

**THE FEDERAL RECOVERY COORDINATION
PROGRAM: FROM CONCEPT TO REALITY**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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MAY 13, 2011
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Serial No. 112-13

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Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

67-188

WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THE FEDERAL RECOVERY COORDINATION PROGRAM: FROM CONCEPT TO REALITY

FRIDAY, MAY 13, 2011

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

The Subcommittee met, pursuant to notice, at 11:24 a.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Runyan, Michaud, and Reyes.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good morning. Please let me begin by apologizing for having you all wait here for the last hour and a half. We had votes and we just finished that series of votes. My sincere apologies for the delay.

I first of all want to thank all of you for being here this morning as we begin to examine the Federal Recovery Coordination Program (FRCP): From Concept to Reality.

I am Ann Marie Buerkle and I am the Chairwoman of the Subcommittee on Health for the House Committee on Veterans' Affairs.

Before we begin, I would like to first of all acknowledge all of the military that we have in our audience today and participating in our hearing. And I ask all of us to remember our active-duty men and women who are serving our Nation. To all of the veterans and to those who gave the ultimate sacrifice, we must never forget what our military has done for this Nation.

This is the greatest Nation in the history of mankind and it is because of the service and the sacrifice of our military. So as we enjoy the freedom today to sit here and be assembled, we must always be aware and remember those who have served and are serving as we speak. Thank you.

The Federal Recovery Coordination Program was the brainchild of the Commission of Care for America's Returning Wounded Warriors, commonly known as the Dole-Shalala Commission.

The Commission, which was established in 2007, rightly recognized that navigating the complex maze of the U.S. Department of Defense (DoD) and the U.S. Department of Veterans Affairs (VA) care, benefits, and services can be a task of almost herculean effort for wounded warriors and their families at a time when all of their energies and focus should be on recovery.

The Commission recommended that we swiftly develop a program to establish a single point of contact for wounded warriors and their families that would make the systems more manageable, eliminate delays and gaps in treatment and services, and break through VA and DoD jurisdictional boundaries to ensure a truly seamless transition.

However, almost 4 years since DoD and VA signed a memorandum of understanding to establish the Federal Recovery Coordination Program, significant challenges persist in areas as fundamental as identifying potential enrollees, reviewing enrollment decisions, determining staffing needs, defining and managing case-loads, and making placement decisions.

Further, it appears that rather than having the joint program envisioned by the Commission to advocate on behalf of the wounded warriors and ensure a comprehensive and seamless rehabilitation, recovery, and transition, we have two separate programs—a VA program that utilizes Federal Recovery Coordinators (FRCs) and a DoD program that utilizes Recovery Care Coordinators (RCCs).

The intent was to streamline. The intent was to simplify. The intent was to serve the most seriously wounded, ill, and injured. But instead, there is duplication, there is bureaucracy, and there is confusion.

This is unacceptable for any program that accepts tax dollars and taxpayer funding, but it is unforgivable in a program that serves our most severely-wounded servicemembers, veterans, and their families.

I look forward to hearing from each of today's witnesses how they are going to solve these problems.

At this time, I would like to recognize our Ranking Member, Mr. Michaud, for any comments he might have.

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

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. I want to thank you, Madam Chair, for having this very important hearing today. It certainly is important and an appropriate topic for this Subcommittee to hear.

And because of the votes this morning, I would ask unanimous consent that my full opening statement be submitted for the record so we can get on and hear the panelists.

[The prepared statement of Congressman Michaud appears on p. 28.]

Ms. BUERKLE. Thank you, Mr. Michaud.

I would like to now welcome the first panel to our witness table. With us this morning are Mr. Randall Williamson who is the Director of the Health Care Team for the U.S. Government Accountability Office (GAO); Dr. Karen Guice, the Executive Director of the Federal Recovery Coordination Program for the Department of Veterans Affairs; and Mr. Robert Carrington, Director, Recovery Care Coordination for the Department of Defense, Office of Wounded Warrior and Transition Policy.

Thank you all very much for joining us this morning. And, again, I apologize for the delay. I am very much looking forward to our discussion.

So, Mr. Williamson, without further delay, we will start with you.

STATEMENTS OF RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; KAREN GUICE, M.D., MPP, EXECUTIVE DIRECTOR, FEDERAL RECOVERY COORDINATION PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND ROBERT S. CARRINGTON, DIRECTOR, RECOVERY CARE COORDINATION, OFFICE OF WOUNDED WARRIOR CARE AND TRANSITION POLICY, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Thank you, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee.

I am pleased to be here today to discuss GAO's recent report on the Federal Recovery Coordination Program, which aims to improve the continuity of care of severely-wounded, ill, or injured servicemembers and veterans including those who have suffered traumatic brain injuries (TBIs), amputations, burns, spinal cord injuries, and post-traumatic stress.

While administered by the VA, it is designed to be a joint DoD and VA program. Currently the FRCP employs 22 recovery coordinators called FRCs in 12 locations nationwide and is serving over 700 active enrollees.

Our report focused on challenges the program faces in identifying and enrolling those who need FRCP services, staffing and placement issues, and coordinating care for its clients.

Regarding the first challenge, we found that it is not clear whether all those who could benefit from the program are being identified and enrolled in the FRCP. Because VA and DoD lack data that specifically designates servicemembers as severely wounded, FRCs have no systematic method to identify potential candidates for the program.

Instead, FRCs must rely largely on referrals from clinicians and caseworkers and other programs. But this method isn't perfect because staff from other programs are often unclear about the eligibility criteria for the FRCP and because close cooperation and collaboration among the FRCP and other wounded warrior programs is sometimes missing. This in turn can affect the ability and willingness of other programs to refer servicemembers to FRCs.

We also have recommended that FRCP strengthen its enrollment, workload management, and placement processes to best service its clients.

Most pressing, however, is the need to improve collaboration and coordination among wounded warrior programs.

Currently FRCs face daunting challenges coordinating with a large number of DoD and VA programs that support wounded servicemembers and veterans.

For example, 84 percent of FRC enrollees are also enrolled in a military wounded warrior program. Coordination among these pro-

grams is paramount to minimize overlap, optimize information sharing, and prevent confusion among clients and their families.

However, we found that considerable overlap does occur along with conflicting recovery plans on occasion. This adds to confusion among servicemembers and their families and it is just not in the best interest of a recovering servicemember.

We found that problems with cooperation and collaboration occur for numerous reasons. For one, there are significant cultural differences between VA and DoD organizations. While the FRCP is a joint program, it is widely perceived as part of VA.

A recurring theme, therefore, as we talk with military staff in other programs was we can take care of our own while they are recovering on active duty. We do not need the VA involved.

Second, VA and DoD programs often cannot easily share information among themselves leading to duplication of effort and conflicting servicemember recovery goals among programs. This occurs largely due to IT issues that limit the transparent exchange of information between VA and DoD programs.

Third, the point at which FRCs should become involved with a severely-wounded servicemember is blurred. Some in DoD would say that FRCs should not be involved until it is determined that the servicemember will likely be discharged. Conversely, FRCs contend that they should be engaged long before that to build rapport and trust with their clients and their families through the continuum of care.

Finally, the primary point of contact once people are enrolled in the FRCP is ill defined. Case managers in military service programs often think they should be the point of contact while FRCs think they serve this role. This has prompted some recovering servicemembers to say I need a case manager to manage my case managers.

In summary, while we offer ways to strengthen the management of the FRCP, the most pressing problem is improving the level of coordination and collaboration among the large number of DoD and VA programs that serve our wounded warriors.

Achieving this will require efforts far beyond just what the FRCP can achieve by itself. In the end, without cooperation from the military services, the FRCP cannot function as intended. This dilutes the program's ability to best serve our wounded, ill, and injured servicemembers and veterans.

That concludes my opening remarks.

[The prepared statement of Mr. Williamson appears on p. 29.]

Ms. BUERKLE. Thank you, Mr. Williamson.

Dr. Guice.

STATEMENT OF KAREN GUICE, M.D., MPP

Dr. GUICE. Good morning, Chairwoman Buerkle and Ranking Member Michaud and Members of the Subcommittee.

I request that my written statement be submitted for the record.

The many investigations that followed the 2007 *Washington Post* article on Walter Reed raised concerns about the multiple transitions our wounded, ill, or injured servicemembers make as they recover from war zone to inpatient care, from one hospital to another,

from a DoD facility to a VA polytrauma center, from inpatient to outpatient, and from a military career to veteran status.

Each transition came with multiple providers and serial hand-offs. System navigation was left to the patient and family who were trying to adjust to the consequences of illness or injury. Access to accurate and timely information was difficult and, if available, often confusing. Perceived and real system barriers prevented access to entitlements.

These observations led to the care coordination concept in order to create seamless synchronization of benefits and care as these servicemembers navigated our complex systems regardless of whether they returned to active duty or became a veteran. The Senior Oversight Committee (SOC) created FRCP to carry out this function.

VA agreed with all four GAO recommendations and I will tell you the steps we have taken to address each one.

The first recommendation called for adequate internal controls to ensure appropriate referral. As an interim solution, FRCs discuss all enrollment decisions with management and each decision is carefully documented.

Our permanent solution is to include an eligibility protocol as we develop our intensity measurement tool.

FRCP does not have visibility of all who might be eligible. As a voluntary referral program, we rely on outreach activities and demonstrated outcomes.

FRCP conducted almost 200 outreach activities over the past 2 years. We will exceed our target this year by 25 percent.

Last year, the FRCP conducted a look-back project to identify veterans who might still benefit from care coordination. Through this process, we identified 35 individuals who needed further evaluation and of those, six were subsequently enrolled.

GAO recommended that FRCP should complete development of a workload assessment tool. Care coordination as implemented across and within Federal agencies by FRCP is a new concept. No guidelines or tools exist to accurately determine and balance a range of cases for this new function. We are developing our intensity measurement tool which will estimate the time and effort FRCs use to coordinate services for clients based on client attributes.

GAO recommended that FRCP should better document hiring decisions. Given the uncertainty about the number of individuals who might need FRCs, we have pursued a scalable resource model based on the number of referrals, the rate of enrollment, and the number of clients made inactive.

Once we complete the intensity measurement tool, we will substitute allowable average intensity points for the current benchmark range.

GAO's final recommendation was that FRCP should develop and document a rationale for FRC placement. Initially FRCs were placed within military treatment facilities where significant numbers of wounded, ill, or injured servicemembers were located. As the program grows, we consider alternative locations.

FRC placement is guided by four factors: Replacement for FRCs who leave the program; supplementation of existing FRCs based on documented need; the creation of a national FRCP network to opti-

mize coordination; and specific requests for FRCs in order to better serve the wounded, ill, and injured servicemembers and veterans.

Over the next 6 months, FRCP will develop a placement strategy based on a systematic analysis of our data. The actual placement of FRCs is based on a case-by-case negotiation for support and space.

Many in DoD believe that FRCP is a redundant program, likely because the DoD's non-clinical Recovery Coordination Program (RCP) was modeled directly from FRCP including the design for the comprehensive recovery plan.

Others, specifically the military services wounded warrior programs, say that FRCs should only provide support for veterans because they are not in the military services' chain of command.

There is no shortage of military and VA programs to support servicemembers and veterans, so many, in fact, that our wounded, ill, and injured servicemembers, veterans, and their families are still confused by the number and types of case managers as well as by benefit eligibility criteria.

FRCP was to be the single point of contact for these individuals through care and recovery, a single point of contact that would help them understand the complexities of medical care provided and the array of benefits and services available to assist recovery.

Our families and clients tell us that the program works best when FRCs are included early in the servicemember's recovery and prior to the first transition, whether that transition is from inpatient to outpatient or from one facility to another.

A single FRC stays with the client throughout all subsequent transitions, coordinating benefits and services as needed. This consistency is important for individuals with severe and complex conditions who require multiple DoD, VA, and private health providers and services.

FRCs remain in contact with their clients as long as they are needed, whether for a lifetime or for a few weeks. FRCs' involvement is voluntary and collaborative.

In closing, we understand that program evaluation, whether by Congress or by an investigative body such as GAO, is a vital part of program growth and maturation. We are grateful to GAO for their comprehensive review of the program and to the Members for this opportunity to discuss our continued challenges.

Thank you and we look forward to your questions.

[The prepared statement of Dr. Guice appears on p. 33.]

Ms. BUERKLE. Thank you, Dr. Guice.

Mr. Carrington, you may proceed.

STATEMENT OF ROBERT S. CARRINGTON

Mr. CARRINGTON. Good morning, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee.

Thank you for the opportunity to be here this morning with Dr. Karen Guice from the VA and Randall Williamson from the GAO.

Also joining me today from the Department of Defense are two of my Wounded Warrior Program leads, Colonel Mayer from the Marine Corps Wounded Warrior Regiment and Colonel Gadson from the Army's Wounded Warrior Program.

I am pleased to discuss the role the Department of Defense in the VA's Federal Recovery Coordination Program or FRCP.

While the FRCP was jointly developed in 2007 by DoD and VA leaders on the Senior Oversight Committee or SOC, the program itself continues to be solely administered and run by the VA.

DoD operates the Recovery Coordination Program or RCP which was established later by Section 1611 of fiscal year 2008 National Defense Authorization Act (NDAA).

This program, which is actually run by the services, uses DoD trained recovery care coordinators or RCCs who focus on the non-medical care coordination issues of our recovering servicemembers and their families.

They accomplish this by being an integral part of the recovery team, by being the central point of coordination to help ensure all needs are met, by establishing a personal relationship and using a comprehensive recovery plan in order to guide and focus the servicemember through all phases of recovery, rehabilitation, and reintegration.

Within DoD, there are 146 RCCs and 170 advocates. Advocates are what the Army calls their RCCs, all of whom are placed in locations to best support the respective service wounded warrior programs.

FRCs and RCCs serve similar functions but for different categories of wounded, ill, or injured servicemembers. RCCs are there from day one working as part of the individual service's Wounded Warrior Program team for all servicemembers regardless of their injury or illness. And FRCs' main focus is on servicemembers who have severe or catastrophic injuries or illness and are unlikely to return to duty and are likely to be medically separated.

Practice has shown the services when, where, and how to best bring the FRC on to their recovery teams in order to transition the focus of the servicemember from being on active duty to being in a veteran status.

Our DoD instruction, which follows the NDAA legislation, directs when an FRC will be added to join with the RCC and others to form a more complete recovery team for this category of servicemember.

The FRC Program is effective at major military medical treatment facilities and at VA centers. At other locations where FRCs are not located, the services use other Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) liaisons and counselors to ensure that transitioning servicemembers and their family needs are met.

As a twice deployed to both Iraq and most recently to Afghanistan DoD civilian, I can attest to the excellent, professional, and complete support of all my medical and non-medical needs when I was medivacked from theater.

From my personal experience, having gone through much of this myself and been providing this care coordination, I am confident that our programs work and that the needs of our wounded, ill, and injured servicemembers, their families, and in my case a deployed government civilian are being met.

As discussed in my written statement, my office recently completed a 2½ day wounded warrior care coordination summit that

included the chartered subgroup that focused entirely on the collaboration between VA and DoD care coordination programs.

Actionable recommendations from the subgroup and the other subgroups are currently being actioned and have been presented to the overarching integrated product team or OIPT, are prepared to be briefed to the SOC, and will continue to be worked until these recommendations and policies are implemented in order ensure that best practices are implemented as we strive for excellence across our service programs.

Also, in conjunction with the efforts of this summit, the SOC directed RCP and FRCP leadership to establish the joint DoD/VA Recovery Coordination Committee to identify ways to better collaborate and coordinate the efforts of FRCs and RCCs and to integrate FRCs where possible.

We recently concluded our second day of meetings with representatives from across both departments and are now finalizing our recommendations on ways to improve the use of FRCs in the DoD Recovery Coordination Program.

Since I came on board late last year, I have already taken actions within the DoD program in order to better integrate the VA's FRC Program. At our DoD provided training to all RCCs, we now include a module taught by the FRCP leadership in what FRCs are, what they do, and how to best use their talents.

I also present a similar class in what RCCs are to the FRC training. At our next training in June, we will also include a lunchtime presentation from an FRC working in one of the major hospitals about their experiences.

In conclusion, this Department is committed to working closely with the FRCP leadership to ensure a collaborative relationship exists between these two programs.

Madam Chairwoman, this concludes my statement. I am happy to answer any questions. Thank you.

[The prepared statement of Mr. Carrington appears on p. 38.]

Ms. BUERKLE. Thank you, Mr. Carrington.

I will now yield myself 5 minutes for questions. I will begin with Mr. Williamson and with a general comment.

It seems pretty clear to me that the intent of this program was to get DoD and VA together and form a single point of contact to assist the wounded warrior in his or her pursuit of services and care. What I hear this morning is that we still have silos after 4 years.

My first question is to you, Mr. Williamson. If we are looking at an integrated program, why were these recommendations just directed at the VA rather than looking at the big picture?

Mr. WILLIAMSON. Madam Chair, the VA administers the program and as such, Dr. Guice reports to the Secretary and the Secretary has the authority to take any action. So normally always when that happens, we always address our recommendations to the Secretary that can actually act on them.

Ms. BUERKLE. I hear what you are saying, but you mentioned that the VA administers the program. So it appears that, whether it is reality or perception, that this is the VA's problem and this is the VA's program.

How can we integrate DoD into your recommendations? Is it possible?

Mr. WILLIAMSON. I think that we are in the process of doing additional work, which will encompass all wounded warrior programs. And at that time, we will have, I am sure, some recommendations in that regard.

I think that even though we do not have a recommendation focused strictly at DoD, I hope they have heard the need for all wounded warrior programs to work together, you know, play well in the same sandbox.

Ms. BUERKLE. Thank you.

If you could provide us with what you are going to be working on and the recommendations as well as a time frame for when these will be accomplished—

Mr. WILLIAMSON. Very good.

[The Subcommittee staff received the information from GAO.]

Ms. BUERKLE [continuing]. I would appreciate it. Thank you.

Dr. Guice, you mentioned in your testimony that the GAO recommended systematic oversight of enrollment decisions, complete development of a workload assessment tool, documented staffing decisions, and the development of a rationale for FRC placement. You mentioned that these were all in the works.

Can you give us a time frame in which these four recommendations will be implemented?

Dr. GUICE. Probably the best time frame for all of them to be completed will be probably a year. The most critical and the most labor intensive of the solutions is development of our intensity tool.

Because FRCs do a very unique job, this one of care coordination, and the needs of the individuals that they deal with vary over time and should vary over time and we hope diminish over time, their involvement with the clients will match that variation and that intensity of need.

We just really do not have any way to accurately kind of account for that at the present time. We are in the process of developing this tool that we will use to create, rather than a typical caseload, you know, 1 to 4 or 1 to 20 or 1 to 200 ratio, it will actually be based on points.

So the intensity of the need of the client is really what drives the FRCs' interaction and time. And if we convert the traditional caseload management into something else, we think it will be a better fit for what this program does over a long period of time for each of its clients.

That said, an assessment tool is a fairly cumbersome thing to do and it needs validity testing and reliability testing and integrated reliability.

We are in the process of doing that. We had FRCs come to town and spend a couple of days. We have been doing it kind of iteratively over the entire time that I have been here and, again, assessing that wealth of data that we need in order to actually create this.

So we think that we will probably have that which would be the final piece to comply with all of the recommendations. In the meantime, we continue to work. We have an equation now for staffing

needs, which is based on the data elements that I put into my written statement. We are working on our placement strategy.

We have now collected data in our data management system about exactly where our clients are, where they live, and where our referrals come from so that we can kind of look and match need. We also know that there is a need to put FRCs at polytraumas and we are currently recruiting three additional full-time equivalent FRCs to add to our portfolio of 25—to bring our portfolio up to 25.

Ms. BUERKLE. My time is running out and I will be yielding to the Ranking Member, but I would say that this need has been identified since 2007 and I am hearing now today this morning that it is going to take another year.

And my question is, and hopefully I will have another opportunity to question this panel, what have you been doing since 2007 that now 4 years later we are hearing it is going to take another year?

Dr. GUICE. Well, in 2007 was when the program was actually given its operational parameters. The program actually really did not start until 2008 and as the program has grown—when I came close to 3 years ago, we only had 97 clients and seven FRCs. I think part of this is growing the portfolio of information to understand what drives the involvement of FRCs so that we can better balance the caseloads and the work that they need to do for that client.

They are not case managers and it is a different paradigm. It is a pure coordination function and there just are not any tools to actually help us. And part of it was building the knowledge about what it takes, what drives the FRCs' time, and we can only get that with a little bit of time to actually understand, you know, if someone has a need for a TBI assistance program, you know, all the pieces that have to fit into getting that resource and aligning that with what the client needs. And we just needed the time to develop that information base.

Ms. BUERKLE. Thank you, Dr. Guice.

I would now yield to the Ranking Member.

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

This is for GAO. What do you think the number one barrier is to fixing the problems that you identify in the report?

Mr. WILLIAMSON. That is a tough one. I think breaking down the culture within DoD and VA so that they can play and can collaborate well, they can cooperate. That probably is the single most important thing.

Mr. MICHAUD. And for the VA and DoD, what do you think it will take to break down that barrier, the culture that has been instilled in both agencies?

Mr. CARRINGTON. Quite frankly, we are more than willing to have a joint program. And our services that run these programs reach out to the available VA representatives that can help them take better care of their wounded, ill, and injured and their family members.

Right now there are two separate programs and I think our services would tell you in short give us those FRCs, let us include them on our team, let us be responsible for them, let us put them under our leadership, let's have them focus on accomplishing our larger

mission, and we would see probably more success than what the GAO reported.

Dr. GUICE. For me, the answer would have been if I had been given the task to create a joint program, I would not have put it in either department. I would have put it somewhere in between with joint ownership by both departments which includes joint funding.

I think if you do not have that cooperation and level of side by side so that you are working the issues every day, you are working the challenges every day, and you have a uniting place where those dialogues and that function can occur, having it isolated in either department just will not work.

I think if you look back to the Dole-Shalala Commission and now having this experience and look at their recommendation, they actually said put it with the Public Health Service. They said do not put it in either house. It will then become one or the other. It will not be joint.

And so that was their recommendation. For a lot of reasons, that did not happen. And I think looking back on it, putting it in a joint space is more appropriate for what we are trying to achieve with all of this activity and programs.

Mr. MICHAUD. So for everyone on the panel, do you think that the FRCPs and the RCP programs can be combined and still be effective? And if the programs are combined, what would have to change in order to do that?

Dr. GUICE. I think that people would have to sit down and talk about that. How does that change the current business model for FRCP? It would not be the same program as it is today. It would change a bit.

The same thing for the Recovery Coordination Program and how it is currently operationalized. I think you would have to talk about how you are going to govern this, who is going to be, you know, sort of—how does the staffing work. It would take a lot of work, but I do not think that is an impossible task, sir. I think a few people and working it hard and truly trying to understand it could come up with a solution that might be workable.

Mr. WILLIAMSON. I think also it may go beyond just the FRCP and the RCC. I think 4 years now after the Walter Reed situation, there have been a lot of resources thrown at helping the servicemember, wounded, ill, and injured servicemembers. And there are now over ten major wounded warrior programs. And I think it is time to step back and have an impartial look at this.

Given the culture differences among DoD and VA or between DoD and the VA, I am just not sure you are going to get that kind of impartialness.

Mr. MICHAUD. And, DoD, you want to comment on that?

Mr. CARRINGTON. I think services run their own unique programs based on their culture, philosophy, size of the population they are taking care of, and the ultimate goals of their wounded warriors and their families. And I think that should continue. I think we should recognize the goodness in that.

I also believe that services do a very good job of their programs. They could do a better job as I described if we could better include the FRC into that team. We are already using their resources at

some locations. Other locations use VBA, VHA resources. We agree that it is a team approach, the recovery team, but that takes care of all the needs medical and non-medical for the recovering service-member.

Mr. MICHAUD. Great. My last question for the VA is, are you experiencing a high turnover rate of FRCs and, if so, do you think that hurts the program as well?

Dr. GUICE. Since I have been the Executive Director, I believe we have had two individuals, three individuals leave the program. That is over a period of 3 years. There was some turnover in the first 6 months of the program and that was, I think, people trying to figure out what the role was and then figuring out their skill set and their interests aligned with that.

We currently have three slots that are open and we never have a shortage of applicants. I think the program has become recognized as a very unique and interesting place to work with a very deserving population of seriously-wounded, ill, and injured service-members that people want to be part of that.

The three that have left since I have been here have been for personal reasons. One retired after 30 years in the VA. Another one had some family issues that had to take care of. Another one left for a different job opportunity that she was interested in.

Mr. MICHAUD. Thank you.

Thank you, Madam Chairman.

Ms. BUERKLE. Thank you, Mr. Michaud.

At this time, I would like to thank the three panel members for testifying here this morning.

We will have another hearing within the next few months in order to follow-up on this. I think that the intent of this was to help the wounded warriors when they are injured and when they come back home and need help to navigate through the system.

Time is of the essence. They need our help now. They do not need it a year from now or 6 months from now. So I think we really need to approach this more urgently. We do not have the luxury of just waiting months and months in order to help our veterans.

So with that, I thank you all very much, and I would invite the second panel to the table.

Thank you all very much and welcome. Again, my apologies for the delay this morning. I apologize that you had to sit here and wait.

Joining us on our second panel is Mr. James Lorraine, the Executive Director of the Central Savannah River Area Wounded Warrior Care Project. Prior to his position there, Mr. Lorraine worked with the U.S. Special Operations Command Care Coalition.

Mr. Lorraine, thank you for joining us.

We are also fortunate to have two Federal Recovery Coordinators with us today to explain their work, Dr. Mary Ramos who is currently stationed at the San Antonio, TX, Military Medical Center and Ms. Karen Gillette who is currently stationed at the Providence VA Medical Center in Providence, Rhode Island.

Also on the panel is Colonel Gregory Gadson, the Director of the United States Army Wounded Warrior Care Program, and Colonel John Mayer, the Commanding Officer of the Marine Corps Wounded Warrior Regiment.

Gentlemen, thank you very much for your service to this Nation and for being here this morning.

Colonel Mayer, I understand that your family is here in our audience.

Colonel MAYER. Yes, ma'am.

Ms. BUERKLE. If we could ask them to stand, we would like to recognize them.

Colonel MAYER. They are sleeping.

Ms. BUERKLE. I hope that is not a commentary on our proceedings.

Thank you all very much for being here this morning.

Mr. Lorraine, we are going to start with you, please.

STATEMENTS OF JAMES R. LORRAINE, EXECUTIVE DIRECTOR, CENTRAL SAVANNAH RIVER AREA WOUNDED WARRIOR CARE PROJECTS, AUGUSTA, GA; MARY RAMOS, PH.D., RN, FEDERAL RECOVERY COORDINATOR, SAN ANTONIO, TX, MILITARY MEDICAL CENTER, U.S. DEPARTMENT OF VETERANS AFFAIRS; KAREN GILLETTE, RN, MSN, GNP, FEDERAL RECOVERY COORDINATOR, PROVIDENCE, RI, DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, U.S. DEPARTMENT OF VETERANS AFFAIRS; COLONEL JOHN L. MAYER, USMC, COMMANDING OFFICER, MARINE CORPS WOUNDED WARRIOR REGIMENT, U.S. DEPARTMENT OF DEFENSE; AND COLONEL GREGORY GADSON, USA, DIRECTOR, U.S. ARMY WOUNDED WARRIOR PROGRAM, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF JAMES R. LORRAINE

Mr. LORRAINE. Thank you, ma'am.

Chairwoman Buerkle, Representative Michaud, distinguished Members of the Committee, thank you for the opportunity to speak with you today about the Federal Recovery Coordination Program.

I would like to ask that my written statement be submitted for the record.

Ms. BUERKLE. So ordered.

Mr. LORRAINE. I would like to thank the Committee for its continuing efforts to support servicemembers and veterans and their families as they navigate through the complex web of government and non-government programs.

I have been a member of the military community my entire life, a Reservist, active-duty servicemember, military spouse, retiree, government civilian, and veteran.

In my previous position as the Founding Director of the United States Special Operations Command Care Coalition, an organization which advocates for over 4,000 wounded, ill, or injured special operations forces and has been recognized as the gold standard of non-clinical care management, I recognized a gap in my advocacy capabilities and incorporated a Federal recovery coordinator as a team member.

This one Federal recovery coordinator dramatically improved how Special Operations provides transition care coordination and made my staff more efficient, more effective in support of the wounded warriors and our families throughout the Nation.

It is essential that our military and veterans have strong advocates both government and non-government working together. One program by itself is not enough when it comes to supporting these heroes.

I recently left government service to assume duties as the Executive Director of the Central Savannah River Area Wounded Warrior Care Project where my current position is to integrate services by strengthening community-based organizations that maximize the potential of government and non-government programs in Augusta, Georgia, and throughout the region. The Federal Recovery Coordination Program is one of these resources.

From my experience, care coordinators require three attributes in order to be successful: The ability to anticipate needs; the authority to act; and the access to work as a team member.

The first attribute, the ability to anticipate need, is much like a chess master thinking five to ten moves ahead. This assumes effectiveness and competence in various levels of the system.

By design, the Federal recovery coordinator has the education credentials and experience to anticipate need by functioning at a high level of competence.

We feel a certification program is necessary to prepare these coordinators to engage in a broad spectrum of Federal and local resources available in areas of not only health care but with a focus on behavioral health, family support, and access to benefits.

The second attribute is the authority to act. In this complex environment of wounded warrior recovery, someone who can not act is an obstacle. Actions must occur at a strategic level to ensure case management is being accomplished, services are being provided, and Veterans Affairs' resources are being maximized in concert with government and non-government programs.

The Federal recovery coordinator's authority should be strengthened from what it is today and remain subordinate to the Veterans Affairs' Central Office in order to influence actions across the Nation. This ability is unique and should be capitalized on by the Department of Defense service wounded warrior programs and strengthened by the Veterans Benefits Administration.

The last attribute is to the access to work as a team. I believe this is the greatest challenge for the Federal Recovery Coordination Program. It is the most complex of the three attributes because it requires others to be inclusive, sharing of information, trust, and a great deal of time and coordinated and synchronized efforts.

Federal recovery coordinators must function in a strategic coordination role working by, through, and with wounded warrior programs while also leveraging Veterans Affairs' case managers and benefits counselors.

Lastly, the scope of the Federal Recovery Coordination Program should be expanded to assist not only those most severe cases, but those in combination of family dynamics, behavioral health issues, unemployment, homelessness where benefits anomalies inhibit their smooth transition to civilian life.

In conclusion, we have three recommendations: Maintain a high credentialing standard, but augment with a nationally recognized certification; ensure coordinators have the authority to act on needs they have identified; make certain the Federal recovery coordina-

tors have access to work as a team member by incorporating them early in the recovery process.

There is currently a very positive feeling in the country towards the service and sacrifice of military, veterans, and their families and a desire to support them. One way to help is to utilize existing programs, especially at the local level.

The Central Savannah River Area Wounded Warrior Care Project stands as a model for many communities throughout the Nation who are at the front line of helping our wounded, our veterans come home all the way from combat to fully reintegrated into our community.

It is important to educate the military and their families about their transition, but it is frequently too late when the transition has occurred and life's daily pace takes over.

Thank you for providing us the opportunity to brief before the Committee.

[The prepared statement of Mr. Lorraine appears on p. 40.]

Ms. BUERKLE. Thank you, Mr. Lorraine, and thank you for your service to our country.

Dr. Ramos.

STATEMENT OF MARY RAMOS, PH.D., RN

Dr. RAMOS. Thank you.

Good morning, Chairman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. My name is Mary Ramos and I have been a Federal Recovery Coordinator located at San Antonio Military Medical Center for 3 years.

I am honored to be here today and I would like to request my written statement be submitted for the record.

Ms. BUERKLE. So ordered.

Dr. RAMOS. In my position, I work hand in hand with those who touch the lives of my wounded, ill, and injured clients in order to facilitate the very best clinical and non-clinical outcomes.

In explaining my role, I often say that I make sure that life details happen so that clients can concentrate on recovery and rehabilitation and so their families can support them as they adjust to a "new normal."

A Federal recovery coordinator is the consummate team member with a unique role in the very complex matrix of care providers. The FRC role is one of overarching coordination. In operational terms, that means while others have a defined "lane," FRCs coordinate across "lanes." We communicate with key members of the provider and support teams and in partnership assess whether there are interventions or bits of information that might assist in optimizing outcomes.

There is a core of people supporting and coordinating care, but the preparation of an FRC is unique in that we are all at least master's prepared health care professionals with expertise and/or resources in all of the systems touching the recovering service-member or veteran.

There are others with more depth of knowledge in a single sphere, but the FRC has the background and experience to put each interfacing system into context. We help others to gain an un-

derstanding of how each issue has an impact on the clients and family.

Our ultimate goal as nurses and social workers is maximizing independence and maximizing life care skill by providing support and education to our wounded, ill, and injured.

FRCs at San Antonio or Brooke Army Medical Center (BAMC) usually introduce clients to the FRCP early in the initial hospitalization. While each client has a full complement of care providers in this phase of high acuity, non-clinical details can be addressed to facilitate future care and quality of life and anticipate upcoming needs.

The FRC provides emotional support to the client and family and interfaces with the team regularly. The most important element the FRC contributes at the early treatment phase is the concept of seamless, long-term clinical and non-clinical care coordination. The FRC is a consistent person in the journey from acute care through community reintegration.

It is true that when a client is in intensive care, he or she is not thinking about whether or not they will want to leave the service or whether or not they will seek funding to attend college, but the FRC can assure the client that when they are ready for those decisions, their FRC will be there supporting those decisions within a close professional relationship that has grown over time.

The key to success in our collaborative role is communication and an understanding of the contribution of each team member.

In the 3 years that I have been an FRC, global understanding of the role has grown. Each working contact increases knowledge about the program. The most effective advertisement for the FRCP is the success each of us has every day in working with clients. Personal contacts and professional relationships mean that referrals are facilitated.

Each day as an FRC is an adventure in providing support that could in all likelihood otherwise fall through the cracks given the complexity of some of these cases. Much of what I provide is not quantifiable and some of what I provide would possibly not be missed by a client who did not anticipate a sound safety net.

However, I have come to realize that an intimate understanding of a servicemember's or veteran's perspective of every-day life with an overlapping and possibly complicated delivery system equips me to find that perhaps small intervention that improves the quality of life for those who risked everything for my freedom and for my grandchildren's freedom.

I have never served in battle, but I am honored to bring every minute of my personal and professional experience to bear in caring for those who have borne the battle.

Thank you for inviting me here to testify today to discuss our program. My colleagues and I are prepared to answer your questions.

[The prepared statement of Dr. Ramos appears on p. 42.]

Ms. BUERKLE. Thank you, Dr. Ramos.

Ms. Gillette.

STATEMENT OF KAREN GILLETTE, RN, MSN, GNP

Ms. GILLETTE. Good morning, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee.

My name is Karen Gillette and I am a Federal recovery coordinator from Providence, Rhode Island.

Thank you for inviting me today to tell you what I do as an FRC and to assist recovering servicemembers, veterans, and their families as they heal and return home.

My testimony will focus on my roles and responsibilities in service of my clients.

Thank you for allowing me to submit my written testimony regarding my role.

I have been an FRC for 3 years. I currently have a caseload of 55 clients. Thirteen of those clients are currently active duty, 42 are veterans. Some of my clients have been recently injured and are still being treated at military treatment facilities while others are receiving care at private rehabilitation facilities.

I have clients, now veterans, who were injured several years ago and continue to need assistance with veterans' benefits, case management, vocational rehabilitation benefits, or help finding community resources.

My experience in this field stems from my clinical and administrative experiences as a nurse practitioner and as a nurse executive and from the extensive training, Federal Recovery Coordination Program training and education on veterans' benefits programs, military programs, TRICARE, Social Security, U.S. Department of Labor programs, and VA programs.

My caseload consists of referrals from many sources. Referrals come from VA case managers, military personnel, caregivers, community and charitable organizations, and clients who also refer other wounded warriors to our program.

I currently work with case managers located in over 35 VAs across the country. We collaborate and share resources, suggestions, and information that meet the clients' needs. I work with VBA personnel who manage the compensation claims, vocational rehabilitation, and fiduciary needs of my clients at VBA sites across the country.

Beyond the VA, I work with staff at the Social Security Administration, State disability and Medicaid case managers, and TRICARE and military nurse case managers on a regular basis.

I stay in close contact with the different Wounded Warrior Program representatives and we discuss resources and options that might be of benefit to the shared clients.

We collaborate closely and make sure that the right person is doing what is needed and ensure that there is no duplication of effort. I work with recovery care coordinators on some cases that we share.

My job is to ensure that all of my clients are moving closer to the goals that they established on their Federal individual recovery plan.

I would like to share an example of a client that I have worked with that is fairly typical of some of the issues we address. I spoke with a case manager at a military treatment facility about a new

referral. This client had not used the VA for health care and had been out of the military for 2 years.

In addition, the client's veterans' benefits monthly special compensation had been decreased, which resulted in the veteran having to relocate across the country to live with family to be able to afford to live.

I reviewed the veteran's rating letter and found that the rating decrease was possibly due to inadequate documentation that had been provided to the rater.

I began to educate this individual and his family about our program and to assist the veteran with collecting the necessary documentation to support his appeals claim.

I called the Marine District Injured Support Cell (DISC) in the area and asked him to contact this former Marine as an additional support to the family. I connected the veteran with a local VA care management team who then contacted the family and this client to provide assistance.

There are many other examples that I could provide that describe how closely I work with VA staff, VBA staff, and military teams including the different wounded warrior programs on a daily basis.

In conclusion, in the 3 years I have worked as a Federal recovery coordinator, I have established rapport with most of the stakeholders involved in moving these catastrophically ill and injured servicemembers and veterans into a more stable and satisfactory life situation.

I found that what appears to be a simple to resolve situation can take multiple phone calls and e-mails to keep the process moving forward towards resolution. It takes effective communication with a variety of people to address my clients' complex needs.

I provide support as relationships are established with VA teams increasing the veteran and family's trust and willingness to choose the VA as their health care provider.

I am proud to serve our country's veterans and servicemembers that have sacrificed so much for our country.

Thank you for having me here today to share with you my experiences and I look forward to your questions.

[The prepared statement of Ms. Gillette appears on p. 47.]

Ms. BUERKLE. Thank you, Ms. Gillette.

Colonel Mayer.

STATEMENT OF COLONEL JOHN L. MAYER, USMC

Colonel MAYER. Good afternoon. Thank you, Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of the Subcommittee. It is my privilege to appear before you today.

I also thank you for allowing my family in and I am sure they are getting a great education from this afternoon.

As the Commanding Officer of the Marine Corps Wounded Warrior Regiment, I am charged with ensuring the Nation's wounded, ill, and injured Marines and their families receive the best medical care and support possible.

These Marines and their families have made selfless sacrifices that have resulted in life-changing events. Some are even catastrophic. Whether wounded in combat, injured in training, or fallen

ill, these great Marines and their families deserve the very best, the very best top-notch support to include resources and tools they need to return to either active duty or transition to civilian life.

This support is provided by the recovery team. The recovery team for the Marine Corps consists of Marine section leaders, staff sergeants in charge of their leadership and accountability and motivation. It consists of recovery care coordinators, which are mandated by Congress, to be the experts in non-medical needs, and then the case managers provided by the hospitals, whether it be Navy or Army, depending on what hospital the current Marine is at. Together this team works to provide the very best support.

The recovery care coordinators are an integral part of the Marines' recovery equation because they are part of the Wounded Warrior Regiment and work hand in hand with all the staff such as the Federal recovery coordinators to ensure Marines not only heal medically, but also pursue programs to improve their mind, body, spirit, and their families.

The Marine Corps recognizes the value of the Federal Recovery Coordination Program and the role that the Federal recovery coordinators serve for Marines to transition at the transition point or when they transition into becoming veterans.

The Federal recovery coordinators also serve a valuable complementary role to recovery care coordinators in providing care to our catastrophically injured active-duty Marines.

Warrior care is a top priority for the Marine Corps and I can assure the Subcommittee that we will continue to enhance the capabilities of the Wounded Warrior Regiment to provide added care and support to our wounded, ill, and injured Marines.

Thank you.

[The prepared statement of Colonel Mayer appears on p. 49.]

Ms. BUERKLE. Thank you, Colonel Mayer.

Colonel Gadson, you may proceed. Thank you.

STATEMENT OF COLONEL GREGORY GADSON, USA

Colonel GADSON. Good afternoon. Thank you, Chairman Buerkle, Ranking Member Michaud, and all the Members of the Subcommittee for inviting me here to appear today. I am honored to be here.

As a wounded warrior myself, I wish to thank all the Members of this Committee for their interest in the health and welfare of our wounded, ill, and injured servicemembers and veterans.

I would like to request my written statement be submitted for the record.

Ms. BUERKLE. So ordered.

Colonel GADSON. The lead proponent of the Army's Warrior Care and Transition Program or WCTP is the Warrior Transition Command under the command of Brigadier General Darryl A. Williams.

I am the Director of the Army Wounded Warrior Program or AW2, an activity of the Warrior Transition Command. AW2 supports severely-wounded soldiers, veterans, and family members through their recovery and transition and even when they separate from the Army. We do this through more than 170 AW2 advocates to provide local personalized support to more than 8,300 soldiers, veterans currently enrolled in the program.

The WCTP also encompasses the 29 warrior transition units or WTUs located around the country and in Europe where wounded, injured, and ill soldiers heal from and prepare for their transition.

I have advocates at each of these WTUs to work with these soldiers, families, and WTU personnel to ensure the smoothest possible transition for soldiers.

Each soldier in a WTU is assigned a triad of care consisting of a primary care manager, usually a physician, a nurse case manager, and a squad leader.

In addition, the WTUs have a multi-disciplinary approach that includes a wide range of clinical and non-clinical professionals. AW2 advocates work closely with each of these professionals in support of their individual soldier.

A requirement for every servicemember in the Federal Recovery Care Program is to have a comprehensive needs assessment or Federal individual recovery plan. This is accomplished within the WTUs through a comprehensive training plan or CTP wherein soldiers set long and short-term goals in each of the six domains of life, family, social, spiritual, emotional, career, and physical.

Families are closely involved with this CTP progress and family is one of the six domains of goal setting in this CTP. They are all invited to all of the focused transition review meetings and to all medical appointments.

When at AW2 soldier separates from the Army and transitions to veteran status, an AW2 advocate continues to support the soldier or veteran and their family.

Another key component of the WCTP is the soldier family assistance centers or SFAC on site at the WTUs. They bring together many of the programs soldiers and families need to provide assistance with everything from child care and lodging to arranging for VA care and benefits.

The Federal Recovery Coordination Program has the potential to facilitate positive quality integration across various programs throughout the Federal Government and supports the severely-wounded, injured, and ill servicemembers.

The AW2 advocates on my staff report having positive relationships with the FRCs and indicate that the FRCs are well-trained professionals. The FRCs are well-versed in the resources provided by the Department of Veterans Affairs and other resources available in their regions.

I want to discuss the GAO's recommended actions for the FRCP. As you have read in the comment section of the GAO report, the Honorable John Campbell, Deputy Assistant Secretary for Defense Wounded Warrior Care and Transition Policy, committed the Department of Defense to continuing to collaborate with the VA on these issues.

A joint DoD/VA Committee has been formed to study how to combine and integrate recovery coordination efforts for wounded, injured, and ill servicemembers, veterans, and families.

Recommendation one of the GAO report discusses establishing adequate internal controls regarding the FRCs' enrollment decisions. This is not a problem at AW2. While FRCs are afforded broad discretion in determining which servicemembers are admit-

ted to the program, AW2 has clear eligibility criteria with all eligibility decisions being made at the headquarters level.

The GAO's next recommendation discusses the FRCP's efforts to manage the workloads of individual FRCs based on the complexity of the services needed. At AW2, we pay very close attention to the caseloads of our AW2 advocates. The average caseload is 1 to 50, but each soldier requires a different level of support depending where he or she is in the recovery and transition process.

For example, AW2 veteran Kortney Clemons, a severely-wounded veteran, who no longer requires significant level of support from AW2, lost his right leg above the knee. Kortney has been out of the Army for more than 5 years. He has gone on to become an elite level runner and is training for the Paralympic games in London next year. He is currently enrolled in a master's program at University of Kansas and no longer requires the same level of support from an AW2 advocate that he did when he was first injured.

AW2 recognizes that many soldiers and veterans we support become more independent as they heal and transition to the next phase of their lives. We developed a life cycle case management plan or LCMP to help AW2 advocates identify the level of support each soldier needs.

There are four phases. When a soldier requires a significant level of support, AW2 calls them at least once a month and in some cases and in many cases more. As they progress and become more independent, we call them less frequently. In the last case, we only call them 180 days.

I am proud to say that I am one of those that is in the lifetime phase of our LCMP.

Soldiers and veterans can always call their AW2 advocates or the AW call center at any time. This initiative allows AW2 advocates to focus on those with more immediate support.

The GAO's third recommendation addresses the FRCP's decision-making process for making staffing decisions. AW2 faces the same challenges as the FRCP on this issue. It is difficult to predict how many soldiers will qualify for our program in the future.

In 2010, we accepted more than 2,000 soldiers into the program. This fact makes it more important that we ensure the AW Program runs as efficiently as possible.

The GAO's final recommendation calls for the FRCP to develop a clear rationale for the placement of FRCs. At AW2, we evaluate our staffing on a quarterly basis. We assign advocates where we have the highest populations of AW2 soldiers and veterans essentially by zip codes.

I would submit that by aligning FRCs in a similar manner regionally would better serve both them and the servicemembers they serve.

The GAO report also highlighted the challenges and information sharing between DoD and VA. We recognize the importance of this challenge. For over a year now, the Warrior Transition Command has been developing automated systems that are part of an integrated system for tracking and managing the care of soldiers and veterans.

Currently being completed for implementation later this year is the central module of this system referred to as the Automated

Warrior Care and Tracking System which contains the history of each soldier and veteran's care.

The Executive Director of the FRCP and Deputy Under Secretary of Defense for Wounded Warrior Care and Transition Policy are also co-chairing an information sharing initiative or ISI to support the coordination of non-clinical care. The ISI will enable sharing of authoritative data electronically between DoD, VA, and the Social Security Administration for case and care management systems.

In closing, I thank you again, Madam Chairman and Ranking Member Michaud, for inviting me here today and for listening to my testimony about the Federal Recovery Coordination Program. I appreciate your attention to wounded, injured, and ill service-members and veterans and their families, and I know that we share the same goal of providing the best possible services to these individuals who have sacrificed so much.

Thank you and I look forward to your questions.

[The prepared statement of Colonel Gadson appears on p. 51.]

Ms. BUERKLE. Thank you, Colonel Gadson.

I will now yield myself 5 minutes for questions.

We have heard from a few of the panelists today about the need to provide our servicemen and women with top-notch care. I think when we talk about providing quality care, we need to provide timely care and access to services.

So I would like it if each one of you would take a few minutes to tell me how can we fix this. What do you see? If you could give me one way you think we can improve the coordination and whether or not you think it is possible to coordinate the Department of Veterans Affairs and DoD and to get the job done for our wounded warriors, a recommendation, and whether or not you think it is possible.

I will start with Mr. Lorraine. Thank you.

Mr. LORRAINE. Thank you, Madam Chairwoman.

My recommendation would be to start where the casualties begin and that is to integrate the Federal recovery coordinators into the wounded warrior programs so that they can be integral at their command level so that they can be part of the process more as an advisor.

What we found was that a bulk of our effort while on active duty came through the Department of Defense, but there were veterans' issues that came along up until the time they retired or separated the servicemembers. At that point, it became very heavy in Veterans Affairs. DoD did not have the authority to influence it. The FRC did. But their success was because they were involved in it beforehand.

What we also found was while the servicemember had an affinity towards Special Operations while they were recovering, the more the Federal recovery coordinator assisted them after their retirement, the more direct they came to the Federal recovery coordinator. It was a very smooth transition.

So if there is one recommendation, it would be to integrate the Federal recovery coordinators at the headquarters levels of the service programs, to engage early and to provide strategic engagement, solving problems, and directing the local folks as needed.

Ms. BUERKLE. Thank you, Mr. Lorraine.

Dr. Ramos, before you comment, are you included when the servicemember is still in acute care and in the hospital setting? Are you a part of the discussion at that point?

Ms. RAMOS. Yes, ma'am. We have been alerted usually by the case management team when patients are still in their initial hospitalization that it is anticipated that they will need the services of the FRCP and that a Federal recovery coordinator would be advantageous as a participant in the team.

We have open access to all of the medical conferences, all of the discussions, all of the records, and have close communication with the care management team as well as the providers. We also identify at that point in time who the squad leader is and we will have discussions with the squad leader as is appropriate.

I also have very close communication with the medical director of our WTU, our warrior transition unit, and with the primary care providers who actually do the medical care on an outpatient basis.

So I have open access to everyone and they will ask me questions. And I will participate as appropriate in the team, although I must admit there are many cases where the coordination is going well and what I am doing at that point in time is establishing a relationship that is supportive of the family so that they know that the things they are anticipating happening in the next 2 to 3 years are going to happen with the support of a Federal recovery coordinator at their side.

And so my usual speech includes, you know, right now your job is to support your servicemember in recovery, to take care of yourself, and to let me know what bumps are in the road so that I can smooth them out for you and you can concentrate on what is important right now.

Ms. BUERKLE. Thank you, Dr. Ramos.

Ms. Gillette.

Ms. GILLETTE. Thank you.

I think what I would find the most beneficial, and it sounds a little self-serving, is more FRCs around the country. You know, we do have a heavy caseload and while I feel like I am being very efficient, I could be a lot more efficient because there are so many clients out there that are considered category two that I assist, but I would really like to carry on my caseload.

Ms. BUERKLE. And in your institution in Providence, do you have the same situation? Are you included in the acute care setting in the discussion in the beginning of the planning?

Ms. GILLETTE. The clients that I have that are in an acute care setting such as right now I have six at Walter Reed, when they have team meetings, I know ahead of time and I can call in and participate.

But when they are in the acute care phase, I spend a lot more time supporting the family, preparing the family for future planning, letting them know that when we are talking about discharge planning, for instance, a client I have right now in Tampa who is from Boston, working with the mother of thinking about future planning for this young man when he comes home to Boston because he will need a type of a TBI-assisted living setting.

Ms. BUERKLE. Thank you.

Colonel Mayer.

Colonel MAYER. Ma'am, as a commander, especially a commander of Marines, I am in charge of everything the Marine does and fails to do. Same with his recovery process. And so from the beginning, we set goals and the team, the recovery team, as I mentioned before, helps the Marine and his family achieve those goals.

And the multi-disciplinary team meetings start right from the beginning and they go sometimes daily at the beginning when there is a big need and then continuing throughout his transition and even beyond.

And the FRC plays an important part and I ask that they get involved with the multi-disciplinary team meetings from the beginning, but realize that the Marine, while he is on active duty, is going to be under the responsibility of the Marine leadership at that particular location. But they play a huge part, a complementary part as a member of the team.

Ms. BUERKLE. Thank you, Colonel.

Colonel Gadson.

Colonel GADSON. Yes, ma'am. I think what I would do is I would kind of echo a little bit of what I said and kind of combine with Jim and Ms. Gillette's statement and that is establishing a uniform criteria for who will receive the services of the FRC.

And I think that is done at the point of entry and I think that will drive, as Ms. Gillette said, more FRCs. If we establish a criteria, then we can predict and understand the population that we are going to go after and serve and then bring up the levels of FRCs that are out there.

They are powerful members of the team and have again tremendous experience and expertise, which everyone has demonstrated. It is just a matter of really, I think, having them in the kind of numbers that would make a difference across the larger force.

Ms. BUERKLE. Thank you, Colonel Gadson.

Since I appear to have extra time for questions, I will indulge myself.

If you could, would you all mind telling me what is the most common issue that you confront with a wounded warrior? We will start with Mr. Lorraine.

Mr. LORRAINE. I think the most common issue that I confront now are folks who fit in the cracks. They do not qualify for the, and I will use the Army, an Army soldier, they may not qualify for the Army Wounded Warrior Program because of the severity of their injury. They are not severe enough to be an FRC. They are already discharged out of the Warrior Transition Command.

So they are a veteran who does not fall within any of the programs that exist and they need some guidance. To get through the system, it is sort of like handing somebody the New York City Yellow Pages and say here you go, you can figure this out. And most of our folks just cannot take that step to do it. It is difficult to find out who they can trust, who will take action. And that is really what the big thing is.

So how do you find the folks who are in the greatest need? There is a lot of folks who slip between the cracks. That is why I would advocate for more FRCs, but a broader—they need one person to touch, as a veteran, one person to touch who can access both the benefits and the health care system, that can guide them through

and shepherd them not just because of the severity of the wound, but the economic or the social position that they may have fallen into post service.

Ms. BUERKLE. Thank you, Mr. Lorraine.

Mr. LORRAINE. Yes, ma'am.

Ms. BUERKLE. Dr. Ramos.

Ms. RAMOS. I think the most common thing that I am having to cope with is a client and a client's family who are frankly totally overwhelmed. This is not a chronic condition. This is an acute injury for the most part. This has been a surprise. Their whole lives have been derailed.

They are coming usually to San Antonio from another place in the country. They are trying to deal with caring for their children, caring for their warrior, caring for themselves, trying to coordinate communication, trying to understand what is going on with their wounded or injured servicemember, and they are totally overwhelmed by the health care issues, the social issues, the logistical issues, and trying to carry on within every-day life.

I think it would help if there were a single point of contact, but I have to tell you that in my particular setting, we kind of negotiate that within the team. Often there is a great level of rapport with the special forces person or the RCC from the Marines or the case manager who is doing the inpatient care. Sometimes it is the Federal recovery coordinator.

But as a team, we kind of decide who is going to be the lead for the moment because the situation is so fluid and it changes so quickly, we feel it is critical so that the family member will have a point of contact.

We also need for them to have a single point of contact because it can be very confusing if we have mom going one place, dad going another place, and wife going another place.

So communication is the key to defusing these situations, but I am constantly coping with people who are overwhelmed by what is going on and feeling responsible for making sure that they feel safe in the situation.

Ms. BUERKLE. And would you say that the services that they need to deal with their situation are available?

Ms. RAMOS. Oh, totally.

Ms. BUERKLE. Okay.

Ms. RAMOS. Totally. I love working with my Marines. We have the most wonderful services for our individual servicemembers. The Navy Safe Harbor people there are wonderful. The AW2s are unfailingly helpful. I love the Marines and, you know, the air force people are great.

I carry clients from all four services obviously and Army medical center, I carry mostly Army people, but as an FRC who takes a lot of the burn patients, I have everybody because we are the burn center. And the confusion is the difficulty, just people being totally overwhelmed by the situation.

Ms. BUERKLE. So it seems to me if the services are available, that is the difficult part. The easy part should be the coordination and so that really needs to be the focus obviously for the first panel as well in order to get the servicemembers what they need.

Ms. RAMOS. I think that at my particular location, we do a great job of that because we do talk to each other openly and we are always in communication with the different members of the care provision team. And we all are totally focused on the client and the family. We just work that way. So it is very satisfying. It is a difficult job, but it is very satisfying.

Ms. BUERKLE. Thank you.

Ms. Gillette.

Ms. GILLETTE. Being located in the northeast, I will have to say that the resources are not available. Many of my clients are in very rural areas. For instance, I have 15 clients in upstate New York. It is very difficult at times to have a young man who had a severe TBI, wants to live at home, which is in a rural part of New York, the VA does not provide transport—they provide transportation into the VA but nowhere else, and he cannot drive. And his family all works.

So when the veterans, even some of them are still active duty but on terminal leave, get into their home setting which is a very rural site, the resources are not there. So I spend a lot of time working with overwhelmed families, wives, mothers who are exhausted, trying to make sure that every VA resource and State resource is available to them and then trying to pull together charitable organizations, veterans' organizations to put all the other pieces together.

Ms. BUERKLE. Thank you.

Colonel Mayer.

Colonel MAYER. Yes, ma'am. For the most part, the opportunities far exceed the demand for the various opportunities. Most of the Marines are 18 to 25 right out of high school, when they join the Marine Corps, went through training, went over to the war, and then are catastrophically injured. And so it is the overwhelming nature of now trying to understand the Marine Corps, trying to understand the hospital system, and trying to understand the future and setting the goals and then sticking with the goals in the new State.

And I think that, ma'am, the coordination is there and I think we do a super job at all the different locations, and you heard about Brooke Army Medical Center down there, of working at the tactical level to achieve the goals of the Marines.

Oftentimes it is too many people saying here is what we should be doing next. And so I would say most are overwhelmed with just trying to understand what is next and the way to go.

Ms. BUERKLE. Thank you, Colonel Mayer.

Colonel Gadson.

Colonel GADSON. Yes, ma'am. I am going to echo Colonel Mayer. As someone who lost, you know, both my legs, you are just overwhelmed with advice, overwhelmed with input. And I think that is still a challenge today.

And then really about the transition, I mean, as well-intentioned as we all are about helping these folks and their families move on, everybody has their own individual timeline and it takes some time. And it might be 3 years, it might be 4 years before someone is ready to come back on a net and move on with their life.

And so there can sometimes be a lot of lost ground and those are some of the big challenges I think all the programs face.

Thank you.

Ms. BUERKLE. Thank you, Colonel Gadson.

Thank you to all of the members of the second panel for sharing your expertise with us.

As I mentioned earlier, I would like to follow-up this hearing with another hearing to hear how the program is progressing and to make sure we, as a Nation, provide what our wounded warriors need from us.

I ask unanimous consent at this time that all Members have 5 legislative days to revise and extend their remarks and include any extraneous materials. Without objection, so ordered.

Thank you all again. Thank you to the witnesses. Again, my sincere apologies for the delay this morning.

And at this time, the meeting is adjourned. Thank you.

[Whereupon, at 12:49 p.m., the Subcommittee was adjourned.]

A P P E N D I X

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

Good morning and thank you all for joining us today as we examine “The Federal Recovery Coordination Program: From Concept to Reality.”

The Federal Recovery Coordination Program was the brain child of the Commission on Care for America’s Returning Wounded Warriors, commonly known as the Dole-Shalala Commission.

The Commission, which was established in 2007, rightly recognized that navigating the complex maze of Department of Defense (DoD) and Department of Veterans Affairs (VA) care, benefits, and services can be a task of almost Herculean effort for wounded warriors and their families at a time when all of their energy and focus should be on recovery.

The Commission recommended that we swiftly develop a program to establish a single point of contact for wounded warriors and their families to make these systems more manageable, eliminate delays and gaps in treatment and services, and break through VA and DoD jurisdictional boundaries to ensure a truly seamless transition.

However, almost 4 years since DoD and VA signed a memorandum of understanding to establish the Federal Recovery Coordination Program, significant challenges persist in areas as fundamental as identifying potential enrollees, reviewing enrollment decisions, determining staffing needs, defining and managing caseloads, and making placement decisions.

Further, it appears that rather than having the joint program envisioned by the Commission to advocate on behalf of wounded warriors and ensure comprehensive and seamless rehabilitation, recovery, and transition, we have two separate programs—a VA program that utilizes Federal Recovery Coordinators and a DoD program that utilizes Recovery Care Coordinators.

The intent was to streamline. The intent was to simplify. The intent was to serve the most seriously wounded, ill, and injured. But, instead, there is duplication, there is bureaucracy, there is confusion.

This is unacceptable in any program that receives taxpayer funding. But it is unforgivable in a program that serves our most severely wounded servicemembers, veterans, and their families. I want to hear from each of today’s witnesses how they are going to solve these problems.

I now recognize our Ranking Member, Mr. Michaud for any remarks he may have.

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

Thank you, Madam Chair.

I would like to thank you for holding this hearing today. Certainly this is an important and appropriate topic for this Subcommittee.

We are here today to examine the effectiveness of the Federal Recovery Coordination Program (FRCP) and to assess if outreach has succeeded in bringing coordinated care to veterans who were injured prior to the FRCP. When a servicemember returns from combat we must make every effort and direct our considerable resources to ensuring that they and their families receive compassionate, comprehensive, and coordinated care from the beginning. Continued oversight of this important program is critical because if it is not done right, servicemembers suffer.

For some time now we have heard stories of servicemembers returning home from serving their country, with no guidance and no support. Too often we hear of families carrying the burden of a servicemember’s recovery and reintegration back into civilian life. In addition, we know that servicemembers experience confusion, redun-

dancy of services, and conflicting advice given by the many coordinators that are part of the recovery process. I am sure you will agree that we must do better. Challenges remain and there is still much work to be done. Although there is a solid foundation for the FRCP, I am looking forward to not only hearing testimony from the panelists but also having a frank discussion on ways to fix the issues and overcome barriers. I am confident that by working together we can do just that.

The Dole-Shalala Commission, which set out recommendations for the care of wounded warriors, said it is not enough “merely patching the system, as has been done in the past. Instead, the experiences of these young men and women have highlighted the need for *fundamental changes* in care management and the disability system.” The Commission emphasized that significant improvements require a “sense of urgency and strong leadership.”

I want to take this opportunity to thank you all for your dedication to our Nation’s veterans.

**Prepared Statement of Randall B. Williamson,
Director, Health Care, U.S. Government Accountability Office**

**FEDERAL RECOVERY COORDINATION PROGRAM: Enrollment, Staffing,
and Care Coordination Pose Significant Challenges**

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

I am pleased to be here today as you discuss the challenges facing the Federal Recovery Coordination Program (FRCP)—a program that was jointly developed by the Departments of Defense (DoD) and Veterans Affairs (VA) following critical media reports of deficiencies in the provision of outpatient services at Walter Reed Army Medical Center. This program was established to assist “severely wounded, ill, and injured” Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) servicemembers, veterans, and their families with access to care, services, and benefits.¹ Specifically, the program’s population was to include individuals who had suffered traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairment, and post-traumatic stress disorder. From January 2008—when FRCP enrollment began—to May 2011, the FRCP has provided services to a total of 1,665 servicemembers and veterans; of these, 734 are currently active enrollees.

As the first care coordination program² developed collaboratively by DoD and VA, the FRCP is more comprehensive in scope than clinical or nonclinical case management programs. It uses Federal Recovery Coordinators (FRC) who are either senior-level registered nurses or licensed social workers to monitor and coordinate both the clinical and nonclinical services needed by program enrollees by serving as a link between case managers of multiple programs. Unlike case managers, FRCs have planning, coordination, monitoring, and problem-resolution responsibilities that encompass both health services and benefits provided through DoD, VA, other Federal agencies, States, and the private sector.

The FRCs’ primary responsibility is to work with each enrollee along with his or her family and clinical team to develop a Federal Individual Recovery Plan, which sets individualized goals for recovery and is intended to guide the enrollee through the continuum of care.³ As care coordinators, FRCs are generally not expected to directly provide the services needed by enrollees. However, FRCs may provide services directly to enrollees in certain situations, such as when they cannot determine whether a case manager has taken care of an issue for an FRCP enrollee, when asked to resolve complex problems, or when making complicated arrangements.

The FRCP is administered by VA, and FRCs are VA employees. Since beginning operation in January 2008, the FRCP has grown considerably but experienced turmoil in its early stages, including turnover of staff and management. At present, there are 22 FRCs who have been located at various military treatment facilities,

¹ OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations. Since September 1, 2010, OIF is referred to as Operation New Dawn.

² According to the National Coalition on Care Coordination, care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator.

³ The continuum of care consists of three phases: acute medical treatment and stabilization, rehabilitation, and reintegration—either a return to active duty or to the civilian community as a veteran.

VA medical centers, and the headquarters of two military wounded warrior programs. While the FRCs are physically located at certain facilities, their enrollees are scattered throughout the country and may not be receiving care at the facility where their assigned FRC is located.

My testimony is based on our March 2011 report,⁴ which examined several FRCP implementation issues: (1) whether servicemembers and veterans who need FRCP services are being identified and enrolled in the program, (2) staffing challenges confronting the FRCP, and (3) challenges facing the FRCP in its efforts to coordinate care for enrollees.

To obtain information about these challenges, we conducted more than 170 interviews of the following groups: FRCs; FRCP leadership, which includes the Executive Director, the Deputy Director for Health, and the Deputy Director for Benefits; leadership officials with DoD and VA case management programs, including leadership officials from each military service's wounded warrior program; and medical facility directors and staff at DoD and VA medical facilities. We interviewed the FRCs individually to learn about challenges they have encountered, using comprehensive interviews of the 15 FRCs who were working in the FRCP in or before December 2009 and limited interviews of the 5 FRCs who were hired in January 2010. To develop an understanding about how clinical and nonclinical officials and staff interact with the FRCs, we conducted site visits and telephone interviews with program officials at DoD and VA headquarters and medical facility staff at the DoD and VA medical facilities where FRCs are located.⁵

We performed content analysis of the qualitative information obtained from the FRCs, DoD and VA program officials, and medical facility staff by grouping their responses by topic and then identifying response patterns. Content analysis of qualitative information obtained from DoD and VA program officials and medical facility staff was conducted using a software package, which enabled us to analyze responses to specific interview topics for a large number of interviews. However, the results from our site visits and interviews cannot be generalized because while all DoD and VA facilities could potentially interact with FRCs, our review focused on facilities where FRCs are located as well as some facilities where FRCs have significant interaction. In addition, we obtained and reviewed documentation related to the FRCP, including VA's October 2009 handbook on care management of OEF and OIF veterans; the FRCP Standard Operating Procedures; the FRCP fiscal year 2010 operating plan; and draft FRCP procedures, such as the VA handbook on the FRCP.⁶

We conducted the performance audit for our report from September 2009 through March 2011 and updated certain data elements in May 2011 for this testimony, in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found that while the FRCP has overcome some early setbacks, it currently faces challenges related to the enrollment of potentially eligible individuals, determination of FRC staffing needs and placement, and the FRCP's ability to coordinate care for enrollees.

- *Challenges in identifying potentially eligible individuals.* It is unclear whether all individuals who could benefit from the FRCP's care coordination services are being identified and enrolled in the program. Because neither DoD nor VA medical and benefits information systems classify servicemembers and veterans as "severely wounded, ill, and injured," FRCs cannot readily identify potential enrollees using existing data sources. Instead, the program must rely on referrals to identify eligible individuals. Once these individuals are identified, FRCs must evaluate them and make their enrollment determinations—a process that involves considerable judgment by FRCs because of broad criteria. However, FRCP leadership does not systematically review FRCs' enrollment decisions,

⁴GAO, *DoD and VA Health Care: Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges*, GAO-11-250 (Washington, DC: Mar. 23, 2011).

⁵These facilities included Walter Reed Army Medical Center; National Naval Medical Center; Brooke Army Medical Center; Naval Medical Center-San Diego; Naval Hospital Camp Pendleton; Eisenhower Army Medical Center; and the VA medical centers in Houston, Texas; Providence, Rhode Island; and Tampa, Florida. In addition, we visited three VA medical centers with which FRCs have significant interaction—the facilities in Richmond, Virginia; Augusta, Georgia; and San Diego, California. At the end of calendar year 2010, following the completion of our site visits, the FRCP placed two FRCs at the VA medical center in Richmond.

⁶The FRCP Handbook was finalized on April 1, 2011.

and as a result, program officials cannot ensure that referred individuals who could benefit from the program are enrolled and, conversely, that the individuals who are not enrolled are referred to other programs.

- *Challenges in determining staffing needs and placement decisions.* The FRCP faces challenges in determining staffing needs, including managing FRCs' caseloads and deciding when VA should hire additional FRCs and where to place them. According to the FRCP Executive Director, appropriately balanced caseloads (size and mix) are difficult to determine because there are no comparable criteria against which to base caseloads for this program because of its unique care coordination activities. The program has taken other steps to manage FRCs' caseloads, including the use of an informal FRC-to-enrollee ratio. Because these methods have some limitations, the FRCP is developing a customized workload assessment tool to help balance the size and mix of FRCs' caseloads, but it has not determined when this tool will be completed. In addition, the FRCP has not clearly defined or documented the processes for making staffing decisions in FRCP policies or procedures. As a result, it is difficult to determine how staffing decisions are made, or how these processes could be sustained during a change in leadership. Finally, the FRCP's basis for placing FRCs at DoD and VA facilities has changed over time, and the program lacks a clear and consistent rationale for making these decisions, which would help ensure that FRCs are located where they could provide maximum benefit to current and potential enrollees.
- *Challenges in coordinating with other VA and DoD programs and supporting FRCs.* A key challenge facing the FRCP concerns the coordination of services by the large number of DoD and VA programs that support wounded servicemembers and veterans. Although these programs vary in terms of the severity of the injuries among the servicemembers and veterans they serve and the specific types of services they coordinate, many programs have similar functions and are involved in similar types of activities. Table 1 illustrates the key characteristics of major DoD and VA programs and the activities in which they are involved.

Table 1: Characteristics of Major Department of Defense (DoD) and Department of Veterans Affairs (VA) Programs for Seriously and Severely Wounded Servicemembers and Veterans

Program name	Program description	Severity of enrollees' injuries ^a	Title of care coordinator or case manager	Type of services provided			
				Lifetime follow-up	Clinical	Non-clinical	Recovery plan
VA/DoD Federal Recovery Coordination Program (FRCP)	Joint DoD/VA initiative that coordinates clinical and nonclinical services and benefits across Federal, State, and private entities for recovering servicemembers, veterans, and their families.	Severe	Federal Recovery Coordinator (FRC)	✓	✓	✓	✓
DoD Recovery Coordination Program	DoD program that coordinates nonclinical services and benefits for recovering servicemembers.	Serious	Recovery Care Coordinator	✓		✓	✓
Army Warrior Transition Units	Army unit that provides complex outpatient case management for servicemembers requiring more than 6 months of medical treatment.	Serious to severe	Triad of nurse case manager, squad leader, and physician		✓	✓	✓
Military wounded warrior programs ^b	Programs operated by the military services that help manage servicemembers' recovery process, including the Army Wounded Warrior Program, Marine Wounded Warrior Regiment, Navy Safe Harbor, Air Force Warrior and Survivor Care Program, and Special Operations Command's Care Coalition.	Serious to severe	Case manager or Advocate (title varies by service)	✓		✓	✓
VA OEF/OIF Care Management Program ^c	VA program that facilitates the transition of care from military to VA medical facilities and the coordination of clinical and nonclinical services for OEF/OIF servicemembers and veterans.	Mild to severe	Case manager, Transition Patient Advocate ^d	✓	✓	✓	✓
VA Spinal Cord Injury and Disorders Program	VA system of care that provides a coordinated continuum of services for servicemembers and veterans with spinal cord injuries.	Mild to severe	Nurse, social worker	✓	✓	✓	✓
VA Polytrauma System of Care	VA system of specialized facilities that provides comprehensive, individually tailored rehabilitation to servicemembers and veterans with multiple injuries.	Serious to severe	Social work and nurse case managers	✓	✓	✓	✓

Source: GAO analysis of DoD and VA program information.
Note: The characteristics listed in this table are general characteristics of each program; individual circumstances may affect the enrollees served and services provided by specific programs.
^a For the purposes of this table, we have categorized the severity of enrollees' injuries according to the injury categories established by the DoD and VA Wounded, Ill, and Injured Senior Oversight Committee. Servicemembers with *mild* wounds, illness, or injury are expected to return to duty in less than 180 days; those with *serious* wounds, illness, or injury are highly unlikely to return to duty in less than 180 days and possibly may be medically separated from the military; and those who are *severely* wounded, ill, or injured are highly unlikely to return to duty and also likely to be medically separated from the military. These categories are not necessarily used by the FRCPs placed at the headquarters of Special Operations Command's Care Coalition and Navy Safe Harbor coordinate clinical and nonclinical care for enrollees in these two programs and for other FRCP enrollees.
^b FRCPs placed at the headquarters of Special Operations Command's Care Coalition and Navy Safe Harbor coordinate clinical and nonclinical care for enrollees in these two programs and for other FRCP enrollees.
^c OEF/OIF refers to Operation Enduring Freedom and Operation Iraqi Freedom.
^d An OEF/OIF care manager supervises the case managers and transition patient advocates and may also maintain a caseload of wounded veterans.

Many recovering servicemembers and veterans are enrolled in more than one program. For example, in September 2010, approximately 84 percent of FRCP enrollees were also enrolled in a military service wounded warrior program. However, limitations on information sharing among the programs has resulted in duplication of services and enrollee confusion, prompting two military wounded warrior programs to cease making referrals to the FRCP. Specifically, the FRCP could not share certain enrollee data maintained on its information system with staff of non-VA programs because VA had not completed public disclosure actions necessary to enable the sharing of this information. In January 2011, VA completed the process needed to resolve this issue. In addition, incompatibility among information systems used by different case management programs limits data sharing as information about enrollees cannot be easily transferred among these systems. Although the ultimate solution to information system incompatibility is beyond the capacity of the FRCP to resolve, the program has initiated an effort to improve information exchange.

Finally, FRCs identified several types of logistical problems that have affected their ability to carry out their responsibilities. These issues center around (1) provision of equipment such as computers, printers, landline telephones, and Black-Berrys; (2) technology support such as equipment maintenance, software upgrades, and systems security; and (3) private workspace at medical facilities.

Overall, as the first joint care coordination program for DoD and VA, the FRCP represents a new patient support paradigm for the departments. Because of its unprecedented nature, the program cannot refer to preexisting data or policies and procedures to manage the program, and as a result, FRCP leadership had to develop management processes as the program was being implemented and has largely relied on informal processes to oversee and manage key aspects of the program. However, now that the program has been operating for several years and continues to grow, it has become apparent that the program would benefit from more definitive management processes to strengthen program oversight and decision-making.

As a result of our examination of the FRCP, we recommended that the Secretary of Veterans Affairs direct the Executive Director of the FRCP to take actions to establish adequate internal controls regarding FRCs' enrollment decisions, to complete development of the workload assessment tool for FRCs' caseloads, and to document procedures to strengthen FRC staffing and placement decisions. In their comments on our report, DoD stated that it continues to increase its collaboration with VA, and VA generally agreed with our conclusions and concurred with our recommendations to the Secretary.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions you or other Members of the Subcommittee may have.

Contacts and Acknowledgments

For further information about this testimony, please contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Individuals who made key contributions to this testimony include Bonnie Anderson, Assistant Director; Frederick Caison; Elizabeth Conklin; Deitra Lee; and Lisa Motley.

Prepared Statement of Karen Guice, M.D., MPP, Executive Director, Federal Recovery Coordination Program, U.S. Department of Veterans Affairs

Good morning Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee. My name is Karen Guice and I am the Executive Director of the Federal Recovery Coordination Program (FRCP), a joint DoD/VA program, administered by VA.

On March 23, 2011, the Government Accountability Office (GAO) report released its report on the FRCP, along with four recommendations for program improvement. VA concurred with the recommendations and I welcome this opportunity to discuss the steps taken since the GAO report was issued. I would also like to share with you some of the current and planned approaches to the FRCP's challenges with outreach, referral, enrollment, communication and staffing in our continuing collaboration with DoD to provide comprehensive care coordination to severely wounded, ill or injured servicemembers and veterans.

Background

The Departments of Defense and Veterans Affairs signed two memoranda of understanding (MOU, August 31, 2007 and October 30, 2007) establishing FRCP as a joint program and providing operational parameters. The program was specifically charged with providing seamless support from the time a servicemember arrived at the initial Military Treatment Facility (MTF) in the United States through care and rehabilitation, regardless of whether the goal was to return to military duty or transition to veteran status.

As required by the MOUs, Federal Recovery Coordinators (FRCs) are master's prepared nurses and social workers who provide support by acting as advocates in all clinical and non-clinical aspects of recovery. FRCs work with the relevant military service and VA programs, the individual's interdisciplinary clinical team, and all case managers. Based on a client's goals, with input from all care providers, the FRC creates a Federal Individualized Recovery Plan (FIRP). FRCs have delegated authority for oversight and coordination of all clinical and non-clinical care identified in the FIRP.

Specific FRCP eligibility criteria were approved by the DoD/VA Senior Oversight Committee (SOC) in October 2007 and included those servicemembers or veterans who received acute care at MTFs; those diagnosed with specific injuries or conditions; those considered at risk for psychosocial complication; and those self or Command-referred based on perceived ability to benefit from a recovery plan.

FRCs are a unique resource for those with severe and complex medical and/or social problems. They coordinate benefits and health care as servicemembers and veterans heal, aligning information and services to deliver support at the right time and in the right order. FRCs do not provide direct medical care, issue military orders, or transport clients to appointments. Instead, they rely on case managers, both clinical and non-clinical, as well as interdisciplinary health care team members and servicemembers' units, for those activities. FRCs anticipate needs and coordinate among service and benefits providers to ensure smooth transitions for their clients, whether the transition is between two hospitals or two agencies, in keeping with the intent of the MOUs signed by the Departments' Secretaries to create a single joint program for care coordination.

In 2008, the National Defense Authorization Act (NDAA) required the creation of a recovery coordination program. This program, the Recovery Coordination Program (RCP), was implemented as a DoD-specific program for non-clinical case management. Recovery Care Coordinators (RCC) are assigned to and employed by the Military Services, with the Office of Wounded Warrior Care and Transition Policy providing program policies.

Although FRCP and RCP provide different services, in an effort to align responsibilities and roles with appropriate levels of RCP or FRCP support, the SOC approved three categories of service. Category 1 individuals were those whose recovery was essentially guaranteed and for whom only medical case management and relevant health care providers were necessary for full recovery. Category 2 individuals were those whose recovery had a high probability of requiring at least 180 days and for whom the addition of a non-clinical case manager or RCC appeared appropriate to assist with service delivery. Category 3 individuals were those with severe and complex medical problems and who had a high probability of leaving military service. Individuals identified for this latter category were to be assigned to FRCP. These service categories and assignment requirements were incorporated into the DoD Instruction 1300.24 which governs the DoD RCP. Because these categories are more administrative than operational, accurate category assignment to FRCP or RCP has been difficult.

GAO Recommendations

The first of four GAO recommendations stated that the FRCP should establish adequate internal controls to ensure that referred servicemembers and veterans who need FRC services are enrolled in the program. VA concurred with this recommendation.

Evaluation of potential FRCP clients is based on an assessment of the individual's medical and non-medical needs and requirements in order to recover, rehabilitate, and reintegrate to the maximum extent possible. A key component in the FRCP evaluation process is the clinical training and experience of the FRCs and their professional judgment of whether an individual would benefit from FRCP care coordination. In general, servicemembers and veterans whose recovery is likely to require a complex array of specialists, transfers to multiple facilities, and long periods of rehabilitation are referred to the FRCP.

Following a referral, FRCs consider a wide range of issues in determining whether an individual meets enrollment criteria. The first consideration is whether the re-

ferred individual meets with the broad SOC eligibility criteria. FRCs then conduct a comprehensive record review to include all relevant and available health and benefit information. They document the medical diagnoses and conditions. They conduct a risk assessment; identify anticipated treatment and rehabilitation needs; determine the individual's access to care and level of support; identify any issues with medications or substance abuse; assess the current level of physical and cognitive functioning; and review financial, family, military, and legal issues. They also discuss the individual with interdisciplinary clinical team members, clinical and non-clinical case managers, and others who might provide insight into the various issues and challenges the servicemembers or veterans and their families face. Finally, and most importantly, the FRCs interview the referred individual and family members. Based on all input, the FRCs determine whether to enroll the referred individual; FRCP enrollment is entirely voluntary. Individuals who are not enrolled are directed to alternative resources that are appropriate for their level of need.

Any program's enrollment criteria should reflect its charge and mission. For the FRCP, the original eligibility criteria and program's defined scope were broad, as specified in the MOUs and approved by the SOC. Following the NDAA 2008 requirement for DoD to create the RCP, and the SOC's approval of the three service categories, the FRCP's scope narrowed to reflect only a Category 3 designation. Since then, the FRCP has been capturing information, based on case experience, to help refine enrollment criteria. The FRCP will use this information, along with a service intensity measurement tool (the development of which is discussed later in this testimony) to define an eligibility protocol within the program's data management system. In the meantime, the FRCP requires all FRCs to discuss each enrollment decision with the FRCP management. The FRCP management makes the final eligibility decision to ensure enrollment consistency. All enrollment decisions are clearly documented in the FRCP data management system. This interim solution was implemented immediately following issuance of the GAO report.

While the FRCP can ensure that all referred severely wounded, ill or injured servicemembers and veterans who would benefit from care coordination are enrolled, the FRCP does not have visibility of all who might be eligible. The FRCP, as currently structured, is a voluntary referral program and, as such, relies on the identification and referral of those who might benefit from the FRCP services by others (case managers, Command, Wounded Warrior Programs, etc.). While the original MOUs do not specify a specific category of wounded, ill or injured, the FRCP was relegated to care coordination for severely or catastrophically wounded, ill or injured once the RCP became operational. Absent a defined, automatic referral process aligned with the DoDI 1300.24 or the original intent of the MOUs, the FRCP has relied on outreach activities and demonstrated outcomes to inform the referral process.

One way for the FRCP to increase referrals is through a robust outreach effort to ensure program awareness. Part of this effort has been to provide iterative, informational stakeholder briefings. In 2008, the FRCP conducted 17 outreach efforts and presentations to a variety of audiences, including MTF personnel, DoD and VA program personnel, and external stakeholders. In 2009 and 2010, the FRCP conducted almost 100 outreach activities each year. In the first quarter of calendar year 2011, the FRCP has conducted 34 informational briefings, on target to exceed previous outreach effort by 25 percent.

The FRCP has created a variety of materials to assist with these outreach efforts. Program brochures are provided to potential clients and families, as well as to participants in the FRCP informational briefings. These brochures are also provided to other groups for distribution upon request. Along with the brochures, the FRCP developed posters and banners for use at conferences or presentations. The FRCP has a 1-800 line for program referrals; approximately 30 percent of received calls either refer an individual or request more information about the program. The FRCP is in the process of creating a specific webpage within the VA's Web site which will contain program and contact information.

In addition to these outreach efforts, last year the FRCP conducted a "look back" project to identify veterans who might still benefit from care coordination. This project required access to data for servicemembers and veterans who: 1) served in the Armed Services since 9/11/2001; 2) were severely wounded, ill or injured; and 3) met the program's eligibility criteria. No single data source had sufficient information to determine this population; instead, the FRCP identified 7 different data sets from DoD and VA, which were cleaned and merged to create a single set of over 40,000 individuals. Within the merged dataset, certain data elements were selected as a substitutes or "proxies" to narrow the list to those more likely to meet the FRCP program criteria. FRCs then contacted these identified individuals and identified only 35 who might still require care coordination.

Currently, the FRCP's most common source of referral is from a DoD or VA clinical case management program or a member of an interdisciplinary clinical team. Ten percent of all FRCP clients have been referred by a service wounded warrior program and 1 percent of referrals have originated from a DoD Recovery Care Coordinator. In contrast, 38 percent of all FRCP referrals are from clinical case managers or members of an interdisciplinary clinical team.

The FRCP has been criticized for the inability to provide client lists to the various case management and military services wounded warrior programs. All Federal agencies, and their programs, must comply with the various laws and regulations protecting personally identifiable and health information. Until recently, the FRCP was not able to provide other agencies' programs with information about clients because the FRCP data management system had not gone through a Systems of Records Notification (SORN) process. With the SORN now in place, the FRCP has clearly prescribed Federal guidelines for the sharing of information as well as disclosure rules. The FRCP is currently in the process of identifying the information required by other programs so that appropriate data transfer agreements can be developed.

In addition, the FRCP is an active participant in a DoD/VA information sharing initiative (ISI). The ISI is currently working on an electronic transfer of information between and among case management/care coordination programs within the two departments. Six specific information items have been identified for exchange. These items are: 1) Names, titles and affiliations of all case/care managers/coordinators assigned to a servicemember or veteran; 2) Ability to track benefits applications, benefits processing status and benefits awards across the DoD and VA; 3) Visibility of all care, recovery or transition plans (medical and non-medical); 4) Ability to view and schedule appointments through a shared calendar for servicemembers and veterans; 5) Role-based visibility of relevant injury or illness information; and 6) Role-based visibility of a shared servicemember and veteran problem lists to help identify qualifying benefits. Requirements for these data transfers are in varying stages of development, with an anticipated exchange of case manager information by September 2011.

GAO recommended that FRCP should complete development of a workload assessment tool. VA concurred with this recommendation.

Care coordination is essential to the effective management of severely wounded, ill or injured servicemembers and veterans, and determining the appropriate caseload for each FRC is critical. Since care coordination is a relatively new concept, particularly as implemented across and within Federal agencies, no guidelines or service intensity measurement tools currently exist to accurately provide a balanced range of cases. The current FRCP caseload target range of 25–35 cases was based on a review of other programs' caseload ratios, along with relevant literature, and the awareness that not all clients will need the same intensity of coordination.

A system intensity measurement tool will measure how much time and effort a FRC uses to identify ongoing care and required benefit needs for a client. By collecting uniform information for these activities, the FRCP can improve resource allocation, determine patterns of need, target those service areas where the need is critical, and measure stabilization over time. The FRCP can also use the system intensity measurement scores to define with improved precision those referred individuals who would benefit from care coordination, as well as those individuals whose needs can be met with alternative resources.

Developing such a tool is a labor intensive task that requires development and testing, along with validity and reliability assessments. FRCs are currently participating in a process to validate assumptions, complete a scoring algorithm, and measure inter-rater reliability prior to full field testing of a new service intensity measurement scheme. Completing the development of this tool may require a year or more of intense effort.

GAO recommended that FRCP should better document how hiring decisions are made. VA concurred with this recommendation.

The FRCP continues to grow in client volume and program referrals. In fiscal year (FY) 2008, the program received an average of 25 referrals per month. In FY 2009, the average number of referrals increased to 37 per month, and in FY 2010 the average increased to 50 per month. Of those referred in 2010, 68 percent were enrolled (Active), 18 percent required minimal assistance (Assist), and 14 percent were redirected to other resources. In FY 2008, the program had enrolled and cared for 226 servicemembers and veterans. In FY 2010 alone, that number had more than doubled to 598. The current number of Active clients is 736 with an average FRC caseload between 30–33 clients.

To determine the number of FRC positions required, the FRCP management considers the number of referrals, the rate of enrollment, the number of clients made inactive, and a benchmark range of 25–35 cases per FRC. The FRCP has established an equation based on these elements and incorporated it into the program's operating plan. Upon completion of the service intensity measurement tool, the FRCP will modify this equation to reflect the average intensity points allowed per FRC instead of the current arbitrary 25–35 benchmark case range. The FRCP will update staffing processes and plans in the annual business operation planning document.

Currently, 22 FRCs are working at six military treatment facilities, four VA medical centers, and two Wounded Warrior Program headquarters. FRCs are supported by a VA Central Office staff that includes an Executive Director, two Deputies (one for Benefits and one for Health), an Executive Assistant, an Administrative Officer, and two Staff Assistants. In the past, the FRCP has received personnel support at VA Central Office from the U.S. Public Health Service and DoD. While the Navy has designated an individual for detail to FRCP, in accordance with the MOU, no other military support is currently forthcoming.

GAO's final recommendation was that the FRCP should develop and document a rationale for Federal Recovery Coordinator (FRC) placement. VA concurred with this recommendation.

The FRCP will develop a FRC placement strategy based upon a systematic analysis of data over the next 6 months. The FRCP's initial placement was guided and directed by the MOU, which required that FRCs be placed at MTFs where significant numbers of wounded, ill or injured servicemembers were located. As the program has grown, and given the current requirement for a single FRC to remain assigned to a client for optimal care coordination and consistency, the FRCP has considered alternative locations. FRC placement is guided by four factors: replacement for FRCs who leave the program, supplementation of existing FRCs based on documented need, creation of a national "FRCP network" to optimize coordination, and specific requests for FRCs in order to better serve the wounded, ill and injured population of servicemembers and veterans. The actual placement of FRCs is based on a case-by-case negotiation for space and support.

Conclusion

Many believe that the FRCP is a redundant program; others suggest that because the FRCP is administered by VA and is not in the military services' chain of command that the FRCP should only provide support for veterans. There are numerous programs that support servicemembers and veterans with recovery. Each of the military services has programs that provide lifetime support servicemembers from the time of injury or diagnosis through recovery. For example, the Marines provide a RCC for every wounded, ill or injured Marine with additional support, command, and control provided through the Wounded Warrior Regiment. The Army provides the Warrior Care and Transition Program for case management and command and control, along with the Army Wounded Warrior (AW2) Program for the most seriously wounded ill or injured soldiers and veterans. The Air Force Warrior and Survivor Care Program and Air Force RCCs care for wounded, ill and injured Airmen. The Navy has the Safe Harbor Program and the Special Operations Command has the Care Coalition.

Each MTF provides clinical case managers for both inpatient and outpatient case management; TRICARE also provides case managers. The Veterans Health Administration (VHA) has the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) clinical case managers at each VA medical center, who assist OEF/OIF/OND servicemembers and veterans navigate the VA's health care system. In addition, there are VHA Liaisons at many MTFs, along with Polytrauma Nurse Liaisons, who coordinate the transfer of servicemembers to VA's health services and programs.

VA also provides home-based primary care; blind, Traumatic Brain Injury (TBI), and spinal cord rehabilitation programs; the homeless program, caregiver support personnel, and more. Each of these programs provides case management, many of them for the lifetime of the veteran. VBA has vocational rehabilitation and the benefits assistance program with additional case managers providing support to the servicemember and veteran. In addition, there are many other programs, such as the Defense Center of Excellence In-Transition Program, the National Guard Transition Assistance Advisor, Defense and Veterans Brain Injury Center's Recovery Coordinators, who also provide case management activities for wounded, ill or injured servicemembers.

Many wounded, ill and injured servicemembers, veterans and their families are confused by the number and types of case managers and baffled by benefit eligibility

criteria as they move through the DoD's and VA's complex systems of care on the road to recovery. The FRCP was envisioned to be the single point of contact for these individuals through care and recovery; a single point of contact that would help them understand the complexities of the medical care provided and the array of benefits and services available to assist in recovery. Currently, the FRCP is the only joint DoD/VA program that provides clinical and non-clinical care coordination for wounded, ill or injured servicemembers, veterans and their families with severe and complex medical and social problems. The FRCP provides alignment of services, coordination of benefits, and resources across DoD, VA and the private sector by managing transitions and providing system navigation for clients.

The program works best when FRCs are included early in the servicemember's recovery and prior to the first transition, whether that transition is from inpatient to outpatient or from one facility to another. One FRC will stay with that individual throughout all subsequent transitions, coordinating benefits and services as needed. This consistency of coordination is important for individuals with severe and complex conditions who require multiple DoD, VA and private health providers and services. FRCs remain in contact with their clients as long as they are needed, whether for a lifetime or a few weeks. FRCs involvement is voluntary and, when used as envisioned, collaborative. However, FRCP cannot carry out this mission without active support from the DoD, including all military services, the VA, and Congress.

In closing, program evaluation, whether by Congress or by an investigative body such as GAO, is a vital part of program growth and maturation. The FRCP is grateful to the GAO for their comprehensive review and to the Subcommittee Members for this opportunity to discuss continued challenges.

Thank you and I look forward to your questions.

**Prepared Statement of Robert S. Carrington, Director,
Recovery Care Coordination, Office of Wounded Warrior Care and
Transition Policy, U.S. Department of Defense**

Madame Chairwoman and Members of the Subcommittee:

Thank you for the opportunity to discuss the Department of Defense's (DoD) role in the Federal Recovery Coordination Program (FRCP). While the FRCP was jointly developed by DoD and Department of Veterans Affairs (VA) leaders on the Senior Oversight Committee (SOC), the program itself is implemented by VA.

Overview of DoD Recovery Coordination Program

The DoD Recovery Coordination Program (RCP) was established by Section 1611 of the FY 2008 National Defense Authorization Act. This mandate called for a comprehensive policy on the care and management of covered servicemembers, including the development of comprehensive recovery plans, and the assignment of a Recovery Care Coordinator for each recovering servicemember. In December 2009, a Department of Defense Instruction (DoDI) 1300.24 set policy standardizing non-medical care provided to wounded, ill and injured servicemembers across the military departments. The roles and responsibilities captured in the DoDI are as follows:

- **Recovery Care Coordinator:** The Recovery Care Coordinator (RCC) supports eligible servicemembers by ensuring their non-medical needs are met along the road to recovery.
- **Comprehensive Recovery Plan:** The RCC has primary responsibility for making sure the Recovery Plan is complete, including establishing actions and points of contact to meet the servicemember's and family's goals. The RCC works with the Commander to oversee and coordinate services and resources identified in the Comprehensive Recovery Plan (CRP).
- **Recovery Team:** The Recovery Team includes the recovering servicemember's Commander, the RCC and, when appropriate, the Federal Recovery Coordinator (FRC), for catastrophically wounded, ill or injured servicemembers, Medical Care Case Manager and Non-Medical Care Manager. The Recovery Team jointly develops the CRP, evaluating its effectiveness and adjusting it as transitions occur.
- **Reserve/Guard:** The policy establishes the guidelines that ensure qualified Reserve Component recovering servicemembers receive the support of an RCC.

There are currently 146 RCCs in 67 locations placed within the Army, Navy, Marines, Air Force, United States Special Operations Command (USSOCOM) and Army Reserves. Care Coordinators are hired and jointly trained by DoD and the

Services' Wounded Warrior Programs. Once placed, they are assigned and supervised by Wounded Warrior Programs but have reach back support as needed for resources within the Office of Wounded Warrior Care and Transition Policy. DoD RCCs work closely with VA FRCs as members of a servicemember's recovery team.

In the DoDI we have codified that severely injured and ill who are highly unlikely to return to duty and will most likely be medically separated from the military (Category 3) will also be assigned a FRC. The DoDI 1300.24 establishes clear rules of engagement for RCCs and FRCs. The RCC's main focus is on servicemembers who will be classified as Category II. A Category II servicemember has a serious injury/illness and is unlikely to return to duty within a time specified by his or her Military department and may be medically separated. The FRC's main focus is on the servicemembers who are classified as Category III. A Category III servicemember has a severe or catastrophic injury/illness and is unlikely to return to duty and is likely to be medically separated.

While defined in the DoDI, Category 1 and 2 and 3 are all administrative in nature and have been difficult to operationalize. The intent of the controlling DoDI is to ensure that wounded, ill, and injured servicemembers receive the right level of non-medical care and coordination. DoD is working with the FRCP to make sure that servicemembers who need the level of clinical and non-clinical care coordination provided by a FRC are appropriately referred.

Government Accountability Office (GAO) Report on Federal Recovery Coordination Program

Although the FRCP is exclusively run and managed by VA, there is a presumptive "hand-off" from DoD Recovery Care Coordinators, and DoD medical case managers to the Federal Recovery Care Coordinators at the point that it is clear that the catastrophically wounded, ill, or injured servicemember will not return back to duty. This determination is highly complex and individualized based on a variety of factors including the servicemember's condition, and their desire to stay on active duty.

The majority the findings of the March 2011 GAO Report "Federal Recovery Coordination Program Continues to Expand, but Faces Significant Challenges," pertain to implementation and oversight of the FRCP. There are, however, two areas of the report that directly involve DoD:

- Duplication of case management efforts between VA and DoD
- Lack of access to equipment at installations

Duplication of case management efforts between VA and DoD

The report outlines the confusion and inefficiency that arises as a result of a servicemember who may have multiple case managers. The GAO report shows a matrix with the various DoD and VA care/case management programs in place. As many as 84 percent of servicemembers in the FRCP are also enrolled in a Military Service Wounded Warrior Program. While the programs vary in the populations they serve and services they provide, there is significant overlap in functions.

The GAO outlined one instance where a recovering servicemember was receiving support and guidance from both a DoD Recovery Care Coordinator and a VA Federal Recovery Coordinator. The two coordinators were effectively providing opposite advice and the servicemember was in receipt of conflicting recovery plans. The servicemember had multiple amputations and was advised by his FRC to separate from the military in order to receive needed Services from the VA, whereas his RCC set a goal of remaining on active duty.

The SOC subsequently directed RCP and FRCP leadership to establish a DoD-VA Recovery Care Coordination Executive Committee to identify ways to better coordinate the efforts of FRCs and RCCs and resolve issues of duplicative or overlapping case management. The Committee conducted its first meeting in March and its final 2-day meeting earlier this week. The results of the Committee's efforts will be briefed to the SOC at its next meeting.

In March 2011, DoD also conducted an intense 2½ day Wounded Warrior Care Coordination Summit that included focused working groups attended by subject matter experts who discussed and recommended enhancements to various strategic wounded warrior issues requiring attention. One working group focused entirely on collaboration between VA and DoD care coordination programs and best practices within recovery care coordination and wounded warrior family resiliency. Actionable recommendations are currently being reviewed, have been presented to the Overarching Integrated Product Team (OIPT) and will continue to be worked until the recommendations and policies are implemented.

Lack of access to equipment at installations

FRCs reported to the GAO that "logistical problems" impacted their ability to conduct day-to-day work. Specific areas causing this include: a) provision of equipment,

b) technology support and c) private work space. There are existing Memoranda of Agreement between the FRCP and the DoD and VA facilities where FRCs work, however compliance with these MOAs remains a challenge.

DoD's Office of Wounded Warrior Care and Transition Policy (WWCTP) is currently evaluating the resources required at DoD facilities for both Recovery Care Coordinators and Federal Recovery Coordinators. WWCTP will work with the Services and the VA to ensure that daily duties are not interrupted by equipment, technology or space constraints.

Conclusion

DoD is committed to working closely with the VA Federal Recovery Coordination Program leadership to ensure a collaborative relationship exists between the DoD RCP and the VAFRCP. The Military Department Wounded Warrior Programs will also continue to work closely with FRCs in support of servicemembers and their families.

Madam Chairwoman, this concludes my statement. On behalf of the men and women in the military today and their families, I thank you and the Members of this Subcommittee for your steadfast support.

Prepared Statement of James R. Lorraine, Executive Director, Central Savannah River Area—Wounded Warrior Care Project, Augusta, GA

Chairman Ann Marie Buerkle, Representative Michaud, and distinguished Members of the Committee: thank you for the opportunity to speak with you today about the Federal Recovery Coordination Program. First of all, I'd like to thank this Committee for its continuing efforts to support servicemembers, veterans, and their families as they navigate through the complex web of Department of Defense, Department of Veterans Affairs, and civilian programs. I've been a member of the military community my entire life; as a Reservist, Active Duty Air Force, Military Spouse, Retiree, Government Civilian, and Veteran. In my previous position as the founding Director of the United States Special Operations Command Care Coalition; an organization which advocates for over 4,000 wounded, ill, or injured special operations forces and has been recognized as the gold standard of non-clinical care management. Recognizing a gap in my Special Operations advocacy capabilities, I incorporated a Federal Recovery Coordinator as a team member in providing input to the recovery care plans for our severely and very severely wounded, ill, or injured servicemembers. This one Federal Recovery Coordinator dramatically improved how Special Operations provides transitional care coordination and made my staff more efficient in support of our special operations warriors and families throughout the Nation. I've found that when supporting our servicemembers, veterans, and their families there is always opportunity for improvement.

It's essential that our military and veterans have strong advocates, both government and non-government, working together at the national, regional, and community levels to improve the recovery, rehabilitation, and reintegration of our warriors and families. However, one program by itself is not enough when it comes to supporting our Nation's most valuable resource—the men and women of the Armed Forces, our veterans, and their families. I recently left government service to assume duties as the Executive Director of the Central Savannah River Area—Wounded Warrior Care Project, where my current position is to integrate services by developing a strong community based organization that maximizes the potential of government and non-government programs in Augusta and throughout our region. The Federal Recovery Coordination Program is one of those resources.

From my experience, advocates or care coordinators require three attributes in order to be successful. The first attribute is the *ability to anticipate need*. This may sound simple, but staying ahead of a problem saves a lot of heartache, money, and time. Much like chess master, thinking five to ten moves ahead, this assumes effectiveness and competence at various levels of the system. The second attribute is the *authority to act*. A case manager or advocate who anticipates needs and develops flawless transition plans, but doesn't have the authority to act is powerless to ensure success. In this complex environment of wounded warrior recovery, someone who can not act is an obstacle. The last attribute is the *access to work as a team member*. This is recognizing that it takes more than one person to reach the goal. Team work is probably the most complex of the three attributes, because it requires others to be inclusive, sharing of information, trust, and requires a great deal of time to coordinate and synchronize efforts. Federal Recovery Coordinators are a critical component to the successful reintegration of over a thousand wounded, ill, or

injured and their families, but as I said “there is always opportunity for improvement”.

By design a Federal Recovery Coordinator has the education and credentials to *anticipate need*. Their level of professionalism, skill, and experience enables the coordinator to function at a high level of competence in supporting our warriors. They are the most clinically qualified of the warrior transition team. However, not everyone has the same clinical expertise and access to perform as a Federal Recovery Coordinator. We feel the development of a Federal Recovery Coordinator certification program is necessary to prepare these Veterans Affairs care coordinators to engage a broad spectrum of resources available in areas not only of health care, but with a focus on behavior health, family support, and benefits availability.

Innately, the FRC has the *authority to act* within the Veterans Affairs Health Care system and interface with Veterans’ Benefits Administration representatives. By reporting to the Veterans Affairs Central Office the Federal Recovery Coordinator can influence across the Nation and regionally. This ability is unique and should be capitalized on by the Department of Defense Service Wounded Warrior programs and strengthened by the Veterans Benefits Administration. The Federal Recovery Coordinator must have the authority to act at the strategic level, to ensure case management is being accomplished, services are being provided, and that Veterans Affairs resources are being maximized, in concert with other government and non-government organizations.

The greatest challenge for the Federal Recovery Coordination Program is their *access to work as a team member*. As I mentioned earlier, team work requires inclusiveness. If the Coordinators do not have timely access to the warriors and families in need they can’t be effective. As the saying goes “You only know what you know.” Involvement in a case must be timely in order to shape an outcome, vice manage the consequences of bad decisions. We must work symbiotically to synchronize our efforts, operating transparently, and maximizing the capabilities of the Departments of Defense, Veterans Affairs, Labor, and Health and Human Services, as well as collaboration with non-government organizations at the national, regional, and local levels. Additionally, the Federal Recovery Coordinators must function in a coordination role, working by, through, and with Service Wounded Warrior Programs while also leveraging local Veterans Affairs case managers and benefits counselors. Relationships are critical and the Federal Recovery Coordinator must develop trusting interchange with those individuals and organizations with the mission to assist the servicemember, veteran, and their family.

Lastly, the scope of the Federal Recovery Coordination Program should be expanded to assist those in the greatest need for a transitional care coordinator. We should not only support the most severely wounded, ill, or injured, but must include those less severe whose family dynamics, behavioral health issues, or benefit anomalies inhibit their smooth transition to civilian life. The current practice of providing “an assist”, which is short term without fully involved care coordination, has been successful. Additionally, those transitioning veterans at the greatest risk for homelessness should have a Federal Recovery Coordinator shepherd the veteran to success. By operating at a strategic level Federal Recovery Coordinators can affect the outcome of far more veterans both regionally and locally.

In conclusion, we have three recommendations to improve the Federal Recovery Coordination program.

1. Maintain the high credential standards for the Federal Recovery Coordinator, but augment with a nationally recognized certification for Federal system care coordination in order to strengthen their *ability to anticipate needs*.
2. Ensure the Federal Recovery Coordinators have the *authority to act* on needs they’ve identified, both on a national and local level.
3. Make certain the Federal Recovery Coordinator has *access to work as a team member*. Incorporate Federal Recovery Coordinators early in the recovery process as strategic partners who can ensure the Veterans Affairs resources are maximized to a larger population of transitioning servicemembers, veterans, and their families in need of someone to shepherd them through this complex system.

There is currently a very positive feeling in this country towards the service and sacrifice of our military, veterans, their families, and a desire to support them. One way to help is to utilize existing programs, especially at the local level. The Central Savannah River Area—Wounded Warrior Care Project stands as the model for many communities throughout the Nation who are at the front line of helping our veterans come all the way home from combat and fully reintegrate into our community. It’s also important to educate the military and their families about their transition,

but it's frequently too late after transition has occurred and life's daily pace takes over.

Thank you for providing us the opportunity to present before the Veterans' Affairs Subcommittee on Health.

**Prepared Statement of Mary Ramos, Ph.D., RN,
Federal Recovery Coordinator, San Antonio, TX, Military Medical Center,
U.S. Department of Veterans Affairs**

Good morning Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee. My name is Mary Ramos, and I work at the San Antonio Military Medical Center as a Federal Recovery Coordinator (FRC).

When asked what I do for a living, the simple answer is that I coordinate long- and short-term care for the most seriously wounded, ill, and injured for the Department of Defense (DoD) and the Department of Veterans Affairs (VA). I say that I help clients get everything they need from DoD, VA, and the community. People ask if that job is very difficult. I have to say that it is certainly a challenge, but also a gift. It is an honor working with servicemembers and with veterans and their families; every day is a learning experience in how people, health care, and systems interface to provide care and benefits to those in need.

I will begin my testimony by providing you with a general picture of who a FRC is, our roles and responsibilities.

My position as a FRC is embedded in a Military Treatment Facility (MTF), San Antonio Military Medical Center (SAMMC). We at SAMMC work hand-in-hand with military health care providers, VA and civilian providers, case managers, care coordinators, and military command as well as countless others whose roles touch the wounded, ill, and injured clients and their families. Our roles as FRCs are unique within the military and VA health care and benefits systems, and each day brings discoveries about the respective niches we fill in providing care and caring for our clients.

The FRC role is one of overarching coordination. In operational terms, that means that while others have a defined "lane," FRCs coordinate across those "lanes" for our clients. The FRC communicates with key members of the provider team within a clinical setting and, in partnership, assesses whether there are interventions or information that might assist those providers in optimizing clinical and social outcomes. For instance, health providers treat the various medical conditions while the clinic staffs facilitate appointments. The FRC will identify client or family issues with transportation, motivation, adherence, or information. If there are such issues, the FRC will validate those impressions with the treatment team and encourage additional personnel participation to provide what is needed, facilitating clinical and nonclinical care. This function is critical when a client is being seen in multiple clinical settings within a single facility and even more so when he or she is being seen concurrently in multiple facilities.

On any given day, an active client might be admitted to a hospital, transferred between facilities, undergo a procedure, or be seen in one of the outpatient clinics. Tracking those events is critical to anticipating emerging needs for the clients and families as well as indicating to whom we should be communicating that day—for example, the client's inpatient case manager, Warrior in Transition Case Manager, Recovery Care Coordinator (RCC), VA Liaison for Health care, VA Case Manager, or provider may be providing care that the FRC can support or facilitate. The client's changing status may introduce questions or identify new immediate needs; an unanticipated change may introduce some instability in an already precarious client's coping strategy. The FRC, then, is constantly reassessing the status of each client, balancing past, emerging, and anticipated needs within the system of care and formulating flexible care coordination plans within the caregiver matrix. That reassessment may also result in a client being evaluated for a decrease in acuity within the program.

The Federal Recovery Coordination Program (FRCP) is most beneficial during periods of recovery and rehabilitation when the FRC can provide stability and support during transitions. Once a client has settled into veteran status, is receiving benefits and has decided to return to school or work, the need for FRCP involvement is often reduced. These clients may transition to "inactive" status with FRCP. Inactive status does not mean that FRCP support is withdrawn entirely. Inactive clients can continue to call the FRC at any time for any reason, but regular contact and the associated Federal Individualized Recovery Plan (FIRP) work will be discontinued. Sometimes clients are made inactive if the client is unresponsive to the FRC's out-

reach for at least 3 months. After that time, the FRC will send a letter to the client stating that they may become inactive or if they contact the FRC, they will remain active. Under these particular circumstances, the FRC will contact any known case manager to ensure the client is receiving appropriate services.

Referrals come to the FRCs at SAMMC in several ways. Most of my referrals come directly to me from VA or MTF case managers, RCCs, military personnel, health care providers, or from current patients referring their friends. I will also get referrals from VA Central Office. All referrals are always accepted and reviewed, since one of the goals of the FRCP is to provide consultative services to the facility and to respond positively to all questions.

When an FRC receives a referral, the first level of review for evaluating possible clients is to collect data from the referral source concerning the client's medical condition, injuries, and social and family data as well as the referral source's impression of the major issues that may be facing the possible client in the next weeks.

- If there is a single issue or a simple question, the client may be assessed briefly and entered into the system as an "assist." If "assists" prove to grow in complexity or if the client's condition starts to indicate that he or she will benefit from the full FRCP, the "assist" client can be moved into active status after the FRC discusses the client with supervisory staff.
- Comprehensive clinical review is usually accomplished with the client placed in "evaluate" status.
- If the clinical condition or other factors do not indicate that the FRCP would be of benefit to the client or family, or if optimal services are being provided, the FRC may, after discussion with the team and with supervisory staff, "redirect" the client back to the team, offering continuing support as needed but without active involvement of the FRC.
- If the clinical condition of the client indicates a possible long-term need for the FRCP, the referred individual's health care records may be reviewed to validate how the FRCP might benefit the individual and family. Additionally, the individual and/or family are interviewed, the program is explained, and the individual and family are given the choice of whether to enroll in the program. If the individual does not want the program, the choice is left open for the indeterminate future. If they decide to enroll, the individual is placed in "evaluate" status. Further assessment follows until a discussion with supervisors may result in the client being placed in "active" status.

FRCs at SAMMC introduce clients to the FRCP very early in the initial hospitalization. While each client has a full complement of caregivers and case managers in this phase of high acuity, there are nonclinical details that can be introduced that will facilitate care and quality of life later in the recovery process. While the client is in the inpatient setting, the FRC provides additional emotional support to the client and family and, in partnership, facilitates whatever processes the case manager and clinical team suggest. The FRC can monitor processes like application for Servicemembers Group Life Insurance Traumatic Injury Protection Program (TSGLI) and Social Security Disability Insurance (SSDI). The FRC can investigate available resources and help arrange after-school child care to enable the spouse to be with the injured servicemember.

In providing such assistance, FRCs establish themselves as willing team members who support not only the client, but the entire care team. Willingness to serve as a team member is critical to the FRC being successful in this unique role. Another function of the FRC is to provide information about resources and benefits that are or will be available to the client and family. Thus, emotional support, instrumental assistance and information are the products of the FRCP in the acute treatment phase.

The most important element the FRC contributes at this early treatment phase is the concept of seamless long-term clinical and non-clinical support. The FRC will be the consistent person in their journey from the most acute care through, and perhaps beyond, community reintegration. It is true that when the client is in intensive care, he or she is not thinking about whether or not they will want to leave the service or whether they will seek funding to attend college. But, the FRC can assure the client that when they are ready for those decisions, the FRC will still be there, carrying information about what the immediate past has been for this family and supporting the decisions within the close professional relationships that have grown over time.

Because of early support during the most acute phases of care, plus a long record of supporting the family through various crises, the FRC builds the closest of professional relationships. Later care is mediated through that relationship. The trust relationship with the client and family is the foundation for continued support

through the stresses and decisions that come with the Integrated Disability Evaluation System (IDES) process and transitions into community life and new health care delivery systems. With constant interaction from early in the recovery trajectory through reintegration into the community, the FRC learns how each client and family member copes and reacts to the stress of injury, treatment, and change. That knowledge shapes FRC responses to each client for the provision of individualized care.

Extensive professional education and experience enable each FRC to make rapid, continuous assessments and formulate action plans efficiently both independently and within multiple teams. Each FRC holds at least a Master's Degree in a health care field with basic education as either a Nurse or a Social Worker. Many have practiced in multiple clinical settings. FRCs bring that clinical experience to the FRC cohort and to the practice setting. The variety of events, outcomes, roles and personalities in military, VA, and civilian health care settings demand an unusual level of professional adaptability in FRC practice. Through the course of each client's health care and recovery, the FRC role flexes to provide whatever is needed at any time. Assessment data are constantly processed and actions formulated to "fill in the blanks."

Despite our expertise and experiences, it is expected that FRCs will be in a constant learning mode. The spheres of knowledge necessary for the position include physical and behavioral health domains, but that knowledge is utilized in a context including organizational psychology, systems theory and transitions, military command systems, military pay systems, military health care, military justice systems, military health care finance, evidence-based practice and research, VA systems of health care, VA benefits systems, community-based care and health care reimbursement, Federal, State and local tax structures, civil and criminal legal systems, real estate law, guardianships and powers of attorney, and risk communication. Additionally, the FRC must understand how to recognize their own personal knowledge deficits and to seek resources to apply to emerging situations. Recognizing what one does not know as a FRC is as important as knowing and teaching what is known.

FRCs practice with many others who coordinate and provide care for patients. The FRC role in coordinating care, however, is unique in several aspects. While the FRC may not possess comprehensive knowledge concerning any one aspect of a client's life, he or she can see that aspect in the context of the client's entire life. The FRC contributes by assimilating what is meaningful to the client's care and by formulating an overarching care coordination plan. Service-based personnel may understand the culture of the service much more deeply than the FRC. The FRC will defer to the Service-based representative in decisions concerning Service-related issues. However, with broader clinical knowledge and the ability to incorporate key elements of service-related information, the FRC can build a new care context for the client. Some explain this as "breadth versus depth."

The care coordination role sometimes colors the character of the relationship between the FRC and the client and family. The FRC identifies processes and actions that must take place in the course of treatment and care management, and then ensures that those tasks are completed. The quasi-oversight function means that the FRC validates processes with the team members and clients and observes and assists, as needed. The FRC listens attentively to the client's perspective and impressions of care, providing encouragement and assurance that processes will be completed. Listening and responding can accentuate the trust relationship and result in a more therapeutic-type relationship than other roles. Maintaining professional boundaries and confidentiality is critical to sustaining an appropriate relationship, especially in light of clients' and families' tendencies to disclose intimate details of their lives.

Relationships with other professionals within the military treatment facility are defined by the documents that set the FRCP in place. The FRCs are provided office space and resources to support their work, and they are given access to clinical teams, patient documents, and information systems. At SAMMC, the FRCs are collocated with a large group of Warrior in Transition Unit (WTU) case managers and the WTU clinical staff. FRCs participate in clinical activities and assist providers in various care processes, establishing their roles as team members. The FRCs meet and greet incoming Commanders of WTU, the MTF Commander, and other key personnel. Interdisciplinary meetings are very productive for the FRCs, including those at the Center for the Intrepid (amputee care) and the outpatient Burn Unit meetings. Each professional encounter serves as an outreach opportunity and to enhance an appreciation of what the FRCP can offer to teams and clients.

FRCs have open door policies, and while some clients will make appointments, some just call or e-mail to ask if they can drop in, or they just come to talk. When a client presents, the FRC checks the extant FIRP, goes over all open goals, or for-

ulates a new plan if necessary. If a client is hospitalized, the FRC will visit several times a week and will interact with the inpatient case manager to see if the FRC can assist with any functions. FRCs have access to client's outpatient appointment schedules and can meet them in the clinics as desired by the clients and families. FRCs receive a copy of patients scheduled in the Center for the Intrepid for outpatient interdisciplinary clinic. It is beneficial to meet with the client's care team and listen to their impressions of the client's progress, any barriers to ongoing care, and what is planned in the clinic visit. By being quietly present, the FRC can be available to answer questions. By observing the clinical team caring for the client, the FRC can gain insight as to how the client is interfacing with the team and whether any FRC coordination would enhance care. Every interaction with the clinical and nonclinical staff serves as outreach. Every success ensures future referrals to the FRCP.

I would like to give you some specific examples of what I, as an FRC, do in a typical work day.

I will review my client list early in the work day using our program's data management system to review tasks. Much of the early activity of the day involves planning and prioritizing, processing incoming e-mails and calls. Of course, the day will never follow the plan, and priorities evolve during the day, but reviewing issues is always beneficial. As an example of our task management, if a new veteran contacts me with a concern that his first benefits check is lost in the system, as a FRC, I can check on the processing of his claim and either resolve an issue or reassure the client that the system is working. Task reminders also cue the FRC to review a client's record to check and see if benefits have been received.

I reviewed the Veterans Health Administration (VHA) record for a client diagnosed with schizophrenia, who recently moved to another city. The client has pending examinations to support the disability rating. VHA's records indicated active communication between the case manager in the originating city and the receiving case manager. To ensure a seamless transition of the client's case, I e-mailed the new case manager and Transition Patient Advocate, introducing myself and my role and offering support. I also spoke with the client to inquire if there were any other issues I could help address.

I received an e-mail from a Polytrauma Rehabilitation Center (PRC) case manager stating that a head injury patient, who was expected to be transferred back to his home VA facility, will be remaining at the PRC. I e-mailed the Veterans Benefits Administration (VBA) representative about the planned home modifications to determine if they would continue on schedule or, given the circumstance, would be delayed or cancelled. I then spoke to the VBA representative and discussed how best to support the family in caring for the client at home following discharge from the PRC. The family has decided to check on new construction rather than modifying the current home. I exchanged e-mails with the spouse of this client to check on the family's well-being.

I received an e-mail from a client's spouse, who is waiting for home modifications. Temperatures are rising with the seasonal change, and the client has very little tolerance for heat due to burn injuries. I talked to the local VBA representative, who stated that logistics were slowing down the process but that he would speak to the client to plan for starting the project. I then directed the spouse to check the Service-Disabled Veterans Insurance Web site, and followed up as to whether the county property tax exemption paperwork had been filed.

I received a phone call from a client's mother. The client is experiencing disturbing medication side effects. She was very upset about several other issues as well, including some recent legal issues and a critical illness in another family member. I provided supportive listening and encouragement. I e-mailed the VHA case manager and asked her opinion about whether the primary care provider might consider seeing the client for a possible medication change. The VHA case manager arranged the appointment.

I received a phone call from the mother of a veteran who is worried that the veteran is not receiving optimal care in a transitional traumatic brain injury (TBI) facility. The mother states that she is afraid that after 3 years of caring for the veteran, her health is suffering, and she has no health insurance or income. She discussed her fear that if the veteran is enrolled in an Independent Living Program and stays in a transitional TBI treatment facility, that she will have to sign over the veteran's VA benefits and she will have no income and no place to live. I called the head of the TBI program to discuss whether the veteran meets criteria for placement and how the current family situation might have an impact on program expectations. I also called the Veteran Outreach Specialist at a local Vet Center to see if she can assist in finding counseling resources for the mother of the veteran.

I received a phone call from a veteran receiving inpatient treatment at a VA Medical Center (VAMC). The veteran called me to clarify whether a Power of Attorney was needed now or whether it could wait until after being discharged from the VAMC. The veteran's spouse is working on financial issues and is worried about money. I e-mailed the VBA Regional Office to check on the client's VA claim adjudication since the family is in financial distress and needs an income. Regional Office personnel confirmed that the client's claim is proceeding. The veteran also expressed anxiety about leaving the current treatment program. I assured the veteran that I have been planning clinical outpatient follow up so that there will be no interruption in treatment. The veteran expressed appreciation for all of the help, and offered to help other veterans facing similar issues.

I met with a case manager to discuss two mutual cases. One of the cases involved an active duty servicemember with a head injury. Rehabilitation progress at this time is slow, and we discussed whether there is an alternative placement or if the current placement is the best. The spouse and mother of the servicemember are discussing the best approach and are anxious about different issues. The mother would like the patient in an acute rehabilitation setting. The spouse is worried about the children, legal, and financial complications. We discussed the best physical location for the servicemember, given the demands of multiple compensation and pension examinations in support of the Medical Board process. We also discussed the family's applications for an auto grant and special adaptive housing, and misinformation that had been given to the spouse during the filing process. By the end of the meeting, we had developed a single message for all family members in order to decrease family anxiety.

A Navy Safe Harbor (NSH) case manager stopped by my office to discuss a case that was troubling her. We discussed her concerns and the scope of the issues with the individual. I then reviewed DoD and VHA treatment records and discussed the case with the FRC located within NSH. My review of the records indicated that the individual has significant physical and behavioral health issues, and that the current care for these conditions is fragmented. I spoke with the individual and discussed FRC structure and function. The individual expressed an interest in the support that the FRC can provide, and agreed that he would work with me to develop a FIRP. I placed the individual in evaluation status and again discussed with NSH case manager and with the FRC at NSH. Navy personnel support the individual working with me as his FRC in partnership with NSH.

I received an email from a veteran who had been told that he had lost his TRICARE coverage. As for many, the interface between Federal programs became quite frustrating. An example is this complex relationships between Social Security Disability Income (SSDI), Medicare, and TRICARE. This wounded servicemember applied for SSDI soon after injury and started receiving SSDI within the first 6 months following his severe injury. After 2 years of being on SSDI, the veteran became Medicare eligible. At that time, Medicare B premiums were deducted from his SSDI (Medicare A is without cost). The SSDI benefit continued when the (then) veteran returned to work. SSDI payment was suspended after 9 months of the veteran's earning more than \$1000 a month. At that time, the Medicare Program billed the Veteran for Medicare premiums. He did not understand the bills and did not pay them. Medicare is suspended. Consequently, TRICARE eligibility ceased. My role was to explain this complicated situation, encourage him to report to the local Social Security office, and assure him that he would get any health care he needed during any transition periods.

I met with another client, who was recently discharged from the hospital. The client and spouse are interested in purchasing a home; however, they have a poor credit rating and have only saved part of their initial TSGLI to use as a down payment. We reviewed all open goals in the FIRP with the client, discussed financial counseling resources, the financial commitment of owning a home, and I provided multiple brochures and contact information. We also discussed the advantages of financial planning and strategies to raise their credit rating.

Conclusion

The examples I have provided hopefully demonstrate for you the kind of flexibility each FRC must have in providing optimal care for veterans, servicemembers, and their families. Each day as a FRC is an adventure in providing support that could, in all likelihood, otherwise fall through the cracks given the complexity of some of these cases. Much of what I provide is not quantifiable, and some of what I provide would possibly not be missed by a client who did not expect a sound safety net. However, I have come to realize that an intimate understanding of a servicemember's or veteran's perspective of everyday life within overlapping, impossibly complicated, delivery systems equips me to find that (perhaps small) intervention

that improves the quality of life for those who risked everything for my freedom and my grandchildren's quality of life. I never served in battle, but I am honored to bring every minute of my personal and professional experience to bear in caring for those who bore the battle.

Thank you again for the opportunity to share my experiences and perspective with you, and I look forward to answering your questions.

**Prepared Statement of Karen Gillette, RN, MSN, GNP,
Federal Recovery Coordinator, Providence, RI, Department of Veterans
Affairs Medical Center, U.S. Department of Veterans Affairs**

Good morning Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee. My name is Karen Gillette, and I am a Federal Recovery Coordinator (FRC) from Providence, Rhode Island. Thank you for inviting me today to tell you what I do as a FRC to assist recovering servicemembers, veterans and their families as they heal and return home. My testimony will focus on my roles and responsibilities in the service of my clients.

Overview

I have been a FRC since 2008. My current active caseload includes 55 clients, all in different stages of recovery and reintegration. Some of my clients have been recently injured and are still being treated at military treatment facilities, while others are receiving care at private rehabilitation facilities. I have clients, now veterans, who were injured several years ago and continue to need assistance with veterans' benefits, case management issues at their local Department of Veterans Affairs (VA) facility, vocational rehabilitation benefits, or help finding community resources in their local area. In addition to my caseload, I also have clients on my inactive case list that occasionally contact me with questions or to just let me know how they are doing.

My experience in this field stems from my clinical and administrative experiences as a nurse practitioner and nurse executive, and from the extensive Federal Recovery Coordination Program (FRCP) training and education on veterans benefits programs, military programs, TRICARE, social security, Department of Labor programs and VA programs. FRCs attend quarterly training at different sites including VA's polytrauma facilities around the country. We have met with the staff at Walter Reed Army Medical Center, National Naval Medical Center, Quantico, and at Veterans Benefits Administration (VBA) Regional Offices. We have had training on mediation, coaching, mentoring and motivational interviewing. My experience and training have helped me to establish a good working relationship with families, and to gain experience in the Veterans Health Administration (VHA) system and a working knowledge of VBA policy and resources.

My caseload consists of referrals from many different sources. Referrals come from VA case managers, military personnel, caregivers, community and charitable organizations, and clients, who also refer other Wounded Warriors to our program. I have Army Wounded Warrior (AW2), Air Force Wounded Warrior (AFW2) and Marine District Injured Support Cells (DISC) staff who ask me to assist with their clients having problems with reintegration into the community. I also make sure to ask these sources if there are any other cases they are aware of where my services might be beneficial.

I currently work with case managers located in over 35 VA Medical Centers (VAMC). These include Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) case managers, polytrauma coordinators, spinal cord injury/disability coordinators, community nurse coordinators, home-based primary care staff, social workers in VA's community living centers, as well as health care providers. We collaborate to share resources, suggestions and information that meet the client's needs. I work closely with fee basis staff and prosthetic department staff, speech therapists and other members of the physical medicine and rehabilitation staff at local VAMCs and clinics. I work with VBA personnel who manage the compensation claims, vocational rehabilitation and fiduciary needs of my clients at VBA sites around the country. Beyond VA, I work with staff at the Social Security Administration, State disability and Medicaid case managers and TRICARE and military nurse case managers on a regular basis.

I stay in close contact with the different wounded warrior program representatives, and we discuss resources and options that might be of benefit to shared clients. We collaborate closely and make sure the right person is doing what is needed. I work with recovery care coordinators on some cases that we share. I usually focus

on VHA and VBA issues and the recovery care coordinators focus on military administrative detail. Our collaboration is effective and complementary.

As a FRC, I provide many informational briefings about the program at national conferences. I have staffed FRCP booths at a variety of meetings and conferences and have used that opportunity to discuss the program with attendees. I attend Veterans Integrated Service Network-level training and conferences in New England and try to stay in contact with VA's polytrauma coordinators. I have also attended military conferences to discuss the role of the FRC in a client's treatment and recovery.

I would now like to share with you some examples of the issues I handle on a typical workday.

My workday begins by reviewing my work list, notes, tasks, phone calls and e-mail so that I can prioritize the day's issues. My goal, however, is to ensure that all of my clients are moving closer to the goals established on their Federal Individual Recovery Plan (FIRP).

In one case, I collaborated with VA staff in getting a client with severe traumatic brain injury (TBI) admitted to a VA polytrauma rehabilitation facility to be evaluated for admission to an emerging consciousness program. The family was relocating, and they were interested in having the client receive care at a VAMC close to their new home. The mother provides 24/7 in-home care for the client, who is minimally conscious but has been showing increased awareness over the last 6 months. I conducted a conference call with the closest VA polytrauma team to the family's intended place of relocation to review the client's case.

In another case, I spoke to an active duty servicemember's mother about the servicemember's progress at a private rehabilitation facility, and we discussed future possibilities with her for the next phase of his recovery. I then called the servicemember's medical case manager at the military treatment facility to discuss future transfer plans for this client from the private rehabilitation facility back to the military treatment facility, and then on to a VA polytrauma facility. The medical case manager agreed to contact the family and make travel arrangements for them, and to assist with accommodations at a Fisher House.

I worked with an OEF/OIF/OND VBA case manager to resolve issues related to a client's VBA compensation and pension rating process. Prior to this, I had worked with VBA to get this client's rating file moved to the seriously injured list to expedite the case. The client is at a VA spinal cord injury/disability center. The case manager will work with the family and the VBA rating official to ensure that the client's claim moves forward.

I received a call from a veteran's family regarding their visit to a private neurological residential center that I had located for them as a possible site for the veteran's next phase of community re-integration. This young veteran is a candidate for VA's TBI Assisted Living pilot program. The family was very pleased with the site, which was in the location of their choice. I provided the TBI-Assisted Living pilot program administrator and the local VA with an update on the family's visit, and they initiated the required contracting process.

I spoke to a case manager at a military treatment facility about a new referral. The veteran had not used VA for health care since a stroke. In addition, the veteran's VBA Monthly Special Compensation had recently been decreased, which resulted in the veteran having to relocate across the country. I reviewed the veteran's rating letter and found that the rating decrease was possibly due to inadequate documentation provided to the rater. I began gathering information to help educate the individual and the family about FRCP and to assist the veteran with collecting the necessary documentation to support the claim.

I called the Marine District Injured Support Cells in that area and asked him to contact this former Marine as an additional support to the family. I connected the veteran with the local OEF/OIF/OND care management team, who then contacted the family to provide assistance.

I assisted an OEF/OIF team in finding a private substance abuse rehabilitation program for a client who required a more controlled environment than VA could provide.

I contacted a VBA regional OEF/OIF officer and asked for his assistance in helping a client whose adapted car recently caught fire and was inoperable. This family had been told that they were not eligible for another auto grant. The VBA representative contacted the family and worked on the issue with them.

I coordinated with multiple levels of leadership to expedite the transfer of one of my clients from one VA community living center to another.

These are just a few examples of what I do every day to assist my clients. Most of my time is spent in making multiple phone calls, writing and responding to e-mails and following-up to ensure that things are progressing as they should. All of

my activities are documented in the FRCP data management system. I spend a lot of time providing medical education to families and clients, as they are sometimes reluctant to take up the health provider's time during a clinic appointment time just to ask questions. I spend a lot of time on the National Resource Directory looking for resources and opportunities for my clients and their families.

Conclusion

In conclusion, in the 3 years I have worked as a Federal Recovery Coordinator, I have established rapport with most of the stakeholders involved in moving these catastrophically ill and injured servicemembers and veterans into more stable and satisfactory life situations. I have found that what appears to be a "simple to resolve" situation can take multiple phone calls and e-mails to keep the process moving forward towards resolution. It takes effective communication with a variety of people to address my clients' complex issues.

I assist my clients in navigating the intricate VA and military health care systems. I have been able to assist many of my families in connecting to the right resources at the right time, assist them with getting their Social Security and VA claims completed, and connect them with private charitable organizations that can meet some of their financial needs. I provide support as relationships are established with VA teams, increasing the veteran and family's trust and willingness to choose VA as their health care provider. I am proud to have served our country's veterans and servicemembers that have sacrificed so much for our country.

Thank you for having me here today to share with you my experiences, and I look forward to your questions.

Prepared Statement of Colonel John L. Mayer, USMC, Commanding Officer, Wounded Warrior Regiment, U.S. Marine Corps, U.S. Department of Defense

Chairwoman Buerkle, Ranking Member Michaud, and distinguished Members of the Health Subcommittee, on behalf of the United States Marine Corps, thank you for this opportunity to provide testimony on interaction between the Marine Corps' Recovery Coordination Program (RCP), which is executed by the Wounded Warrior Regiment (WWR), and the Department of Veterans Affairs Federal Recovery Coordination Program (FRCP), which is overseen by the DoD/VA Wounded, Ill, and Injured Senior Oversight Committee. Many severely wounded, ill, and injured (WII) Marines are unable to return to active duty and the Marine Corps WWR works to ensure these Marines are postured for success as they reintegrate to their communities. We fully recognize that reintegration success is largely dependent upon the programs and services offered by the Department of Veterans Affairs. As such, the WWR welcomes opportunities to increase collaboration between the Department of Defense and Department of Veterans Affairs and to integrate efforts where appropriate.

The Marine Corps Wounded Warrior Regiment: Background and Assets

To provide the Subcommittee context on interaction between the Marine Corps' RCP and the VA's FRCP, it is important to provide background on the mission and scope of the WWR. Established in 2007, the WWR was created to provide and facilitate non-medical care to WII Marines, and Sailors attached to or in direct support of Marine units, and their family members in order to assist them as they return to duty or transition to civilian life. Whether wounded in combat, suffering from an illness, or injured in the line of duty, the WWR does not make distinctions for the purposes of care. The Regimental Headquarters element, located in Quantico, VA, commands the operations of two Wounded Warrior Battalions located at Camp Pendleton, CA and Camp Lejeune, NC, and multiple detachments in locations around the globe, including Military Treatment Facilities and at Department of Veterans Affairs Polytrauma Rehabilitation Centers.

In just a few years, the WWR has quickly become a proven unit providing WII Marines, their families, and caregivers coordinated non-medical support. Some of the Regiment's primary care assets include: a Resource and Support Center, the Sergeant Merlin German Wounded Warrior Call Center, which extends support to Marines and families through advocacy, resource identification and referral, information distribution, and care coordination; Clinical Services Staff that provide immediate assistance and referral for Marines with psychological health issues and/or post traumatic stress or traumatic brain injury; a Job Transition Cell, manned by Marines and representatives of the Departments of Labor and Veterans Affairs; and District Injured Support Cells (DISCs) located throughout the country to con-

duct face-to-face visits and telephone outreach to WII Marine and their families who are recovering or transitioning to their assigned region.

Care Coordination: The Importance of Recovery Teams

The complexity of WII Marines' care requires a heightened level of coordination between various medical and non-medical care providers. There is no "one size fits all" approach to care and the Regiment responds to this requirement by delivering a cross-section of services and resources tailored to meet the specific needs of WII Marines and their families. We determine the specific requirements to meet these needs through the coordinated efforts of medical and non-medical care providers who are part of our Marines' Recovery Teams. The Recovery Team includes, but is not limited to, Marine Corps leadership; Section Leaders who provide daily motivation and accountability; non-medical care managers; medical case managers; and Recovery Care Coordinators (RCCs). Recovery Team participation may be expanded depending on the acuity of the Marine's case or the needs of the Marine and family and may include the Primary Care Manager, mental health advisors, and the Federal Recovery Coordinator (FRC).

Marine Corps Recovery Care Coordinators

The Marine Corps' RCCs are highly qualified and dedicated individuals who serve as a point of contact for our WII Marines and families, and they work hand-in-hand with the WWR's support staff. Typically, our RCCs have case management experience, have college degrees (some with master's degrees), prior military experience (the majority are prior Marines), are combat veterans, and have military leadership experience. We have found that this combination of credentials provides our WII Marines and their families a high level of support. For example, the WWR's 2010 Recovery Care Coordinator Survey showed 81 percent of WII Marines and their family members were either satisfied or very satisfied with the attributes pertaining to their RCC (i.e., timeliness, availability, frequency of communication, advocating for needs and goals, coordinating and monitoring medical and non-medical care, and facilitating reintegration back into the community). Moreover, of the respondents that stated they had an RCC, a very high percentage (96 percent) reported that their RCC satisfied their explained roles and responsibilities. This is particularly important, as we know recovering servicemembers and their families can be confused by myriad of case managers who may become involved in their recoveries.

Our Recovery Care Coordinators are located at Military Treatment Facilities, VA Polytrauma Centers, and are imbedded within the Regiment and Battalions to provide immediate, face-to-face support to our WII Marines and their families. Along with their unique ties to the Marine Corps, this close proximity to Regimental staff precludes logistical challenges, improves information sharing, facilitates care coordination, and enhances the quality of care provided. Per WWR policy, which comports with Federal statute and regulation, RCCs are assigned to certain active duty (typically seriously ill/injured and severely ill/injured) WII Marines. RCC caseloads do not exceed the prescribed Department of Defense Instruction 40:1 ratio. Assignment priority is given to Marines who are joined to the WWR; however, the Marine Corps' RCP is available to WII Marines and their families whether they are assigned to the WWR or remain with their operational units. A key attribute of the Marine Corps recovery care program is that it allows WII Marines to remain with their parent commands so long as their medical conditions allow and their parent command can support their needs. Accordingly, our RCCs allow our WII Marines to "stay in the fight" by providing assistance to WII Marines who are not joined to the WWR.

Whenever possible, the RCC is one of the first points of contact the Marine and family has with the WWR support network. Usually within 72 hours of assignment, RCCs engage their WII Marine and family and immediately begin development of their Comprehensive Transition Plan (CTP). RCCs help Marines with immediate needs and set goals for the long-term. RCCs perform comprehensive needs assessments with their Marines and families, which takes into consideration various recovery components such as employment, housing, financing, counseling, family support, the disability evaluation process, and more. The information derived from the needs assessment becomes the basis for the Marine's CTP and is often referred to as a "life map" for the recovering Marine and family. It reflects their medical and non-medical goals and milestones from recovery and rehabilitation to community reintegration. The CTP is updated frequently to reflect changes in the Marine's health, financial situation, or transition goals. A Marine's outlook or goals for their future may be somewhat limited during the recovery phase and will improve and become more focused when they start rehabilitation, get involved in reconditioning sports, and begin to accomplish what may have at one time seemed to be impossible. The RCC, in coordination with the Marine Corps leadership and other Recovery

Team members, will regularly reassess the Marine's mental, physical, and emotional state to ensure that their transition plan reflects their progress.

For Marines who move to veteran status and require continued transition support, RCCs coordinate the transfer of their case to the WWR's DISCs for continued support. Additionally, when a catastrophic WII Marine is preparing for transition to veteran status, the RCC may coordinate transfer of the Marine's case to an FRC.

RCC-FRC Collaboration

The Marine Corps fully recognizes the potential of the FRCP and where appropriate, we engage FRCs to ensure our severely injured Marines who are approaching veteran status receive their support. Across the country, we have situations where RCCs are working with FRCs on behalf of our severely WII Marines who are approaching veteran status. Especially for our Marines who are at VA Polytrauma Centers, the FRC provides a valuable support resource to our RCCs.

As the Marine Corps continues to standardize its RCP, we look for opportunities to establish practices with external programs, to include the FRCP, to enhance the recoveries of our seriously injured Marines and their families. Additionally, we look forward to collaboration and leveraging best practices. The Marine Corps actively participated in the March 2011 Wounded Warrior Care Coordination Summit, which included a working group on Federal Recovery Coordination Program/Recovery Coordination Program Collaboration. We also regularly coordinate with the other services' wounded warrior programs to identify best practices and improve care. We will continue to work with VA, DoD, our sister services and all other stakeholders to ensure care provided to our WII servicemembers and their families is complementary, not duplicative, and fulfills our missions to posture those we serve for recovery and transition success, free of unnecessary bureaucracy.

Conclusion

In his 2010 Planning Guidance, the Commandant of the Marine Corps, General James F. Amos, pledged to "enhance the capabilities of the Wounded Warrior Regiment to provide added care and support to our wounded, injured and ill." This is in keeping with the Marine Corps' enduring pledge to take care of their own. We are proud of our "Once a Marine, always a Marine" ethos and are grateful for the support of this Committee and its dedication to the well being of the Marines who have so proudly served our great Nation.

Prepared Statement of Colonel Gregory Gadson, USA, Director, U.S. Army Wounded Warrior Program, U.S. Department of Defense

Thank you, Chairwoman Buerkle, Ranking Member Michaud, and all Members of the Subcommittee for inviting me to appear today. I am honored to be here. As a wounded warrior myself, I wish to thank all the Members of the Committee for their interest in the health and well-being of wounded, ill, and injured servicemembers and veterans.

The lead proponent for the Army's Warrior Care and Transition Program (WCTP) is the Warrior Transition Command (WTC), under the command of Brigadier General Darryl A. Williams. The WTC supports the Army's commitment to the rehabilitation and successful transition of wounded, ill, and injured soldiers back to active duty or to veteran status and ensures that non-clinical processes and programs that support wounded, ill, and injured soldiers are integrated and optimized throughout the Army. I am the director of the U.S. Army Wounded Warrior Program, or AW2, an activity of WTC. AW2 supports severely wounded soldiers, veterans, and families throughout their recovery and transition, even when they separate from the Army. We do this through more than 170 AW2 advocates who provide local, personalized support to the more than 8,300 soldiers and veterans currently enrolled in the program.

The Warrior Care and Transition Program (WCTP) also encompasses the 29 Warrior Transition Units, or WTUs located around the country and in Europe where wounded, ill, and injured soldiers heal and prepare for transition. I have AW2 advocates at each of these WTUs, and we identify the severely wounded as quickly as possible, so AW2 can begin providing support.

Each soldier in a WTU is assigned to a Triad of Care consisting of a primary care manager, usually a physician, a nurse case manager, and a squad leader. In addition, the WTUs have a multi-disciplinary approach that includes a wide range of clinical and non-clinical professionals, such as physical therapists, behavioral health professionals, chaplains, social workers, and occupational therapists. AW2 advocates work closely with each of these professionals in support of the individual soldier.

A requirement for every servicemember in the Federal Recovery Care Program is a comprehensive needs assessment, or Federal Individual Recovery Plan. Within the WTUs we conduct this comprehensive needs assessment through the development of what is referred to as a Comprehensive Transition Plan or CTP. The CTP is not the Army's plan for the soldier—it is the soldier's plan for him/herself. Each soldier completes a CTP within 30 days of arriving at the WTU, in coordination with the multi-disciplinary team. They set long- and short-term goals in each of six domains of life: Family, Social, Spiritual, Emotional, Career, and Physical. Our goal is to make sure each soldier is well-prepared for the next phase of their lives, whether they return to the force or transition to civilian life. The AW2 advocates are closely involved in this process, including the periodic Focused Transition Review meetings where the WTU commander gathers the soldier, family member or caregiver, and the health care professionals involved in caring for the soldier, and they discuss the soldier's progress.

Families are closely involved with the CTP process, and family is one of the six domains of goal-setting in the CTP. Family members and caregivers are invited to all of the Focused Transition Review meetings and to all medical appointments, therapy treatments, informational briefings, etc. AW2 advocates and squad leaders also work closely with the families to make sure that their needs are met. When an AW2 soldier separates from the Army and transitions to veteran status, an AW2 advocate continues to support the soldier/veteran and family just as they did when the soldier was in the WTU.

Another key component of WCTP is the Soldier Family Assistance Centers, or SFACs. SFACs are operated by the Army's Installation Management Command, and they are on-site at WTUs. They bring together many of the programs and experts the WTU soldiers and families need to provide assistance with everything from childcare and lodging to arranging for Department of Veterans Affairs (VA) care and benefits.

AW2 advocates work closely with Federal Recovery Coordinators (FRC) where they are available. As you know, FRCs are currently located in 10 military and VA medical facilities. There are more than 170 AW2 advocates on my staff, spread throughout the country, Germany, and five U.S. territories. They are present at 60 VA facilities and 29 WTUs, and those that are co-located with FRCs do coordinate closely with them. We have an open referral process where AW2 advocates and the Triad of Care can refer soldiers and veterans to the FRC if we believe they may qualify.

The Federal Recovery Coordination Program (FRCP) has the potential to facilitate positive, quality integration across the various programs throughout the Federal Government that support severely wounded, ill, and injured servicemembers. It has the potential to be a critical resource for these servicemembers and their families.

The AW2 advocates on my staff report having positive relationships with the FRCs and indicate that these FRCs are well trained, proficient professionals. The FRCs are well-versed in the resources provided by the VA and the resources available in their regions. They are also very knowledgeable about policies that can support the needs of the wounded, ill, and injured population.

I also want to discuss GAO's recommended actions for the FRCP. As you have read in the comments section of the GAO report, the Honorable John Campbell, Deputy Assistant Secretary of Defense for Wounded Warrior Care and Transition Policy committed the Department of Defense to continuing to collaborate with the VA on these issues. A Joint Department of Defense (DoD)/VA Committee has been formed to study how to combine or integrate recovery coordination efforts for wounded, ill, and injured servicemembers, veterans, and families.

Recommendation 1 of the GAO's report discusses establishing adequate internal controls regarding FRC's enrollment decisions. This is not a problem at AW2. While FRCs are afforded broad discretion in determining which servicemembers are admitted to the program, AW2 has very clear eligibility criteria. We accept and support soldiers who receive an Army disability rating of at least 30 percent for a single injury since September 11, 2001, regardless of whether that injury was sustained in combat or not. In 2009, based on AW2's understanding of the long-term needs of this population, we expanded that criterion. We now also accept Soldiers who receive a combined Army disability rating of 50 percent or greater for conditions that are the result of combat or are combat-related. All AW2 eligibility decisions are made at the headquarters level, by a team of nurses and a Masters-level behavioral health professional who closely review all eligibility requests. We often accept soldiers before they receive their formal disability ratings, if the nature of their injuries makes it very clear that they will meet the AW2 eligibility requirements.

The GAO's next recommendation discusses the FRCP's efforts to manage the workloads of individual FRCs based on the complexity of the services needed. At

AW2, we pay very close attention to the caseloads of AW2 advocates. The average caseload is 1 to 50, but each soldier requires a different level of support, depending on where he or she is in the recovery and transition process, to include veterans.

For example, AW2 veteran Kortney Clemons is a severely wounded veteran who no longer requires a significant level of AW2 support. He was a combat medic in Iraq, and he stepped on an IED just 5 days before his enlistment was up. He lost his right leg above the knee. Kortney has been out of the Army for more than 5 years. He's gone on to become the national Paralympic champion in the 100 and 200 meter dash and is training for the Paralympic Games in London next year. He is currently enrolled in a Masters Degree program through the AW2 Education Initiative, a partnership between my program, the U.S. Army Training and Doctrine Command, and the University of Kansas. He no longer requires the same level of support from an AW2 advocate as he did when he was first injured.

AW2 recognizes that many of the soldiers and veterans we support become more independent as they heal and transition to the next phase of their lives. We developed the Lifecycle Case Management Plan, or LCMP, to help AW2 advocates identify the level of support each soldier needs. There are four phases. When the soldier/veteran requires a significant level of support, AW2 calls them at least once a month, sometimes more, if their personal situation requires it. As they progress and become more independent, we call them less frequently, every 60 or 90 days in the next two phases. In the last phase, where Kortney is, we only call them every 180 days. I am proud to say that I personally "graduated" to the last phase of the LCMP in March.

Soldiers and veterans can always call their AW2 advocate or the AW2 call center if they need support and we will be here for them. This initiative allows the AW2 advocates to focus on those with a more immediate need for their support, such as the most recently injured, those going through the Medical Evaluation Board, or those facing significant personal or medical challenges.

GAO's third recommendation addresses the FRCP's decision-making process for determining when and how many FRCs the VA should hire. AW2 faces some of the same challenges as the FRCP on this issue. It is difficult to predict how many additional soldiers will qualify for our program in the future. In 2010, we accepted more than 2,000 new soldiers into the program. On average, that means we added one additional Soldier to each AW2 advocate's caseload every month. We are increasing our staff levels as quickly as possible. This fact makes it even more important that we ensure the AW2 program is run as efficiently as possible. The LCMP allows us to manage the rate at which additional advocates are required.

One way we have dealt with the need for more advocates is to strengthen the communication between AW2 soldiers, veterans and families so that they educate and support each other. We have launched peer-to-peer tools to enable the AW2 soldiers, veterans, and families to communicate with one another. We have established a blog and a Facebook[®] account to facilitate a conversation among the population online.

GAO's final recommendation calls for the FRCP to develop and document a clear rationale for the placement of FRCs, including a systematic analysis of data to support these decisions. At AW2, we evaluate our staffing on a quarterly basis. We make advocate assignments by zip codes and place them where we have the greatest populations of AW2 soldiers and veterans. We have reassigned some of the contract positions based on the locations of the population we support. As I mentioned before, we have 170 AW2 advocates. Sixty of them are at VA facilities and at each of the 29 WTUs, to provide local, personalized support to AW2 soldiers, veterans, and families where they are. I would submit that aligning FRCs in a similar manner regionally would better serve both them and the servicemembers for whom they are responsible.

There are a couple of other items in the GAO report that I want to acknowledge. One is access to office space and technology at various VA facilities. Many AW2 advocates on my staff have experienced similar challenges finding a private space to conduct sensitive conversations and getting access to technology. AW2 now has a designated liaison with the VA and this has significantly helped the situation. There are still individual challenges but by facilitating that relationship and proactively talking to regional VA facilities before the new advocate arrives we have been able to mitigate this problem.

The GAO report also highlighted the challenges in information sharing between the DoD and VA. We recognize the importance of this challenge. For over a year now, the Warrior Transition Command has been developing automated systems that are part of an integrated system for tracking and managing the care of soldiers and veterans. The CTP mentioned previously is a fully automated process which provides managers at every level the ability to thoroughly analyze, in real time, the

performance of staff in the development and updating of these plans. Currently being completed for implementation later this year is the central module of the system referred to as the Automated Warrior Care and Tracking System; the automated CTP will interface with this module which contains the history of each soldier and veterans care.

The Executive Director of the FRCP and the Deputy Under Secretary of Defense for Wounded Warrior Care and Transition Policy are co-chairing an information sharing initiative (ISI) to support coordination of non-clinical care for seriously wounded, ill and injured Operation Enduring Freedom and Operation Iraqi Freedom (now Operation New Dawn) servicemembers, veterans, and families. The Army has been an active participant in this joint DoD/VA ISI. The ISI will enable sharing of authoritative data electronically between DoD, VA, and the Social Security Administration case and care management systems. This will eliminate resource-intensive and error-prone work-arounds. A pilot for this initiative is underway for the bi-lateral sharing of benefit and case manager information. Further efforts will include such items as select care plan information and appointment and calendar functions. These efforts will significantly improve the challenges to information sharing between the agencies.

In closing, I again thank you, Madam Chairman and Ranking Member Michaud, for inviting me here today and for listening to my testimony about the Federal Recovery Coordination Program. I appreciate your attention to wounded, ill, and injured servicemembers, veterans, and their families, and I know that we share the same goal of providing the best possible services to these individuals who have sacrificed so much.

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

Madam Chairwoman and Members of the Subcommittee on Health:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and our Auxiliary members, thank you for inviting our organization to submit testimony to your Subcommittee today on the topic of the Federal Recovery Coordination Program (FRCP), and in particular your continuing focus on whether the program has begun to fulfill its promise to those who have made major sacrifices while serving our Nation in hostile combat deployments during the worldwide war on terror.

To examine the FRCP for the purposes of this hearing, it is important to view this program in context. As this Subcommittee is aware, the Department of Veterans Affairs (VA) has the authority to coordinate care with the Department of Defense (DoD) pursuant to sections 523(a) and 8111 of title 38, United States Code (U.S.C.). Both Departments are also required under Public Law 107-772, which amended section 8111 to establish an interagency committee to recommend strategic direction for the joint coordination and sharing of health care resources and efforts between and within the two Departments.

VA's current transition, care and case management program can be traced back to 2003 with the designation at each VA facility of a Combat Veteran Point of Contact and clinically trained Combat Case Manager. These individuals were responsible for receiving and expediting transfers of servicemembers from the DoD to VA health care systems, VA took steps to modify and grow its transition, care and case coordination program. Early seamless transition efforts were limited to VA and the Army—specifically, with Walter Reed Army Medical Center (WRAMC), Brooke, and Eisenhower and Madigan Army Medical Centers—and placement of full time Veterans Health Administration (VHA) social workers and Veterans Benefits Administration (VBA) representatives.

The VA Office of Seamless Transition was established in January 2005, staffed by VHA and VBA staff and DoD's Disabled Soldier Liaison Team, where information about servicemembers to be served by the office was relayed to VA from DoD in the form of a Physical Evaluation Board list of those who were medical separated or retired. Then, as now, data flow from DoD to VA and patient tracking were identified challenges.^{1, 2}

Section 302 of Public Laws 108-422 and 108-447 required VA to designate centers for research, education, and clinical activities on complex multi-trauma associ-

¹ <http://www.urbanhealthcast.com/NAADPC/SlidesSeamlessTransition.pdf>.

² U.S. Government Accountability Office. Testimony before the House Committee on Veterans Affairs, GAO-05-1052T, September 28, 2005.

ated with combat injuries. In June 2005, VA designated four Polytrauma Rehabilitation Centers (PRCs) to be co-located with the four existing Traumatic Brain Injury (TBI) Lead Centers. In fact, these TBI Lead Centers are not commonly referred to as Polytrauma Centers.

Also in June 2005, VA's policy for the polytrauma system of care was issued, which included the infrastructure designation of Level I PRCs, Level II Polytrauma Network Sites, Level III Polytrauma Support Clinic Teams, and Level IV Polytrauma Points of Contact. Staff at these levels include the PRC Clinical Case Managers and PRC Social Work Case Managers, OEF/OIF Program Manager, Transition Patient Advocates, OEF/OIF Program Manager, OEF/OIF Nurse and Social Worker Case Managers for clinical and psychological care management respectively, OEF/OIF VBA Counselor, VA Liaisons at military treatment facilities, and other case and care managers (Women Veterans, Spinal Cord Injured, Visual Impairment Service Team, Polytrauma Support Clinic Teams).³

DoD's current transition, care and case management program, the Wounded Warrior Care and Transition Policy program, is based on recommendations made by commissions and other review groups⁴ that were convened before and after the deficiencies at WRAMC came to light in February 2007.

Taken from the July 2007 report of President's Commission on Care for America's Returning Wounded Warriors, the FRCP was implemented through two Memoranda of Understanding dated August 31, 2007, and October 15, 2007.⁵ However, it should be noted that developing the FRCP occurred simultaneously with legislation subsequently enacted in January 2008 as Public Law 110-181, directing VA and DoD to "jointly develop and implement comprehensive policies on the care, management, and transition of recovering servicemembers."

The law's requirements specifically include:

- creating the Recovery Coordination Program (RCP) for recovering servicemembers and their families;
- developing uniform program for assignment, training, placement, supervision of Recovery Care Coordinators, Medical Care Case Managers, and Non-Medical Care Managers;
- developing content and uniform standards for the Comprehensive Recovery Plan, including uniform policies, procedures, and criteria for referrals; and
- developing uniform guidelines to provide support for family members of RSMs.

Moreover, deployment of the FRCP program occurred during the development of what is now the current state of VA and DoD care and case management programs.

DoD's current Wounded Warrior Care and Transition Policy program, now includes the FRCP, Recovery Coordination Program, Transition Assistance Program, the National Resource Directory, and Wounded Warrior Employment initiatives. Within the Recovery Coordination Program, front line service is provided by recovery care coordinators, medical and non-medical care managers, and an individualized recovery or transition plan. Each military service has its own program implementing Public Law 110-181 and DoD's four cornerstones and ten steps of care, management and transition Coordination policy.⁶ These programs include the Army Wounded Warrior Program, Marine Wounded Warrior Regiment Recovery Coordination Program, the Navy's Safe Harbor program, and the Air Force Wounded Warrior program.⁷ In addition to direct support and assistance to servicemembers, each mili-

³Department of Veterans Affairs, Veterans Health Administration, *VHA Directive 2005-024, Polytrauma Rehabilitation Centers*, June 8, 2005; Department of Veterans Affairs, Veterans Health Administration, *VHA Directive 2006-043, Social Work Case Management in VHA Polytrauma Centers*, July 10 2006. (Rescinded VHA Directive 2005-024, June 8, 2005; Department of Veterans Affairs, Veterans Health Administration, *VHA Directive 2009-028, Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 2, 2009;

⁴Inspector General Review of DoD/VA Interagency Care Transition, DoD Task Force on Mental Health, the Independent Review Group, the Veterans Disability Benefits Commission, the President's Interagency Task Force on Returning Global War on Terror Heroes, and Commission on Care for America's Returning Wounded Warriors.

⁵Accessible at: <http://www.tricare.mil/DVPCO/downloads/Final%20MOU%20VA%20DoD.pdf>

⁶Department of Defense Instruction 6025.20, *Medical Management Programs in the Direct Care System and Remote Areas*, January 5, 2006; Department of Defense Instruction 1300.24, *Recovery Coordination Program (RCP)*, November 24, 2009; Department of Defense, *The Foundations of Care, Management and Transition Support for Recovering Servicemembers and Their Families*, September 15, 2008.

⁷Established in 2004, AW2 assigns an AW2 advocate, and the Warrior Transition Units (WTUs) where a servicemember is assigned a triad of care and development of a Comprehensive Transition Plan. The triad includes a primary care manager (normally a physician), nurse case manager, and squad leader—who coordinate their care with other clinical and non-clinical pro-

tary service has programs in place to support the families of wounded, ill or injured servicemembers.

As this Subcommittee is well aware, this coordination program, like some of its sister efforts, was born in controversy. In fact we believe most of the efforts to create coordinator positions came about on discovery of gaps in services or difficulties in conducting a seamless transition for the wounded. In particular, when the scandal at WRAMC erupted in February 2007, and a number of Federal agencies, task forces and commissions reviewed the transition process of injured servicemembers, it became obvious that our government was not fully supporting the rights and benefits of seriously disabled veterans from Iraq and Afghanistan in repatriating to their homes and families in an orderly way.

At WRAMC and elsewhere, hundreds of patients were unnecessarily being held in “medical holds,” with little prospect of discharge or retirement, and with many of their families also held in that same limbo. Per diem support and living conditions for family members were woefully inadequate. Information was scarce or confusing. Support services tailored to individual needs were thin to nonexistent, but expectations on these troops were very high that they remain in an organized and focused military posture while dealing with their medical responsibilities.

Since the program’s inception, servicemembers, veterans and their loved ones recognize the assistance they receive from their assigned FRC is invaluable, which is a testament to the FRCP. Further, DAV is encouraged that the FRCP has been expanded over the years; however, in previous testimony our organization has provided to Congress, because the FRCP was developed after VA’s polytrauma system of care and before DoD’s Wounded Warrior Care and Transition Policy program, we believe this is the source of many of our questions that remain regarding the effectiveness of the FRCP in meeting the need of severely injured servicemembers.

With so many coordinators, clinical and non-clinical case managers created in the development of VA and DoD’s transition programs, we sought out basic information to validate these programs are working as intended. In April 2008, we testified the data we were receiving at that time indicated that for each injured servicemember who is currently enrolled in the FRCP, as many as 6 FRCs may be assigned.⁸ A number of the families who are beneficiaries of this work have reported that the advice they receive is often overlapping, redundant, confusing and conflicting. Many of them seek a singularity of advice rather than a chorus of competing advisors, to help them steer their paths toward recovery.

For as much emphasis as was placed on the need for a single recovery coordinator and the heralding of the FRC as the “ultimate resource,” DAV remains deeply concerned that the workload and expansion of this program has not been accompanied by appropriate resources being allocated.

DAV also raised concerns in testimony about integration of Information Technology (IT) access within VA and the Military Training Facility (MTF). VA and DoD, at least in the medical arena understand the necessity of data systems and information support technologies. These can serve an important role in facilitating the timely transfer of essential information as patients traverse care systems and settings. Moreover, VA and DoD are well aware of the complexity of medical and non-medical needs of injured servicemembers, veterans and their families, yet the IT support for the FRC remains inadequate.

Unfortunately, it appears our concerns are well founded as portrayed in the March 2011 Government Accountability Office (GAO) report titled, “Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges.”

If FRCs must, by definition, ensure that systemic barriers to care and services are resolved at both the individual and the system level, and the FRCP is to provide a system that transcends all boundaries to coordinate servicemembers’ and veterans’ care and benefits through recovery, rehabilitation, and reintegration into their home

fessionals. WTUs also have platoon sergeants to assist where needed. The Marine Wounded Warrior Regiment commands the East and West Wounded Warrior Battalions and other detachments and uses Recovery Care Coordinators to help define and meet a member’s recovery plan as well as District Injured Support Cells to assist recovering mobilized reserve Marines. Established in 2005 the Safe Harbor Program offers two levels of support: Non-medical case managers to support and assist member and family needs, and Recovery Care Coordinators who oversee and assist with the member’s Comprehensive Recovery Plan. The Air Force Warrior and Survivor Care Program initially depended on family liaison officers and community readiness consultants to assist in community reintegration. Air Force Recovery Care Coordinators were added whose area of responsibility is regionalized and who work closely with family liaison officers, patient liaison officers, and medical case managers.

⁸ *Update on VA and DoD Cooperation and Collaboration, Hearing before the U.S. Senate Committee on Veterans’ Affairs, 110th Congress (2008).*

communities,⁹ we believe it is only proper that commensurate authority and resources to effect change and accomplish such a lofty task must be provided.

Madam Chairwoman, in March of this year, the DoD held a Care Coordination Summit that focused some of its work on the FRCP. A number of recommendations are emerging from that consensus conference, based on lessons learned from the past 3 years, that we believe warrant the attention of this Subcommittee as you continue your oversight of the FRCP. Among the findings and recommendations of the conference's workgroups pertinent to this oversight hearing include the following:

FRCP/RCP Collaboration Recommendations:

Objective: *Re-defined Care Coordination Program*

Recommendations:

1. Eliminate category 1, 2, and 3 eligibility criteria. Establish appropriate eligibility criteria for care coordination.
2. Improve integration within the Care Coordination Program.
3. Improve education and develop a strategic communications process.

Objective: *Improved integration of the Care Coordination Program*

Recommendations:

1. Improve education and develop a strategic communications process.
2. Provide interagency access to Information Technology systems.
3. Develop and implement a standardized referral and Intake Process for the Care Coordination Program.
4. Consider geographic alignment of the FRCs.
5. Continue to expand and enhance the National Resource Directory.

A comprehensive report based on the outcome of the Wounded Warrior Care Coordination Summit identifying best practices with actionable recommendations will be developed with full support from the Wounded Warrior Program Directors from each military service, the DoD Recovery Coordination Program Director and the Executive Director of the VA FRCP.

This report will be received by the Deputy Assistant Secretary of Defense for Wounded Warrior Care and Transition Policy who will in turn brief those actionable recommendations to be initiated prior to the end of fiscal year 2011, to the Under Secretary of Defense for Personnel and Readiness and to the Senior Oversight Committee.

We urge this Subcommittee to engage the appropriate office in the Administration to ensure these recommendations made by front line personnel of the VA and DoD care, management, and transition programs receive due attention.

Madam Chairwoman, we hope the Subcommittee will work with its counterpart in the Armed Services Committee to instill in both DoD and VA a stronger interest in making the FRCP the program that was intended by showing a stronger interest in implementing the recommendations of its own consensus conference. Moving forcefully on these recommendations may also bring VA into compliance with recommendations of the Government Accountability Office in its March 2011 report to Congress on the VA FRCP.

Madam Chairwoman, this concludes my testimony on behalf of Disabled American Veterans.

Statement of the Military Officers Association of America

EXECUTIVE SUMMARY

Response to Recommendations of GAO Report on VA's Federal Recovery Care Program (FRCP)

The Military Officers Association of America (MOAA) concurs with the findings and recommendations in the Government Accountability Office's (GAO) report, GAO-11-250, issued March 2011, titled, *DoD and VA Health Care; Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges.* Specifically, we agree that VA should:

- *Establish systematic oversight of enrollment decisions;*
- *Complete development of a workload assessment tool;*
- *Document staffing decisions; and,*

⁹Department of Veterans Affairs, VA Handbook 0802, *Federal Recovery Coordination Program*, March 23, 2011.

- *Develop and document a rationale for Federal Recovery Coordinator (FRC) placement.*

While we have seen great progress in VA's development and expansion of the FRCP and just how effective these coordinators are based on feedback from those wounded warriors and family members receiving these services, MOAA believes, as GAO indicates in its report, that more needs to be done in the area of program management and accountability.

Our Association continues to hear from frustrated, and sometimes angry wounded warriors and their caregivers who are confused, overwhelmed or intimidated by the FRCP. Some have been told they are ineligible for an FRC, some were not informed they were eligible, and others were constrained in accessing program services when and where needed because of improper timing of receipt or coordination of the information.

MOAA believes the absence of a way to systematically identify, track FRCP eligibles and administer case management for this population presents significant issues that need immediate attention.

Additional Recommendations

MOAA offers the following additional recommendations to improve the FRCP:

- Establish a consistent and uniform system of care coordination in both VA and DoD that includes common terminology and definitions, and provides a simpler way for wounded warriors and their families to access and transition from DoD to VA programs.
- Incorporate and integrate FRCP GAO recommendations and future program enhancements into the newly establish VA primary caregiver program mandated in the *Caregivers and Veterans Omnibus Health Services Act of 2010* to ensure consistent and uniform enrollment criteria, terminology, and tracking procedures across the system.
- Expand outreach and communication efforts in DoD and VA medical and benefit systems to help increase awareness of the FRCP and how to enroll eligible members and by conducting periodic needs assessment surveys to get feedback from wounded warriors and their families to improve the program and identify unmet needs.

MADAM CHAIRMAN BUERKLE, RANKING MEMBER MICHAUD AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, thank you for convening this important hearing and allowing the Military Officers Association of America (MOAA) to provide our observations concerning the GAO findings on the FRCP and offer our recommendations.

MOAA thanks the Subcommittee for its leadership in recent years to enhance programs in the VA for our wounded warriors and their families and to provide necessary oversight to ensure progress continues to be made in the area of health care and benefits so these individuals will have the best quality of life possible over their lifetime.

GAO Report Findings

Many of the broad departmental issues plaguing both VA and DoD systems are also impacting and limiting FRCP, and likely a number of other wounded warrior programs, preventing them from effectively and efficiently meeting the needs of our most vulnerable servicemembers and disabled veterans who critically need these support services.

Specifically, GAO cites limitations in:

- information sharing;
- multiple VA and DoD case management programs for the same wounded warriors;
- Federal Recovery Coordinators (FRCs) relying on referrals to identify eligible enrollees;
- role confusion on the part of FRCs and DoD–Service Recovery Care Coordinators and the numerous other case managers overseeing wounded warrior care; and
- issues of compliance, accountability and oversight within the FRCP and across VA that inhibit uniformity and consistency of operations to achieve a state of seamless transition.

MOAA is deeply troubled at GAO's finding that "VA does not know the number of severely wounded servicemembers in the Operation Enduring Freedom/Operation

Iraqi Freedom (OEF/OIF) conflicts because 'severely wounded' is not a categorical definition used by the DoD or VA medical and benefits programs. Further, that estimates of the size of the severely wounded population vary depending on definitions and methodology."

While much has improved in the last 2 years as the FRCP expanded to meet workload and improve seamless transition between the two programs, MOAA is very concerned that VA and DoD systems still struggle with basic terminology, policy, and management and technological system differences after more than a decade of war.

The fact that the FRCP system was the first care coordination program jointly developed by the two agencies would lead one to believe that the program will be institutionalized and serve as a model for other VA-DoD collaboration. But persistent problems with information sharing and other long standing issues, to include the proliferation of duplicative programs for recovering servicemembers and veterans, points to a greater systemic problem well above the control of the Executive Director of the FRCP.

The fact that VA must rely on referrals to identify eligible individuals for the program makes the program vulnerable to inconsistencies and inefficiencies, and those not identified are also more likely to fall through the administrative cracks, resulting in unintended medical consequences.

MOAA concurs with GAO's assessment of the program and urges the Congress to require both VA and DoD to provide a report to this Subcommittee on their progress in addressing these issues and implementing the GAO recommendations.

Additional Recommendations for Consideration

MOAA believes that fixing the FRCP, in and of itself, will not address the challenges facing the program. Multiple case management systems and case managers assigned to wounded warriors and the proliferation of programs and services in both the VA and DoD medical, personnel and benefits systems have greatly confused and overwhelmed wounded warriors and their families and have further stressed systems already unable to meet the demands and fallout of war.

Recommend establishing a consistent and uniform system of care coordination in both VA and DoD that includes common terminology, definitions, and provides a simpler way for wounded warriors and their families to access and transition from one system to the other.

With the lessons learned from establishing and implementing the FRCP and remaining issues that need to be addressed, VA has a unique opportunity to apply these experiences and knowledge as it rolls out the new primary caregiver program mandated in the *Caregivers and Veterans Omnibus Health Services Act of 2010*. VA officials have stated on a number of occasions their difficulty in identifying the population that is eligible for the new caregiver services and benefits. If the two systems are focusing on the same population of severely wounded, then the transition process should be more streamlined and seamless.

We repeatedly hear from servicemembers and veterans who have an FRC how great the program is and how the FRCs are an important lifeline. Our Association believes it is important for DoD and service programs to learn from VA and wounded warriors' experiences.

MOAA recommends VA incorporate FRCP GAO recommendations and future program enhancements into the newly established VA primary caregiver program to ensure consistent and uniform enrollment criteria, terminology, and tracking procedures across the system.

A recurring theme we hear from wounded warriors and family members is the overwhelming amount of information and program services pushed at them when they aren't ready to receive it, or are not in a position to understand the information given to them, rather than making it accessible when and where they need it. Disturbingly, others have never received information or have been given only limited information about programs like the FRCP or support services.

Wounded warriors and families have become increasingly vocal in letting government program leaders know that they want to be consulted and included in developing and establishing new programs rather than having the administrators assume they know what is best for these individuals. In other words, they want leaders to make greater efforts to ask about and understand their needs before programs are developed that don't fit them.

MOAA recommends expansion of outreach and communication efforts in DoD and VA medical and benefit systems to help increase awareness of the FRCP and how to enroll and by conducting periodic needs assessment surveys to obtain and use feedback from wounded warriors and their families to improve the program and identify unmet needs.

Statement of Paralyzed Veterans of America

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit a statement for the record regarding the progress and development of the Federal Recovery Coordination Program (FRCP).

For more than 65 years it has been PVA's mission to help catastrophically disabled veterans and their families obtain health care and benefits services from the Department of Veterans Affairs (VA), and provide support during the rehabilitative process to ensure that all disabled veterans have the opportunity to build bright, productive futures. It is for this reason that PVA strongly supports the FRCP, and appreciates the Subcommittee's continued work on improving the transition from active duty to veteran status for severely injured, ill, or wounded veterans and servicemembers.

The FRCP was created as a joint program between VA and the Department of Defense (DoD) to provide severely injured, ill, or wounded servicemembers and veterans with individualized assistance obtaining health care and benefits, and managing rehabilitation and reintegration into civilian life. Through the program, veterans and servicemembers are assigned a Federal Recovery Coordinator (FRC) and create a Federal Individual Recovery Plan that consists of long-term goals for the veteran and his or her family members. Such a plan motivates veterans to fight through the initial difficulties of adjusting to life after a catastrophic injury.

The purpose of today's hearing is to assess the progress and challenges of the FRCP and identify potential ways in which the program can be improved in order to fulfill its mission. In the past year, the FRCP has made changes to enhance service delivery and expand its outreach; however, more work must be done in order to adequately meet the needs of veterans. Specifically, PVA believes that VA, DoD, and Congress must work together to address challenges in the areas of continuity of care, care coordination, and program awareness in order to make a difference in the lives of those that have made the ultimate sacrifice for our country.

Continuity of Care

A primary component of the FRCP is continuity of care. As it relates to the FRCP, we believe that continuity of care means providing veterans and servicemembers with individualized care that is facilitated by an assigned primary Federal Recovery Coordinator (FRC) who maintains a working relationship with the veteran and his or her family to help manage a successful transition into civilian life after an illness or injury.

PVA believes that one way in which continuity of care can be improved within the FRCP is to ensure that FRCs remain in contact with veterans not only during the initial phases of enrollment and administration of the Federal Individual Recovery Plan, but also after the veteran has become reintegrated in his or her community setting and home. PVA believes it of extreme importance that FRCs keep in touch with veterans and their families at this point to ensure that they are adjusting to life after a disability, and providing information when necessary to make certain that the veteran is aware of VA and DoD benefits and services that may be beneficial to him or her as utilization of the FRCP lessens.

In support of continuity of care, VA and DoD must also work to create a system that monitors and manages the level of complexity and size of FRC caseloads. As it is a goal of the FRCP to meet the individualized needs of veterans and servicemembers, each case will be unique and require different levels of attention. These factors must be taken into consideration if FRCs are expected to provide timely quality assistance that is truly helpful to veterans and their families.

In conjunction with FRC caseloads, the staffing of FRCs is another area of concern that must be assessed to determine if current staffing levels are adequate to meet veterans' needs. In a recent study conducted by the Government Accountability Office (GAO) it was reported that "the FRCP faces challenges in determining staffing needs and has not clearly defined or documented its process for managing

FRC caseloads . . . ”¹ With a limited number of FRCs, issues involving transportation and distance have the potential to hinder access to care and resources for many veterans in rural areas, and thus, become threats to continuity of care. PVA encourages VA to develop an outreach strategy for veterans living in rural areas to make certain that they are aware of the FRCP and have access to a FRC if necessary. We also strongly recommend that VA develop a system to monitor and measure the complexity and size of FRC caseloads. We ask that as the program expands, VA, DoD, and Congress consider placing FRCs in locations where veterans with disabilities are already seeking services such as VA spinal cord injury centers or amputation centers of care.

Care Coordination

It is important to remember that veterans participating in the FRCP are also utilizing a multiplicity of other services from both VA and DoD. Care coordination of all the services and programs that a veteran chooses to utilize is extremely important for the success of the FRCP. In *The Independent Budget* for FY 2012—co-authored by PVA, AMVETS, Disabled American Veterans, and Veterans of Foreign Wars—it was reported that “. . . veterans transitioning from the DoD to VA who are not assisted by the FRCP may be forced to interact with as many as five VA representatives . . . ”² Interaction with so many different points of contact can be burdensome and overwhelming for veterans and their families and lead to disengagement of not only the FRCP, but other programs and services as well.

On the contrary, when a veteran participates in the FRCP, the FRC is familiar with these various services and programs and can help the veteran better manage the multiple areas of care. Therefore, it is vital for FRCs to be fully aware of the different programs and services available to FRCP participants to avoid a duplication of efforts and conflicting information that can lead to “information overload” and confusion for veterans and servicemembers.

With regard to VA health care, the Veterans Health Administration is currently undergoing a change in the way it delivers health care to veterans by utilizing patient aligned care teams (PACT). PACT is designed to provide patient-centered care through a team-based approach that emphasizes care coordination across disciplines. PVA encourages the FRCP leadership to work closely with the VA Office of Patient Centered Care and Cultural Transformation since FRCs serve as an information resource during the medical recovery process and the PACTs will be making FRCP referrals.

Additionally, in support of care coordination, PVA hopes that FRCs will reach out to the service officers and advocates who represent various veteran service organizations and work with veterans in a similar capacity on a daily basis. PVA has a network of National Service Offices within VA that provide services to paralyzed veterans, their families, and disabled veterans. These services range from bedside visits to guidance in the VA claims process to legal representation for appealing denied claims.

In fact, we recently received multiple reports describing close working relationships between PVA’s Senior Benefits Advocates and FRCs. Our Senior Benefit Advocates and the FRCs work together on a daily basis to assist veterans and their families. National Service Officers can be a great resource to the FRC for referrals, information on VA benefits and programs, and getting the word out about the FRCP within the veteran community.

Program Awareness Among Veterans

Making sure that veterans and servicemembers, as well as their families and caregivers, are aware of the FRCP has proven to be a continuous challenge. While participation numbers are growing, FRCP leadership must work to keep information about the program circulating throughout the veteran and military communities. This can best be accomplished as a joint effort that incorporates the different offices and departments across both the VA and DoD.

Information posters and pamphlets should be made available to veterans and servicemembers when they visit other VA and DoD offices to promote the FRCP. Such educational literature would be useful not only for the veteran or servicemember, but for their families and caregivers as well. As previously mentioned, veterans participate in many VA programs, but it is often a loved one or caregiver who

¹ United States Government Accountability Office, Report to Congressional Requestors: “DoD and VA Health Care: Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges.” March 2011; GAO-11-250.

² *The Independent Budget*, “The Continuing Challenge of Caring for War Veterans and Aiding Them in Their Transition to Civilian Life,” pp. 91; 2011.

is helping manage and coordinate the various services of care and who could significantly benefit from the help of an FRC.

Collaboration between FRCP staff and specialized services teams is another way to reach the targeted population that can benefit from FRCP services. The referral criteria for the FRCP includes veterans and servicemembers who have sustained a spinal cord injury, amputation, blindness or vision limitations, traumatic brain injury, post-traumatic stress disorder, burns, and those considered at risk for psychosocial complications—all areas included in VA's system of specialized services. Therefore, it is only logical for the FRCP to work with these specialty teams to promote the FRCP, and educate veterans entering VA specialized systems of care on the FRCP services and benefits.

In conclusion, PVA urges continued Congressional oversight of this extremely important program and recommends that FRCP leadership periodically survey veterans and servicemembers, and their families, to identify areas for improvement. As the FRCP is a new program, there are numerous lessons to be learned and an abundance of opportunities for development.

PVA appreciates the emphasis this Subcommittee has placed on reviewing the care being provided to the most severely disabled veterans and servicemembers. Navigating through America's two largest bureaucracies is a daunting task, but it can be particularly overwhelming when doing so after incurring a catastrophic injury such as a spinal cord injury, amputation, or as a polytrauma patient. Providing veterans with professional guidance and stability during this process gives them the resources to make informed decisions involving their health care and benefits and focus on their recovery and future endeavors.

PVA would like to once again thank this Subcommittee for the opportunity to submit a statement for the record. We look forward to working with you to continue to improve the Federal Recovery Coordination Program. Thank you.

Statement of Wounded Warrior Project

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

In presenting our policy agenda in March at a joint hearing before the full House and Senate Veterans Affairs Committee, Wounded Warrior Project recommended that the Committees review the operation and effectiveness of the many programs Congress created to improve warriors' transition from military service to civilian status. The Federal Recovery Coordination Program may be among the most important of those initiatives to our warriors and their families.

The program has its roots in the President's Commission on the Care of America's Returning Wounded Warriors (the Dole-Shalala Commission), which found that the system of care, services, and benefits created to assist those who had been injured was too complex to navigate alone. The Commission recommended the creation of "recovery coordinators" or, in the words of the father of a severely wounded Marine, "a case manager to manage my case managers." Ultimately, the National Defense Authorization Act of 2008 (NDAA 2008) directed the Departments of Defense (DoD) and Veterans Affairs (VA) to develop and implement a comprehensive policy to improve care, management and transition of recovering servicemembers and their families, to include the development of comprehensive recovery plans, and the assignment of a recovery care coordinator for each recovering servicemember.¹ Working jointly, DoD and VA entered into a memorandum of understanding establishing a joint VA-DoD Federal Recovery Coordination Program to assist those with category 3 injuries—those with a severe or catastrophic injury or illness who are highly unlikely to return to active duty and will most likely be medically separated. (A separate DoD Recovery Coordinator Program was designed for those with category 2 injuries who might or might not return to duty.)

In WWP's view, the Federal Recovery Coordination Program is a too-rare instance of a holistic, integrated effort to help injured veterans thrive again. The unique contributions—both medical and non-medical—that Federal recovery coordinators are making in facilitating wounded warriors' care-coordination and reintegration underscores the importance of ensuring that this program reaches all who need that help, and that it operate as effectively as possible. But while Federal Recovery Coordinators provide extraordinary assistance to warriors and their families, overarching systemic problems must be addressed to ensure that the program fully meets its objectives.

¹Public Law 110-181, sec. 1611.

GAO Identifies Systemic Problems

The General Accountability Office's recent report on the program identifies important issues and proposes constructive recommendations for VA action. But most importantly, in our view, GAO advises that "[s]ome of the daunting challenges facing FRCs and the program are beyond the capability of the program's leadership to resolve." The issues that GAO identifies may appear daunting, but to fail to resolve them is to compromise this critical program's effectiveness and to fail our warriors. We welcome this hearing as an important step toward that needed resolution.

In essence, GAO highlights critical problems that VA alone cannot rectify, including—

- The lack of a DoD data system that readily and systematically identifies those servicemembers who are severely wounded, ill, or injured, and whose medical conditions are highly likely to prevent their return to duty and also likely to result in medical separation from the military, namely those who may be considered for enrollment into the program;
- Overlap between DoD and VA case-management and care-coordination programs that compromises effective coordination—the core mission of the FRC program—resulting in duplication of effort, waste, confusion for enrollees and families, and failures to take needed action based on a mistaken belief that another was assisting the servicemember;
- DoD and VA data-system incompatibility that impedes sharing basic information; and
- Inconsistency in DoD facilities providing FRCs needed work space, equipment and technology support, despite memoranda of agreement calling for such support.

We commend GAO for identifying these problems, but are disappointed that its report did not go further and offer recommendations for a more substantial DoD role in addressing them. GAO did recognize that the FRC program was jointly developed by DoD and VA. But since the program is staffed by VA, operated by VA, and headquartered in VA, it is too often seen as simply a VA program, rather than a joint DoD-VA undertaking. This must change for the benefit of those the program is intended to serve.

An Inter-Departmental Solution

The two departments each share a deep obligation to severely wounded warriors and their families, but the reality is that they do not now share full responsibility for the FRC program. With its critical role in ensuring that severely wounded warriors experience a seamless transition, the FRC program suffers from such troubling interdepartmental gaps that an *interdepartmental solution* should at least be on the table for discussion. We would go further. WWP recommends a structural change in the program's governance—specifically, we propose establishment of an interdepartmental FRC program office. We offer this recommendation not because we are critical of VA, but in recognition of the inherent limitations of the current structure and the overarching obligation owed these warriors and their families. The concept of a DoD-VA program office is neither novel nor unprecedented.² While different structural solutions could be pursued, we foresee continued difficulties for the program, and most importantly our warriors, unless fundamental changes are brought about that establish truly shared responsibility.

Referrals for an FRC Assignment: A Broken Process

One of the many issues that GAO identified particularly underscores how important it is that the FRC program become a truly joint enterprise. GAO aptly recognizes the importance of identifying all who could benefit from having an FRC. But the report confirms that individual service departments are not uniformly referring severely and catastrophically wounded warriors to the FRC program for assignment, or are doing so at much too late a point in the transition process. To illustrate, one of the service departments routinely assigns even the most severely wounded warriors a Recovery Care Coordinator (RCC), but makes no FRC referral. Another service department does not necessarily even assign wounded warriors an RCC let alone an FRC, apparently deeming that the support provided at warrior transition units meets care-coordination needs. It is difficult to reconcile service-department practices that defer referral of a severely wounded warrior until that individual has retired with a longstanding DoD policy or with the DoD-VA understanding under

²Section 1635 of NDAA 2008 mandated establishment of a DoD/VA Interagency Program Office (IPO) to act as a single point of accountability for the department's development of electronic record systems.

which the FRC program was established. The DoD policy makes it clear that “all category 3 servicemembers shall be enrolled in the FRCP [Federal Recovery Coordination Program] and shall be assigned an FRC [Federal Recovery Coordinator] and an RT [recovery team].”³ The policy instructs further that the Federal Recovery Coordinator is to coordinate with the recovery care coordinator and recovery team to ensure the needs of the servicemember and his or her family are identified and addressed.

While we are not proponents of blind adherence to policy for its own sake, the care-coordination policy developed jointly by VA and DoD to implement the care-coordination provisions of the National Defense Authorization Act of 2008 is sound. That policy furthers the fundamental goal of ensuring that wounded warriors have a seamless transition from DoD to VA that best meets their needs, rather than furthering the interests of one department or another. Appropriately implemented, the policy also helps minimize confusion on the part of wounded warriors regarding the roles of those working on their behalf. Rather than advancing seamless transition, individual service department practices that defer referral for a possible FRC assignment until a severely wounded warrior has retired tend to frustrate realization of the goals the program was developed to achieve.

One might ask, what difference does it make whether a wounded warrior has a “Recovery Care Coordinator,” a “Federal Care Coordinator,” or some other assistance? In fact, the differences are real and substantial.

The VA-DoD policy recognizes the importance of providing a Federal care coordinator for a warrior who has a severe or catastrophic injury or illness, is highly unlikely to return to duty, and is most likely to be medically separated. Given the complexity of care and transitional needs of those with severe or catastrophic wounds, warriors and their families may be eligible for and need assistance not only from military treatment facilities and the TRICARE program, but from the Veterans Health Administration, the Veterans Benefits Administration, the Social Security Administration, and Medicare. (As the GAO report recognizes, “FRCs are intended to be care coordinators whose planning, coordination, monitoring and problem-resolution activities encompass both health services and benefits provided through DoD, VA, other Federal agencies, States, and the private sector.”) It is critical that a *Federal* coordinator have the depth of experience, training, and authority to navigate these multiple care/benefits systems. In contrast to those demanding requirements for an FRC, neither warrior transition unit staff nor recovery care coordinators (RCCs)—who are to assist servicemembers whose injuries are not deemed likely to result in a need for medical separation⁴—have the training, let alone the authority, to help coordinate care and other needs outside the military system.

Resolving this referral problem is gravely important: failing to make a referral for an FRC until severely wounded servicemembers retire can mean delay in their recovery, rehabilitation and re-integration. These are the very kinds of problems that sparked the call for a seamless transition, and it is alarming that they should remain unresolved.

Practices that defer referrals for an FRC until the servicemember retires seem to reflect a fundamental lack of understanding of the purpose of the FRC program. At a recent DoD-sponsored summit on care coordination, Service program personnel repeatedly referred to FRC services as “bringing in the VA.” Rather than being seen—and marginalized—as a “VA program,” the FRC program should be operated as a joint, integrated effort aimed at coordinating *Federal* care and services. What should be a seamless, coordinated undertaking is too often the opposite, as illustrated by the fact that rather than having a single recovery plan, warriors may find themselves with multiple “comprehensive recovery care plans.”

Given the very substantial inter-departmental problems GAO identified, it is striking that its recommendations were directed only to VA. As such, the report tends to reinforce the unfortunate impression that the Department of Defense has no responsibility for this program. Indeed, DoD’s March 4th response to the report (appendix II)—coming after nearly a decade of war and years since Congress directed the Departments to ensure seamless recovery-care coordination—does not seem to reflect any sense of urgency or commitment to action. Rather, in a one-sentence comment, the DoD response states that “a Joint DoD/VA Committee has been formed to *study* how to combine or integrate recovery care coordination efforts for wounded, ill, and injured servicemembers, veterans, and their families.” (Emphasis added.) We urge the Subcommittee to consider GAO’s work a starting point, but not necessarily the final word on these issues.

³Department of Defense Instruction (DoDI) Number 1300.24, “Recovery Coordination Program (RCP),” Enclosure 4, sec. 2.d. (December 1, 2009).

⁴DoDI 1300.24, Enclosure 4, sec. 2.a.

Finally, WWP has also heard concerns from a number of wounded warriors and their caregivers regarding lack of communication between FRCs and their clients. While some are frustrated at not having heard from an FRC, or don't think to initiate a call, FRCs are often working on their behalf behind the scenes. WWP recommends that the program establish clear expectations regarding the frequency and means of communication to ensure that there is common understanding.

In closing, we urge the Committee to work with the Armed Services Committee to ensure that the departments move beyond "study," and jointly take on and resolve the problems that impede full realization of this program's vital mission. Given the importance of this program to severely wounded warriors, it is critical that both departments fully support it. We believe shared governance would best achieve that objective, and legislation may well be necessary to accomplish that.

Wounded Warrior Project would be pleased to work further with the Subcommittee to realize in full the goals of this important program.

