination/Home Telehealth (CCHT)

Care Coordination in VA uses information technologies such as computerized patient records and Telehealth technologies to provide health care to veterans with chronic illness when it is needed, and where it is needed. CCHT enhances and extends care and case management via a care coordinator to support veterans remotely, in their own homes. It is about understanding the holistic needs of veteran patients and addressing these needs in a prompt manner by the care coordinator. The goal of this program is to improve clinical outcomes and access to care while reducing complications, hospitalizations, and clinic or emergency room visits for patients in post-acute care settings and for those veterans with chronic disease who are considered high-risk. More than 22,000 veterans are currently receiving this service across the nation.

Community Residential Care

The Community Residential Care Program provides room, board, limited personal care and supervision to veterans who do not require hospital or nursing home care, but are not

able to live independently because of medical or psychiatric conditions. Many veterans being served by this program do not have family who are available and/or willing to provide care. The veteran pays for the cost of this living arrangement. VA's contribution is limited to the cost of administration and clinical services, which include regular safety inspections of the home and periodic visits to the veteran by VA health care professionals. Medical care is provided to the veteran on an outpatient basis at local VA facilities. The Community Residential Care Program was primarily focused on veterans with psychiatric illness in the past. The program is now expanding to include older veterans with multiple chronic illnesses that can be managed in the home under proper care and supervision.

Contract Home Health Care

Professional home health care services, mostly nursing services for skilled care, can be purchased from local community home health care providers. This service is available at every VA medical center. The program is commonly called "fee basis" home care and coordinated through the facility's Community Health Nurse or Social Worker.

Domiciliary Care

Domiciliary Care is a residential rehabilitation program that provides short-term rehabilitation and long-term health maintenance to veterans who require minimal medical care as they recover from medical, psychiatric or psychosocial problems. Most Domiciliary Care patients return to the community after a period of rehabilitation.

Domiciliary Care is provided by VA and state homes. VA currently operates 43 facilities. State Homes operate 49 domiciliary in 33 states. VA also provides a number of psychiatric and residential rehabilitation programs for veterans. These include programs for veterans coping with post-traumatic stress disorder, substance abuse, compensated work therapy or transitional residences for homeless, chronically mentally ill veterans, and veterans recovering from substance abuse.

Geriatric Evaluation and Management (GEM)

Older veterans with multiple medical, functional or psychosocial problems and those with particular geriatric problems receive assessment and treatment from an interdisciplinary team of VA health professionals. GEM services can be found on inpatient units, in outpatient clinics and in geriatric primary care clinics. In 2004, there were 57 inpatient GEM programs and more than 195,000 visits to GEM and geriatric primary care clinics across the nation.

Geriatric Research, Education and Clinical Centers (GRECC)

These centers increase the basic knowledge of human aging for health care providers and improve the quality of care through the development of improved models of clinical services for the aging veteran. Each GRECC has an identified focus of research in the basic biomedical, clinical and health services areas, such as the geriatric evaluation and management program. Medical and associated health students and staff in geriatrics and gerontology are trained at these centers. Begun in 1975, there are now 21 GRECCs in all but two of VA's health care 23 networks.

Home Based Primary Care (HBPC)

This program (formerly Hospital Based Home Care) began in 1970 and provides long-term primary medical care to chronically ill veterans in their own homes under the coordinated care of an interdisciplinary treatment team. This program has led to guidelines for medical education in home care, use of emerging technology in home care, and improved care for veterans with dementia and their families who support them. Home Based Primary Care programs are located at most VA medical centers.

Home Hospice Care

Home Hospice Care provides comfort-oriented and supportive services in the home for persons in the advanced stages of terminal disease. The goal is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration or maintenance of functional capacity. Services are provided by an interdisciplinary team of health care providers and volunteers from a local community hospice agency.

Bereavement care is also available to the family following the death of the veteran. VA staff coordinates Hospice Care Services for veterans via the Hospice Veterans Partnership that has been established in most VA networks across the nation. Hospice Care Services provided by community hospice agencies are available 24 hours a day, seven days a week. This service is arranged through the facility's Community Health Nurse or Social Worker.

Homemaker and Home Health Aide (H/HHA)

VA began this program of purchased health-related services for veterans needing nursing home care in 1993. These Homemaker/Home Health Aid services are provided to veterans in their own community by public and private health care agencies under a system of case management provided directly by VA staff. In 2004, VA purchased H/HHA services were available at 122 medical centers. This service is coordinated through the facility's Community Health Nurse or Social Worker. [VA Fact Sheet, 2005](#)

Nursing Home Care

VA's Nursing Home Care programs include VA-operated Nursing Home Care Units, Contract Community Nursing Homes and State Homes. VA contracts with approximately 2,500 community nursing homes across the nation. The State Home program is growing and currently encompasses 114 nursing homes in 47 states and Puerto Rico. In fiscal year 2003, approximately 70 percent of VA's institutional nursing home care occurred in Contract Community Nursing and State Homes.

Nursing Home Care Units (NHCU) are located at VA hospitals where they are supported by an array of clinical specialties. The Contract Community Nursing Home Program has the advantage of being offered in many local communities where veterans can receive care near their homes and families. VA contracts for the care of veterans in Community Nursing Homes approved by VA. The State Home Program is based on a joint cost-sharing agreement between VA, the veteran and the state. This service is arranged for eligible veterans through the facility's Community Health Nurse or Social Worker.

The following describe the eligibility requirements for Nursing Home Care:

- Any veteran who has a service-connected disability rating of 70 percent or more
- A veteran who is rated 60 percent service-connected and is unemployable or has an official rating of "permanent and total disabled"
- A veteran with combined disability ratings of 70 percent or more
- A veteran whose service-connected disability is clinically determined to require nursing home care
- Nonservice-connected veterans and those officially referred to as "zero percent, non-compensate, service-connected" veterans who require nursing home care for any nonservice-connected disability and who meet income and asset criteria or
- If space and resources are available, other veterans on a case-by-case basis with priority given to service-connected veterans and those who need care for post-acute rehabilitation, respite, hospice, geriatric evaluation and management, or spinal cord injury
- Millennium Act and VA's Efforts to Increase Long-Term Care Capacity
Public Law 106-117, the Veterans Millennium Health Care and Benefits Act, enacted in November 1999, requires VA to provide extended care services in its

facilities, including nursing home care, domiciliary, home-based primary care and adult day health care, with the goal of providing as much care as was provided in 1998

Respite Care

Respite Care temporarily relieves the spouse or other caregiver from the burden of caring for a chronically ill or disabled veteran at home for a specified timeframe. In the past, Respite Care admissions were limited to an institutional setting, typically a VA nursing home. The Veterans Millennium Health Care and Benefits Act in 1999 expanded Respite Care services to include care in the veteran's home and other community settings. Currently, Respite Care Programs are operating in many VA medical centers. Respite Care is usually limited to 30 days per year. This service is coordinated through the facility's Community Health Nurse or Social Worker. [VA Fact Sheet, 1999](#)

Other internal VA resources are listed below:

Chaplain Services

Chaplain Services began in VA in 1865 when Abraham Lincoln signed legislation for the first national homes for disabled volunteer services. Today, Chaplain Service works to support veterans and their families in many ways. These services include support during hospital admission, support throughout the course of serious illness, and pre/post surgical visitations to assess for further needs. The Chaplain Service educates patients and families during their regular visits regarding available spiritual activities and services.

Chaplain services also accept consults and referrals from clinical staff to provide a variety of other services as well. These include bereavement counseling to family members, participating in Hospice and Palliative Care programs, outreaching to veterans in outpatient clinics, the provision of group counseling such as alcohol and drug abuse counseling, and mental health spirituality support. Some chaplains use Telehealth to support patients in their homes. Chaplains often are on call 24 hours per day and work within community churches to provide liaison support when patients return home. Social Work Services works very closely with Chaplain Services to address psycho-social needs and requirements.

Counseling services within Veteran Service Centers <http://www.va.gov/RCS/>

Veterans Service Centers provide counseling and outreach at no cost to those veterans and their families who have served in a combat zone. Find the closest Veterans Service Center by clicking on the following link
http://www1.va.gov/directory/guide/vetcenter_flesh.asp?isFlash=1

Social Work Services

The mission of Social Work Services is to "eliminate psychosocial complications as significant barriers to healthcare interventions for veterans and families". This is accomplished by developing and maintaining integrated, quality programs in patient care, research, education and prevention. Social Work Services also works in alignment with the Office of Care Coordination. Social workers are present in almost all VA facilities and are specially trained professionals to provide support to patients and their families in a number of areas.

Social workers provide not only individual and group counseling in mental health care, but also provide resource support and advocacy to veterans with many other illnesses. Some of the most common support systems in VA include utilizing social workers to assist patients who need help with finances or housing, accessing community resources such as Adult Day Care or Meals on Wheels, help with applying for benefits such as Social Security or Medicare, help with Advance Directives, Respite Care, drug and

alcohol abuse and many other activities that may affect functioning of patient, family or caregivers

Support Groups

Available support groups within the VA vary depending on need and resources, but examples of support groups for patients, families and caregivers that might be available include groups for HIV/AIDS, Cancer, Tube Feeding, Stroke, Multiple Sclerosis, ALANON and ALATEEN, Hepatitis, Dementia, PTSD, Weight Loss, Parkinson's and many others. Contact Social Work Services to see what might be available in a local facility.

Voluntary Services

The Voluntary Service at your Medical Center can be very helpful in assisting veterans and their caregivers with a multitude of needs. Volunteers are often recruited to provide such things as transportation, and friendly visiting. Some facilities have developed programs where carefully screened and closely supervised volunteers actually go to the veterans' homes to assist with light household chores and other activities of daily living. Other Voluntary Services have assisted with Caregiver Recognition Events. There are all sorts of possibilities that may be worth exploring with your local Voluntary Service Chief.

Veteran Service Organizations

The Veteran Service Organizations (VSO) can also offer invaluable assistance to veterans and caregivers. Such groups as the American Legion, AMVETS, DAV, Paralyzed Veterans of America, and the VFW often have representatives on-site at facilities, and they can assist individuals in applying for various financial and other benefits that they may be entitled to through the VA. This can include Disability Compensation, Aid and Attendance, Housebound Benefits, Vocational Rehab and Employment, and Education and Training, Home Loan Guaranties and more. They also often provide transportation and other support such as advocacy. They can be great partners in more comprehensively addressing the many needs veterans and caregivers present with.

External Resources within the community

There are a number of external resources that can be obtained for both veterans and caregivers in the community. Services may vary within local communities depending on a number of factors including physical location and funding. Links and service descriptions of many external resources are available in the Local Area Office on Aging, the OCC Caregiver Resource Guide, and by typing key words into an internet search engine. A few of the more common external resources and their web sites have been listed for you below.

2-1-1

2-1-1 connects people with resources, community services and volunteer activities. Most states are utilizing 2-1-1 services even if not completely implemented. The most recent update includes that by September 2006; 2-1-1 will be serving approximately 185 million Americans - over 62% of the US population; 199 active 2-1-1 systems covering all or part of 40 states (including 17 states with 100% coverage) plus Washington, DC and Puerto Rico. Canada has an additional 5 locations. For more information:

<http://www.211.org/about.html>

AARP

The AARP foundation leads positive social change and delivers value to those 50 years and older with an emphasis on those at social and economic risk.

http://www.aarp.org/about_aarp/aarp_foundation/

Alzheimer's Association

The only national voluntary health organization dedicated to research and to providing support and assistance to people with Alzheimer disease.

<http://www.alz.org/>

American Cancer Society

Provides community based early detection/prevention programs and patient assistance.

<http://www.cancer.org/docroot/home/index.asp>

American Red Cross

A humanitarian organization led by volunteers, to provide relief to victims of disasters and helps prevent, prepare and respond to emergencies. They also have programs specific to family caregiving.

<http://www.redcross.org/>

Catholic Social Services and other Faith Ministries

Another Christian based organization that offers a wide variety of social assistance programs, including spiritual programs, counseling, youth and senior programs, Christmas assistance, etc.

<http://www.catholiccharitiesusa.org/>

Faith in Action

Faith in Action is an interfaith volunteer caregiving initiative of The Robert Wood Johnson Foundation. Local Faith in Action programs bring together volunteers from many faiths to work together to care for their neighbors who have long-term health care needs.

Volunteers help those in need by providing non-medical assistance with tasks such as picking up groceries, running errands, providing rides to doctor appointments, friendly visiting, reading or helping to pay bills.

<http://www.fiavolunteers.org/what/index.cfm>

Family Caregiver Alliance

Provides information on publicly-funded caregiver support programs in each of the 50 states and the District of Columbia. Information is provided on programs funded through the National Family Caregiver Support Program, Aged/Disabled Medicaid waivers, and state funded programs that either have a caregiver-specific focus, or include a family care giving component in their service package.

<http://www.caregiver.org/caregiver/jsp/home.jsp>

National Alliance for Caregiving

The Alliance was created to conduct research, do policy analysis, develop national programs and increase public awareness of family caregiving issues. Recognizing that family caregivers provide important societal and financial contributions toward maintaining the well-being of those they care for, the Alliance's mission is to be the objective national resource on family caregiving with the goal of improving the quality of life for families and care recipients.

<http://www.caregiving.org/index.htm>

National Alliance on Mental Illness

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a national organization including NAMI organizations in every state and in over 1100 local communities across the country who join together to meet the NAMI mission through advocacy, research, support, and education.

<http://www.nami.org/>

National Family Caregivers' Association

The National Family Caregivers Association educates, supports, empowers and speaks up for the more than 50 million Americans who care for loved ones with a chronic illness or disability or the frailties of old age. NFCA reaches across the boundaries of diagnoses, relationships and life stages to address the common needs and concerns of all family caregivers.

<http://www.nfcacares.org/>

National Hospice and Palliative Care Organization

The National Hospice and Palliative Care Organization (NHPCO) is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end of life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones.

<http://www.nhpc.org/templates/1/homepage.cfm>

Salvation Army

A Christian organization that offers a wide variety of social assistance programs, including spiritual programs, hot meals, emergency housing and services, counseling, youth programs, Christmas assistance, etc.

http://www1.salvationarmy.org/ihq/www_sa.nsf

United Way

Improving people's lives by mobilizing the caring power of communities, through the building of partnerships forgoing consensus and leveraging resources to make a difference.

<http://national.unitedway.org/>

YMCA

Parts of a world-wide movement, helping people grow in spirit, mind and body. Programs include childcare, camping, sports, teen development, aquatics, health and fitness.

<http://www.ymca.net/>

What are some other available caregiver support resource guides that might be helpful to review?

Veterans Administration Social Work Resource Directory – This resource directory can be downloaded, printed, and given to veterans or their families. It may also be used as a desktop resource for VA staff. <http://vaww.va.gov/occ/Docs/CaregiverResGuide.pdf>

VISN 22 OCC Electronic Caregiver Resource Directory – This national resource guide is available online on the VA Intranet and can be utilized as a quick search tool for VA staff who may wish to identify common resources for individuals and their families.

<http://10.181.1.92/v22caregiverRD/list.cfm>

How can I learn more about building partnerships with community agencies to better serve veterans?

For ideas about how one might go about forming such collaborations, you might review The Hospice Veteran Partnership Toolkit which is an excellent example of what could be done.

http://vaww.va.gov/oaa/archive/hvp_toolkit3.pdf

SECTION 6: DOCUMENTATION

The question of where the clinician should document their interactions with the caregiver (also known as collateral in VA terminology) is one that often comes up. The answer depends on whether the caregiver is seen separately or with the veteran. It might first be helpful to define who a “collateral” is and what constitutes a “collateral visit”. Once this is clarified, we will address questions of how these interactions should be documented by sharing two note templates available for clinician use in CPRS.

Frequently Asked Questions:

Who is considered a “collateral” in the VHA?

“Collateral” is a person, related to or associated with a veteran receiving care from the VA. The person is seen by a professional member of the VA health care facility's staff either within the facility or at a site away from the facility for reasons relating to the veteran's clinical care. The purpose of this clinical contact must be an integral part of the veteran's treatment plan; it must be documented in the treatment plan and progress notes in such a way as to demonstrate the role of the person in assisting the veteran to achieve a specific treatment goal or goals.

What is a “collateral visit”?

Examples of appropriate designation of a collateral visit include: initial and follow-up contacts for a person assisting in a veteran's physical rehabilitation program in the home; participation of a family member in outpatient family psychotherapy; continuing education and follow through with the primary care giver such as residential care sponsor, and finally bereavement care provided to families following the death of a veteran.

What are the “rules” related to a collateral visit?

Two important rules to remember about collateral visits are:

- Collaterals will not be billed
- Each member of the family (significant other/caregiver) that meets the definition above may be credited as a collateral

Do I document my work with the collateral (caregiver) in the veteran's medical record?

If the collateral and the veteran are seen together or are both participants the same group, the collateral's participation is documented in the progress note as a part of the veteran's treatment and there is no separate encounter.

What if I see the collateral (caregiver) alone, without the veteran present?

In this case, a separate medical record must be created. For example, if there is a family support group where the family is having a group session with a provider while the veteran is in a separate location having a group session with other veterans, the collateral workload should be documented in the collateral's medical record as a separate note and encounter. Collateral workload can be captured separate from the veteran **ONLY** when the veteran is not present and

participating. This practice is currently used when documenting bereavement services provided to family after a veteran's death.

How do I create a separate collateral record?

You will first need some information from the caregiver. This information must include the caregiver's name, year of birth, full Social Security Number and the patient's name/SSN for whom they are a collateral.

Your Medical Administration or Business Office staff would then need to enter this person in their data base, just as they would a new veteran. This collateral or caregiver can then be selected by you when you are ready to enter the visit and document the contact for workload credit.

What if the collateral won't or can't provide their SSN information?

There will be times when users must enter a pseudo SSN because the collateral (caregiver) either refuses to provide this information, or it's unknown, or not appropriate. This would be the case of a non US citizen who does not reside in this country or for a young child. A new field is being added to VistA to identify the reason a pseudo SSN was entered for a beneficiary, spouse or dependent.

Facility staff should encourage veterans/beneficiaries to provide their SSN. Since pseudo SSNs are not unique, it makes linking a person's record across systems difficult and error prone (and with electronic medical records and data sharing, this is a pretty significant point). Collaterals don't necessarily have to be concerned about whether they qualify for a "benefit" but being able to associate them as a unique caregiver to the veteran is important to the veteran's records, medical information and VA for workload/record keeping purposes.

Talk to your Medical Administration or Business Office staff about how to establish a pseudo SSN should this need arise.

What kinds of progress notes should I be doing on interactions with caregivers?

There are two broad categories of documentation that the clinician may need to capture.

1. The first category is the caregiver screening, and referrals made as a result of that screening/assessment. To assist in this documentation, two templates have been developed and screen prints explaining the use of these are displayed below.
2. The second category will be broadly defined as "other". That is, it is recognized that there may be a need to document "other" interactions with a collateral (caregiver) that do not fit into the category of screening/assessment and intervention. It is also recognized that medical centers have a variety of tools and templates at the clinician's disposal and that these may be customized by site. Therefore, documentation on collaterals for other than assessment/referral purposes should be performed according to locally created guidelines and templates (i.e. Standard Progress Note, Social Work note, etc)

What tool do I use to document caregiver screening and referral in CPRS?

The following document templates (created by Mel Sharer and Cathy Harity Clinical Application Coordinators from the VAMC in Altoona, Pennsylvania) are an example of how to document caregiver screening, assessments and/or referrals made on behalf of the caregiver. By contacting either of them, these templates can be made available to you for use at your facility.

How do I utilize the templates designed for caregiver screening and referral?

Please review the slides on the following pages for more information regarding these templates

Caregiver Assessment Note

With CR Dialog

Reminder Resolution: Caregiver Assessment Screen

CCHT Caregiver High Risk Screening and Assessment

- 1. Do you feel that because of the time you spend with you relative(s) that you don't have time for yourself?
- 2. Do you feel stressed between caring for your relative and trying to meet other responsibilities (work/family)?
- 3. Do you feel strained when you are around your relative(s)?
- 4. Do you feel uncertain about what to do concerning your relative(s)?
- Add above scores and check appropriate box

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note
Caregiver Assessment Screen:
CCHT Caregiver High Risk Screening and Assessment

<No encounter information entered>

* Indicates a Required Field

Note and Dialog are activated by (a) no previous ASSESSMENT or an ASSESSMENT older than 6 months.

Reminder Resolution: Caregiver Assessment Screen

CCHT Caregiver High Risk Screening and Assessment

1. Do you feel that because of the time you spend with you relative(s) that you don't have time for yourself?

Never = 0
 Rarely = 1
 Sometimes = 2
 Quite Frequently = 3
 Nearly Always = 4

Value: Quite Frequently = 3

2. Do you feel stressed between caring for your relative and trying to meet other responsibilities (work/family)?

Never = 0
 Rarely = 1
 Sometimes = 2
 Quite Frequently = 3
 Nearly Always = 4

Value: Nearly Always = 4

3. Do you feel strained when you are around your relative(s)?

Never = 0
 Rarely = 1
 Sometimes = 2
 Quite Frequently = 3
 Nearly Always = 4

Value: Sometimes = 2

4. Do you feel uncertain about what to do concerning your relative(s)?

Never = 0

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note

Caregiver Assessment Screen:
CCHT Caregiver High Risk Screening and Assessment
1. Do you feel that because of the time you spend with you relative(s) that you don't have time for yourself?
4. Do you feel uncertain about what to do concerning your relative(s)?

Health Factors: CCHT INSUFFICIENT TIME FOR SELF, CCHT STRAIN FROM RELATIVES, CCHT STRESS DUE TO CONFLICTS, CCHT UNCERTAIN ABOUT RELATIVES

* Indicates a Required Field

Questions are Health Factors

Reminder Resolution: Caregiver Assessment Screen

Never = 0
 Rarely = 1
 Sometimes = 2
 Quite Frequently = 3
 Nearly Always = 4

Value: Sometimes = 2

4. Do you feel uncertain about what to do concerning your relative(s)?

Never = 0
 Rarely = 1
 Sometimes = 2
 Quite Frequently = 3
 Nearly Always = 4

Value: Rarely = 1

Add above scores and check appropriate box

Total Points Score

Score was 0 to 7
 Score equaled 8
 Points equals 9
 Points equals 10
 Score equals 11
 Score equals 12
 Score equals 13
 Score equals 14
 Score equals 15
 Score equals 16

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note

Caregiver Assessment Screen:
CCHT Caregiver High Risk Screening and Assessment
1. Do you feel that because of the time you spend with you relative(s) that you don't have time for yourself?
4. Do you feel uncertain about what to do concerning your relative(s)?

Health Factors: CCHT ASSESS SCORE 10, CCHT INSUFFICIENT TIME FOR SELF, CCHT STRAIN FROM RELATIVES, CCHT STRESS DUE TO CONFLICTS, CCHT UNCERTAIN ABOUT RELATIVES

* Indicates a Required Field

Scores are Health Factors and are the Cohort or Resolution for the ASSISTANCE REMINDER

Health Summary Health Factors

09/25/2006 11:20
 ***** CONFIDENTIAL Health Factors SUMMARY pg. 1 *****
 ZMZMISTAKE, CONNER 000-00-9928 DOB: 01/01/1900

----- HF - Health Factors (max 40 occurrences or 1 year) -----

Category	Health Factor	Visit Date
CARE COORDINATION	HOMETELEHEALTH	
	CCHT ASSESS SCORE 10	10/27/2005
	CCHT ASSESS SCORE 12	10/27/2005
	CCHT INSUFFICIENT TIME FOR SELF	10/27/2005
	Quite Frequently 3	
	CCHT STRAIN FROM RELATIVES	10/27/2005
	Sometimes = 2	
	CCHT STRESS DUE TO CONFLICTS	10/27/2005
	Nearly Always = 4	
	CCHT UNCERTAIN ABOUT RELATIVES	10/27/2005
	Rarely = 1	
IMMUNIZATION		
	IMMUNIZATION SITE LEFT DELTOID	10/27/2005
	INFLUENZA LOT #	10/27/2005
	Influenza Lot #U1854AA	

*** END ***** CONFIDENTIAL Health Factors SUMMARY pg. 1 *****

Health Factors on Reports

Orders | Notes | Consults | Surgery | D/C Summ | Labs | Reports

Clinical Note

Caregiver Assessment Screen:

CCHT Caregiver High Risk Screening and Assessment

- Do you feel that because of the time you spend with you relative(s) that you don't have time for yourself?
Value Quite Frequently 3
- Do you feel stressed between caring for your relative and trying to meet other responsibilities (work/family)?
Value Nearly Always = 4
- Do you feel strained when you are around your relative(s)?
Value Sometimes = 2
- Do you feel uncertain about what to do concerning your relative(s)?
Value Rarely = 1

The total score for the High Risk Screening and Assessment:
The Caregiver High Risk Screening and Assessment score was 10 points.

/es/ MELVIN C SHARER
 Clinical Coordinator
 Signed: 09/25/2006 11:19

Note body

Diagnoses: VACCIN FOR INFLUENZA
 Procedures: IMMUNIZATION ADMIN , FLU VACCINE, 3 YRS, IM
 Immunizations: FLU,3 YRS

Consults | Surgery | D/C Summ | Labs | Reports

Clinical Reminders	Due Date
Diabetic Foot Exam	DUE NOW
Diabetes-Hemoglobin A1C	DUE NOW
Diabetes-Lipid Profile	DUE NOW
Diabetes-Creatinine Screen	DUE NOW
Diabetes-microalbuminuria	DUE NOW
V4 Colorectal Cancer Report (503)	DUE NOW
PTSD Nursing Screen	DUE NOW
LDL > 100	DUE NOW
Colorectal Cancer Screen (503)	DUE NOW
Colonoscopy	DUE NOW
Double Contrast Barium Enema	DUE NOW
Sigmoidoscopy	DUE NOW
MEL TEST	DUE NOW
INJECTIONS (LONG ACTING)	DUE NOW
PTSD Screen (Nursing)	DUE NOW
Acute Coronary Syndrome	DUE NOW
CCHT Caregiver Assistance Reminder	DUE NOW
Caregiver Assessment Screen	Apr 28,06

Display in Reminders Due.
Positive assessment activates ASSISTANCE

Acute Coronary Syndrome
CCHT Caregiver Assistance Reminder
Caregiver Assessment Screen

Assessment now due 6 months from today's date

CCHT Caregiver Assistance

Clinical Reminder Dialog

Pulls in patient information regarding primary care provider and next of kin

Reminder Resolution: CCHT Caregiver Reminder Template

CCHT Referral for Care Giver Assistance

The following VA/Community services are indicated as being needed by the caregiver in order to better support the veteran.

Primary Care Provider: No data available
Primary Next of Kin Information
No Next of Kin Enter
Relationship Unknown
No Address Information Enter

Applicable to:

Caregiver
 Veteran

Referral made

Caregiver Utilization: Use the below questions as ADDENDUM to Follow-up Care Plan for the Caregiver

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note
CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Primary Care Provider: No data available
Primary Next of Kin Information

<No encounter information entered>

* Indicates a Required Field



Caregiver section

Reminder Resolution: CCHT Caregiver Reminder Template

CCHT Referral for Care Giver Assistance

The following VA/Community services are indicated as being needed by the caregiver in order to better support the veteran.

Primary Care Provider: No data available
 Primary Next of Kin Information
 No Next of Kin Enter
 Relationship Unknown
 No Address Information Enter

Applicable to:

Caregiver

Select requested services.

Individual Counseling
 Family Counseling
 Caregiver Support Group
 Education/Training (re: veteran's diagnosis and how to provide appropriate care)
 Medical Evaluation/Follow-up Care
 Bereavement Support
 Other Service

Veteran

Referral made
 Caregiver Utilization: Use the below questions as ADDENDUM to Follow-up Care Plan for the Caregiver

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note
CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Primary Care Provider: No data available
 Primary Next of Kin Information

<No encounter information entered>

* Indicates a Required Field



Health factors are recorded

Reminder Resolution: CCHT Caregiver Reminder Template

CCHT Referral for Care Giver Assistance

The following VA/Community services are indicated as being needed by the caregiver in order to better support the veteran.

Primary Care Provider: No data available
 Primary Next of Kin Information
 No Next of Kin Enter
 Relationship Unknown
 No Address Information Enter

Applicable to:

Caregiver

Select requested services.

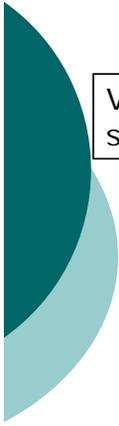
Individual Counseling Comment:
 Family Counseling Comment:
 Caregiver Support Group Comment:
 Education/Training (re: veteran's diagnosis and how to provide appropriate care)
 Comment:
 Medical Evaluation/Follow-up Care Comment:
 Service Comment:

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note
CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Primary Care Provider: No data available
 Primary Next of Kin Information

Health Factors: CCHT CAREGIVER SUPPORT GROUP, CCHT EDUCATION/TRAINING, CCHT FAMILY COUNSELING, CCHT INDIVIDUAL COUNSELING, CCHT MEDICAL EVAL/FOLLOW UP, CCHT SERVICE

* Indicates a Required Field



Veteran section

Reminder Resolution: CCHT Caregiver Reminder Template

Applicable to:

Caregiver
 Veteran

Select requested services.

- Individual Counseling
- Family Counseling
- Education/Training (re: veteran's diagnosis and how to provide appropriate care)
- Medical Evaluation/Follow-up Care
- Legal Assistance
- Financial Assistance
- Employment Assistance
- Housing
- Transportation
- Home Health Service
- Homemaker/Chore Assistant
- Respite (in home of out of home)
- Adult Day Care
- Hospice
- Nursing Home Placement
- Service

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note
CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Primary Care Provider: No data available
Business Visit of Via Information

<No encounter information entered>

* Indicates a Required Field



Referral section

Through health factors, you can capture whether the referral was made within VA or outside.

Reminder Resolution: CCHT Caregiver Reminder Template

Select requested services.

- Individual Counseling
- Family Counseling
- Education/Training (re: veteran's diagnosis and how to provide appropriate care)
- Medical Evaluation/Follow-up Care
- Legal Assistance
- Financial Assistance
- Employment Assistance
- Housing
- Transportation
- Home Health Service Comment:
- Homemaker/Chore Assistant
- Respite (in home of out of home)
- Adult Day Care
- Hospice
- Nursing Home Placement
- Service

Referral made

Referral was made within the VA.
 Referral was made outside the VA.
Referral made to:

Caregiver Utilization: Use the below questions as ADDENDUM to Follow-up Care Plan

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note
CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Applicable to Veteran
Home Health Service

Health Factors: CCHT HOME HEALTH SERVICE, CCHT NON-VA REFERRAL, CCHT VA REFERRAL

* Indicates a Required Field

Section for addendum

Reminder Resolution: CCHT Caregiver Reminder Template

Family Counseling
 Education/Training (re: veteran's diagnosis and how to provide appropriate care)
 Medical Evaluation/Follow-up Care
 Legal Assistance
 Financial Assistance
 Employment Assistance
 Housing
 Transportation
 Home Health Service Comment:
 Homemaker/Chore Assistant
 Respite (in home of out of home)
 Adult Day Care
 Hospice
 Nursing Home Placement
 Service

Referral made
 Caregiver Utilization: Use the below questions as ADDENDUM to Follow-up Care Plan for the Caregiver

Caregiver was satisfied with referral.
 Caregiver was not satisfied with referral.
 Due to: *
 Caregiver did not utilize referral.

Clear Clinical Maint Visit Info < Back Next > Finish Cancel

Clinical Note

CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Caregiver Utilization
Caregiver was not satisfied with referral

Health Factors: CCHT CAREGIVER NOT SATISFIED

* Indicates a Required Field

Vista CPRS in use by: Harrity, Catherine L Rhio (vista.altoona.med.va.gov)

ZZMCCOY, MICHAEL E CHART May 22, 06 14.17 Primary Care Team Unassigned

Visit: 05/22/06 CHART REVIEW/FOLLOW-UP, CHART REVIEW (ALTOONA), CATHERINE L. HARRITY RHIA (May 22, 06@14:59)

TITLE: CHART REVIEW/FOLLOW-UP
DATE OF NOTE: MAY 22, 2006@14:59 ENTRY DATE: MAY 22, 2006@15:00
AUTHOR: HARRITY, CATHERINE L REXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient's Phone Number: 814-349-8186

Allergies: PENICILLIN, VICODIN, ASPARTAME

Clinical Note

CCHT Caregiver Reminder Template:
CCHT Referral for Care Giver Assistance
Primary Care Provider: No data available
Primary Next of Kin Information
No Next of Kin Enter
Relationship Unknown
No Address Information Enter
Applicable to Veteran
Medical Evaluation/Follow-up Care
Comment: test
Housing
Comment: test
Referral was made within the VA.

/s/ CATHERINE L. HARRITY RHIA
Clinical Applications Coordinator
Signed: 05/22/2006 15:03

Health Factors: CCHT MEDICAL EVAL/FOLLOW UP, CCHT HOUSING, CCHT VA REFERRAL

Sample progress note

Health Factors

Health factors are data elements that can be sorted and stored for reporting. They create a tremendous advantage when compared to progress note free text which can only be reviewed by searching individual progress notes. Health Factors transmit data to Patient Care Encounter (PCE), and they can be used to initiate clinical reminders or resolve clinical reminders when placed in the cohort or resolution logic of a clinical reminder.

The Health Factors can also be added to Health Summaries for immediate review in the Reports Tab of CPRS. Reports can be run by your Clinical Reminder Managers on the number of Caregiver High Risk Screens you've done, the number who were found to be at high risk, and the number and types of referrals that were made. This information could be aggregated by program area, by facility, and even by VISN and nationally.

SECTION 7: CODING AND WORKLOAD

In the past there has been much confusion about which codes to use when documenting interactions with caregivers. In many cases documentation regarding caregivers has not happened because of this confusion. In this section, coding and workload will be addressed to aid the clinician in accurately capturing their work with caregivers. Also included is information on what reports can be obtained regarding workload, and how to get them.

Frequently Asked Questions

Which V Codes should we use to document issues pertaining to caregivers?

The CCHT Data Cube contains two ICD 9 V codes (V60.3 - Person living alone and V60.4 - No other household member able to render care) that if utilized consistently, could yield good information on the number of veterans enrolled in the CCHT program who have no caregiver. This is information about the care giving situation as it pertains to the veterans in the CCHT program that has been difficult to collectively ascertain.

There is another series of V-codes (the V 65 series) that are used when some other person is seeking consultation on behalf of the veteran. They include:

- V 65.0 – Healthy person accompanying sick person
- V 65.1 – Person consulting on behalf of another person
- V 65.2 – Person feigning illness
- V 65.3 – Dietary surveillance and counseling,
- V 65.4 – Other counseling, not elsewhere classified e.g. health advice, education and instruction
- V 65.5 – Person with feared complaint in whom no diagnosis was made. Feared condition was not demonstrated, problem was normal state. Used for the “worried well”
- V 65.8 – Other reasons for seeking consultation. Excludes: Specified symptoms
- V 65.9 – Unspecified reason for consultation

Which CPT Codes should we use to capture family interventions?

There are several CPT Codes available that can be used to capture family interventions and workload. Some that might be appropriate for use in your work with caregivers include:

- 90846 Spec Family Therapy without Patient
- 90847 Spec Family Therapy Conjoint (with the patient present)
- 90849 Multiple Family Group Psychotherapy
- 96154 Health and Behavior Intervention – Family (with the pt present)
- 96155 Health and Behavior Intervention – Family (w/o the pt present)
- 99078 Patient/Family Education
- 99429 Unlisted preventive medicine service (can only be used if the service is STRICTLY preventive)
- 99510 Home Visit for individual, family or marriage counseling

** Note that 96154-96155 are to be used ONLY with patients that do NOT have an established mental health disorder. If they do, use the psychotherapy codes

What are the most frequently used codes for work with caregivers?

A recent survey of care coordinators was done to determine usage of the various V Codes and CPT Codes for their work with caregivers. The most frequently used V code was 65.4 - Other Counseling, Not Elsewhere Specified. 23.4% of the respondents had used it, and when asked why they selected this code, 61.5% said because it was easiest, and 38.5% said because no other code fit the circumstances. Clinicians are HIGHLY cautioned against using this code as the provider should know why the patient/caregiver is seeking consultation.

Regarding the CPT Codes, the one used most frequently (by 31.4% of the respondents) was 99078 Pt/Family Education.

How should collateral workload be entered?

There currently is no separate Stop Code or DSS identifier to be used for workload related to families/caregivers. Workload should be entered under the stop code used for the veteran. For example, in the CCHT program, the high risk screen should be done at the time of the veteran's initial evaluation. So, the workload should be entered under the same stop code you would be using to document the veteran's Initial Evaluation. If the veteran/caregiver were seen in Primary Care, it would be the stop code pair of 323 – 371. If a subsequent referral or action is taken, the progress note should be linked to stop code 323 – 684.

What reports can be obtained regarding my caregiver workload, and how can they be run?

For those concerned about accounting for the time being spent with family members/caregivers, one rough measure of workload could be the number of times the progress note titles for "Caregiver High Risk Screening" and "Referral for Caregiver Assistance" are used. You will at least be able to tell how many high risk screens were done, how many referrals were made by individual, facility and even by VISN.

You could also ask your local Decision Support Staff (DSS) to run a report looking at the number of times the various V Codes or CPT codes are used by you and others in your program area which would give a rough sense of how many times you are addressing caregiver issues in the course of your work with veterans.

Here are the instructions that can be given to your DSS Site Manager on how to do an audit of the number of times V Codes related to family work are used by care coordinators (via use of the CCHT clinic stop codes):

Care Coordination V Code Audit

Instructions for DSS Site Managers

Print from the OENCTR file in Ad Hoc Inquiry with these 'Find' Criteria, and Print Qualifications.

COMPANY CODE = XXX

FISCAL YEAR = 2006

PRIMARY ICD9 = V65.19 OR V65.0 OR V65.2 OR V65.3 OR V65.4 OR V65.5 OR V65.8-

**OR V65.9
(STOP CODE = 674 OR 685 OR 683) OR (CREDIT STOP = 179 OR 684 OR 685 OR 371)**

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SmarTerm - [DSS 3270 Session.stw]
File Edit View Tools Properties Connection Window Help

S552CBG UTLR.ADHOC.QUAL          2006 S541 UTILITIES          06 NOV 01
PTIISV10 5.4.01                  ADHOC QUALIFY                1:37:49PM

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SPECIFY 'FIND' CRITERIA FOR FILE OENCTR          COUNT = 75
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COMPANY CODE = 541
FISCAL YEAR = 2006
PRIMARY ICD9 = V65.19 OR V65.0 OR V65.2 OR V65.3 OR V65.4 OR V65.5 OR V65.8-
OR V65.9
(STOP CODE = 674 OR 685 OR 683) OR (CREDIT STOP = 179 OR 684 OR 685 OR 371)

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COMMAND==>
1/HELP          3/QUIT          4/FOR SPEC          6/PRINT
                12/CANCEL

0          >>          21,13
  
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To determine the number of times the various Family Counseling CPT codes were used by clinic stop codes, you can go to the VSSC Website, and run the following report: (It can be run with or without OEF/OIF veterans)

Family Counseling Services: Workload and Cost by Service Clinics

**Total Unique Outpatient SSN's In The VHA FYTD; Total Unique SSN's With A Period Of Service In Operation Iraqi Freedom Or Operation Enduring Freedom Seen FYTD
SSN Cohort From NPCD; OIF/OEF SSN Cohort From DOD Environment Medicine Extract
CPT Identification Through Stop codes In The NDE Database**

This report has been enhanced by the use of the 6 character stop code / credit stop pairing to provide the data at the provider type or actual provider service level. The report provides the option to select the primary stop code and secondary credit stop. Selections are by an individual service or all services combined. Information regarding the counseling or bereavement services provided in the Vet Centers is not collected in VistA or available to DSS; therefore these services, although significant, are not identified in this report. This report focuses on the family counseling services provided to all outpatient veterans in VHA. A separate breakout report is

available for only the veterans of Operation Iraqi Freedom/Operation Enduring Freedom. It identifies Therapeutic Counseling services provided to the family (a) with and without the veteran present, (b) marriage counseling services provided to the veteran and family in the home and (c) the unique encounters in the bereavement counseling clinic. The report shows the Workload (volume of unique patient's families provided counseling services), and Total Actual Costs (direct and indirect) of the seven (7) specific CPT codes. Selections can be made by specific Services such as Mental Health or Social Work or Chaplin services, which have a further breakout by Stop Code/Credit Pair.

Fiscal Year	Summary Level	Finest Breakout Level	Type of Service Clinic	Cohort	Gender
2006 2005	National Network Station	Division	Select All Mental Health Social Work Primary Care	Select All Total VHA Outpatient SSN OIF / OEF per DOD Extract	Select All Male Female

Enter text

Text to Find:

Click to Find

Select Facilities:	Stop Code	Select Secondary Credit Stop
(V01) (402) Togus, ME (V01) (405) White River Junction, VT (V01) (518) Bedford, MA (V01) (523) VA Boston HCS, MA (V01) (525) Brockton VAMC (V01) (608) Manchester, NH (V01) (627) Newington Campus (V01) (631) Northhampton, MA (V01) (650) Providence, RI (V01) (689) VA Connecticut HCS, CT	***SELECT ALL*** 122-PUB HEALTH NURS 125-SOCIAL WORK SVC 165-BEREAIVE. COUNSEL 166-CHA PLAIN-IND 167-CHA PLAIN-GROUP 168-CHA PLAIN COLLATE 169-TELEPHONE/CHA PLA 170-HBPC PHYSICIAN 171-HBPC Nursing (RN/LP)	NO SELECTION ***SELECT ALL*** 101-EMERGENCY UNIT 102-ADMIT/SCREENING 105-X-RAY 108-LABORATORY 115-ULTRASOUND 117-NURSING 122-PUB HEALTH NURS 123-NUTR/DIET - IND

SECTION 8: EDUCATIONAL RESOURCES FOR CLINICIANS AND CAREGIVERS

To meet the needs of clinical staff, various coursework has been developed through a collaborative partnership between the Sunshine Training Center and the Employee Education System within the VHA. The primary goal is to ensure high quality, just in time education to meet the short, intermediate and long term needs of VHA staff. There are numerous educational resources available for both clinicians and caregivers. The few resources listed in this guide are simply a beginning and are not by any means inclusive.

Frequently Asked Questions:

As a clinician within the VA, I would like to learn more about caregivers. What caregiver coursework is available and how do I access it?

Please refer to the following links for Caregiver Coursework for clinicians located on the VA Intranet at the links below:

Care Coordination/Home Telehealth Caring for the Caregiver Part 1

<https://vaww.ees.aac.va.gov/userlogin.asp>

Lesson 1: The Face of VA Caregivers

Author: Nancy Campbell, MSW, LCSW

This lesson will provide information on the changing demographics of VA caregivers and how these demographics impact CCHT Programs.

Lesson 2: Caregiver Assessment

Author: Nancy Campbell, MSW, LCSW

This lesson will familiarize participants with potential assessment tools and the importance of doing caregiver assessments. It will also discuss the Office of Care Coordination's pilot study for establishing a national assessment process.

Lesson 3: Seamless Care

Author: Robert Lodge, MSW, LCSW

This lesson will define what seamless care is and how it pertains to caregivers. It will also address the purpose, mission and activities of the VHA Seamless Transition Office.

Lesson 4: Performance Measuring for Success

Author: Nancy Campbell, MSW, LCSW

The purpose of this lesson is to describe evaluation approaches for CCTH, including sources of data and recommended outcome measures.

Care Coordination/Home Telehealth Caring for the Caregiver Part 2

<https://vaww.ees.aac.va.gov/userlogin.asp>

Lesson 1: Caregiver Stress and Coping Strategies

Authors: Nancy Campbell, MSW, LCSW

This lesson will provide information on the characteristics of caregiver stress and burn-out and how to apply successful coping strategies.

Lesson 2: Keeping the Professional Caregiver Healthy

Authors: Carla Anderson, MSN, RN; and Rita Kobb, MN, GNP-BC

this lesson will discuss the impact of family care giving on professional caregivers and coping strategies to keep healthy.

Lesson 3: Loss and Role Changes

Authors: Robert Lodge, MSW, LCSW; Linda Torres, LCSW; and Barbara Weber, RNC, MSN, CCM

This lesson will discuss the impact of loss on caregivers and how losses can affect family dynamics and roles.

Lesson 4: The Ethics of Care giving

Author: Tara Stablein, LCSW, MSCS

The purpose of this lesson is to describe potential ethical situations and resolutions when working with caregivers and health information

Please refer to the following link for more information regarding the Sunshine Training Center.

<http://vaww.va.gov/occ>

What education resources are available for the caregiver?

Research has shown that caregivers who learn coping and care giving skills are better prepared and able to handle the daily stressors of care giving. Important to this concept is that professionals understand the needs of caregivers and that caregivers maintain self care and have the appropriate skills and training to manage the daily tasks of care giving. There are a number of creative strategies to support caregiver education and training. Some of the concepts that should be taken into consideration include a caregiver's ability to leave the care giving environment and options for caregiver training in a workplace environment or on-the-job training. The Administration on Aging's National Family Caregiver Support program also advocates for programs that take into consideration the needs of older children and other family members who may live in the home to be involved with caregiver training.

There are a number of courses and support resources in place for family caregivers. Some of these include:

Caregiving across the States

A newly updated interactive database can point professional and family caregivers to opportunities for education and training.

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1274

The Red Cross Family Caregiver Course

The program is designed in a "train the trainer" format with materials and training available at low cost. Training Modules include:

- Home Safety
- General Care giving Skills
- Positioning and Helping Your Loved One Move

- Assisting with Personal Care
- Healthy Eating
- Caring for the Caregiver
- Legal and Financial Issues
- Caring for a Loved One with Alzheimer's Disease or Dementia
- Caring for a Loved One with HIV/AIDS
- For more information, contact:

<http://www.redcross.org/services/hss/care/family.html>

Powerful Tools for Care giving

This program was developed by Legacy Health Systems and modeled after Standord's Chronic Disease Self Management Program. The program was recently sold to Mather Lifeway and recommended by Family Caregiver Alliance. The program consists of a 2.5 day "train the trainer" workshop and teaches caregivers to "better care for themselves, while caring for others"

http://www.matherlifeways.com/re_powerfultools.asp

The National Family Caregiver Support Program

This offers a number of resources for professionals and family caregivers. Coursework, resources, support groups and more can be found at:

<http://www.aoa.gov/prof/aoaprogram/caregiver/carefam/carefam.asp>

SECTION 9: SPREADING THE WORD ABOUT CAREGIVER SUPPORT

As professionals we know that caregivers play an important role in providing care for our veterans. In fact we could not possibly provide all of the care necessary without them. Yet, we may not always understand what their needs as caregivers are. To adequately support our caregivers, we must have a comprehensive understanding of their needs, stresses, and burdens. With this knowledge, we can provide the type of education and support services that our caregivers want and need so that they can continue in their care of veterans. With sufficient education and support, caregivers can be the long arm of the healthcare team. These key individuals have great potential to create and support an environment that can be most optimal for our veteran's health and quality of life. To achieve these goals, a strong message must be spread across the VHA.

Frequently Asked Questions:

You have a vision about supporting the caregiver ...how can you share it?

Marketing

Marketing is about communication by all means available. Marketing strategies are aimed at convincing people to try out or keep using particular products or services. Marketing strategies and performance should be directed to keep their presence in the market strong, acceptable to customers, and to obtain the desirable buy-in to an innovative product or service. Marketing is based on the importance of customers to the business and must be directed toward satisfying customer needs.

The first step is to identify customer groups that will be working with you or will receive your services. This includes our veterans and their caregivers as well as our health care partners within the VHA. Then the dissemination of relevant information to all possible areas must happen. Every marketing program contains these key components:

- Description of Products or Services
- Target Customers
- Promotion & Dissemination
- Performance Evaluation

There may be several key players in marketing Caregiver Support Programs such as the care coordinator and social work service. These are the people that will facilitate communication, develop marketing strategies and execute the plan to promote caregiver support services throughout all levels of the organization.

Promotion

Promotion strategies include advertising and direct customer interaction. Good salesmanship is essential because of the limited availability of funds for advertising. Some of the elements to use include but are not limited to:

- Direct mail or email with informative letters, flyers, brochures, etc.
- Personal presentations at all levels
- Video presentations have been developed with real caregivers describing their story. They are available through such resources as Employee Education Service, the Office of Care Coordination, the GRECCs and the MIRECs
- When marketing to leadership and business offices, share with them outcome data such as veteran/caregiver satisfaction scores and success stories from veterans and their caregivers

Evaluation

After implementing your marketing program, it is important to evaluate its performance. Every program should have performance standards to compare with actual results. At least quarterly evaluate if you are moving forward with your plan. Check the following:

- Is your program doing all it can to be customer-oriented?
- Do employees ensure that customers are satisfied?
- Are you getting the projected flow of referrals from your providers?
- Are all your customers, business partners and executive leadership well aware of caregiver support opportunities?
- Is everyone engaged in improving caregiver support services?

If the answer is “no” to one or more of these questions, there is a need to adjust the marketing strategy to obtain the positive results addressed in the questions.

"You're in business to serve a customer need," says Derek Hansen, founder of American Capital Access. "If you're not sensitive to customers, don't know who your customers are how to reach them and, most of all, what will convince them to buy your product or service, get help."

Internal Support

By partnering with Social Work Services, Voluntary Services, Veterans Service Organizations, and Employee Education and outside community agencies, assistance can be gained in developing supportive caregiver education and outreach programs at your facility. These groups may be underutilized in a caregiver campaign, yet they each have significant and unique training, knowledge and expertise as well as professional goals that often include patient and caregiver advocacy. GRECCs, MIRECS, and other Centers of Excellence within the VHA also have excellent materials and processes in place that can contribute to or supplement your efforts.

Marketing is all about sharing the vision! By understanding what care givers need, by developing collaborative partnerships within and outside of VHA, and by being aware of available programs to support our caregivers, we can succeed in providing caregivers the right support at the right time in the right place!

What is National Family Caregiver Month?

National Family Caregiving Month is observed each November. November is a perfect time to raise awareness and establish regular marketing and education to develop awareness about the needs of Caregivers in VA and the community. The National Family Caregivers Association (NFCA) maintains a website that hosts marketing materials and ideas for methods in which to support awareness. There are a number of items that can be ordered directly from the site as well as resources that are free to share under the guidelines of NFCA. Ideas for celebrating the month are listed here and include hosting workshops or activities and encourage reaching out to your own loved ones and friends in appreciation for their care giving efforts.

http://www.thefamilycaregiver.org/empowerment/nfcmmonth_celebrate.cfm

One innovative way in which to recognize caregivers is to encourage caregivers you support to tell their stories in a shared journal format. The process of writing personal thoughts about care giving experiences can be therapeutic and can help others in similar situations. The national family story project can be found at: <http://www.thefamilycaregiver.org/who/story.cfm>

SECTION 10: ETHICS AND BOUNDARIES

The practice of establishing and maintaining boundaries is sometimes not easy for the health professional. Our relationship with veterans and their caregivers is based on a framework of health care needed. The veteran's health care needs determine the course of the relationship such as when it begins and when it ends. Interventions and goals of care are for the benefit of the patient not the health professional. As health professionals we hold considerable authority because of the scope of our practice, whereas the veteran and/or caregiver may be in a weak position and feel they are unable to control what happens to him/her during the course of their health care. The following section will answer questions regarding ethics and boundaries associated with supporting the caregiver.

Frequently Asked Questions:

What if caregivers don't follow your recommendations about caring for the veteran?

As a care coordinator, your role and responsibility is to care for the veteran holistically. If a veteran has a caregiver providing care to him/her, it is part of the care coordinator's responsibility to make sure that the caregiver has the knowledge and skills to safely care for the veteran. Throughout the episode of care, several recommendations on how to safely and appropriately care for the veteran may be offered to the caregiver. A caregiver may not follow a recommendation for several reasons which include the following:

- The caregiver does not understand the recommendation and how to ask questions about the recommendation
- The caregiver is overwhelmed and stressed so the recommendation may have been forgotten or ignored
- The caregiver may believe they are following the recommendation
- The caregiver may be setting limits on what they will do or not do
- The caregiver is not vested in providing care or following your recommendations. They may be involved with the veteran for other reasons

It is your ethical responsibility to protect the health, safety and rights of the veteran patient. It is important to first explore with the caregiver the reasons behind his/her failure to follow through with your recommendations. If the caregiver doesn't understand them or how to provide them then further instruction and support is necessary. If the caregiver is overwhelmed and stressed to the point of failing to follow through with instructions then it is up to the care coordinator to make appropriate referrals for respite and other services that can provide the care to the veteran and/or relief to the caregiver. The care coordinator should discuss this with their supervisor and/or social worker or interdisciplinary team to arrange these services.

If you determine that the caregiver is ignoring your recommendations because they are neglecting the patient, then further action must be taken. VA policy does require any suspicion of neglect and abuse to be reported. States vary however, in their reporting laws regarding neglect and abuse. In most states, a care coordinator needs only to suspect, not verify that neglect and/or abuse is occurring. It is recommended that you first report and discuss the situation with your supervisor. If after discussion with your supervisor you conclude that the situation must be reported to local authorities, then the caregiver and the veteran should be notified that you are

filing this report. Usually the result of reporting these issues leads to more needed services being provided to the veteran. If a report is filed, then this and any outcome is documented in the patient's medical record.

What if caregivers ignore recommendations about caring for themselves?

Caring for someone else becomes a balancing act for most caregivers. Sometimes caregivers do not succeed in balancing the burden of care with their own ability to cope. They become extremely vulnerable to tremendous stress and burnout. A caregiver may not be able to follow your recommendations because they do not have the resources or the energy available to follow through. It is important as a care coordinator to understand the caregiver's vulnerability. It is also necessary to conduct regular assessments to determine the needs of the caregiver before they reach a crisis stage. Again, discussing these situations with your supervisor and making appropriate referrals to provide the additional support needed is critical in supporting the caregiver in the home.

A caregiver does have the right to refuse your recommendation of caring for self, but if the caregiver's refusal to care for self jeopardizes the health, safety and rights of the veteran patient, then it does need to be reported and discussed with your supervisor and /or an ethics committee at your facility.

How can I find the time to work with families when I can barely get my regular job done?

One of the Codes of Ethics from the American Nurses Association (<http://www.nursingworld.org>) prescribed for nursing states: "The nurse's primary commitment is to the patient whether an individual, family, group or community." Other professions have similar Codes of Ethics depending on the discipline. Working with families and /or caregivers is the responsibility of the care coordinator. The care coordinator may need to discuss how to plan and manage the workday to include the work involved with families with their supervisors, particularly if some families require more attention than others. Delegation of other duties may need to occur so that family work can be accomplished. Caregiver course work has been developed within the VA that includes strategies on stress reduction for the care coordinator. This online learning material can be accessed at: <http://vaww.sites.lrn.va.gov/vacatalog>. Time management and organizational skills can be learned by anyone. The result is the care of families and/or caregivers becomes part of the care coordinators' daily routine.

Regarding boundaries, I have developed a good relationship with my veteran's husband who is also the veteran's caregiver. Yesterday the husband came to my office and asked me out to dinner. Should I accept?

Creating boundaries and keeping them intact can be very difficult for the health professional. Two sources are available to help you better understand how to set your boundaries. These include: Your profession's code of ethics, and the VHA's policies and procedures regarding ethics and practice. For example, if you are a nurse, you could refer to your state's nurse practice acts and the American Nurse Association Code of Ethics and standards of practice and social workers can refer to NASW Code of Ethics (<http://www.naswdc.org/pubs/code/code.asp>).

Using these standards as a guideline, one can then determine reasonable boundaries based on the kind of health care needed and provided. Be alert to your gut feelings. Ask yourself the following questions: Is this activity part of the care plan for this veteran? Would this action contribute to the therapeutic nurse /patient relationship? Who benefits from your actions-you or the veteran? How would your colleagues respond to your actions?

The care coordinator is very independent by the nature of their role. The care coordinator has to be especially cautious not to lose sight of their professional role because of this independence. It may be helpful to consult with your supervisor if you are unsure of your boundaries in certain situations. By understanding the standards of practice and applying good judgment, the care coordinator can secure their professional integrity in any situation.