

**THE FEDERAL RECOVERY COORDINATION
PROGRAM: ASSESSING PROGRESS TOWARD
IMPROVEMENT**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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**THE FEDERAL RECOVERY PROGRAM:
ASSESSING PROGRESS TOWARD
IMPROVEMENT**

THURSDAY, OCTOBER 6, 2011

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

The Subcommittee met, pursuant to call, at 8:30 a.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Bilirakis, Roe, Michaud, and Donnelly.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good morning. I want to thank all of you for joining us this morning as we continue our oversight of the Federal Recovery Coordination Program (FRCP).

Last May, our Subcommittee held a hearing to examine the significant challenges that the FRCP faces in areas as fundamental as identifying potential enrollees, reviewing enrollment decisions, determining staffing needs, defining and managing caseloads, and making placement decisions.

At that hearing, unfortunately, it became patently clear that rather than having a single joint program to advocate on behalf of our wounded warriors and to ensure a comprehensive and seamless rehabilitation, recovery, and transition, we have two separate overlapping programs, the Recovery Coordination Program (RCP) operated within the U.S. Department of Defense (DoD) and the FRCP operated within the U.S. Department of Veterans Affairs (VA).

Needless to say, this has created unnecessary and unacceptable confusion about the roles and the responsibilities of each program and has added yet another burdensome bureaucratic maze for our wounded warriors and their families to navigate through at a time when recovery and reintegration should really be their only focus.

I was so concerned about the pervasive issues with the operation of these two programs that immediately following that hearing, I sent a letter jointly with Ranking Member Michaud to the co-chairs of the VA-DoD Wounded, Ill, and Injured Senior Oversight Committee (SOC) with oversight over the FRCP.

In that letter, we requested a detailed plan and a timeline for how the VA and DoD jointly would implement the recommendations contained in the recent U.S. Government Accountability Of-

rice (GAO) report, which identified significant shortcomings of the FRCP.

Further, we asked for an analysis on how the FRCP and RCP could be integrated under a single umbrella to reduce redundancy and ensure the seamless transition of our wounded warriors.

A response was requested by June the 20th. More than 2 months passed since this deadline and, following the notice of this additional hearing, we finally received a response to our letter. Unfortunately, it did not include the detail nor the timeline we requested and expected.

With regard to an analysis of and potential actions for integrating the FRCP and the RCP, we were told that SOC, quote, is currently considering several options to maximize resources in care coordination and preparing for final recommendations, end quote. These programs are not new and the time for considering and recommending has long since passed.

As Chairwoman, it has been my privilege this year to spend time with our honored heroes who have returned from battle bearing the wounds of war and the families who stand by their side through it all.

I have traveled to Brooke Army Medical Center, the Center for the Intrepid, and VA medical facilities across our great country. It is clear to me that FRCP is failing.

It is also clear to me that these families cannot wait any longer. They can no longer be party to the bureaucratic in fighting and turf battles. They can no longer be told that they have several points of contact.

When answers are needed, we cannot take 3 months to respond to a letter. When answers are needed, we cannot continue to consider our options. Today we are looking for answers.

I now recognize the Ranking Member, Mr. Michaud, for any remarks he might have.

[The prepared statement of Chairwoman Buerkle appears on p. 33.]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Madam Chair. I would like to thank you for holding this hearing today on this extremely important program.

As you heard, in May, this Subcommittee held a hearing on the very same issue and I am pleased that we are the critical oversight of this very critical program. If it is not done right, our service-members will suffer.

Following that Subcommittee hearing, I joined the Chairwoman in sending a letter on May 26 to the Senior Oversight Committee requesting a detailed response to how the VA and the DoD can work together on implementing the Government Accountability Office recommendations and requesting an analysis of integrating the FRCP and the Recovery Coordination Program.

On August 19th, we then sent a follow-up letter because of the lack of response from the Senior Oversight Committee. The letter that we did finally receive dated September 12th was hardly what we were expecting.

The GAO reports that the agencies reached an impasse on the content of the final letter responding to our concerns as a Committee. This lack of response only serves to magnify in my mind the continued problems between the VA and the DoD in working collaboratively and highlights the lack of progress that we have heard and read about in recent submissions and testimony.

I can only imagine what this means with other critical decisions that directly impact veterans and their families. I do not feel confident that the Department of Veterans Affairs and the Department of Defense can overcome existing barriers and the tangling of bureaucracy seems to surround the implementation of this program.

Let us all keep in mind that this is not about individuals sitting in this room. This is about the brave men and women who wear the uniform, who have been injured while serving this country, and our absolute commitment to their recovery and reintegration back into the communities where they live. Whatever it takes, we owe that much to them.

Today I would like to hear about solid progress that has been made and what is being done to move this forward in an effective and efficient manner. I would also like to hear from each of the panels what this Subcommittee might be able to do to help.

It is unconscionable that we have a bureaucracy that is supposed to be helping our soldiers and our veterans but because of the entanglement within the bureaucracy, these brave men and women are not being served like they should.

I would encourage each and every one of you who are responsible for this program to step up to the plate, think of what these men and women have gone through and are going through each and every day. And I look forward to your testimony.

Madam Chair, I want to thank you for holding this hearing on this very important topic. So thank you very much.

[The prepared statement of Congressman Michaud appears on p. 34.]

Ms. BUERKLE. Thank you, Mr. Michaud.

At this time, I would like to welcome our first panel to the table. With us this morning is Dr. Debra Draper, Director of the Health Care team at the United States Government Accountability Office.

Thank you very much for joining us this morning and I look forward to hearing your testimony. We will start with you now. Thank you.

**STATEMENT OF DEBRA A. DRAPER, DIRECTOR, HEALTH CARE,
U.S. GOVERNMENT ACCOUNTABILITY OFFICE**

Ms. DRAPER. Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, I am pleased to be here today as you discuss efforts by DoD and VA to address issues of concern that were raised during your May 13th hearing on the Federal Recovery Coordination Program, a program jointly developed by DoD and VA to provide care coordination for our most severely wounded, ill, and injured servicemembers and veterans, individuals who because of the severity of their injuries and illnesses could benefit greatly from care coordination services.

At the May 13th hearing, we highlighted various concerns identified in our March 2011 report about the program. We also emphasized the importance of this program's coordination with other DoD and VA programs that are similarly intended to improve care coordination and case management including DoD's Recovery Coordination Program.

In my statement today, I will discuss the status of actions taken by DoD and VA to implement the recommendations from our March report. I will also discuss efforts by DoD and VA to identify and analyze potential options to better integrate their care coordination programs.

Regarding our March recommendations, we are pleased that VA has made progress in improving program management of enrollment decisions as well as care coordinator staffing needs, case loads, and placement decisions.

While our recommendations were directed to the Secretary of VA because VA administers the program, DoD and VA were both asked to provide a response to the Subcommittee about how the Departments could jointly implement them.

We found that DoD's assistance to VA has been limited to a June 30th e-mail to the commanders of the military services' Wounded Warrior programs about referrals to the program. According to VA officials, however, they have seen no change in referrals since the e-mail was sent.

More troubling, however, is the status of DoD and VA's efforts to jointly identify and analyze potential solutions to better integrate their care coordination programs. The Departments have made little progress reaching agreement on integration options despite a number of attempts to do so.

Most recently, DoD and VA failed to provide a timely response to the Subcommittee's May 26 request to jointly develop potential solutions for integrating their care coordination programs.

On September 12, several months after the request, a joint letter was issued stating that the Departments were considering a number of options to maximize their care coordination resources. However, this letter did not specifically identify or outline any of these options. Other efforts have also failed to advance a jointly devised solution.

This lack of progress to better integrate the Departments' care coordination programs illustrates the continued difficulty by DoD and VA to reach a collaborative solution to address program duplication and overlap.

We currently have work underway to further study this issue and identify key impediments affecting recovering servicemembers and veterans during the course of their care.

Also, as we have previously reported, there are numerous DoD and VA programs that provide similar services to individuals who are often enrolled in more than one program and as a result may have multiple care coordinators and case managers.

One Federal Recovery Coordinator (FRC) told us that in one instance, five case managers were working on the same life insurance for the same individual.

In another instance, DoD and VA care coordinators unknowingly established conflicting recovery goals for a servicemember about

whether to separate from the military. This created considerable confusion for the individual and his family.

The bottom line is that there has been little progress made by DoD and VA to more effectively align and integrate their care coordination and case management programs across the Departments.

This is particularly disconcerting as the number of individuals served by these programs continues to grow. Without better interdepartmental coordination, problems with duplication and overlap will persist and perhaps worsen.

Furthermore, the confusion this creates for recovering servicemembers, veterans, and their families may hamper their recovery. Unfortunately, the intended purpose of these programs to better manage and facilitate care and services may actually have the opposite effect.

Based on our continuing concerns, we are recommending that the secretaries of DoD and VA direct the Senior Oversight Committee to expeditiously develop and implement a plan to strengthen integration across all DoD and VA care coordination and case management programs including the Federal Recovery Coordination and Recovery Coordination programs to improve their effectiveness, efficiency, and efficacy.

Madam Chairwoman, this concludes my opening remarks. I am happy to answer any questions.

[The prepared statement of Ms. Draper appears on p. 34.]

Ms. BUERKLE. Thank you, Dr. Draper.

I will now yield myself 5 minutes for questions.

I just want to pick up on a couple of things and follow-up with some of your testimony here this morning.

The first thing that concerns me is that you are saying that the failure of VA and DoD to reach some sort of an agreement and the duplication and the conflicting goals of these two programs may hamper their recovery.

So it is your testimony this morning that this program is right now in its current form hurting our veterans rather than helping them?

Ms. DRAPER. Well, we have concerns because there appears to be little, if any, cooperation or collaboration. And since our May testimony, the situation actually seems to be worsening based on our updated work for this particular hearing.

For our work related to the testimony, we received differing versions as to why further progress has not been made, and it was very difficult to get a clear understanding of what the difficulties are between the two Departments.

We are aware of some activity, but we do not know the details of those activities, and the activities seem to be done in silos at VA and at DoD but nothing collaboratively.

Our concern is that the lack of cooperation and collaboration not only fails to address existing program duplication and overlap but fails to fully consider the impact on our most severely wounded servicemembers and veterans.

As you know, these are particularly vulnerable individuals that can benefit greatly from care coordination services. Somehow this interdepartmental tug of war seems to have lost sight of why the

programs exist in the first place, which is to care for our wounded servicemembers and veterans.

Ms. BUERKLE. Thank you.

You mentioned that your recommendation is to expeditiously develop and implement a plan.

So if you would give us some insights. What do you consider expeditious and what should our expectation be? What is realistic from what you have observed from DoD and VA?

Ms. DRAPER. We have a couple of things that we would think are important to consider in moving towards a solution. First of all, I would just say that the progress made has been too slow. Ensuring that the Departments address our recommendation is important.

Reevaluating the role of the Senior Oversight Committee, that is probably something that needs to be done. Is there more that they can be doing? Should they be doing something differently?

The Departments should determine whether the original intent of the program continues to be important, and if so, they should ensure that the proposed solutions really preserve that original intent.

And if the desire is for this to be a truly joint DoD and VA program, it seems reasonable that DoD and VA should have joint administrative, budgetary, and other responsibilities, and joint incentives should be designed to ensure that the desired outcomes are achieved. As, you know, currently DoD does not have administrative or a budgetary role in this program.

And, you know, to be quite frank, it would be helpful to hold the Department's feet to the fire and require them to periodically report on their plans and progress.

Ms. BUERKLE. In your opinion, where should we go from here as a Subcommittee?

We want to see this program moved along. As the Ranking Member mentioned as well as myself, this is not about the people in this room. This is about our wounded warriors. So if you could just give us some insight as to where you think we should go from here.

Ms. DRAPER. Well, we strongly encourage DoD and VA to examine the strength of their coordination for these programs.

But I do want to reiterate that our concerns go beyond the Federal Recovery Coordination or Recovery Coordination programs. As I mentioned in my testimony, there are numerous care coordination and case management programs across the Departments, and we believe that it is now time to take a comprehensive look at all these similar programs to identify duplication and overlap and to develop and implement a plan to improve their overall effectiveness, efficiency, and efficacy.

Ms. BUERKLE. Thank you, Dr. Draper.

I now yield 5 minutes to the Ranking Member.

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

While you were conducting the interview and performing your audits, were you confused by the way that these programs were set up to function or could you understand the functionality of the programs?

Ms. DRAPER. I would say we were confused more by the responses we were getting from DoD and VA. They did not seem to

be very aligned, and we got differing views from each of the Departments. So, it was very hard to piece the story together.

Mr. MICHAUD. First of all, it is disheartening to me that the DoD and VA have made little progress towards integrating the care and coordination and case management across the Departments.

What can we do to help facilitate the coordination and communication between the agencies? I mean, to me, it seems it is very simple, but evidently—well, it is not working. So what do you think that we should do to help facilitate that?

Ms. DRAPER. Well, again, I think holding their feet to the fire, creating joint incentives for the programs that force that alignment of the Departments' goals, and giving joint responsibilities and accountability to both Departments.

I do want to say, though, that there is some inherent tensions between the way the Federal Recovery Coordination Program is set up between DoD and VA that involves when and how best to involve the Federal Recovery Coordinators.

DoD's stance is that they are concerned about involving VA too soon because it sends the wrong message to a recovering servicemember, mainly that their military career may be over. Also, I think there is a cultural stance within the military services to take care of their own.

On the other hand, you have VA who has authority to really work with recovering servicemembers veterans, and their families, and they want to get involved early so that they can make the transition for that recovering servicemember to civilian life much easier.

Mr. MICHAUD. Would you agree then by the fact that the DoD is reluctant to let the VA step in early because they are afraid that there might be the perception of kicking them out?

The bottom line that concerns me is the fact that if a servicemember or veteran is not getting the service that they need, that is going to cause a lot more stress on the individual member of the service as well as the family and ultimately could potentially lead to suicide. And that is the huge concern that I have with the lack of coordination and the lack of the case management as I have heard about since we implemented the program.

And have you heard any concerns about that or in your investigation about the suicide?

Ms. DRAPER. We did not hear about that.

Mr. MICHAUD. Thank you, Madam Chair.

Ms. BUERKLE. I yield 5 minutes to the gentleman from Tennessee, Mr. Roe.

Mr. ROE. Thank you, Dr. Draper, for being here.

And let me just start out by saying that this should be something we are really good at. You know, we provide the best health care on the battlefield that there is in the world or ever has been. And people are surviving injuries now that they did not survive when I was in service in the 1970s and during Vietnam. So this is something we should be really good at.

I looked at these numbers last night and there are 21 of the Federal Recovery coordinators and there are 1,827 servicemen that have been treated so far. And this is over a period of 3½ years.

Ms. DRAPER. Uh-huh.

Mr. ROE. Eighteen hundred and twenty-seven people got care. I saw between 3,000 to 4,000 patients a year myself plus assisted or did several hundred operations during 1 year, one person did.

And I did the math on this and these people average taking care of one person every other week. This should not be overwhelming anybody. And I do not know what in the world, why this has been so hard. And you pointed out something that we see.

Sometimes you have several people involved in a discussion when maybe a veteran does not get the answer or a soldier does not get the answer they want. It is a tremendous waste of resources when you have five people working on the same issue. That is ridiculous.

And you had stated here the GAO references one FRC that estimates that his enrollees have on average eight different case managers affiliated with eight different programs. This overlap can lead to significant redundancy, conflict, and frustration for the servicemember or veteran and their family throughout the recovery and reintegration process.

I could not agree more. I mean, you do not have anybody leading the ship and that is what I thought the FRC was. Am I right or wrong about that?

Ms. DRAPER. Well, the original intent was to have one person being the umbrella to coordinate both the clinical and non-clinical services. I mean, that is our concern with the duplication and overlap. Having so many people involved runs counter to the intent of the program.

Mr. ROE. Yeah. But, I mean, I guess what I am looking at, if I had this many resources to take care of 1,827 people, I believe I could do that pretty well, pretty easily, and without all this confusion. And that is what I am baffled by.

Where is the problem? I mean, when you do the math on this in 3½ years, the average coordinator is taking care of 25 persons per year. That is one every other week. Am I wrong?

Ms. DRAPER. That is correct.

Mr. ROE. Do you have an explanation for that?

Ms. DRAPER. I do not.

Mr. ROE. I think maybe later in the testimony, we will get an explanation for that, but I agree. And I see this in our office and I know all of us that have offices that work with veterans. Sometimes they are in the senator's office. Sometimes they are in our office. I know it gets conflicted sometimes when a case gets in two different places.

But this is a situation where that should not happen because we have control of these folks. They are either in DoD under their umbrella, or in VA under their umbrella.

Ms. DRAPER. And I want to emphasize that these are very important services, particularly for this population that is very vulnerable. And as you know, we just need to find a way to make the programs work and work well.

Mr. ROE. And they are critical services. I want to hear actually later in the testimony, and thank you for the work you have done, Dr. Draper, to point out why this is not working after going on now 4 years.

I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

Mr. Donnelly.

Mr. DONNELLY. Just a follow-up to Dr. Roe's question. Where would we look for the explanation as to the numbers that he was talking about as to the productivity and how many people were being taken care of?

Ms. DRAPER. Yes. I would direct that to the program officials.

Mr. DONNELLY. Okay. The next question is about cooperation. You have DoD. You have VA. What have you found in terms of cooperation and working with them?

Ms. DRAPER. We have found that it is not working very well at all.

Mr. DONNELLY. And what are the major causes of that? I know in your testimony, you pointed at some of the quote. How do we get these people to work seamlessly together?

Ms. DRAPER. As I mentioned earlier, there are some inherent tensions based on differences between the two Departments, and I think these differences are key to improving collaboration.

One difference is looking at when and how to get a Federal Recovery Coordinator involved in care. There seems to be a lot of disagreement about that when that happens.

I think also that the Departments should be held accountable, and they should be required to periodically report on their plans and progress.

And I also would strongly recommend that they implement the recommendation that we are making in our testimony today and that is to expeditiously develop and implement a plan to look at integration across care coordination and case management programs.

And I want to reiterate that our concerns are much beyond the Federal Recovery Coordination and Recovery Coordination programs and extend to the numerous care coordination and case management programs. I think this is a time to take a comprehensive look across those programs to identify and eliminate duplication and overlap.

Mr. DONNELLY. I was going to ask you, the other programs, it is the same difficulty or there are the same difficulties?

Ms. DRAPER. We are currently doing work looking at some of those programs, so I cannot say that for sure. But I think that when you see evidence, when a Federal Recovery Coordinator tells you that five case managers are working on the same life insurance issues and that is problematic. And to me that indicates there is the potential for deeper problems.

Mr. DONNELLY. Madam Chair, the only other thing I would like to say is that in terms of focus, the focus should not be on what makes DoD happy and what makes VA happy, but what helps our wounded warriors and using our taxpayer dollars to the best effect.

As Mr. Roe was talking about, he saw 3,000 plus patients a year by himself and I know he is a good doctor, but that is not unusual, I do not think. You know, I think the focus has to be on the people who deserve it.

Ms. BUERKLE. Thank you.

Dr. Draper, thank you very much for being here this morning—

Ms. DRAPER. Thank you.

Ms. BUERKLE [continuing]. For your work on this very important issue. You are now free to go.

Ms. DRAPER. Thank you very much.

Ms. BUERKLE. I would like to invite our second panel to the witness table. Joining us from the Department of Defense is Mr. Philip Burdette, Principal Director of Wounded Warrior Care and Transition Policy for the Office of the Under Secretary of Defense for Personnel and Readiness.

Also on our second panel is John Medve, the Executive Director for the Office of VA-DoD Collaboration for the Office of Policy and Planning for the Department of Veterans Affairs.

Thank you both for joining us this morning.

Mr. Burdette, you may proceed.

STATEMENTS OF PHILIP A. BURDETTE, PRINCIPAL DIRECTOR, WOUNDED WARRIOR CARE AND TRANSITION POLICY, OFFICE OF THE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE; AND JOHN MEDVE, EXECUTIVE DIRECTOR, OFFICE OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS-U.S. DEPARTMENT OF DEFENSE COLLABORATION, OFFICE OF POLICY AND PLANNING, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF PHILIP BURDETTE

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

I am pleased to be here this morning with my colleague and friend, Mr. John Medve, from the Department of Veterans Affairs. It is not an uncommon occurrence for me to appear with Mr. Medve who heads the VA-DoD Collaboration Office as we meet weekly and often more often than that to discuss our Departments' interaction.

Discerning and discussing the redundancies and the overlap between the Federal Recovery Coordination Program and DoD's Recovery Coordination Program is from my perspective a wonderful problem. This dialogue simply would not have taken place in 2008 when the problem was not too many resources but too few.

On March 13th, 2008, Sergeant Edward Wade's wife, Sarah testified before this Committee. Sergeant Wade suffered multiple injuries in Iraq in 2004. Mrs. Wade testified that they had difficulty accessing necessary services for her husband where and when he needed them.

She recommended patient specific case management and the development of individualized treatment plans. Today we have delivered just what she asked for. Today, Sergeant Wade would receive the clinical expertise of a Federal Recovery Coordinator and the non-clinical assistance of a Recovery Care Coordinator as part of his care team.

The use of FRCs and RCCs demonstrates just how far we have come in those 4 years. Rather than a scarcity of care and a lack of available resources, today we are discussing how to best utilize a multitude of resources available 24/7 for recovering service-members and their families.

The perception that we have put too many overlapping resources in place really highlights an intentional safety net of concurrent resources. We firmly believe that the programs are not duplicative but complementary, with a redundancy that is important for our recovering servicemembers to truly have seamless coordination in their recovery period.

This is no less than our servicemembers expect and no less than what they deserve. We simply cannot over-invest in the care management of our wounded warriors.

I do not mean to infer that the Departments are not taking serious and thoughtful steps towards efficiency and wise stewardship of these complementary programs. We are.

After the release of the GAO report on the Federal Recovery Coordination Program, the Deputy Secretary of Defense and the Deputy Secretary of Veterans Affairs challenged us to actively and aggressively address the GAO findings. We have.

As a result, the Departments have been focused on improving our care coordination and continually working to bring the counterpart programs closer together.

The Wounded Warrior Care Coordination Summit, held this past March and the DoD-VA Executive Committee agreed upon expectations for how this can be best accomplished.

This summer, the Senior Oversight Committee focused on those expectations and the four areas raised by the GAO. We have also used the findings of the Recovering Warrior Task Force, which was established by this Congress as an independent and objective guide in our efforts.

From my seat, the biggest problem surrounding the programs is probably the programs' names themselves which are simply too similar despite intentionally different roles. This not only confuses us at the policy level, but most importantly, it confuses recovering servicemembers and their families at our military treatment facilities (MTFs).

While we have obvious work to do in eliminating that confusion at the headquarters level, I can report that these programs are delivering critical resources to our recovering servicemembers nationwide.

Just this past Monday, I visited the new Walter Reed National Military Medical Center in Bethesda, as I do every month. While there, I met with a recovering Marine corporal and his wife along with their Federal Recovery Coordinator and their Recovery Care Coordinator.

I can report to you, and this is not anecdotal, that these programs work in our hospitals every day where trauma teams triage new patients and collectively make decisions about which servicemembers need an FRC most.

These educated decisions are made where they should be made, at the hospitals and by the trauma teams and care coordinators. This is where the referral is made, FRC caseloads are managed, and appropriate resources are assigned to the care team.

I can tell you that although better integration is always the goal, quality services can and do coexist during this critical time for our recovering servicemembers and their families.

As servicemembers, we pay close attention not only to what is said but also to what is written. We pay close attention to details.

One such detail speaks more to unity than any testimony you will hear today and that is simply the business card that that FRC gave me on Monday and that every FRC provides to their servicemembers. On this card, side by side is not the seal of the VA but those of both the DoD and the VA symbolizing both agencies striving to deliver the collaborative services to our servicemembers who need them most.

Madam Chairwoman, this concludes my statement. I look forward to your questions.

[The prepared statement of Mr. Burdette appears on p. 41.]

Ms. BUERKLE. Thank you, Mr. Burdette.

Mr. Medve, you may proceed.

STATEMENT OF JOHN MEDVE

Mr. MEDVE. Good morning, Chairman Buerkle and Ranking Member Michaud and Members of the Subcommittee.

I am John Medve, Executive Director, Office of VA–DoD Collaboration within the VA’s Office of Policy and Planning. I am pleased to be here with my partner, Phil Burdette, today to discuss the Federal Recovery Coordination Program and the progress that has been made in addressing improvements recommended by the GAO.

The FRCP is designed to complement existing military service and VA-provided case management support and transition coordinators. FRCP is specifically charged with providing seamless support for its referred clients from the servicemember’s arrival at the initial military treatment facility in the United States through the duration of their recovery, rehabilitation, and reintegration.

The FRCP is an integral part of VA and DoD efforts to address issues raised about the coordination and care and transitions between the two Departments for recovering servicemembers.

On behalf of the clients, FRCs work closely with clinical and non-clinical care and case managers from the military services, the VA, and the private sector as part of their recovery team.

The March GAO report contained four recommendations. VA concurred with the recommendations and is taking action to implement each of them.

GAO’s first recommendation was that the FRCP establish adequate and internal controls regarding FRCs’ enrollment decisions. As a result, more stringent internal controls were implemented to include management review of all enrollment decisions.

The challenge still remains in getting the referrals from the military services for those needing FRCP services. The program’s visibility on these potential clients is based solely upon those who are referred.

For those who are referred to the FRCP, they are evaluated to determine the individual’s medical and nonmedical needs and requirements in order for them to recover, rehabilitate, and reintegrate.

A key component in the FRCP evaluation process is whether an individual would benefit from the FRC level of care coordination.

The bottom line is that while FRC clients represent a small portion of the recovering servicemember population, those who are re-

ferred and who meet the established criteria are offered enrollment in FRC.

GAO's second recommendation was to complete development of a workload assessment tool. FRCs have embarked on the development of a service intensity tool that would fulfill the workload assessment requirements of the GAO recommendation and further tie the assessment to enrollment decisions. This process will likely be completed by the summer of 2012.

GAO's third recommendation to the VA was to clearly define and document the FRCP's decision-making process for determining when and how many FRCs VA should hire. FRC positions are based on an analysis of an anticipated number of referrals, the rate of enrollment, and the number of clients made inactive and a targeted caseload.

Upon completion of the service intensity tool evaluation, FRC will modify this equation.

GAO's fourth and final recommendation was to develop and document a clear rationale for placement of FRCs. Original placements were based upon putting FRCs at MTFs where significant numbers of wounded, ill, or injured servicemembers were located.

As the program has grown, the assignment of FRCs has spread to additional locations.

Servicemembers, veterans, and their family are often confused by the number and types of case management and baffled by benefit eligibility criteria as they move through the DoD and VA's complex system of care. FRCP clients say the program works best when FRCs are included early in the servicemember's recovery and prior to the first transition.

Once assigned, an FRC will continue to support a client regardless of where the client is located. This consistency of coordination is important for individuals whose conditions require multiple DoD, VA, and private health providers and services transitions.

FRCs will remain in contact with their clients as long as they are needed whether for a few months or a lifetime.

This concludes my statement. I am happy to answer any questions you may have.

[The prepared statement of Mr. Medve appears on p. 43.]

Ms. BUERKLE. Thank you very much.

I will now yield myself 5 minutes for questions.

Mr. Burdette, with all due respect, I feel like I am in a parallel universe with what I just heard from the GAO and with what you are saying here this morning.

A card that says VA and DoD on it does not mean anything. Saying that that indicates that there is a good partnership concerns me.

I am more interested in what the GAO is reporting and that is that you are not good partners. You are not working together.

When you applaud this duplication as a safety net, that is inefficiency. That is a lack of coordination of care and effort. And I think you have to be really careful.

As Dr. Roe pointed out, 1,800 enrollees so far. You have 26 care coordinators. There is a lot of resources as you stated, but I am not sure and I feel pretty confident they are not being used effectively and efficiently.

So I am really concerned. Let's worry less about cards and symbolism and more about what is actually happening here for our wounded warriors.

You mentioned that you are a full partner with the VA and that you assist with the implementing of the GAO's recommendations, yet the GAO in Dr. Draper's testimony said that DoD has provided limited assistance to the VA with the implementation of the GAO recommendations.

I was extremely disappointed to read that DoD's response to serious deficiencies was an email, you outlined an email telling the Wounded Warrior Programs that they should refer all severely wounded, ill, and injured to the FRC Program.

VA states they have not noticed any difference in the number of referral numbers or patterns since that time. So this flies in the face of that card that has got DoD and the VA as a partnership. So I would like to just give you an opportunity to explain that.

Mr. BURDETTE. Thank you, Madam Chairwoman.

I think the card is and symbolism are enormous. One of the big perceptions of the program as was alluded to by Dr. Draper is the real fear of a servicemember when she meets the VA representative and then it dawns on her she is not going back to her unit.

The fact that that DoD seal is still on the card I think is enormously heartening to that servicemember that says this is a concerted effort. This person is there as a resource for me. I might be able to stay in military service.

So I absolutely accept your viewpoint on that, but I think that that is the importance of the fact that the two seals are on the card.

Ms. BUERKLE. If I could interrupt just for a second. It is not my concern with the symbolism to the servicemember. It is my concern that you see you have a viable and a working partnership with the VA. That card does not mean anything if the veterans and the wounded warriors are not getting the care they need.

So my concern is the symbolism with regards to your partnership because what I am seeing and hearing from the GAO is that you do not have a good partnership, that you are not working together, and the coordination of care is not effective.

Mr. BURDETTE. Yes, Madam Chairman. I began my response with the servicemember focus because that is where we are all focused. First and foremost is how we deliver that service to that servicemember at the military treatment facilities. So that has to be the be all and end all.

I think the Ranking Member said it absolutely correctly. If we do not get this right, servicemembers will suffer.

So to take that then to your other point about the DoD-VA collaboration at a more strategic level, the synergy is tremendous.

The fact that both Secretaries now meet on a quarterly basis and then help drive SOC agenda items, the fact that this issue has been on the SOC agenda every time the SOC has met this year, the absolutely groundbreaking work that the VA has taken on through an internal task force, top to bottom care coordination that Dr. Draper talked about, and some of the impacts of the many programs through the leadership of Mr. Gingrich at the VA, they have absolutely gone top to bottom and said how do we impact and touch

every one of our servicemembers and new veterans, how can that be most efficient, what is the VA doing to complement that, what can we do away with, and what can we then amplify to make sure that that quality service is given to the servicemember.

In the area of referral, ma'am, we have work to do. I accept that. I hold up this fax form that we have asked the field to use. So when Dr. Draper referenced my guidance to the services to do a better job on referring, in 2011, if I am telling the services to go to a fax machine, I am behind. But that is the tool we have today. We are going to get better and get away from a fax machine referral form and make that a better process.

My commitment to you is we will get there. That is one of just many steps that she highlighted that we have taken over the summer as a result of our care coordination summit which was a 3-day off-site with the VA and the FRCs, many of whom are in the back of the room today and have traveled to this hearing because they care so deeply about their patients and about the programs that they are involved in.

But that is just one step. Throughout the summer, a whole tally of efforts has been undertaken by both Departments to make sure that we study the problem, that we get the answer right, and as the Ranking Member has asked us to deliver is to deliver the right solution.

Ms. BUERKLE. Thank you, Mr. Burdette.

I just have one last question and then I will yield to the Ranking Member.

You mentioned in your testimony that the program titles create confusion for those transitioning or possibly transitioning out of active duty into the veterans' world. But it also creates policy confusions.

That concerns me with a program that is 4 years old that we have not gotten the policies down and what we are trying to accomplish and how we are going to accomplish it. So if you could just comment on that.

Mr. BURDETTE. Yes, Madam Chairwoman.

This program grew out of the horrors of Walter Reed revelations in 2007. And the SOC, to its great credit, enacted quick solutions and fielded resources to help the wounded warriors and their families.

As that matured over the last 4 years, a lot of programs have been put in place. If we had thought, I think, when we fielded the Recovery Coordination Program to clearly delineate titles and responsibilities at that time, we would be better off than we are today. We owe that to you. I think that that work is really in earnest.

We spoke earlier about the lateness of the letter. I think that the lateness of the letter really reflects our intense desire to get it right but also to be timely, but to err on the side of getting it right.

So I think that that work will be completed soon and we look forward to reporting it to you.

Ms. BUERKLE. Thank you.

I yield now to the Ranking Member.

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

Is the Defense Center of Excellence out at Bethesda supposed to coordinate with the VA as well?

Mr. BURDETTE. Mr. Ranking Member, when a servicemember is evacuated from the battlefield in Afghanistan, most frequently they will go to Landstuhl. Then they will be air lifted back to Andrews Air Force Base. And on September 2 with the closing of Walter Reed as we knew it, they will now be air ambulated or motorcade ambulated to Bethesda.

At that point, the trauma team meets with that patient and the families and that's when the care team comes together and makes triage decisions on what resources we are going to give immediately to that family and then downstream through the recovery period.

Mr. MICHAUD. So at that point in time, they are supposed to coordinate with the VA—

Mr. BURDETTE. Absolutely.

Mr. MICHAUD [continuing]. At the Center of Excellence?

Mr. BURDETTE. At Bethesda, at those trauma and triage teams, and the FRCs in the back of the room are a part of those trauma teams, meet when the servicemembers arrive and the doctors and the nurse case managers and that trauma team assembles and says what resources are we going to apply.

Mr. MICHAUD. Well, that is interesting because I just came from Bethesda on Monday. I went to visit a wounded soldier from Maine, and the doctor at the Center of Excellence told me that there was zero coordination with the VA.

The other part of the trip was to see what a soldier would have to go through in that process, but not once was I introduced to a Recovery Coordinator.

So from what you are saying and what is actually being implemented are two separate things. And it is consistent with what we heard from the GAO about a lack of coordination between DoD and the VA, which is a huge concern because my bottom line is to take care of the wounded soldier.

The Military Officers Association made a recommendation that we mandate a single joint VA–DoD program so we do not have to worry about two. It would be one program if I understand their recommendations.

I would like you both to comment on that.

Mr. BURDETTE. Mr. Ranking Member, I think the easiest thing to do and the quickest thing to do would be go back to the SOC, where I serve as the Executive Director, and we issue a memo that says we now have a joint program. I think that does little on the ground to effect and fix the coordination.

We have intentionally written policy with flexible language to allow the military treatment facilities and the doctors and the case managers on the ground to decide what resources need to be applied to patients. That is a patient-centric focus that we have not wavered from.

So I think that is the right approach to get that is to get it right rather than the names and what we put on the letterhead. If we declare a joint program, we have not fixed anything. If we fix the mechanics and the roles and responsibility is clearly delineated, I do not think it matters who they pay, who pays them, or who they

work for as long as that family feels supported and has the resources they need.

Mr. MICHAUD. So it sounds to me like we have a problem with those who are implementing these programs, and that is a big concern. We can change the titles. You are right. I think the law is very clear on the coordination and there does not appear to be any coordination.

So if that is not happening, then that leads me to believe that those that are responsible for these programs are not doing their jobs and, therefore, probably should be fired and get someone in there who can do the job in taking care of these soldiers.

Like I said, when I went out to the Center of Excellence, when I heard the doctor say there is no coordination with the VA system, that is concerning. When I read the GAO report, that is concerning.

And I hear both of you here saying there is coordination. There probably could be some improvements. But the bottom line is they are not being taken care of.

I will ask the VA to comment.

Mr. MEDVE. Sir, I think what I identified is we do have challenges with accession into the program and contact. But I will also say that a number of our referrals are coming from the medical teams in the hospitals.

What the DoD instruction has in it is referral of Category 3 and they are supposed to be severely and catastrophic. As I am not a clinician, but when I have asked our VHA, Veterans Health Administration, people what that means to them, it does not mean a lot.

So I have been instructed by our Under Secretary of Health to translate what that means into more clinical terms so that the teams on the ground then have something as they are looking at somebody in a clinical setting to say, all right, this meets the criteria, we need to call the FRC in to meet on this particular case.

Mr. MICHAUD. Thank you.

I see my time has run out. Thank you, Madam Chair.

Ms. BUERKLE. I now yield to the gentleman from Tennessee, Dr. Roe.

Mr. ROE. Thank you, Madam Chairman.

Back to just it is not a lack of resources, it seems like we have plenty of help.

When I look at the FRCs and it says in here the program has 777 current active enrollees, that is 37 people per FRC. That is not a very heavy caseload and at least looking at it from my standpoint from what I have done for 30 plus years.

It looks to me like that it is a coordination problem. How do you answer the question? And I realize that the bureaucracy is big.

Having served in the military and being a young officer back from overseas duty, we had 2,000 women that needed PAP smears at Fort Eustis, Virginia, in 1973 and I was absolutely convinced I was going to fix that problem.

When I left almost a year later, there were 2,000 people on there. So I do share some of your frustration of getting it done. I just ran into a brick wall.

But as Mr. Michaud said, that we should not accept that. We are having people that are surviving injuries now that they would never have survived before and they need help and their families

need help. We have the resources to do it and we are good at this. This is not something we are bad at. Health care is something we are really good at.

I do not know why it took months to answer a letter. Could you square me away on that.

Mr. MEDVE. Sir, I will just say that I take responsibility for not ensuring that on the VA side that the letter was delivered in a reasonable time frame. We worked it through the system and—

Mr. ROE. Well, let's don't worry about letters. We are here now and the important thing is to get these soldiers taken care of.

And I know if I am a soldier, I am thinking to myself what Mr. Michaud just described at Bethesda. If you are there, you are looking for help. If you are a family member, you do not know all these things that your wife or husband are going to need. And we need to take care of all that problem so they do not have to worry about that. They know right where to go for these resources.

And how would you answer when you have five people working on the same thing or eight in some cases?

And as you well know, we are up here fighting back and forth about the resources now and not having enough resources and having budget cuts. We have the resources. Matter of fact, we have over-resourced. We are not using them very well, it does not sound like.

Mr. BURDETTE. Sir, I think I might answer that question by quoting a young spouse that I met when I traveled to Brooke Army Medical Center earlier this spring.

And I said tell me about the perception. Did we inundate you on arrival, rip you out of Fort Hood, Texas, tell you you have to meet your loved one here at Brooke Army Medical Center and your husband is in a bad medical condition?

And then we immediately overwhelm you and we leave you with 25 business cards and you feel overwhelmed and a little confused and perhaps not well taken care of.

And she looked me right in the eye and said I would be upset if I did not have 25 business cards. She said if I do not get an answer from the first person, I will call the second and third.

Mr. ROE. My point is, though—wait a minute, whoa, whoa right there—she should be able to get the answer from the first person. That is what their job is. That is what they do.

And that is the problem that I ran into is that somebody needs to be in charge of the ship. Otherwise, it just goes in 50 different directions like an amoeba.

Mr. BURDETTE. Sir, completely agree. On a Sunday night at 7:00 p.m. when the servicemember needs help, that first business card might not always get—that phone might not always get answered. So I think what we are speaking there to is the redundancy of available resources.

I am certain and I have watched the briefs be given that we brief on the—

Mr. ROE. Back up again. When somebody is getting ready to have a baby in my practice and the phone rings, somebody answered it.

Mr. BURDETTE. I apologize, sir, for not making a distinction. The clinical teams are always available. The doctor who is in charge of

the care for that patient is always available and the Recovery care team is always available.

When we are talking about somebody to talk about life insurance benefits or transition benefits to the VA, that person may not be available.

Mr. ROE. They could make a call to the Recovery coordinator or, look, you said that a name change, call it the health team of the hero team or whatever you want to call it. If you want to do that, change the name if that is confusing to somebody.

But I ought to be able to as a family member make a phone call and that person says I am going to help you. I will get that information for you and I will be back to you in a timely fashion.

Mr. BURDETTE. Sir, I am confident that the Recovery Teams offer that availability to that servicemember. And then I am also confident that if that person is not available for whatever reason, in surgery, unavailable for a holiday or vacation or something, that there is another person right behind them to step up and help that family member.

Mr. ROE. So in some length of time, can you all tell, are you going to implement the four GAO recommendations and if we ask this question 6 months from now, what is the answer going to be?

Mr. BURDETTE. Sir, the four GAO recommendations that came in March, the VA-centric ones, VA has already undertaken much progress to get those done. Those detailed plans were included in our September 13th letter. So that was a part of it.

The second part of the Chairwoman's letter and Ranking Member's letter to us was what is the future of this program. The Recovering Warrior Task Force that this body chartered reported to us on September 2nd with some additional recommendations for the program.

I think that combined with the VA's top to bottom review now gives us the body of evidence, objective and otherwise, to chart the road ahead.

I am confident that in our next meeting that we will have that answer. I think we will publish it to you in a letter in advance of the next hearing on just what the future was in essence an answer, ma'am, to your second question from that letter.

Mr. ROE. I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

I now yield to Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chair. Appreciate it very much.

Again, the same issue. I like the concept of having a single point of contact so that injured servicemembers and veterans have a one-stop shop in which to go for assistance. And I hear about this all the time in my district but also up here at the hospitals.

Do you think that there is any circumstance where it is necessary or appropriate for an individual to have multiple of these caseworkers or coordinators? Is there a circumstance?

And it seems to me that if coordinators all have a similar and uniform level of training, they would provide similar advice. So the question is, what is the standard of training for caseworkers and care coordinators?

Mr. BURDETTE. Sir, I can speak to the Recovery Care Coordinators. The Recovery Care Coordinators on the DoD side, we have approximately 167 at over 67 sites nationwide. At the DoD level, they are all uniformly trained in what they deliver in the non-clinical case management.

By that, I mean life plans for the family members, life plans for the servicemembers, and things that open them to opportunities such as vocational rehab through the Veterans Affairs and other educational opportunities.

I think Mr. Medve can speak to what the FRCs are trained and deliver.

Mr. MEDVE. Yes, sir. Congressman, we currently have 23 FRCs. They are all either Master's trained nurses or social workers. They have a series of quarterly training events back here in DC to level them.

As a matter of fact, this afternoon, I am going to be addressing a series of FRCs to update them on changes to the Integrated Disability Evaluation System so they understand the process for that as they advise their clients.

So we set a fairly high bar in terms of the certification of FRCs.

Mr. BILIRAKIS. Thank you very much.

I yield back, Madam Chair. Thank you.

Ms. BUERKLE. Thank you, Mr. Bilirakis.

I am going to just start a second round of question in case any of the other Members have questions.

Mr. Medve, I would like to ask you. We have heard about disagreements between DoD and the VA. Can you elaborate on that. What is your understanding? Where are the points of disagreement and how will we overcome those?

Mr. MEDVE. Madam Chairwoman, I would be less than honest if I did not tell you we clearly have an issue with accession into the FRC Program of ensuring that we identify who needs to come into the program. That is one of the issues that Mr. Burdette and I are currently working on.

Part of what we are grappling with, and I shared with him just the other day a draft set of clinical definitions to help guide the teams and the MTFs to help make those referrals more timely so we bring in the FRCs earlier. And that to me is the largest challenge we face at this time.

Ms. BUERKLE. Mr. Burdette, how are you going to address that issue and do you see that as a problem as well?

Mr. BURDETTE. Madam Chairwoman, at the DoD, we have taken several steps to make sure that the referral process is a solid one from our standpoint.

The Deputy Secretary of the VA uses the analogy all the time if you do not throw me the football, I cannot catch it. That is my responsibility to make sure that we are referring the servicemembers to the VA.

The email that Dr. Draper referenced and the letter that I sent to the services clearly did not do it enough. I need to give them a better tool than the fax sheet as well.

And also in the area of language, I think that Mr. Medve alludes to a perfect example. We have used the very broad language of whoever most needs an FRC intentionally because if we get down

to a clinician's viewpoint point system of who gets one, then we find that year over year, we will exclude people who really need an FRC.

For example, the complex injuries we are seeing today from the battlefields are staggering. And it is not just a single amputee anymore. It is multiple internal injuries. It is multiple non-visible injuries with traumatic brain injury (TBI) and with post-traumatic stress disorder (PTSD) and other things that just make it so complex that the FRCs and the clinicians and the practitioners said if we had written criteria that were very specific, a point system, for example, in 2007 and 2008, it would be outdated now and we again would be in that round of now who gets one. And we would have had a totally different clientele that we would have excluded had we been too prescriptive.

That is our challenge. Our balance is to get that right. And we need to get it right.

Ms. BUERKLE. Do you have a policy in place for referrals?

Mr. BURDETTE. We do. We do. But the prob—

Ms. BUERKLE. Can you provide that to the Committee?

Mr. BURDETTE. Absolutely. Absolutely.

[The DoD subsequently provided the following information:]

The Department of Defense Instruction (DoDI) 1300.24, which appears on p. 56, is the policy document governing the Department's Recovery Coordination Program, including servicemembers who are referred to the Department of Veterans Affairs Federal Recovery Program. For severely and catastrophically injured and ill servicemembers who will most likely transition from military service, a Federal Recovery Coordinator will become part of the Recovery Team in addition to the Recovery Care Coordinator and assist the servicemember as they transition to Veterans status.

Ms. BUERKLE. It seems to me now 4 years after this program started that you would have policy and then you would work through that policy. And when VA says we are not getting referrals quickly enough, you would alter that policy and this would be a moving, developing policy.

But, it seems like we do not have that. It is not about something that is out there. It is about wounded warriors. It is about people who served this Nation. It is about people who are in need.

This is 4 years old. If we are not meeting their needs, we have a problem here. And the fact that they come home and they need services and DoD is not making a timely referral or one person is working on the same issue, five people are working on the same issue, that is a problem.

This is not something where we have the luxury of time and it is some policy thing. It is people and it is people's lives. And that is why we are having this hearing and we will continue to monitor this, to stay on top of this, and to make sure that our veterans get what they need.

I am going to ask if any of the other Members would like a second round of question.

Mr. MICHAUD. Yes. Mr. Burdette, you mentioned that you are coming forward with some options regarding the current policies and how we might be able to maximize the resources of care and coordination.

Can you tell us what some of those options that you are coming up with?

Mr. BURDETTE. Again, Mr. Ranking Member, the options are all pre-decisional. There has always been, I think, a sincere desire to take the GAO recommendations and the Recovering Warrior Task Force recommendations and perhaps just say an overarching umbrella over both sides of this house may make it a little more of the direct line and not a dotted line of lines of responsibility.

There are smart people at the field level who think that is not the way to go either. That is why we brought them all in in March and said let's sit around the table and talk. Some dozens of recommendations come out that we are not discussing today how we improved both programs.

But that core issue is the definition of who gets referred and that is when we have to get it right to your first opening comment, sir, and that is what we are committed to doing.

Mr. MICHAUD. And are you working with the wounded warriors themselves to find out what would be helpful to them versus what might be easier for VA or DoD? Have you requested their assistance as well?

Mr. BURDETTE. We could not do it without that, Mr. Ranking Member. I saw you on Monday also when you were on the campus of Bethesda. As well, we do not go there for optics. We go there for information and to ask them directly what do you need and are the systems we have fielded serving you well. Without their input, we do not have a solution.

Mr. MICHAUD. Thank you.

I yield back the balance of my time. Thank you.

Ms. BUERKLE. Thank you.

Dr. Roe.

Mr. ROE. Just one question that I did not get answered a minute ago on the coordination.

When GAO references one FRC who estimates his enrollees have on average eight different case managers affiliated with eight different programs, is that going to continue or is there a one-stop shop that somebody can go to to get headed in—if they are maybe injured, have sight impairment or an orthopedic problem or a prosthesis problem?

I am going to get you to where you need to be and take care of you. You do not have to worry about it. You call me. I am going to get you down the right road. I am your GPS in this maze.

Mr. MEDVE. Congressman, I could not agree more that at least from my perspective, the FRCs are designed to be that overarching lynchpin. That is why they handle both the clinical and non-clinical piece.

Now, sometimes they think we, and I know again not being a clinician, as somebody who is assigned to an MTF and they are having specific procedures, we have designated liaison specialists to handle that component of it, but the FRC should be the one that is helping to arrange all that and ensure that is all happening in a synchronized manner.

Mr. ROE. Because I know that Recovery coordinators have some frustrations. And I would like to hear what they have to say.

I mean, my door is always open in the office to hear what their frustrations are because I think if you call the people actually

doing the work and they can tell you where the bumps in the road are.

I mean, the 21 people that are doing that, I think they have a lot of information to share with us. We have not heard them today and maybe in some written testimony or either just make an appointment in my office and come back and let me know.

I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

Mr. Bilirakis.

Mr. BILIRAKIS. One, Madam Chair.

When do you realistically, and I may have missed this because I came in late, when do you realistically estimate you will have a concrete plan to maximize this care coordination between DoD and the VA?

Mr. BURDETTE. Sir, if I could, we get a new Deputy Secretary of Defense today. And when Dr. Carter takes his post today, he will become the co-chair of the Senior Oversight Committee.

If I could take that answer for the record, I need to get his guidance on time tables as the new co-chair of the SOC and then he will meet with the Deputy Secretary of the Veterans Affairs.

But I am confident we have all the data we need at this point. We need to forward a decision memo for those two co-chairs and then have them make the decision. They are anxious for that decision and I know Dr. Carter awaits my brief on that options matrix.

Mr. BILIRAKIS. Can you get back to us?

Mr. BURDETTE. I will, sir.

Mr. BILIRAKIS. Maybe other Members of the Committee would like to know as well.

Mr. BURDETTE. I will, sir.

[The DoD subsequently provided the following information:]

Currently, DoD and VA are working on the decision memorandum regarding the future of the Federal Recovery Coordination Program and Recovery Coordination Program. In December, I am scheduled to deliver the memorandum to the Senior Oversight Committee for consideration and decision.

Mr. BILIRAKIS. Thank you.

Thank you very much. I yield back, Madam Chair.

Ms. BUERKLE. Thank you.

At this time, we are finished with our questioning for our second panel.

Mr. Burdette, you will provide to the Committee the policies and procedures with regards to the referrals from DoD?

Mr. BURDETTE. I will, ma'am.

[The DoD subsequently provided the following information:]

The Department of Defense Instruction 1300.24, which appears on p. 56, is the policy document governing the Department's Recovery Coordination Program, including who is referred to the Department of Veterans Affairs Federal Recovery Program. For severely and catastrophically injured and ill servicemembers who will most likely transition from military service, a Federal Recovery Coordinator will become part of the Recovery Team in addition to the Recovery Care Coordinator and assist the servicemember as they transition to veterans status.

Ms. BUERKLE. Thank you.

Thank you both very much for being here this morning.

Mr. MEDVE. Thank you, Madam Chair.

Ms. BUERKLE. Would our third panel please join us at the table.

Joining us on our final panel this morning are representatives from our veterans service organizations (VSOs). First, we have Ms. Abbie Holland Schmit, Manager and Alumnus from the Wounded Warrior Project (WWP); Althea Predeoux, Associate Director of Health Legislation from the Paralyzed Veterans of America (PVA); and Commander René A. Campos of the United States Navy, retired, the Deputy Director of Government Relations from the Military Officers Association of America (MOAA).

Thank you all very much for joining us this morning.

Ms. Schmit if you would like to start.

STATEMENTS OF ABBIE HOLLAND SCHMIT, MANAGER, ALUMNI, WOUNDED WARRIOR PROJECT; ALETHEA PREDEOUX, ASSOCIATE DIRECTOR OF HEALTH LEGISLATION, PARALYZED VETERANS OF AMERICA; AND COMMANDER RENÉ A. CAMPOS, USN (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

STATEMENT OF ABBIE HOLLAND SCHMIT

Ms. SCHMIT. Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for inviting the Wounded Warrior Project to testify on this important subject. We appreciate the Committee's oversight of Federal Recovery Coordination Program.

My background in working with wounded warriors has given me an on-the-ground perspective on the importance of this program to warriors and their families.

As all of my managers with the WWP in Chicago, I work with warriors and their families on a daily basis. Before joining WWP in June, I served for more than 2 years as an advocate with the Army's AW2 Program (Army's Wounded Warrior Program).

As someone who served in the Army National Guard, I had a hard journey home due to PTSD and traumatic brain injury. The issues before you are deeply personal to me.

The FRCP was designated to assist those warriors who need help in navigating an often complex transition process. FRCs are making a real difference in helping severely injured warriors and their families thrive again.

But as you heard in your hearing in May, individual service Departments are not routinely referring those servicemembers who need the help to the program.

The service Departments seem to view the FRCP as a VA program and tend to make referrals to the program only when the warrior is about to separate or retire.

The FRCP should be operated as a joint integrated effort to coordinate Federal care and services. But current practices risk delaying warriors' recovery, rehabilitation, and reintegration. These are not just hypothetical concerns. Let me share the case of Army specialist Steven Bohn, who testified before the Senate VA Committee in May and had been badly injured in 2008 when a suicide bomber in Afghanistan detonated explosives that buried him under collapsed debris and resulted in his suffering severe internal and spinal injuries.

Breakdowns in coordination led initially to his being sent to the wrong military treatment facility. Later, poor communication led his Army command to threaten him with an AWOL (absent without leave) while he was still recovering from surgery.

Eventually he underwent a DoD Medical Evaluation Board that rated him at 40-percent disabled for spinal and neck injuries. But it did not take into his account his internal injuries.

While his transition from DoD to VA seemed to begin smoothly, backlogs in scheduling his VA compensation exams bogged down the process. Seven months after retiring from service, VA had still not adjudicated his claim and he was struggling financially. Unable to work because of his injuries, he was living on a military retired pay of \$700 a month.

Steve also fell through the cracks in getting his VA medical care. It took more than 6 months before anyone approached him to discuss any VA treatment. Steve testified that no one ever discussed with him or his family the possibility of having an FRC assigned to his case. It seems clear it would have made a big difference.

Steve's experience is not unique, but it shows how easily a severely wounded warrior can fall through the cracks. This frequent failure to refer severely wounded warriors or an FRC is a problem that can and must be remedied. But the joint VA-DoD response to the Subcommittee's questions fails to provide that remedy.

In their cover letter, the two Department secretaries state that all Category 3 servicemembers who would be most eligible from the Federal Recovery Coordination, FRC, would be referred. But in quotes, their letter states just the opposite saying the program cannot ensure that all potentially eligible individuals are referred to FRCP.

It is difficult to understand why the senior leadership of the two Departments have failed to resolve this problem. VA and DoD share a deep obligation to severely wounded warriors and their families. But the reality is that they do not share full responsibility of the FRCP.

Warriors and families need this help early in their transition process. In our view, our warriors would be better served if they were truly shared VA and DoD responsibilities for the program.

In that regard, WWP welcomes the introduction of H.R. 3016, a bill that would require VA and DoD to jointly operate this important program. We strongly support this legislation, which we believe would go a long way towards resolving critical issues affecting the program and toward ensuring its goals are fully realized.

Thank you again for this opportunity to testify. I would be pleased to respond to any questions you may have.

[The prepared statement of Ms. Schmit appears on p. 45.]

Ms. BUERKLE. Thank you very much.

Ms. Predeoux, you may proceed.

STATEMENT OF ALTHEA PREDEOUX

Ms. PREDEOUX. Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, Paralyzed Veterans of America would like to thank you for the opportunity to present our views on the Federal Recovery Coordination Program, the 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 from the Department of Veterans Affairs and provide support during the rehabilitative process to ensure that all disabled veterans have the opportunity to build bright and 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, and wounded veterans and servicemembers.

When PVA provided the Subcommittee with a statement for the record for the hearing held on May 13th which examined the progress and challenges of the FRCP, we identified three areas in need of improvement, continuity of care, care coordination, and program awareness.

Today, we still believe that these areas are critical to the success of the FRCP and are in direct alignment with the issues and recommendations outlined by the Government Accountability Office, GAO, in a March 2011 report entitled, "The Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges."

The first recommendation from this report was to ensure that referred servicemembers and veterans who need Federal Recovery coordinator, FRC, services, that they establish adequate internal controls regarding the FRC's enrollment decisions.

In particular, this recommendation identified the need to require FRCs to record the factors they consider in making FRCP enrollment decisions as well as the need to create an assessment tool to evaluate these decisions.

PVA believes that the use of recording methods and assessment tools will help streamline the enrollment process and ensure that veterans and their families are receiving help when it is requested.

Servicemember enrollment is one of the most critical elements of the FRCP. Ensuring 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 different offices and Departments across both VA and DoD.

The second recommendation from the GAO report encouraged complete development of an FRCP workload assessment tool that will enable the program to assess the complexity of services needed by enrollees.

PVA believes that monitoring and managing the level of complexity and size of FRC caseloads is extremely important to adequately addressing the needs and concerns of veterans and servicemembers.

No matter how well prepared and trained an FRC may be, he or she will not be able to effectively help veterans and servicemembers to the best of their ability if they are spread too thin and overwhelmed with an unreasonable caseload.

The third recommendation to clearly define and document the FRCP's decision-making process for determining when and how many FRCs VA should hire is an area of serious concern for PVA. Adequate staffing of the FRCP is essential for providing veterans and servicemembers with timely and helpful assistance.

With a limited number of FRCs, issues involving transportation and distance have the potential to hinder access to FRCP services for many veterans in rural areas and, thus, becomes a threat to continuity of care for newly injured and severely ill veterans and servicemembers.

The GAO final recommendation calls for the FRCP to develop and document a clear rationale for the placement of FRCs. We understand that as a newer program, time is needed to create, implement, and assess the inner workings of such a comprehensive initiative.

However, we ask that as the program expands, VA and DoD consider placing FRCs in locations where veterans with disabilities are already seeking services, such as spinal cord injury centers and amputation centers of care.

In conclusion, PVA recommends that FRCP leadership periodically survey veterans, servicemembers, and their families to identify areas for improvement. There are numerous lessons to be learned and an abundance of opportunities for development.

Thank you for this opportunity to testify today and I would be happy to answer any further questions that you and the Committee may have.

[The prepared statement of Ms. Predeoux appears on p. 48.]

Ms. BUERKLE. Thank you very much.

Commander Campos.

STATEMENT OF COMMANDER RENÉ A. CAMPOS, USN (RET.)

Commander CAMPOS. Madam Chair and distinguished Members of the Subcommittee, on behalf of the 370,000 members of the Military Officers Association of America, I am grateful for this opportunity to present our observations on the FRCP.

MOAA commends the Subcommittee for its leadership and sense of urgency on the critical topic of care coordination of wounded, ill, and injured.

We also thank the VA and DoD for expending a great deal of effort and resources on our Nation's heroes these last 10 years. However, we are extremely troubled by the business as usual message conveyed by VA and DoD officials at the May 13th hearing and in a recent letter to the Subcommittee indicating that the Departments have significant command and control issues and lack a roadmap for addressing system failures.

It is not possible to talk about the FRCP without talking about the DoD Recovery Coordination Program, RCP, since the two programs are seen as fulfilling the same roles in their respective agencies.

To better understand the programs, it is helpful to look back at the timelines for establishing them. August and October of 2007, the secretaries of VA and DoD signed Memorandums of Understanding (MOUs) establishing and implementing the FRCP design-

nating FRCs as the ultimate resource for assisting wounded warriors.

January 28, 2008, the fiscal year 2008 National Defense Authorization Act directed the agencies to establish joint policy for care, management, and transition of recovering servicemembers to include policy on recovery care coordination not later than July 1st, 2008.

DoD did not establish that policy until almost a year and a half later on December 1st, 2009 and then delegated responsibility to the service wounded warrior programs.

Three months later, VA published a handbook establishing the FRCP procedures for both agencies. In that handbook, the RCCs are assigned to servicemembers whose period of recovery is anticipated to exceed 180 days but who are likely to return to active duty, assisting them through the DoD system of benefits and care.

Because the FRCP was the first coordination program and was to be the ultimate resource, many believed the program would serve as a model for other VA and DoD collaboration. Instead, VA and DoD continue to struggle today to implement a joint program that they committed to over 4 years ago and is highlighted in a September DoD Recovering Warrior Task Force report.

The report cites a number of Wound Warrior Program discrepancies and specifically recommends standardizing and clearly defining the roles, responsibilities, and criteria for assigning FRCs, RCCs, and other case managers.

Additionally, beneficiaries in the programs continue to talk about their experiences are all over the map. Some say too many coordinators doing opposite of each other. Others love their FRC or their FRC and still others who say they have no assistance or assistance comes too late in the process.

Clearly the two Departments have been unable to fix the issues of care coordination for this relatively small population of catastrophically wounded and disabled members and are unlikely to do so in the immediate future without outside intervention to address policy and program compliance, accountability, communications, and oversight issues across all wounded warrior programs.

MOAA recommends Congress, one, revise and expand Section 1611 of Public Law 110-181 to mandate a single joint VA-DoD program, establishing an office for care coordination, and requiring DoD to adopt VA's FRCP policies and procedures.

Two, to conduct joint Veterans' Affairs and Armed Services Committee hearings on wounded warrior issues to ensure common understanding and guidance in addressing the problems.

Three, to commission an outside entity to evaluate the FRCP and RCP within the context of the broader wounded warrior programs.

Four, to require VA and DoD medical and benefit systems to expand outreach and communication efforts, and, finally, to conduct periodic needs assessment surveys among beneficiaries to improve programs and identify unmet needs.

MOAA is grateful to the Subcommittee for your commitment to our Nation's wounded, ill, and injured and their families, and we appreciate this opportunity to provide our views.

Thank you.

[The prepared statement of Commander Campos appears on p. 50.]

Ms. BUERKLE. Thank you all very much.

I will now yield myself 5 minutes for questions.

My first question is to all three of you. Have any of your organizations been asked to participate with representatives from either DoD or VA about ways in which to revamp or merge or eliminate and to make these programs more efficient?

Ms. SCHMIT. Not that I am aware of.

Ms. PREDEOUX. Not that I am aware of.

Commander CAMPOS. No.

Ms. BUERKLE. Thank you.

It would seem to me that we should reach out to the veterans, to those who are in need and learn from their experiences.

The three of you, how would each of you respond to the GAO's comment with regards to the confusion and the lack of coordination actually hampering recovery for our veterans rather than helping them, if you would comment on that?

Ms. PREDEOUX. I will take a stab at that. With regard to coordination and multiple care coordinators and confusion, that is obvious how that can happen. But at the same token, I think it is important not to lose sight that the Federal Recovery coordinators serve a very unique purpose. They are the only coordinators that straddle both systems and they are able to provide all of the services both social supports as well as clinical.

So regardless of redundancy or multiple care coordination, we must keep in mind that FRC coordinators are supposed to be the main coordinators.

Ms. SCHMIT. And just to dovetail, the FRCs are the people that are coordinating the coordinators. And so if I was a warrior that was critically injured, ill, or wounded, that would be my first and primary point of contact.

And I think that is important any time that you are going through the transition. My transition was not as bad as someone that would need an FRC, but knowing who to call. And once you have a person like that, I think it really does help.

Commander CAMPOS. I think I would refer back to what GAO said. And these are really the issues with the FRCP and the RCP programs are really systemic of broader issues throughout the two systems.

And we see it in a lot of other wounded warrior programs that are within DoD and VA. And so we just believe that the FRC and RCP programs are just kind of victims of bigger problems within the systems.

Ms. BUERKLE. Thank you.

And then if I could just ask the three of you for your insights as to where you think we should go from here to get this program up and running and get it to the point where it should be.

Ms. PREDEOUX. Perhaps continued oversight from the Subcommittee would be recommended. And, additionally, perhaps also establishing, I guess, enforced and understanding of where to start. Establish a point where regardless of what department identifies, whether it be DoD or VA, that an FRC is needed, but that each

side knows that it starts with the Federal Recovery Coordination Program.

Commander CAMPOS. I believe that the oversight issue is a big issue. We saw many of the wounded warrior programs develop over time because of Congress' active engagement after Walter Reed. And over time, we have seen with the change in administration and leadership in the agencies a lowering of the SOC in the organizations. There just has not been the level of oversight and transparency.

So we believe, one, that, as I said in our testimony, that we need to combine these two programs, but there really needs to be, and as GAO recommended, there needs to be a broader review of all the wounded warrior programs because there is a tremendous amount of, you know, confusion across all the programs.

And we believe that there needs to be again accountability and I think only through Congress having frequent and periodic hearings will focus that level of urgency on the two systems.

Ms. SCHMIT. I will just kind of dovetail what both of these women have said. I would say that it needs to go beyond a memorandum of understanding, that we need to actually see both the VA and the DoD work together, and that, you know, hopefully you cannot tell where one ends and the other begins and we will have that seamless transition.

Ms. BUERKLE. Thank you all very much.

I now yield 5 minutes to the Ranking Member.

Mr. MICHAUD. Thank you, Madam Chair.

I just want to follow-up on the Chairwoman's question. I do know that there was a summit, the Wounded Warrior Care Coordination Summit in March of 2011. I understand that you did not participate in that summit?

Ms. PREDEOUX. No, sir.

Ms. SCHMIT. No, sir.

Mr. MICHAUD. Well, I wish the Committee staff will follow-up on who did if the VSOs and the different organizations here did not participate in that summit. I would like to have a follow-up question on that.

How do each of you feel? You talk about the handoff and clearly the program is not working. How do you feel about the smooth transition? If any one thing that this Committee or the VA or DoD could do to make that transition smooth, what would you recommend?

Ms. SCHMIT. And this is from my own personal experience as an AW2 advocate. I would say that the sharing systems, the non-sharing systems, and the fact that each component has their own way to take notes and keep logs and not all of those notes are always passed along. The recovery care plan needs to go from the Warrior Transition Units (WTU) to the VA so they can continuously follow-up on that plan and make it go in motion. So better communication.

Ms. PREDEOUX. I would have to agree with Ms. Schmit. The GAO report, I believe, discussed the information sharing initiative. And just to get that in place and actually have it work would be extreme progress in addition to again identifying a specific point of contact earlier within the FRCP, be it on the VA or the DoD side.

Commander CAMPOS. The two systems still view themselves, I think, as separate systems. And in doing so, I think it is clear that they want to identify the point where one point of care is done and the next system takes over. And I do not think the systems really have embraced that these wounded warriors and family members will be moving back and forth between the systems. So in that seamless transition, it is not a one way, one direction care. So these folks will be moving back and forth in between the systems.

So I think that there has to be a better understanding of even again what the role is of the RCCs and the FRCs. I think DoD has delegated too much to the services and each of the services have a different way of identifying or have different terminology for RCCs. The Army has the AW2 Program. So, again, other terminology problems.

So, again, I think DoD probably needs to do a little more oversight over the services to make sure that they are implementing the policies that have been put in place.

Ms. SCHMIT. And to back into what I just said is that each one of those different branches all have their own network, their own computer way of tracking their servicemembers and none of those notes are shared with anyone else, not with the DoD, not with the VA. And if you are at a VA site, you cannot put your own notes into the VA. So there is a communication kind of mishap there.

Mr. MICHAUD. So from what you are saying then, there is more than just a problem with the DoD coordinating with the VA? It is the DoD coordinating within itself?

Commander CAMPOS. Absolutely.

Mr. MICHAUD. My last question is, when you talk to some of the RCCs or FRCs, what are some of the frustrations? Have they explained some of their frustrations within the system that they might not be able to explain to their hierarchy? Have they told any of you some of their problems?

Commander CAMPOS. In the field, the FRCs that we talk to in the field have sort of like the FRCs and RCCs kind of look at each other, not sure what each other is doing or again they are duplicating efforts.

So there is a sense of frustration there, too, in not being able to work with DoD in again trying to identify who they are, why they are there. Again, the communication in these two programs between the systems here, you know, at the headquarters level but all the way down to the field is just not clear.

Mr. MICHAUD. Thank you very much.

Madam Chairwoman, I hope that both the VA and the DoD, especially the DoD, hears the bigger problem within DoD coordinating among the services let alone coordinating with the VA.

Hopefully that they will go back and do everything that they can to make sure that this is seamless not only within DoD, but between the two Departments because I just want to restate the bottom line for me is to make sure we provide that service to the soldier. And that is the bottom line. And I think we have to do everything that we can.

And there is no reason why that coordination of caregiver services cannot happen if we put aside the different silos that the dif-

ferent Departments have to work in and focus on the wounded warrior.

So with that, I yield back the balance of my time.

Ms. BUERKLE. Thank you very much.

Let me begin by thanking our panel, our third panel for being here today. Thank you for your service to our Nation. We deeply appreciate that. Thank you for being here.

I also would like to take this opportunity on behalf of the Ranking Member and myself to thank all of you in this room who are serving or who have served our Nation. We owe a debt of gratitude to our military, to the men and women who serve this Nation and keep us safe. And that is what this Committee, the Subcommittee is committed to do, to make sure our veterans get what they need and really deserve.

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

Thank you again today to all of our witnesses and our audience for joining us and joining in this very important conversation.

As has been recommended, you can be assured that this Subcommittee will continue to be vigilant and will be providing oversight to make sure that this program gets implemented and that our wounded warriors get what they need as they transition out of active duty into the veteran world.

Thank you all very much for being here.

This hearing is adjourned.

[Whereupon, at 10:05 a.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. I want to thank you all for joining us today as we continue our oversight of the Federal Recovery Coordination Program (FRCP).

Last May, the Subcommittee held a hearing to examine the significant challenges the FRCP program faces in areas as fundamental as identifying potential enrollees, reviewing enrollment decisions, determining staffing needs, defining and managing caseloads, and making placement decisions.

At that hearing it became patently clear that rather than having a single, joint program to advocate on behalf of wounded warriors and ensure a comprehensive and seamless rehabilitation, recovery, and transition, we have two separate, overlapping programs—the Recovery Coordination Program (RCP) operated within the Department of Defense (DoD) and the FRCP operated within the Department of Veterans Affairs (VA).

Needless to say, this has created unnecessary and unacceptable confusion about the roles and responsibilities of each program and has added yet another burdensome bureaucratic maze for our wounded warriors and their families to navigate at a time when recovery and reintegration should be their only focus.

So concerned was I about the pervasive issues with the operation of these two programs, that immediately following the hearing, I sent a letter jointly with Ranking Member Michaud to the co-chairs of the VA/DoD Wounded, Ill, and Injured Senior Oversight Committee (SOC), with oversight authority over the FRCP.

In that letter, we requested a detailed plan and a timeline for how VA and DoD jointly would implement the recommendations contained in the recent Government Accountability Office (GAO) report which identified significant shortcomings of the FRCP. Further, we asked for an analysis on how the FRCP and RCP could be integrated under a single umbrella to reduce redundancy and ensure the seamless transition of our wounded warriors.

A response was requested by June 20. More than 2 months past the deadline and following the notice of this additional hearing, we finally received a response to our letter.

Unfortunately, it did not include the detail or timeline we requested and expected.

With regard to an analysis of and potential options for integrating the FRCP and the RCP, we were told that the SOC is “. . . currently considering several options . . . to maximize resources in care coordination . . . and preparing for final recommendations . . .”

These programs are not new and the time for considering and recommending has long past.

As Chairwoman, it has been my privilege this year to spend time with our honored heroes who have returned from battle bearing the wounds of war and the families who stand by their side through it all. I have traveled to Brooke Army Medical Center, the Center for the Intrepid in Bethesda, and VA medical facilities across our great country.

It is clear to me that the FRCP is failing to meet its mission.

It also clear to me that these families cannot wait any longer. They can no longer be party to bureaucratic in-fighting and turf battles. They can no longer be told that they have several “single points of contact.”

When answers are needed, we cannot take 3 months to respond to a letter. When answers are needed, we cannot keep considering our options.

Today, I want answers.

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 today's hearing on the progress of the Federal Recovery Coordination Program (FRCP). In May, this Subcommittee held a hearing on the very same issue, and I am pleased with the continued oversight of this critical program. If it is not done right, servicemembers suffer.

Following the Subcommittee hearing, I joined Ms. Buerkle in sending a letter on May 26th to the Senior Oversight Committee requesting a detailed response as to how the VA and DoD can work together on implementing the Government Accountability Office's recommendations and requesting an analysis of integrating the FRCP and the Recovery Coordination Program.

On August 19th, we then had to send a follow-up letter because of the lack of a response from the Senior Oversight Committee. The letter we finally did receive, dated September 12, 2011, was hardly detailed. The GAO reports that the agencies reached an "impasse" on the content of the final letter responding to our concerns.

This lack of response only serves to magnify, in my mind, the continuing problems between the VA and DoD in working collaboratively and highlights the lack of progress that we have heard and read about recently in submitted testimony. I can only imagine what this means for other critical decisions that directly impact veterans and their families. I do not feel confident that the Department of Veterans' Affairs and the Department of Defense can overcome existing barriers and the tangle of bureaucracy that seems to surround the implementation of this program.

Let us all keep in mind that this isn't about the individuals sitting in this room today. This is about the brave men and women who have been injured while serving this country and our absolute commitment to their recovery and reintegration back into the communities where they live—whatever that takes. We owe them that.

Today, I would like to hear about solid progress that has been made and what is being done to move this forward in an efficient and effective manner. I also would like to hear from each of the panels what this Subcommittee might be able to do to help.

Madam Chair, thank you again for holding this hearing, the second in a series of hearings to assist in our oversight of the Federal Recovery Coordination Program. As we continue to monitor this issue, we will work to actively engage the VA and DoD as we move forward.

I yield back.

**Prepared Statement of Debra A. Draper, Director,
Health Care, U.S. Government Accountability Office**

**DoD and VA Health Care: Action Needed to Strengthen Integration across
Care Coordination and Case Management Programs**

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

I am pleased to be here today as you discuss the actions taken by the Departments of Defense (DoD) and Veterans Affairs (VA) to address issues of concern that were raised during your May 13, 2011, hearing on the Federal Recovery Coordination Program (FRCP). Our statement for that hearing,¹ based on our March 2011 report,² outlined several implementation issues for the FRCP, which was jointly implemented by DoD and VA to assist some of the most severely wounded, ill, and injured servicemembers, veterans, and their families with access to care, services, and benefits. Specifically, we reported on challenges faced by FRCP leadership when identifying potentially eligible individuals for program enrollment and determining staffing needs and placement locations. We also cited challenges faced by the FRCP when coordinating with other VA and DoD care coordination³ and case manage-

¹ GAO, Federal Recovery Coordination Program: Enrollment, Staffing, and Care Coordination Pose Significant Challenges, GAO-11-572T (Washington, D.C.: May 13, 2011).

² GAO, DoD and VA Health Care: Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges, GAO-11-250 (Washington, D.C.: Mar. 23, 2011).

³ 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.

ment⁴ programs that support wounded servicemembers, veterans, and their families, including DoD's Recovery Coordination Program (RCP). Specifically, we reported that poor coordination among these programs can result in duplication of effort and enrollee confusion because these programs often provide similar services and individuals may be enrolled in more than one program.

Based on the concerns raised during the May 2011 hearing, your Subcommittee requested that DoD and VA provide a detailed response on how they plan to jointly implement the recommendations to improve FRCP management that were outlined in our report. You also requested that the two Departments analyze potential options for integrating the FRCP and RCP under a single administrative umbrella to reduce redundancy and to better fulfill the goal of establishing a seamless transition for wounded servicemembers and their families. Although a response was requested by June 20, 2011, the Departments had not responded by September 2, 2011, when this Subcommittee announced that it intended to hold an oversight hearing on continuing concerns about the care coordination issues of the FRCP and RCP.

Our review of DoD's and VA's care coordination and case management programs, including the FRCP and RCP, is part of a body of ongoing work that is focused on the continuity of care for recovering servicemembers and veterans. My testimony today addresses the status of DoD and VA's efforts to (1) implement the recommendations to improve FRCP management from our March 2011 report and (2) identify and analyze potential options to integrate the FRCP and the RCP as requested by this Subcommittee.

We conducted the original performance audit for our 2011 report from September 2009 through March 2011 and obtained updated data and additional information in September 2011 for this testimony. Specifically, to obtain information on the status of the recommendations contained in our March 2011 report, we reviewed documentation provided by VA and interviewed the Acting Executive Director for the FRCP. Although our recommendations were directed to VA, which administers the program, we also obtained information from DoD officials that described to what extent they have worked with VA to implement them based on your request for the Departments to work together. To obtain information regarding the status of DoD and VA's efforts aimed at identifying and analyzing options for integrating or otherwise revamping the FRCP and RCP, we conducted interviews with DoD and VA officials and reviewed documents provided by both Departments. We also obtained updated information about DoD's and VA's care coordination and case management programs by reviewing program documentation and by interviewing DoD and VA program officials.

We conducted our work for this testimony in accordance with generally accepted government auditing standards. Those 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.

Background

The FRCP was jointly developed by DoD and VA following critical media reports of deficiencies in the provision and coordination of outpatient services at Walter Reed Army Medical Center. It was established to assist severely wounded, ill, and injured Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) servicemembers,⁵ veterans, and their families with access to care, services, and benefits provided through DoD, VA, other Federal agencies, States, and the private sector. The FRCP is intended to serve individuals who are highly unlikely to return to active duty and most likely will be separated from the military, including those who have suffered traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairment, and post-traumatic stress disorder. From January 2008—when FRCP enrollment began—to September 12, 2011, the FRCP has provided serv-

⁴ According to the Case Management Society of America, case management is defined as a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

⁵ 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.

ices to a total of 1,827 servicemembers and veterans;⁶ of these, 777 are currently active enrollees.⁷

As the first care coordination program developed collaboratively by DoD and VA, the FRCP uses Federal Recovery Coordinators (FRC) to monitor and coordinate both the clinical and nonclinical services needed by program enrollees; FRCs are intended to accomplish this by serving as the single point of contact among case managers of DoD, VA, and other governmental and private care coordination and case management programs. As of September 12, 2011, there were 21 FRCs located at various military treatment facilities and VA medical centers. Although the program was jointly created by DoD and VA, it is administered by VA, and FRCs are VA employees.

Separately, the RCP was established in response to the National Defense Authorization Act for Fiscal Year 2008 to improve the care, management, and transition of recovering servicemembers. It is a DoD-specific program that uses Recovery Care Coordinators (RCC) to provide nonclinical care coordination to both seriously and severely wounded, ill, and injured servicemembers. Servicemembers who are severely wounded, ill, and injured and who will most likely be medically separated from the military, also are to be assigned an FRC. While the program is centrally coordinated by DoD's Office of Wounded Warrior Care and Transition Policy, it has been implemented separately by each of the military services, which have integrated RCCs⁸ within their existing wounded warrior programs.⁹ According to DoD's Office of Wounded Warrior Care and Transition Policy, in September 2011, there were 162 RCCs and over 170 Army Advocates¹⁰ who worked in more than 100 locations, including military treatment facilities and VA medical centers. As of September 2011, these RCCs have assisted approximately 14,000 recovering servicemembers and their families and sometimes continue this assistance for those servicemembers who separate from active duty.¹¹

The FRCP and RCP are two of at least a dozen DoD and VA programs that provide care coordination and case management services to recovering servicemembers, veterans, and their families, as we have previously reported.¹² Although these programs may vary in terms of the severity of injuries or illnesses among the population they serve, or in the types of services they provide, many, including the FRCP and RCP, provide similar services. (See table 1.)

Table 1: Characteristics of Selected Department of Defense (DoD) and Department of Veterans Affairs (VA) Care Coordination and Case Management Programs for Seriously and Severely Wounded, Ill, and Injured Servicemembers, Veterans, and Their Families

Program	Severity of enrollees' injuries ^a	Title of care coordinator or case manager	Type of services provided		
			Clinical	Nonclinical	Recovery plan
VA/DoD Federal Recovery Coordination Program (FRCP).	Severe	Federal Recovery Coordinator (FRC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

⁶In addition to active enrollees in the FRCP, the 1,827 servicemembers and veterans served includes individuals who were evaluated for the program but were not enrolled (in which case the FRCs provided temporary assistance to the individual, redirected the individual to another program, or both) and enrollees who were deactivated from the program because they could not be contacted, no longer required FRCP services, or had died.

⁷FRCP enrollment has continued to grow. In September 2010, for example, the FRCP had 607 active enrollees and had provided services to a total of 1,268 servicemembers and veterans.

⁸RCCs are assigned to and supervised by each of the military services' wounded warrior programs.

⁹The military wounded warrior programs are the Army Wounded Warrior Program, Marine Wounded Warrior Regiment, Navy Safe Harbor, Air Force Warrior and Survivor Care Program, Army Reserve Wounded Warrior Component, and Special Operations Command's Care Coalition.

¹⁰The Army's Wounded Warrior Program refers to its nonclinical care coordinators as "Advocates."

¹¹According to a DoD official, the number of servicemembers in the RCP program has steadily increased over time as conflicts continue and people take longer to transition out of the military.

¹²GAO-11-250.

Program	Severity of enrollees' injuries ^a	Title of care coordinator or case manager	Type of services provided		
			Clinical	Nonclinical	Recovery plan
DoD Recovery Coordination Program (RCP).	Serious	Recovery Care Coordinator		<input type="checkbox"/>	<input type="checkbox"/>
Army Warrior Transition Units.	Serious to severe	Nurse case manager, squad leader, physician (one of each is assigned)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Military wounded warrior programs ^{b,c} .	Serious to severe	Case manager or Advocate (title varies by service)		<input type="checkbox"/>	<input type="checkbox"/>
VA OEF/OIF Care Management Program ^d .	Mild to severe	Case manager, Transition Patient Advocate ^e	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VA Spinal Cord Injury and Disorders Program.	Mild to severe	Nurse, social worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VA Polytrauma System of Care.	Serious to severe	Social work and nurse case managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: GAO analysis of DoD and VA program information.

Notes: 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.

^aFor 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 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 are also likely to medically separate from the military. These categories are not necessarily used by the programs themselves.

^bThe military wounded warrior programs are the Army Wounded Warrior Program, Marine Wounded Warrior Regiment, Navy Safe Harbor, Air Force Warrior and Survivor Care Program, Army Reserve Wounded Warrior Component, and Special Operations Command's Care Coalition.

^cAn FRC placed at the Special Operations Command's Care Coalition headquarters coordinates clinical and nonclinical care for Care Coalition and other FRCP enrollees.

^dOEF/OIF refers to Operation Enduring Freedom and Operation Iraqi Freedom, respectively. Since September 1, 2010, OIF is referred to as Operation New Dawn.

^eAn OEF/OIF care manager supervises the case managers and transition patient advocates and may also maintain a caseload of wounded veterans.

VA Has Made Progress in Addressing Our Recommendations to Improve FRCP Management Processes, and DoD Has Provided Limited Assistance

VA has recently made progress addressing the recommendations from our March 2011 report, and although our recommendations were directed to VA, DoD has provided limited assistance for one of the recommendations. We previously reported that the FRCP would benefit from more definitive management processes to strengthen program oversight and decision-making, and that program leadership could no longer rely on the informal management processes it had developed to oversee and manage key aspects of the program. Because VA maintains administrative control of the program, we recommended that the Secretary of VA direct the FRCP to take actions to address management issues related to FRC enrollment decisions, FRCs' caseloads, and program staffing needs and placement decisions. VA concurred with all of our recommendations and its progress in addressing them is outlined below:

- *FRC enrollment decisions.* To ensure that referred servicemembers and veterans who need FRC services are enrolled in the program, we recommended that the FRCP establish adequate internal controls regarding enrollment decisions by requiring FRCs to record the factors they consider in making enrollment decisions, to develop and implement a methodology and protocols for assessing the

appropriateness of enrollment decisions, and to refine the methodology as needed.

In May 2011, VA reported that the FRCP had fully implemented an interim solution, which requires that FRCs present each enrollment decision to FRCP management for review and approval. The discussion between the FRC and management and the final decisions are documented in the program's data management system. As of September 2011, VA reported that the FRCP continues to review and refine the enrollment process and establish document protocols.

- *FRC caseloads.* In an effort to improve the management of FRCs' caseloads, we recommended that the FRCP complete the development of a workload assessment tool, which would enable the program to assess the complexity of services needed by enrollees and the amount of time required to provide services.

As of September 2011, the FRCP has implemented a workload intensity tool within the program's data management system, and FRCs began using it for all new referrals in September 2011. According to the Acting Executive Director for the FRCP, the FRCP will be monitoring the effectiveness of the workload intensity tool and will be making modifications to it as needed.

- *Staffing needs and placement decisions.* We recommended that the FRCP clearly define and document the decision-making process for determining when VA should hire FRCs, how many it should hire, and that the FRCP develop and document a clear rationale for FRC placement.

In September 2011, VA reported that the FRCP has documented the formula that the program currently uses to determine the number of FRC positions required. In addition, the FRCP is developing a systematic analysis to better inform decisions about the future placement of FRCs. This analysis considers referrals received by the program, client location upon reintegration into the community, and requests from programs or facilities for placing FRCs at particular locations. According to the Acting Executive Director for the FRCP, the FRCP will report updated information about staffing and placement processes annually in its business operation planning document.

Although our recommendations to improve the management of the FRCP were directed to the Secretary of VA, both DoD and VA were asked to provide a response to this Subcommittee about how the Departments could jointly implement the recommendations. DoD has provided limited assistance to VA with the implementation of our recommendation regarding enrollment. Specifically, according to DoD and VA officials, an e-mail communication was sent on June 30, 2011, to the commanders of the military services' wounded warrior programs stating that they should refer all severely wounded, ill, and injured servicemembers who could benefit from the services of an FRC to the program for evaluation. Despite this effort, VA officials stated that they have not noticed any change in referral numbers or patterns from DoD since the e-mail was sent.

DoD and VA Have Made Little Progress Reaching Agreement on Options to Better Integrate Care Coordination Programs

DoD and VA have made little progress reaching agreement on options to better integrate the FRCP and RCP, although they have made a number of attempts to address this issue. Most recently, DoD and VA experienced difficulty jointly providing potential options for integrating these programs in response to this Subcommittee's May 26, 2011, request to the deputy secretaries, who co-chair the DoD and VA Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee).¹³ The Subcommittee requested that the co-chairs provide a written response to the Subcommittee by June 20, 2011. In the absence of such a response, on August 19, 2011, the Subcommittee contacted the Secretaries of DoD and VA and requested that they facilitate moving this matter forward.

On September 12, 2011, the co-chairs of the Senior Oversight Committee issued a joint letter that stated that the Departments are considering several options to maximize care coordination resources. However, these options have not been finalized and were not specifically identified or outlined in the letter. According to DoD and VA officials, the development of this response involved a back-and-forth be-

¹³ In May 2007, DoD and VA established the Senior Oversight Committee to address problems identified with the care of recovering servicemembers. The Committee is co-chaired by the deputy secretaries of DoD and VA and includes military service secretaries and other high-ranking officials within both Departments.

tween the Departments because of disagreement over its contents. Although officials of both Departments collaborated on the development of the letter, changes were made during the review process that resulted in the delay of its release to the Subcommittee. According to DoD and VA officials, after VA had signed the letter and sent it to DoD for review and signature, DoD officials unilaterally modified the wording, to which VA officials objected. Officials from both Departments told us that the resulting impasse caused considerable delay in finalizing the letter and was resolved only after DoD agreed to withdraw its changes. Issuance of the letter followed notification by the Subcommittee that it would hold a hearing on the FRCP and RCP care coordination issue in September 2011.

The two Departments have made prior attempts to jointly develop options for improved collaboration and potential integration of the FRCP and RCP. Despite these efforts, no final decisions to revamp, merge, or eliminate programs have been agreed upon. For example:

- Beginning in December 2010, the Senior Oversight Committee directed its care management work group¹⁴ to conduct an inventory of DoD and VA case managers and perform a feasibility study of recommendations on the governance, roles, and mission of DoD and VA care coordination. According to DoD and VA officials, this information was requested for the purpose of formulating options for improving DoD and VA care coordination. DoD officials stated that following compilation of this information, no action was taken by the Committee, and care coordination was subsequently removed from the Senior Oversight Committee's agenda as other issues, such as budget reductions, were given higher priority. Recently, care coordination has again been placed on the Committee's agenda for a meeting scheduled in October 2011.
- In March 2011, the DoD Office of Wounded Warrior Care and Transition Policy sponsored a summit that included a review of DoD and VA care coordination issues. This effort resulted in the development of five recommendations to improve collaboration between the FRCP and RCP, including a more standardized methodology for making referrals to the FRCP, and two recommendations to refine the FRCP and the RCP. However, there was no joint response to these recommendations and no agreement appears to have been reached to jointly implement them. Although DoD officials contend that they have taken action on many of these recommendations within DoD's care coordination program, VA maintains that no substantive action has been taken to jointly implement them. The degree of disagreement that exists between DoD and VA on implementing these recommendations may be illustrated by the continued disagreement between the Departments about when the FRC should engage with a seriously wounded, ill, and injured servicemember. In discussing one of the outcomes of this coordination summit, DoD officials asserted that the FRCP should become engaged with the servicemember during rehabilitation after medical treatment has been finished. In contrast, VA maintains that the point of engagement should be in the early stage of medical treatment to build rapport and trust with their clients and their clients' families throughout their course of care.

In July 2011, a task force consisting of staff representing different VA programs, including the FRCP, began meeting independently of DoD to examine more broadly the range of services VA provides to the wounded, ill, and injured veterans it serves. VA officials said that this task force was formed to provide a critical examination of how VA's care coordination and case management programs are meeting the needs of this population. However, a VA official stated that this is an ongoing effort, and that the task force has not yet identified any options or recommendations related to its review. While the task force has not yet shared information about its efforts with DoD, a VA official told us that it is planning to make a presentation of its efforts to the Senior Oversight Committee at a meeting scheduled in October 2011.

The lack of progress to date in reaching agreement on options to better integrate the FRCP and the RCP illustrates DoD's and VA's continued difficulty in collaborating to resolve care coordination program duplication and overlap. We currently have work underway to further study this issue and identify the key impediments that continue to affect recovering servicemembers and veterans during the course of their care. Additionally, as we have previously reported, there are numerous programs in addition to the FRCP and RCP that provide similar services to recovering

¹⁴The Senior Oversight Committee is supported by several internal work groups devoted to specific issues, such as DoD and VA care coordination and case management. Participants in the Committee's care management work group include officials from the FRCP and the RCP.

servicemembers and veterans—many of whom are enrolled in more than one program and therefore have multiple care coordinators and case managers. For example, as of September 12, 2011, 75 percent of active FRCP enrollees also were enrolled in DoD's wounded warrior programs. According to one FRC, his enrollees have, on average, eight case managers who are affiliated with different programs. We found that inadequate information exchange and poor coordination between these programs has resulted in not only redundancy, but confusion and frustration for enrollees, particularly when care coordinators and case managers duplicate or contradict one another's efforts. For example, an FRC told us that in one instance there were five case managers working on the same life insurance issue for an individual. In another example, an FRC and RCC were not aware the other was involved in coordinating care for the same servicemember and had unknowingly established conflicting recovery goals for this individual. In this case, a servicemember with multiple amputations was advised by his FRC to separate from the military in order to receive needed services from VA, whereas his RCC set a goal of remaining on active duty. These conflicting goals caused considerable confusion for this servicemember and his family.

Conclusions

Numerous programs, including the FRCP and RCP, have been established or modified to improve care coordination and case management for recovering servicemembers, veterans, and their families—individuals who because of the severity of their injuries and illnesses could particularly benefit from these services. While well intended, the proliferation of these programs, which often provide similar services, has resulted not only in inefficiencies, but also confusion for those being served. Consequently, the intended purpose of these programs—to better manage and facilitate care and services—may actually have the opposite effect. Particularly disconcerting is the continued lack of progress by DoD and VA to more effectively align and integrate their care coordination and case management programs across the Departments. This concern is heightened further as the number of enrollees served by these programs continues to grow. Without interdepartmental coordination and action to better coordinate these programs, problems with duplication and overlap will persist, and perhaps worsen. Moreover, the confusion this creates for recovering servicemembers, veterans, and their families may hamper their recovery.

Recommendation for Executive Action

To improve the effectiveness, efficiency, and efficacy of services for recovering servicemembers, veterans, and their families, we recommend that the Secretaries of DoD and VA direct the Senior Oversight Committee to expeditiously develop and implement a plan to strengthen functional integration across all DoD and VA care coordination and case management programs that serve this population, including the FRCP and RCP, to reduce redundancy and overlap.

Agency Comments

We obtained oral comments on the content of this statement from both DoD and VA officials. These officials provided additional information and technical comments, which we incorporated as appropriate.

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

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Bonnie Anderson, Assistant Director; Jennie Apter; Frederick Caison; Deitra Lee; Mariel Lifshitz; and Elise Pressma.

Prepared Statement of Philip Burdette, Principal Director, Wounded Warrior Care and Transition Policy, Office of the Under Secretary of Defense for Personnel and Readiness, U.S. Department of Defense

Madam 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) in August 2007, the program is administered by VA.

Overview of DoD Recovery Coordination Program

The DoD Recovery Coordination Program (RCP) was established later by Section 1611 of the FY 2008 National Defense Authorization Act. This mandate called for a comprehensive policy on the non-medical care and management of recovering servicemembers, including the development of a comprehensive recovery plan, and the assignment of a Recovery Care Coordinator for each recovering servicemember. In January 2009, a Directive-Type Memorandum followed in December 2009 with 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. A summary of the roles and responsibilities captured in the DoDI are as follows:

- **Recovery Care Coordinator (RCC):** The RCC supports eligible servicemembers by ensuring their non-medical needs are met along the road to recovery.
- **Comprehensive Recovery Plan (CRP):** The RCC has primary responsibility for making sure the CRP 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 CRP.
- **Recovery Team:** The Recovery Team (RT) includes the recovering servicemember's Commander, the RCC, Medical Care Case Manager, Non-Medical Care Manager, and, when appropriate, the Federal Recovery Coordinator (FRC) for catastrophically wounded, ill or injured servicemembers. The RT jointly develops the CRP, evaluating its effectiveness and adjusting it as transitions occur.

There are currently 162 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.

The DoDI 1300.24 establishes the standardized processes for referral for care coordination of seriously, severely and catastrophic injured and ill servicemembers for RCCs and FRCs. The RCC's focus is on servicemembers who will be classified as Category 2 and 3. A Category 2 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. A Category 3 servicemember has a severe or catastrophic injury/illness and is unlikely to return to duty and is likely to be medically separated. The FRC's focus is on those servicemembers referred by Service Wounded Warrior programs.

While defined in the DoDI, Categories 1, 2 and 3 are all administrative in nature and have proven difficult to operationalize. The intent of the DoDI is to ensure that wounded, ill, and injured Servicemembers receive the right level of non-medical care and coordination. DoD is continuing to work with the FRCP to ensure that servicemembers who need the level of medical and nonmedical care coordination provided by a FRC are appropriately referred.

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

The Departments recognize that the FRCP and RCP are complementary, not redundant programs. There is a "hand-off" from DoD RCCs to the VA FRCs. This occurs when it is clear that the catastrophically wounded, ill, or injured servicemember will not return back to duty, which is a highly individualized determination based on multiple factors, including the servicemembers' condition, and their desire to stay on active duty. While we concur in principle that the establishment of a sin-

gle recovery coordination program may be the preferred course of action to provide fully integrated care coordination services, the two Departments are still in the process of working out the details.

As a full partner with the VA, the Department of Defense will assist with implementing the GAO recommendations. Specifically, in accordance with DoD Policy, all Category 3 (severe or catastrophic injury or illness) and other recovering servicemembers who would most benefit from the services of a Federal Recovery Coordinator (FRC) will be referred. In order to ensure the capabilities are in place to address these recommendations, we are in the process of evaluating the care coordination resources and capabilities of VA and DoD so that the necessary personnel are available with the appropriate skill levels to support the wounded, ill, and injured population.

Following are DoD's responses to the GAO report.

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 a necessary overlap in functions.

The GAO outlined one instance where a recovering servicemember was receiving support and guidance from both a DoD RCC and a VA FRC. 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 VA, whereas with his RCC he set a goal of remaining on active duty. We recognize that better coordination in the future will avoid these situations.

The SOC directed RCP and FRCP leadership to establish a joint 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 two-day meeting in May. The results of the Committee's efforts were briefed to the SOC and DoD supports the recommendations to better integrate the FRCP into the RCP while considering options to improve transitions for Recovering servicemembers. In March 2011, DoD also conducted an intense two and a half 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. One chartered working group focused entirely on collaboration between VA and DoD care coordination programs. Actionable recommendations were reviewed, presented to the Overarching Integrated Product Team and will continue to be worked until the recommendations and policies are implemented. The joint DoD-VA Committee also considered the work produced by the working group at this summit in coming up with its recommendations on how to best collaborate, coordinate, or integrate these two programs.

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 (MOA) between DoD and VA at facilities where FRCs work, however immediate compliance with these MOAs in an environment of reduced or limited resources is always a challenge.

DoD's Office of Wounded Warrior Care and Transition Policy (WWCTP) stands ready to assist in securing the resources required at DoD facilities for FRCs and will work with the services and VA to ensure that daily duties are not interrupted by equipment, technology or space constraints.

Conclusion

The Committee requested an analysis of, and potential options for, integrating the FRCP and RCP under a single umbrella, to reduce redundancy and better fulfill the goal of establishing a seamless transition for wounded warriors and their families. The Departments recognize that the FRCP and RCP are complementary, not redundant programs. While we concur in principle that the establishment of a single recovery coordination program may be the preferred course of action to provide fully integrated care coordination services for the wounded, ill, or injured service-

members, Veterans, and their families, the two Departments are still in the process of working out the details for the SOC.

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 VA FRCP. The Military Department Wounded Warrior Programs will also continue to work closely with FRCs in support of recovering 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 John Medve, Executive Director, Office of the
U.S. Department of Veterans Affairs-U.S. Department of Defense Office
Collaboration Office of Policy and Planning, U.S. Department of Veterans
Affairs**

Good afternoon Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee. I am John Medve, Executive Director, Office of VA-DoD Collaboration within the Office of Policy and Planning. I am pleased to be here today to discuss the Federal Recovery Coordination Program (FRCP) and the progress that has been made in addressing improvements recommended by the Government Accountability Office (GAO).

The FRCP is a designed to complement existing military service-and VA-provided case management, support, and transition coordinators. FRCP is specifically charged with providing seamless support from the servicemember's arrival at the initial Medical Treatment Facility (MTF) in the United States through the duration of their recovery, rehabilitation, and reintegration. The FRCP staff at the policy level coordinates with its DoD counterparts under the umbrella of the Senior Oversight Committee. The FRCP is an integral part of VA and DoD efforts to address issues raised about the coordination of care and transitions between the two Departments for recovering servicemembers. On behalf of its clients, Federal Recovery Coordinators (FRCs) work closely with clinical and non-clinical care and case managers from the military services, the VA, and the private sector as part of their Recovery Team. FRCs are master's degree-prepared nurses and clinical social workers who support severely wounded and ill Servicemembers, Veterans and their families by advocating in all clinical and non-clinical aspects of recovery. FRCs work with 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 and coordinators, the FRC creates a Federal Individual Recovery Plan (FIRP). FRCs oversee and coordinate all clinical and non-clinical care identified in the FIRP. To show greater transparency with Servicemembers and Veterans, the FIRP is available through the eBenefits portal 24 hours-a-day, 7 days-a-week.

GAO issued a report in March 2011 containing four VA recommendations. VA concurred with the recommendations and has taken action to implement each of them. GAO's first recommendation was that VA establish adequate internal controls regarding FRCs' enrollment decisions to ensure that referred Servicemembers and Veterans who need FRC services are enrolled in the program. GAO also recommended that FRCP leadership require FRCs to record in the Veterans Tracking Application (VTA) the factors considered in making the enrollment decision, develop and implement a methodology and protocol for assessing the appropriateness of enrollment decisions, and refine the methodology as needed. VA concurred with this recommendation and immediately implemented more stringent internal controls to include management review of all enrollment decisions and documentation of decision determinations in VTA to ensure that referred Servicemembers and Veterans who need FRC services are offered enrollment in FRCP.

Potential clients referred to FRCP are evaluated to determine 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 offered enrollment in 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 referred individual meets the broad Senior Oversight Committee (SOC) eligibility cri-

teria. The SOC criteria covers Servicemembers or Veterans who are: in an acute care setting within a military treatment facility; diagnosed or referred with spinal cord injury, burns, amputation, visual impairment, traumatic brain injury and/or Post-Traumatic Stress Disorder; considered at risk for psychosocial complication; or self or Command referred based on perceived ability to benefit from a recovery plan. 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 recommend enrollment of the referred individual into the FRCP. The FRCs then present the case for their recommendation to a member of the FRCP leadership team for final approval. The results of the final decision are documented in the FRCP data management system. FRCP enrollment is entirely voluntary. Individuals who are not enrolled are directed to alternative resources that are appropriate for their level of need. FRCP continues to review and refine the enrollment process and establish and document protocols as recommended by GAO. FRCP has completed the first phase of an intensity tool designed to add further consistency to the enrollment decision process. Testing was completed in late summer and we began using the tool on all new referrals earlier this month.

GAO's second recommendation was to complete development of a workload assessment tool that will enable the program to assess the complexity of services needed by enrollees and the amount of time required to provide services to improve management of FRCs' caseloads. FRCP embarked on the development of a service intensity tool that would fulfill the workload assessment requirements of the GAO recommendation and further tie the assessment to enrollment decisions. FRCP dedicated substantial time and research into the development and testing of its service intensity tool. Several comprehensive sessions with FRCs, analysts, and FRCP management were held to develop the tool, validate assumptions, conduct reliability testing and refine the scoring mechanisms. As noted in VA's original response to GAO, this process will likely be completed by summer 2012. The first phase of the tool was launched program-wide. FRCP will further analyze the results as we continue development of the second phase which will be used to assess the amount of time required to provide services. In the interim, FRCP is testing other caseload management strategies. Currently, FRCP is evaluating the feasibility of establishing intensity levels within the active client population to meet the needs of clients and improve management of FRC caseloads.

GAO's third recommendation to VA was to clearly define and document the FRCP's decision-making process for determining when and how many FRCs VA should hire to ensure that subsequent FRCP leadership can understand the methods currently used to make staffing decisions. VA concurred with the recommendation and documented the formula used to determine the number of FRC positions required. These positions are based on an analysis of the anticipated number of referrals, the rate of enrollment, the number of clients made inactive, and a target caseload range of between 25-35 per FRC. Upon completion of the service intensity tool, FRCP will modify this equation to reflect the average intensity points allowed per FRC instead of the current caseload range.

GAO's fourth and final recommendation was to develop and document a clear rationale for placement of FRCs, which should include a systematic analysis of data, such as referral locations, to ensure that FRC placement decisions are strategic in providing maximum benefit for the program's population. VA concurred with this recommendation and is developing a systematic analysis to inform future placements. The original placement of FRCs was guided and directed by an October 2007 Memorandum of Understanding, signed by the Secretary of Defense and the Acting Secretary of Veterans Affairs, which required that FRCs be placed at MTFs where significant numbers of wounded, ill, or injured Servicemembers were located. As the program grew, the FRCs spread to additional 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 to better serve the wounded, ill, and injured population of Servicemembers and Veterans.

Thanks to the flexibility of the program, VA has made significant progress in implementing the GAO's recommendations during these past 6 months. FRCP is continuously improving and provides a unique service to severely wounded, ill, and injured Servicemembers, Veterans, and their families. FRCP is not redundant with existing support programs in VA and DoD, but rather complementary as stated in its establishing Memorandum of Understanding (MOU).

FRCP was established specifically to provide care coordination across VA and DoD for the most complex cases. FRCs assist clients by coordinating health care and benefits from DoD, VA, and other Federal agencies as well as State, local and private entities. Most coordination and case management support is facility-based. This is not true for FRCs. Once assigned, a FRC will continue to support a client regardless of where the client is located. This philosophy provides an invaluable level of consistency for a client at time when care needs and transitions can be overwhelming. Feedback suggests FRCP clients are extremely satisfied with the services provided by FRCs. FRCs assist clients in overcoming systems barriers, ensure smooth transitions, educate clients concerning complex benefits and services, and help them navigate across the many systems, programs, and agencies to obtain necessary services and benefits. These needs continue to exist for the FRCP client population. FRCs clinical backgrounds combined with an intensive and comprehensive education on programs and services available to Servicemembers and Veterans make them uniquely qualified to provide the care coordination services necessary for successful recovery and reintegration.

Beginning next month, FRCP will pilot a new data management system. Efforts are already underway to ensure that the data collected and stored in the new Internet-based platform is capable of being shared throughout VA and DoD. Additionally, VA is engaged in an Information Sharing Initiative (ISI) with DoD. ISI is designed to further support smooth transitions between DoD and VA. ISI will provide care coordinators and case managers the ability to track benefits applications, benefits processing status, and benefits awards. It will also provide visibility of all clinical and non-clinical care plans and provide the ability to view a shared calendar for Servicemember and Veterans appointment scheduling.

In an effort to ensure VA is providing the greatest level of coordinated support to the wounded, ill, and injured population, VA recently established an internal Wounded, Ill, and Injured Task Force to examine current VA programs and ensure appropriate resources, programs, and services are available to our wounded, ill, and injured populations. A goal of the Task Force is to ensure effective access to and delivery of health care and benefits.

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 DoD's and VA's complex systems of care on the road to recovery, rehabilitation, and reintegration. The FRCP was envisioned to be the consistent resource available to these individuals through care and recovery -a consistent resource 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 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.

Our clients tell us 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. Once assigned, a FRC will continue to support a client regardless of where the client is located. 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 few months or a lifetime.

This concludes my statement, and I am happy to answer any questions you may have.

**Prepared Statement of Abbie Holland Schmit,
Manager, Alumni, Wounded Warrior Project**

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

Wounded Warrior Project (WWP) applauds the Subcommittee for your important oversight into the Federal Recovery Coordination Program (FRCP). The Subcommittee's hearing in May raised important issues regarding the program's management and governance, and we appreciate your follow-up questions to the Co-Chairs of the Senior Oversight Committee and your scheduling this second hearing today.

In testifying today for WWP, I hope to share an "on the ground" perspective on the FRCP based on my experience in working with wounded warriors. As a WWP Alumni Manager in Chicago, I work with wounded warriors and their families on a daily basis. Prior to joining WWP in June, I served for more than 2 years as an advocate with the Army's Wounded Warrior Program—referred to as the AW2 program. The AW2 program assists and advocates for severely wounded, ill, and injured soldiers, veterans, and their families during their recovery and transition. Those who qualify are to be assigned to the program as soon as possible after arriving at a Warrior Transition Unit. As one who served for 6 years in the Army National Guard and had a hard journey home due to PTSD and traumatic brain injury after deploying to Iraq from 2003 to 2004, the issues before you are not only important, but deeply personal for me.

The FRCP was designed to help those warriors, who—given overwhelming injuries—would not only be unable to return to active duty, but would likely encounter difficulty in navigating a transition process that might involve three or more Federal Departments of government and issues ranging from income support, to continuing health care and rehabilitation, specially adapted housing, vocational rehabilitation and education, caregiver support, and more. In assigning knowledgeable, savvy "special navigators" in the form of Federal Recovery Coordinators (FRC), to assist those warriors and their families with this complex process, the program has proven highly successful—and unique—in providing holistic, integrated support. FRCs are making a real difference in helping severely injured warriors and their families to thrive again.

As your May hearing underscored, individual service Departments are not routinely referring severely and catastrophically wounded servicemembers to the FRCP, or are doing so at much too late a point in the transition process. The Service Departments appear to view the FRCP as a VA program; and tend to only refer warriors and their families to the program when the warrior is about to separate or retire from service. Rather than being marginalized as a VA-only program, the FRCP should be operated as initially intended, a joint, integrated effort aimed at coordinating Federal care and services. But current practices—seemingly reinforced by a shortsighted insistence on service-specific care—risk delaying recovery, rehabilitation and reintegration rather than fostering a seamless transition. What should be a seamless, coordinated undertaking is too often the opposite, as illustrated by the experience of warriors who—rather than having a single "comprehensive recovery plan"—find themselves with multiple recovery plans.

These are not abstract or hypothetical concerns. Consider the case of Army Specialist Steve Bohn who described his difficult transition at a Senate Veterans Affairs Committee hearing in May. Steve was badly injured in November 2008, when a suicide bomber in Afghanistan detonated 2000 pounds of explosives that buried him under collapsed debris and resulted in his suffering severe internal injuries and spinal injuries. He experienced multiple breakdowns in the coordination of his care and benefits. Steve was initially flown from Germany to Fort Campbell, Kentucky—apparently in error—given that he needed surgery. After finally undergoing spinal surgery at Walter Reed, Fort Campbell threatened to put him on AWOL if he didn't return. As a result, he was flown back to Fort Campbell, later returning to Walter Reed to undergo bladder surgery. Ultimately he underwent a DoD Medical Evaluation Board that eventually assigned him a 40 percent Permanent disability rating, 30 percent for spinal injuries and 10 percent for neck injuries. But that rating did not take account of his internal injuries. He was finally medically retired from the Army in October 2010.

While his transition from DoD to VA seemed to begin appropriately with his paperwork being sent to VA 180 days before the estimated separation date to permit timely claims-adjudication, backlogs in scheduling VA compensation examinations bogged down the process. At the time Steve testified—7 months after retiring from service—VA had not adjudicated his case and he was struggling financially. Unable to work because of his injuries, he was living on his military retired pay of less than \$700/month.

Steve also seemed to have fallen through the cracks in terms of getting VA medical care. While he had had multiple VA compensation examinations, it took more than 6 months before anyone at VA approached him to discuss any treatment. And many months after becoming a veteran, he had yet to be assigned a VA primary care doctor. Steve testified that no one ever discussed with him or his family the

possibility of having an FRC assigned to his case. It seems clear it would have made a big difference.

Steve's experience is hardly unique. But it underscores how easily a severely wounded servicemember can fall through the cracks—despite very serious injuries, and despite how much emphasis has been placed on “seamless transition.”

Following the direction of the National Defense Authorization Act of 2008 (NDAA 08), VA and DoD entered into a memorandum of understanding establishing the joint VA–DoD FRCP to assist servicemembers with Category 3 injuries, defined as 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 to assist those with injuries falling below this defined category who's return to duty may in some way be possible. Inconsistency within the individual service Departments in operationalizing the term “Category 3 injuries” has arguably created ambiguity as to who is to be referred for an FRC.

This referral issue is a problem that can and must be remedied. But the recent response from the Co-Chairs of the Senior Oversight Committee to the Subcommittee's questions fails to provide that remedy. In their cover letter, Deputy Secretaries Gould and Lynn state categorically that “in accordance with DoD Policy, all Category 3 (severe or catastrophic injury or illness and other recovering servicemembers who would most benefit from the services of a Federal Recovery Coordinator (FRC) will be referred.” Yet in the enclosure to their letter, which the Co-Chairs describe as setting out “detailed implementation plans,” they state just the opposite: “[T]he program cannot ensure that all potentially eligible individuals are referred to FRCP.” According to the enclosure, the reason is that “FRCP, as currently structured, is a voluntary referral program and, as such, relies on the identification and referral of those who might benefit from FRCP services by others.”¹ Yet DoD's strongly worded policy requires that “All Category 3 recovering servicemembers shall be enrolled in the FRCP and shall be assigned an FRC and Recovery Team.” Given that policy, it would follow that—if something about the program's “current structure” or voluntary referral process impedes a reliable, effective referral process, that could and should be changed. Rather than advising the Committee that this problem has been resolved or reporting on a specific plan to remedy it, the Deputy Secretary of Defense has simply advised this Committee that the terms used to describe the population who should be referred to the FRCP are “left to interpretation,” and “currently mechanisms are not in place to measure compliance with this policy.” It is difficult to understand why the senior leadership of the two Departments have failed to resolve this problem.

VA and DoD 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 FRCP. As we advised the Subcommittee in our statement for the record for your hearing in May, the FRCP has become much less a joint program, and seen as more a VA program—to the detriment of the warriors it was designed to serve. Warriors and families continue to need this kind of help early in the transition process. With the program's critical role in ensuring that severely wounded warriors experience a seamless transition, those warriors and their families would be better served if there were truly shared responsibility for the program, such as through establishment of an interdepartmental FRCP office. Such a proposal should not be deemed to reflect a lack of confidence in VA, but rather recognition of the inherent limitations of program governance residing in any single department. The concept of a DoD–VA program office is neither novel nor unprecedented.² While different structural solutions could be pursued, WWP foresees continued difficulties for the program, and most importantly our warriors, unless fundamental changes are instituted to ensure truly shared responsibility. To that end, we urge the Subcommittee to consider taking up legislation to ensure that objective.

Thank you again for the opportunity to testify. I would be pleased to respond to any questions you may have.

¹DoD/VA Wounded, Ill, and Injured Senior Oversight Committee. Response to the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives regarding the Federal Recovery Care Coordination Program and GAO recommendations. (September 12, 2011).

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.

**Prepared Statement of Alethea Predeoux, Associate
Director of Health Legislation, 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 present our views on 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 from the Department of Veterans Affairs (VA), and to 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 again assess challenges of the FRCP and identify ways in which we can continue to improve this program to best meet the needs of veterans and servicemembers. 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.

When PVA provided the Subcommittee with a statement for the record for the hearing held on May 13, 2011, which examined the progress and challenges of the FRCP, we identified three areas in need of improvement: continuity of care, care coordination, and program awareness. Today, we still believe that these areas are critical to the success of the FRCP and are in direct alignment with the issues and recommendations outlined by the Government Accountability Office (GAO) in a March 2011 report entitled, "DoD and VA Health Care: Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges (GAO-11-250)." In this report, GAO identified three primary challenges with implementation of the FRCP: servicemember enrollment, hiring Federal Recovery Coordinators (FRCs), and care coordination. GAO concluded the report with four main recommendations to help VA leadership address issues stemming from the main challenges facing the program. Today, PVA will provide our position in support of the GAO recommendations, and our views on the current progress of the implementation of the FRCP.

FRCP Enrollment

The first recommendation from the GAO report was to "ensure that referred servicemembers and veterans who need FRC services are enrolled in the program by establishing adequate internal controls regarding the FRCs' enrollment decisions." In particular, this recommendation identifies the need to require FRCs to record the factors they consider in making FRCP enrollment decisions, as well as the need to create an assessment tool to evaluate such decisions. PVA believes that the use of such recording methods and assessment tools will help streamline the enrollment process, and ensure that veterans and their families are receiving help when it is requested. Additionally, as it relates to veterans seeking assistance and looking to enroll in the FRCP, tracking enrollment decisions will provide FRCs with the opportunity to identify how a servicemember has learned about the FRCP. Identifying referral sources will enable both VA and DoD to establish partnerships with other Departments in and outside of their agencies to promote the FRCP and possibly reduce duplication of care-coordination efforts across VA and DoD programs.

PVA believes that servicemember enrollment is one of the most critical elements of the FRCP. Servicemembers must be informed of the FRCP and the variety of services available to them through the program. However, 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 different offices and Departments across both the VA and DoD.

To promote the FRCP, information posters and pamphlets should be made available to veterans and servicemembers when they visit different offices within VA and DoD. The FRCP services should also be announced through social media tools such as *Facebook* and *Twitter* to inform veterans and servicemembers of this program. Such educational literature would be useful not only for veterans and servicemembers, but for their families and caregivers as well. Veterans and servicemembers participate in many VA programs, but it is often a loved one or caregiver who is helping manage and coordinate the various services of care and they can 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 program, and educate veterans entering VA specialized systems of care on the FRCP services and benefits.

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 can make referrals when a veteran or servicemember appears to be in need of FRCP services.

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, and 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.

FRCP Caseloads

The second recommendation from the GAO report encouraged “complete development of the FRCP's workload assessment tool that will enable the program to assess the complexity of services needed by enrollees and the amount of time required to provide services to improve the management of FRCs' caseloads.” PVA believes that monitoring and managing the level of complexity and size of FRC caseloads is extremely important to adequately addressing the needs and concerns of veterans and servicemembers enrolled in the FRCP.

No matter how well prepared and trained an FRC may be, he or she will not be able to effectively help veterans and servicemembers to their best ability if they are spread too thin and overwhelmed with an unreasonable caseload. Conversely, an FRC managing a smaller caseload of enrollees with polytraumatic and severe injuries will need fewer cases to provide adequate attention and assistance to those veterans and servicemembers. That said, a work load assessment tool is absolutely necessary to ensuring that FRCs are available to hear the concerns and needs of veterans and servicemembers and provide appropriate assistance during the recovery and rehabilitation processes.

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 servicemembers and their families.

Hiring FRCs

The third recommendation, to “clearly define and document the FRCP's decision-making process for determining when and how many FRCs VA should hire to ensure that subsequent FRCP leadership can understand the methods currently used

to make staffing decisions,” is an area of serious concern for PVA. Adequate staffing of the FRCP is essential for providing servicemembers with timely, quality care.

PVA believes that in conjunction with the aforementioned 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’ and servicemembers’ needs. With such a limited number of FRCs, issues involving transportation and distance have the potential to hinder access to FRCP services for many veterans in rural areas, and thus, become threats to continuity of care. Further, developing a decision-making tool to determine when and how many FRCs should be hired has the potential to increase the program retention.

If FRC caseloads are manageable, and the FRCs believe that they can actually help veterans and servicemembers, it is likely that employee job-satisfaction will be high, and FRCs will continue performing their duties. This will lead to adequate staffing of the program, which will allow for FRCs and enrollees to develop effective long-term relationships. It is these relationships that can help veterans and servicemembers adjust to life after a severe or catastrophic injury.

Placement of FRCs

The final GAO recommendation calls for the FRCP to “develop and document a clear rationale for the placement of FRCs, which should include a systematic analysis of data, such as referral locations, to ensure that future FRC placement decisions are strategic in providing maximum benefit for the program’s population.” PVA believes that all veterans and servicemembers who are injured, ill, or wounded have earned access to the FRCP. We understand that as a new program, time is needed to create, implement, and assess the inner-workings of such a comprehensive initiative.

As recommendations for improvement are provided to VA leadership, we strongly encourage both VA and DoD to utilize existing care-delivery models such as telehealth and teleconferencing, or electronic enrollee accessible programs like *My HealtheVet* to meet with and communicate with veterans and servicemembers in areas that do not have reasonable access to an FRC.

Particularly, 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 an FRC if necessary. Specifically, 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. Developing a clear rationale for the placement of FRCs will help ensure that those who have paid a significant price in service to our country are not only aware of the resourceful programs available to them, but also have the opportunity to participate in them.

In conclusion, PVA would like to thank the Committee for their 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. 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 two of America’s 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 testify today, and we look forward to working with you to continue to improve the Federal Recovery Coordination Program. Thank you.

**Prepared Statement of Commander René A. Campos,
USN (Ret.), Deputy Director, Government Relations,
Military Officers Association of America**

EXECUTIVE SUMMARY

The Military Officers Association of America (MOAA) was extremely troubled by the findings 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,” and even more disappointed by the testimony presented to this Subcommittee at the May 13, 2011 hearing on the Federal Recovery Coordination Program (FRCP).

Further, MOAA found the September 12, 2011 letter signed by the Deputy Secretary of VA and DoD to the Subcommittee’s May 26 letter requesting their plan for implementing GAO’s recommendations and analysis of how the FRCP and DoD’s Recovery Coordination Program (RCP) could be integrated indicates to us more of a ‘business as usual’ approach rather than a roadmap of specifics that show the Departments’ sense of urgency in addressing these issues in the immediate future.

MOAA’s assessment of the current state of the FRCP supports GAO’s findings and centers around three key areas.

Many of the issues identified in the GAO report are similar to those in the Defense Department’s RCP. We believe strongly the FRCP and RCP are victims of much larger systemic problems in wounded warrior care across the Departments of Defense (DoD) and Veterans Affairs (VA). These systemic issues inhibit uniformity and consistency of operations to achieve a state of seamless transition, and include:

- Lack of systematic compliance, accountability, and oversight;
- Limitations on information sharing, accuracy of information, and communications; and,
- Multiple segregated policies, programs, and services that are duplicative, inefficient, ineffective, and add to the already confusing bureaucratic morass.

Recommendations:

MOAA fully concurs with the four recommendations outlined in the GAO’s report. Additionally, we offer the following recommendations to improve the FRCP and address the larger systemic issues that exist in delivering care coordination between and within the DoD and VA:

- Revise and expand Sec. 1611 of Public Law 110–181 to mandate a single, joint VA–DoD program, establishing an office for managing, coordinating and assisting severely wounded, ill, and injured servicemembers, veterans and their families through recovery, rehabilitation, and reintegration. Direct DoD to adopt and fully integrate VA’s FRCP policy and procedures outlined in VA Handbook 0802, March 23, 2011.
- Future hearings related to wounded warrior care coordination should be joint hearings before both the Veterans Affairs and Armed Services Committees.
- An outside entity should be commissioned to evaluate the FRCP and RCP, assess how the programs function and operate within the context of the 10 major VA and DoD wounded warrior programs, and collect feedback from recovering warriors and family members on how to provide simpler ways for wounded warriors and their families to access care and services during transition.
- Require VA and DoD medical and benefit systems to expand outreach and communication efforts to help increase awareness of all wounded warrior programs.
- Conduct periodic needs assessment surveys to gather information from wounded warriors and their families on ways to improve programs and identify unmet needs.

MADAM CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, on behalf of the 370,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA’s observations concerning the Federal Recovery Coordinator Program (FRCP).

MOAA does not receive any grants or contracts from the Federal Government.

MOAA thanks the Subcommittee for its commitment to enhancing the Department of Veterans Affairs (VA) care and support to our Nation’s wounded, ill and injured and their families so they experience no loss of continuity in care, and their transition is as seamless as possible.

Our Association also commends the Subcommittee for its leadership, persistent oversight and sense of urgency on the critical topic of care coordination for the heroes and the families these programs are intended to support.

FRCP and RCP Issues

While the focus of this hearing is on the FRCP, it is not possible to have a discussion on the program without including the DoD Recovery Coordination Program (RCP) since the two programs are interrelated and are seen as fulfilling the same roles and responsibilities in their respective agencies.

To better understand the two programs, it is helpful to look back at the timelines and purposes for establishing them.

- The Senior Oversight Committee (SOC) implemented the FRCP through two Memorandums of Understanding (MOU) between the VA and DoD.
- The first MOU was signed by the Secretary of Veterans Affairs and the Secretary of Defense on **August 31, 2007**, requiring the establishment of the FRCP.
- On **October 31, 2007**, the VA released a statement announcing the agency and DoD had signed an agreement (October 30), establishing the FRCP to help “ensure medical services and other benefits are provided to seriously wounded, injured and ill active duty servicemembers and veterans.”

The program supported one of the recommendations of the President’s Commission on Care for America’s Returning Wounded Warriors, better known as the Dole-Shalala Commission.

The MOU further “defined the FRCP, designated the Federal Recovery Coordinators (FRCs) as the *‘ultimate resource’* for monitoring the implementation of services for wounded, ill and injured servicemembers and veterans enrolled in the FRCP. VA would provide the coordinators in collaboration with DoD, to coordinate services at military treatment facilities, services between the two Departments, private-sector facilities.”

- On **January 28, 2008**, the President signed into law the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110–181), directing VA and DoD to jointly develop and implement a comprehensive policy on improvements to care, management, and transition of recovering servicemembers *not later than July 1, 2008*.

As part of this joint policy, recovery care coordinators were to be assigned to recovering servicemembers. Their duties were to include “overseeing and assisting the servicemember’s course through the entire spectrum of care, management, transition, and rehabilitation services available from the Federal Government, including assistance and services provided by the DoD, VA, Department of Labor, and the Social Security Administration.”

- On **December 1, 2009**, DoD Instruction 1300.24 established the RCP. The instruction assigns Commanders of Military Departments’ Wounded Warrior Programs overall responsibility for the management of their individual RCPs. Further, the instruction requires recovering servicemembers to be referred to the appropriate RCP, either the DoD RCP or the FRC.
- On **March 23, 2010**, VA Handbook 0802 established procedures for the FRCP—a combined initiative of VA and DoD to assist severely wounded, ill and injured post-9/11 servicemembers, veterans and their families through recovery, rehabilitation, and reintegration into their home community.

In the handbook, VA defines the RCC as “an individual assigned by the military services to recovering servicemembers whose period of recovery is anticipated to exceed 180 days, but who are likely to return to active duty. RCCs’ duties include assisting servicemembers as they process through the DoD system of benefits and care.”

The fact that the FRCP was the first care coordination program jointly created and implemented by the two agencies and was to be the *‘ultimate resource for wounded warriors and their families with questions or concerns about VA, DoD or other Federal benefits’* would lead one to believe that the program would be institutionalized and should serve as a model for other VA–DoD collaboration.

While both VA and DoD care coordination programs boast of being joint, the reality is both are managed and operated in the opposite manner, separate and distinct from each other as was clearly stated by VA and DoD FRC and RCP officials at the May 13 hearing. During the hearing:

- The VA official concurred with the GAO recommendations, mentioning that many in DoD/Service wounded warrior programs refer to the FRCP as a VA program and think the FRCP should only care for wounded warriors when they become or are about to become veterans.
- The DoD official talked about the RCP being directed by Congress and that FRCs and RCCs serve similar purposes, but cover different categories of wounded warriors—RCCs are assigned, day one. The official pointed to the RCP instruction that identifies when the FRCs come into the DoD process to provide more comprehensive care. While DoD told the Subcommittee they were willing

to bring the FRCs earlier into the process, the Department was quite clear that they “wanted control over their people,” and so did the military services.

The latter statement sums up the problem quite succinctly. Rather than fulfill the objective of jointness and seamlessness, the various bureaucracies too often end up putting their organizational interests ahead of those of wounded members and families.

A recent letter signed by the Deputy of Secretary of VA and DoD on September 12, corroborates our view that the two agencies continue to operate as separate programs, struggling to implement the joint program they committed to over 4 years ago when the agency’s leadership signed the first MOU establishing the FRCP program in October of 2007. Comments such as:

- “In order to ensure the capabilities are in place to address these (GAO) recommendations, we are in the process of evaluating the care coordination resources and capabilities of VA and DoD so that the necessary personnel are available with the appropriate skill levels to support the wounded, ill and injured population.
- The Departments recognize that the FRCP and RCP are complementary, not redundant programs.
- While we concur in principle that the establishment of a single recovery coordination program may be the preferred course of action to provide fully integrated care and coordination services for the wounded, ill and injured servicemembers, veterans and their families, we are still in the process of working out the details for the Senior Oversight Committee.”

Clearly, the two Departments have not been able to fix these policy and programmatic gaps on their own these last 4 years—and, unlikely to do so in the immediate future without some sort of immediate outside intervention and oversight. Wounded warriors and their families are struggling and need help now—the last thing they want to hear policymakers say is that ‘we are working on the problem and we will have a plan in place soon.’

So today, wounded, ill and injured servicemembers, disabled veterans and their families are once again faced with trying to understand the complexities, nuances, and navigate two more separate programs in the VA and DoD systems, including unique and fragmented service care coordination programs in each of the Military Departments. Simply put, the programs that were built to be joint and help them navigate the complicated processes have themselves become parochial and part of the navigation problem.

The current FRCP and RCP policies are opaque, confusing and incongruent with the intent of Congress. The VA and DoD were supposed to jointly develop and implement a comprehensive policy on improvements to care, management, and transition of recovering servicemembers, but have in fact developed separate and independent programs.

While the FRCP was operational January 2008, program procedures weren’t published until this year, March 2011. Additionally, DoD did not publish its RCP policy until December 2008, well past the July 1, 2008 congressional deadline.

The *Department of Defense Recovering Warrior Task Force, 2010–2011 Annual Report*, published September 2, 2011, highlights a significant number of program deficiencies, recommending the need to “standardize and clearly define the roles and responsibilities of the RCC, FRC, non-medical care manager, VA Liaison for Health care, and VA Polytrauma Case Managers serving a recovering warrior and his or her family. Standardize the criteria for who is eligible to be assigned to a RCC (or Army Wounded Warrior (AW2) Advocate) and FRC.”

While both the FRCP and RCP programs have deficiencies, MOAA hears far less complaints and far more compliments for the FRCP. VA’s policy and procedures also tend to be more comprehensive and easier to understand than DoD’s RCP regulations.

MOAA urges the Subcommittee to revise and expand Sec. 1611 of Public Law 110-181 to mandate a single, joint VA-DoD program and establish an office for managing, coordinating and assisting severely wounded, ill, and injured servicemembers, veterans and their families through recovery, rehabilitation, and reintegration. DoD should be directed to adopt and fully integrate VA's FRCP policy and procedures outlined in VA Handbook 0802, March 23, 2011.

Systemic Issues

Many of the broad departmental issues plaguing both VA and DoD systems are also impacting and limiting the FRCP, the RCP and likely the 10 other major wounded warrior programs cited by GAO at the May hearing. The persistent problems with information sharing, and the long-standing issues of inadequate collaboration between the agencies are well documented and alive and well today. These issues continue to impede progress and prevent VA and DoD from effectively and efficiently serving our most vulnerable servicemembers and disabled veterans who critically need these support services.

MOAA believes strongly that the key systemic issues which inhibit uniformity and consistency of operations to achieve a state of seamless transition include:

- Lack of systematic compliance, accountability, and oversight;
- Limitations on information sharing, accuracy of information, and communications; and,
- Multiple segregated policies, programs, and services that are duplicative, inefficient, ineffective, and add to the already confusing bureaucratic morass.

The DoD Recovering Warrior Task Force highlighted similar themes in its report (*Department of Defense Recovering Warrior Task Force, 2010-2011 Annual Report*):

“Disparities exist across recovering warrior (RWs) programs and policies in the Headquarters or Department vision and in the way in which those programs and policies are implemented in the field and experienced by RWs and their families. Clear, consistent, and accurate information does not reliably reach RWs about the programs and policies intended to support them. Also, parity of care across the services has not been achieved. From language used to services offered, eligibility criteria, and staffing requirements, the services implement policies and programs differently. There also are significant differences in the experiences of Active Component (AC) RWs, Reserve Component (RC) RWs healing at Active Duty installations, and RC RWs receiving community-based care.”

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, management, and technological system differences after more than a decade of war.

The impact of these system failures can have a profound impact on the medical outcomes and the quality of life our wounded warriors and their families will experience. The impact and experiences of these individuals today continue to be all over the map, regardless of the time frame of the injuries.

- One caregiver whose loved one was injured early in 2010 told the Senate Veterans Affairs Committee of the difficulties in transitioning out of the military at a hearing this past July, “. . . Coordination of care for her wounded warrior has also been a problem. There seem to be so many coordinators that they are actually not all on the same page and sometimes doing things opposite of each other. Though she was trying to help, I rarely got to see our FRC, who seemed to have too many people she was responsible for. The lack of communication also extended to benefits and programs” she said.
- To another caregiver, the mother of her severely disabled son, “Our FRC is affectionately called our ‘Wonderful FRC!’ It is as simple as that, yet, what she has done, and continues to do for our family is nothing short of miraculous and a Godsend. She has taken care of every aspect of my son’s care back to 2008 when he was critically injured. Not only has the FRC provided excellent care and has been my son’s number one advocate, she has been supportive and an inspiration to me as my son’s primary caregiver—and I know she must be the same to the dozen or more wounded warriors families she also cares for each and every day.”
- Another wounded warrior couple whose servicemember was injured in 2009 and was first introduced to their RCC at the time of their medical board, was pro-

vided no information about the FRCP. This spouse told us, “*We completely trust our RCC, though things were a little rocky at first—now he has our full trust! Financially, the transition has been difficult. Her wounded warrior is on the Temporary Duty Retirement List (TDRL) . . . The military has taken months to reevaluate her husband’s condition, and the family no longer has the financial resources while on active duty. The TDRL process and navigating the medical and benefits systems has been a battle from the beginning of his injury—no one has been there to explain the process.*”

Wounded, ill and injured servicemembers, disabled veterans and families deserve the very best care and support from systems that are simple, transparent and accessible. They don’t want more policies or programs to further bog down the progress—they just want the systems to do their job—and to fulfill the obligations, promises and commitments made to them.

MOAA urges Congress to provide the necessary leadership in:

- ***Ensuring that future hearings related to wounded warrior care coordination are joint hearings that include both the Veterans Affairs and Armed Services Committees.***
- ***Commissioning an outside entity to evaluate the FRCP and RCP, to include how the programs operate within the context of the 10 major VA and DoD wounded warrior programs and collection of feedback from recovering warriors and family members on how to develop simpler ways for wounded warriors and their families to access services and support during transition.***
- ***Requiring VA and DoD medical and benefit systems to expand outreach and communication efforts to help increase awareness of all wounded warrior programs.***
- ***Conducting periodic needs assessment surveys to gather information from wounded warriors and their families to improve programs and identify unmet needs.***

Conclusion

MOAA is grateful to the Subcommittee for your leadership in supporting our wounded, ill and injured servicemembers, disabled veterans and their families who have “borne the battle” in defense of the Nation.

Prepared Statement of Hon. Russ Carnahan, a Representative in Congress from the State of Missouri

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, thank you for hosting this hearing to discuss expansion and revision of the Federal Recovery Coordination Program (FRCP). Providing support to those who were injured or became ill in service to our country is of paramount importance. Today’s hearing facilitates a conversation between Congress and those with knowledge of what needs to be done to ensure our Nation’s heroes receive the most expedient and effective assistance in their time of need.

In 2007, following reports of poor outpatient care from Walter Reed Medical Center, the Department of Defense (DoD) and the Veteran’s Administration (VA) jointly created FRCP to coordinate clinical and nonclinical services for recovery, rehabilitation and reintegration of wounded, ill or severely injured servicemembers and Veterans. While the program continues to expand, practices must be reviewed to ensure that our servicemembers and Veterans across the country uniformly receive the best care possible.

A recent Government Accountability Office (GAO) report found concern with the client referral system employed by FRCP. Eligible patients are not being identified in existing DoD and VA databases because records are currently not coded to classify veterans and servicemembers as “severely wounded, ill, and injured.” The program relies solely on referrals to identify qualified individuals. Also, FRCP is understaffed and there is no current system to place new hires and delegate caseload. Additionally, FRCP has been confronted with problems in communicating patient information from DoD and VA facilities to supporting organizations.

I look forward to hearing from our witnesses on ways we can overcome challenges facing the Federal Recovery Coordination Program and expand services to ensure comprehensive care for our Nation’s heroes.

MATERIAL SUBMITTED FOR THE RECORD**U.S. Department of Defense****INSTRUCTION**

NUMBER 1300.24
December 1, 2009
USD(P&R)

SUBJECT: Recovery Coordination Program (RCP)

References: See Enclosure 1

1. **PURPOSE.** In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)) and the guidance in sections 1611, 1614, and 1648 of Public Law 110-181 (Reference (b)), this Instruction:
 - a. Establishes policy, assigns responsibilities, and prescribes uniform guidelines, procedures, and standards for improvements to the care, management, and transition of recovering servicemembers (RSMs) across the Military Departments.
 - b. Establishes the RCP evaluation process to provide for a coordinated review of the policies, procedures, and issues of the program.
 - c. Incorporates and cancels Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Directive-type Memorandum 08-049 (Reference (c)).
2. **APPLICABILITY.** This Instruction applies to:
 - a. OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense.
 - b. The Joint Task Force National Capital Region Medical (JTFCapMed).
 - c. RSMs as defined in the Glossary, regardless of component or duty status.
 - d. Eligible family members of RSMs as defined in the Glossary.
3. **DEFINITIONS.** See Glossary.
4. **POLICY.** It is DoD policy that:
 - a. The RCP shall be established to provide program and policy oversight of DoD resources necessary to ensure uniform care and support for RSMs and their families when the RSM has been wounded or injured or has an illness that prevents him or her from providing that support. Implementation of uniform guidelines, procedures, and standards for the care, management, and transition of RSMs shall ensure consistent, high quality medical and non-medical care for RSMs and their families.
 - b. DoD programs established for the benefit of RSMs and their families shall comply with DoD RCP policies and support the needs of the RSM.
 - c. All RSMs shall be eligible to receive uniform standard support, resources, and access to programs, whether members of the Army, Navy, Air Force, Marine Corps, or Coast Guard.
5. **RESPONSIBILITIES.** See Enclosure 2.
6. **PROCEDURES.** Enclosures 3 through 7 provide overarching procedures and requirements for the administration, implementation, and management of the RCP.
7. **INFORMATION REQUIREMENTS**
 - a. The collection, use, and dissemination of personally identifiable information (PII) shall be administered in compliance with DoDD 5400.11 (Reference (d)) and DoDD 5411.11-R Reference (e)).
 - b. Collection of PII from immediate family members and non-dependent family members must be preceded by provision of an appropriate privacy act statement as required by Reference (e).
8. **RELEASABILITY.** UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Web Site at <http://www.dtic.mil/whs/directives>.
9. **EFFECTIVE DATE.** This Instruction is effective immediately.

Gail H. McGinn
Deputy Under Secretary of Defense (Plans)
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosures

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2. 2. Responsibilities
3. 3. Program Management
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ENCLOSURE 1

REFERENCES

- a. DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R)), June 23, 2008
- b. Sections 1611, 1614, and 1648 of Public Law 110–181, "The National Defense Authorization Act for Fiscal Year 2008," January 28, 2008
- c. Directive-Type Memorandum (DTM) 08–049, "Recovery Coordination Program: Improvements to the Care, Management, and Transition of Recovering Servicemembers (RSMs)," January 19, 2009 (hereby canceled)
- d. DoD Directive 5400.11, "DoD Privacy Program," May 8, 2007
- e. DoD Regulation 5400.11–R, "DoD Privacy Program," May 14, 2007
- f. DoD Centers of Excellence for Psychological Health and Traumatic Brain Injury, "Suicide Assessment Five Step Evaluation and Triage (SAFE–T)," 2007
- g. Assistant Secretary of Defense for Health Affairs Memorandum, "TRICARE Policy for Access to Care and Prime Service Area Standards," February 21, 2006
- h. Parts A and B of Volume I of the Joint Federal Travel Regulations, current edition
- i. Secretary of Defense Memorandum, "DoD Housing Inspection Standards for Medical Hold and Holdover Personnel," September 18, 2007
- j. TRICARE Management Activity, "Medical Management Guide," January 2006
- k. Public Law 104–191, "Health Insurance Portability and Accountability Act of 1996," August 21, 1996
- l. Chapter 61 and section 1145 of title 10, United States Code
- m. DoD Directive 1332.18, "Separation or Retirement for Physical Disability," November 4, 1996
- n. DoD Directive 1332.35, "Transition Assistance for Military Personnel," December 9, 1993
- o. DoD Instruction 1100.13, "Surveys of DoD Personnel," November 21, 1996
- p. Chapter 77 of title 38, United States Code

ENCLOSURE 2

RESPONSIBILITIES

1. *USD(P&R)*. The USD(P&R) shall be responsible for RCP policy and program oversight and shall:
 - a. Execute RCP policy and program oversight through the USD(P&R) Office of Wounded Warrior Care and Transition Policy (WWCTP). The WWCTP shall:
 1. Administer the RCP and provide oversight of its implementation and guidance for continuous process improvement pursuant to Reference (a).
 2. Coordinate with the Assistant Secretary of Defense for Health Affairs (ASD(HA)) regarding programs that support RSMs and their families when preparing RCP policy.

- b. Oversee all RSM support programs throughout the Department of Defense and adjust RCP policy and procedures as necessary.
 - c. Oversee the development of core training conducted by the WWCTP for the Military Department recovery care coordinators (RCC).
 - d. Oversee Military Department development of policies and procedures that are uniform and standardized across the Military Departments to provide services and resources for RSMs and their families.
 - e. Coordinate with the VA to develop and implement administrative processes, procedures, and standards for transitioning RSMs from DoD care and treatment to VA care, treatment, and rehabilitation that are consistent with Enclosure 5 of this Instruction.
2. *ASD(HA)*. The ASD(HA), under the authority, direction, and control of the USD(P&R), shall:
- a. Provide RSMs with timely access to inpatient and outpatient medical and behavioral health services through DoD facilities, purchased care, or in coordination with the VA.
 - b. Ensure that policies and procedures for RSM medical care case managers (MCCMs) are developed, implemented, and consistent across the Military Departments.
 - c. Establish uniform professional qualifications, including education and training, for MCCMs identified to become members of the RSM recovery team (RT).
 - d. Ensure that MCCM workload is delineated based on the medical constraints and requirements of the RSMs served.
 - e. Develop medically appropriate training for RCCs, MCCMs, and non-medical care managers (NMCMs) that addresses detection, notification, and tracking of early warning signs of post-traumatic stress disorder, suicidal or homicidal thoughts or behaviors, and other behavioral health concerns among RSMs. Ensure such training includes procedures for the appropriate specialty consultation and referral following detection of such signs in accordance with DoD Centers of Excellence for Psychological Health and Traumatic Brain Injury publication (Reference (f)) for initiating behavioral health early warning sign notification and tracking procedures.
 - f. Coordinate with the VA to develop and implement medically related processes, procedures, and standards for transitioning RSMs from DoD care and treatment to VA care, treatment, and rehabilitation that address:
 - 1. RSM transition without gaps in medical care or the quality of medical care, benefits, and services to the maximum extent feasible.
 - 2. RSM enrollment in the VA health care system.
 - 3. Assignment of DoD and VA case management personnel in military treatment facilities (MTFs) VA medical centers, and other medical facilities caring for RSMs.
 - 4. Integration of DoD and VA medical care and management of RSMs during transition, to include the accommodation of VA medical personnel in DoD facilities as required to participate in the needs assessments of RSMs.
 - 5. VA access to the health records of RSMs receiving or anticipating receipt of care and treatment in VA facilities.
 - 6. Utilization of a joint separation and evaluation physical examination that meets the DoD and VA requirements for disability evaluation of RSMs.
 - 7. Measurement of RSM and family satisfaction with the quality of health care for RSMs provided by the Department of Defense to facilitate appropriate oversight of such care and services by leadership. (This measurement is separate from that conducted by the WWCTP in the annual RCP evaluation described in Enclosure 7 of this Instruction.) Measured results shall be reported to the WWCTP.
3. *SECRETARIES OF THE MILITARY DEPARTMENTS*. The Secretaries of the Military Departments shall:
- a. Ensure RSM care, management, and transition policies are uniform and standardized.
 - b. Establish uniform procedures for tracking RSMs that facilitate:
 - 1. Locating RSMs.
 - 2. Tracking RSM attendance at medical care, physical exam, and evaluation appointments and scheduling additional appointments as needed.
 - 3. Tracking RSM progress through medical and physical evaluation boards (PEBs).

- c. Ensure their RCPs are extended to include RSMs in their Reserve Components (RC) and incorporate all program services, to include identifying RSMs, assigning RSMs to RCCs, and preparing recovery plans.
- d. Establish and appropriately resource their Military Department RCP elements, wounded warrior programs, and family support programs.
- e. Ensure that wounded warrior and family support programs execute the policies of this Instruction.
- f. Exercise the authority to:
 - 1. Grant waivers to the maximum number of RSM cases assigned to RCCs and NCMCs as described in subparagraph 1.a.(2) of Enclosure 6.
 - 2. Grant RSM requests to continue on duty after being found unfit for duty as described in paragraph 3.b. of Enclosure 5.
- g. Ensure the Surgeons General comply with the requirements of section 1 of Enclosure 3.
- h. Authorize access to basic outpatient and inpatient medical and behavioral health services through DoD facilities for members of families who are providing support to RSMs and who are not otherwise eligible for care as dependents (e.g., parents, siblings) and are providing support to RSMs.

ENCLOSURE 3

PROGRAM MANAGEMENT

1. SURGEONS GENERAL OF THE MILITARY DEPARTMENTS. The Surgeons General of the Military Departments shall:
 - a. Establish policies and procedures to ensure compliance with this Instruction within their respective components and MTFs.
 - b. Provide appropriately trained medical personnel in accordance with Reference (a) to support RSM care management throughout the continuum of care.
 - c. Ensure that installation medical directors provide oversight of the medical care delivered to RSMs.
 - d. Ensure that MTF commanders facilitate access to family support services within MTFs, and between MTFs and local family service entities (e.g., childcare).
 - e. Ensure that RSMs have the highest priority for appointments to non-urgent and other health care services in DoD MTFs and for any purchased care medical services. Ensure RSMs receive referrals to other DoD, VA, or purchased care providers if appointments are not available within the MTF that meet TRICARE access standards in accordance with ASD(HA) Memorandum (Reference (g)).
2. COMMANDER, JTFCAPMED. The Commander, JTFCapMed, shall ensure compliance with this Instruction within the JTFCapMed area of responsibility.
3. COMMANDERS, WOUNDED WARRIOR PROGRAMS. Commanders shall:
 - a. Have overall responsibility for the management of their Military Department RCP, and shall maintain operational, tactical, and administrative control of their RCP and non-medical personnel to ensure they execute the roles and responsibilities in this Instruction.
 - b. Ensure that RSMs are referred to the appropriate RCP, either the DoD RCP or the Federal Recovery Coordination Program (FRCP), established by the Department of Defense and/or the VA.
 - c. Provide appropriately trained RCCs, NCMCs, and other non-medical members of the RT, in accordance with Reference (b), to support RSM care management throughout the continuum of care.
 - d. Conduct Military Department-specific training for their RCCs, MCCMs, and NCMCs, provide a certificate of completion to those who have attended the training, and forward a roster of attendees' names to the WWCTP training office.
 - e. Establish work and duty assignments for RSMs, with the recommendation of appropriate medical and non-medical authorities, that support recovery, rehabilitation, and reintegration, and that may include training and education tailored to the abilities of RSMs.

- f. Assist RSMs in obtaining needed medical care and services by providing transportation and subsistence in accordance with parts A and B of Volume 1 of the Joint Federal Travel Regulations (Reference (h)).
 - g. Ensure RSMs have access to educational and vocational training and rehabilitation opportunities at the earliest possible point in their recovery.
4. RTs
- a. Composition. All RTs shall include the RSM's Commander, RSM; an RCC or a Federal recovery coordinator (FRC); an MCCM; and an NMCM. They may also include medical professionals such as primary care managers, mental health providers, physical and occupational therapists, and others such as PEB liaison officers, VA military services coordinators, chaplains, and family support program representatives.
 - b. Overarching Roles and Responsibilities. RT members shall:
 1. Complete Military Department-specific training prior to independently assuming the duties of their positions, and comply with continuing education requirements.
 2. Collaborate with the RCC and other RT members to develop the comprehensive recovery plan (CRP), evaluate its effectiveness in meeting the RSM's goals, and readjust it as necessary to accommodate the RSM's changing objectives, abilities, and recovery status.
 3. Determine the RSM's location of care based primarily on the RSM's medical care needs, with consideration given to the desires of the RSM and family and/or designated caregiver. Provide the RSM and family or designated caregiver options for care locations during development of the CRP that address:
 - a. The RSM's medical care and non-medical support needs.
 - b. Capabilities required for the RSM's care.
 - c. The availability of DoD, VA, or civilian facilities with appropriate capabilities and accreditation or licensure.
 4. Determine the appropriate course of action for the RSM when he or she is located at an MTF, specialty medical care facility, military quarters, or leased housing that is found to be deficient in accordance with Secretary of Defense Memorandum (Reference (i)); this course of action may be temporary or permanent based on the deficiency and the RSM's needs.
 5. Reevaluate the needs of the RSM in accordance with the options for care locations if relocation is required.
 6. Facilitate the most expeditious appointment available for the RSM for non-urgent care to include appointments for follow-up and/or specialty care, diagnostic referral and studies, and surgery.
 7. Allow the RSM to waive the TRICARE standards for access to care detailed in the TRICARE Management Activity guide (Reference (j)) when either of these circumstances occur:
 - a. No appointment is available that meets access standards within DoD MTFs or the TRICARE program.
 - b. Travel is required beyond the TRICARE catchment area, and the health care provider has determined that travel will not adversely affect the health of the RSM.
 8. Document in writing, and maintain in the RSM's records, any situation in which the RSM waives a standard for access to care.
 - c. RCC Responsibilities. The RCC shall:
 1. Complete uniform core training conducted by WWCTP, and Military Department-specific training conducted by the cognizant wounded warrior program prior to assuming the duties of their positions.
 2. Have primary responsibility for development of the CRP, in conjunction with the RT, and assist the commander in overseeing and coordinating the services and resources identified in the CRP.
 3. Ensure, in coordination with the Secretary of the Military Department concerned, that the RSM and family and/or designated caregiver have access to all medical and non-medical services throughout the continuum of care.
 4. Minimize delays and gaps in treatment and services.
 5. Provide a hard copy of the CRP to the RSM and family and/or designated caregiver upon completion and whenever changes are made to the document. Review and update the CRP in person (when possible) with the RSM and family or designated caregiver as frequently as necessary based on the

RSM's needs and during transition phases in the RSM's care (change in location or familial, marital, financial, job, medical, or retirement status).

6. Facilitate and monitor the execution of services for the RSM across the continuum of care as documented in the recovery plan, to include services available from the Department of Defense, the VA, the Department of Labor, and the Social Security Administration.
 7. Coordinate the transfer of an updated CRP to, and directly communicate with, appropriate medical and non-medical personnel should the RSM be moved to a different location for care.
 8. Close out the CRP when the RSM has met all goals or declines further support and retain all documents according to applicable Military Department policies.
- d. MCCM Responsibilities. MCCMs shall:
1. Ensure the RSM understands his or her medical conditions and treatments and receives appropriate coordinated health care.
 2. Assist the RSM and family or designated caregiver in understanding the RSM's medical status during care, recovery, and transition.
 3. Assist the RSM in receiving well-coordinated prescribed medical care during all phases of the continuum of care.
 4. Conduct periodic reviews of the RSM's medical status. When possible, reviews shall be conducted in person with the RSM and family or designated caregiver.
- e. NCMC Responsibilities. The NCMC shall:
1. Work within established service program procedures to ensure the RSM and family or designated caregiver gets needed non-medical support such as assistance with resolving financial, administrative, personnel, and logistical problems.
 2. Provide feedback on the effectiveness of the CRP in meeting the RSM's personal goals.
 3. Communicate with the RSM and family or designated caregiver regarding non-medical matters that arise during care, management, and transition; assist the RSM in resolving non-medical issues.
 4. Assist the RSM with finding the resources to maintain or improve his or her welfare and quality of life.

ENCLOSURE 4

RECOVERY COORDINATION PROCESS

1. SERVICEMEMBER SCREENING
 - a. In accordance with standard medical practice, servicemembers shall be screened for medical and psychosocial needs upon initial presentation to a medical care provider. For servicemembers who are unlikely to return to duty within a specific period of time determined by their Military Departments wounded warrior program, care and support needs will be assessed by their wounded warrior programs using standardized tools for RCP category assignment and enrollment.
 - b. Servicemembers may self-refer to the RCP or be referred by their command, medical care provider, Military Department wounded warrior program, or the Wounded Warrior Resource Center.
2. CATEGORY ASSIGNMENT
 - a. The Military Departments shall use the care coordination categories shown in the table or a similar process standardized within their wounded warrior program to determine an initial care coordination category.

Table.

Servicemember Care Coordination Categories

Category 1 (CAT 1)	<ul style="list-style-type: none"> • Has a mild injury or illness • Is expected to return to duty within a time specified by his or her Military Department • Receives short-term inpatient medical treatment or outpatient medical treatment and/or rehabilitation
Category 2 (CAT 2)	<ul style="list-style-type: none"> • Has a serious injury or illness • I unlikely to return to duty within a time specified by his or her Military Department • May be medically separated from the military
Category 3 (CAT 3)	<ul style="list-style-type: none"> • Has a severe or catastrophic injury or illness • Is highly unlikely to return to duty • Will most likely be medically separated from the military

- b. Servicemembers who are determined to be CAT 2 and CAT 3 or who fall within their equivalent Military Department's wounded warrior program's standardized care coordination categories are RSMs.
 - c. A CAT 2 RSM who is enrolled in the RCP shall be assigned an RCC and an RT. The Military Department wounded warrior program shall assign the RCC to provide assistance for the RSM's recovery, rehabilitation, and transition activities.
 - d. All CAT 3 RSMs shall be enrolled in the FRCP and shall be assigned an FRC and an RT. The FRC will coordinate with the RCC and RT to ensure the needs of the RSM and his or her family are identified and addressed.
 - e. An RSM assigned to CAT 2, who later meets the criteria for CAT 3, shall be placed in CAT 3 and an FRC shall be assigned.
 - f. An RSM assigned to CAT 3, who later meets the criteria for CAT 2, shall be placed in CAT 2. The FRC shall remain with the RSM until such time as the FRC and RSM and family agree that the services of the FRC are no longer needed.
 - g. An RSM assigned to CAT 1, who later meets the criteria for CAT 2 or 3, shall be placed in the appropriate category and assigned an RCC, FRC, and an RT as required by the category.
3. DESIGNATED CAREGIVERS. RSMs who do not have or want immediate families (spouse or children) to support them with their recovery shall be permitted to designate another individual as a caregiver. The caregiver may be a friend, fiancée or fiancé, co-worker, member of the family who is not a military dependent, etc. RSMs may also decide that he or she does not want to designate a caregiver.
4. CRP
- a. All RSMs enrolled in a Military Department RCP shall receive a CRP. (RSMs assigned an FRC shall also receive a Federal individual recovery care.) The RSM, family or designated caregiver, and RT members will create action steps for accomplishing plan goals that must be specific, measurable, and achievable within an agreed upon time frame. In addition to the action to be taken, action steps shall contain these data elements:
 1. An identified point of contact for each step.
 2. A list of the support and resources available to the RSM and family or designated caregiver for each action, including the location of the support and resources.
 - a. The RSM and family or designated caregiver, and the RCC shall review the CRP and sign the document, demonstrating their understanding of the plan and commitment to its implementation.
 - b. The Military Departments may customize the CRP based on internal requirements, provided the criteria in paragraphs 4.a. and 4.b. of this enclosure are met.
5. FAMILY SUPPORT
- a. Response to Family Needs. The NMCM shall:

1. Identify any immediate family needs upon first interaction with the family. Needs may include lodging, transportation, medical care, finances, or childcare.
 2. Contact the appropriate family support programs to obtain services and resources that respond to the identified family needs. This initial interface with family support services and resources is key to ensuring the RSM's family is appropriately supported.
 3. Ensure key family needs are addressed in relevant goals in the recovery plan.
2. Medical Support for Non-Dependent Family Members. The RCC or FRC, MCCM, and NMCM, in coordination with the Secretary of the Military Department concerned or designee, shall facilitate non-dependent family member access to medical care at DoD MTFs. The RCC or FRC, MCCM, and NMCM shall facilitate non-dependent family member access to non-Federal care providers as needed (not at Government expense). In general, medical care and counseling may be provided at a DoD MTF on a space-available basis when:
 1. The family member is on invitational travel orders to care for the RSM.
 2. The family member is issued non-medical attendant orders to care for the RSM.
 3. The family member is receiving per diem payments from the Department of Defense while caring for the RSM.
 - c. Advice and Training Services. Advice and training services include, but are not limited to, financial counseling, spouse employment assistance, respite care information, and childcare assistance. When the family has arrived at the treatment facility, the NMCM, RCC, or FRC should provide information on services and resources available through the National Resource Directory (<https://www.nationalresourcedirectory.org>), the Wounded Warrior Resource Center Call Center (1-800-342-9647) and Web Site (<http://www.woundedwarriorresourcecenter.com>), and the Wounded, Ill, and Injured Compensation and Benefits Handbook (<http://tricare.mil/mybenefit/Download/Forms/Compensation-Benefits-Handbook.pdf>).
 - d. Financial Assistance and Job Placement Services. The RT shall:
 1. Identify any loss of income and financial challenges facing the RSM's family.
 2. Ensure the recovery plan identifies benefits, compensation, services (such as job placement services), and resources from Federal, State, and local agencies and non-profit organizations for which the RSM's family is eligible.

ENCLOSURE 5

TRANSITION PROCEDURES

1. *TRANSITION FROM DoD CARE AND TREATMENT TO VA CARE, TREATMENT, AND REHABILITATION*
 - a. Prior to transition of the RSM to the VA, the RCC (assisted by the RT) shall ensure that all appropriate care coordination activities, both medical and non-medical, have been completed, including:
 1. Notification to the appropriate VA point of contact (such as a Transition Patient Advocate) when the RSM begins physical disability evaluation process, as applicable.
 2. Scheduling initial appointments with the Veterans Health Administration system.
 3. Transmittal of the RSM's military service record and health record to the VA. The transmittal shall include:
 - a. The RSM's authorization (or that of an individual legally recognized to make medical decisions on behalf of the RSM) for the transmittal in accordance with Public Law 104-191 (Reference (k)). The RSM may have authorized release of his or her medical records if he or she applied for benefits prior to this point in the transition. If so, a copy of that authorization shall be included with the records.
 - b. The RSM's address and contact information.

- c. The RSM's DD Form 214, "Certificate of Release or Discharge from Active Duty," which shall be transmitted electronically when possible, and in compliance with Reference (d).
 - d. The results of any PEB.
 - e. A determination of the RSM's entitlement to transitional health care, a conversion health policy, or other health benefits through the Department of Defense, as explained in section 1145 of title 10, United States Code (U.S.C.) (Reference (l)).
 - f. A copy of requests for assistance from the VA, or of applications made by the RSM for health care, compensation and vocational rehabilitation, disability, education benefits, or other benefits for which he or she may be eligible pursuant to laws administered by the Secretary of Veterans Affairs.
4. Transmittal of the RSM's address and contact information to the department or agency for veterans affairs of the State in which the RSM intends to reside after retirement or separation.
 5. Update the CRP for the RSM's transition that shall include standardized elements of care, treatment requirements, and accountability for the plan. The CRP shall also include:
 - a. Detailed instructions for the transition from the DoD disability evaluation system to the VA disability system.
 - b. The recommended schedule and milestones for the RSM's transition from military service.
 - c. Information and guidance designed to assist the RSM in understanding and meeting the schedule and milestones.
- b. The RCC and RT shall:
1. Consider the desires of the RSM and the family or designated caregiver when determining the location of the RSM's care, treatment, and rehabilitation.
 2. Coordinate the transfer to the VA by direct communication between appropriate medical and non-medical staff of the losing and gaining facilities (e.g., MCCM to accepting physician).
2. TRANSITION FROM DoD CARE AND TREATMENT TO CIVILIAN CARE, TREATMENT, AND REHABILITATION
 - a. Prior to transition of the RSM to a civilian medical care facility, the RCC (assisted by the RT) shall ensure that all care coordination activities, both medical and non-medical, have been completed, including:
 1. Appointment scheduling with civilian medical care facility providers.
 2. Transmittal of the RSM's health record to the civilian medical care facility. The transmittal shall include:
 - a. The RSM's authorization (or that of an individual legally recognized to make medical decisions on behalf of the RSM) for the transmittal in accordance with Reference (i).
 - b. A determination of the RSM's entitlement to transitional health care, a conversion health policy, or other health benefits through the Department of Defense, as explained in section 1145 of Reference (l).
 - b. Transmittal of the RSM's address and contact information.
 - c. Preparation of detailed plans for the RSM's transition, to include standardized elements of care, treatment requirements, and accountability of the CRP.
 - d. The RCC and RT shall:
 1. Consider the desires of the RSM and the family or designated caregiver when determining the location of the RSM's care, treatment, and rehabilitation.
 2. Coordinate the transfer by direct communication between appropriate medical and non-medical staff of the losing and gaining facilities (e.g., RCC to FRC, MCCM to accepting physician).
3. RETURN TO DUTY
 - a. An RSM who is found fit for duty by a PEB shall be returned to duty in accordance with the policies and procedures of the Military Department concerned.

- b. In accordance with DoDD 1332.18 (Reference (m)), an RSM may request to continue on permanent limited duty status or active duty in the Ready Reserve after being found unfit for duty. The Secretary of the Military Department concerned may grant such requests based on a determination that the needs of the Service and the RSM's service obligation, special skills, experience, or reclassification justifies the continuation. Transfer of the RSM to another Service may also be considered.
- c. Members of the RC who are not designated as RSMs, who are released from active duty and are returned to their units, and who are entitled to non-urgent medical care for injuries or illnesses incurred while on active duty are required to coordinate authorization for medical care and schedule appointments through their units and the Military Medical Support Office.

4. MEDICAL SEPARATION OR RETIREMENT

- a. Upon medical retirement, the RSM will receive the same benefits as other retired members of the Military Departments. This includes eligibility for participation in TRICARE and to apply for care through the VA.
- b. An RSM who is enrolled in the RCP and subsequently placed on the temporary disability retired list shall continue to receive the support of an RCC, including implementation of the recovery plan, until such time as the wounded warrior program determines that the services and resources necessary to meet identified needs are in place through non-DoD programs.

5. TRANSITION SUPPORT

- a. Transition From DoD Care. The RT shall provide transition support to the RSM and family or designated caregiver before, during, and after relocation from one treatment or rehabilitation facility to another or from one care provider to another. Transition preparation will occur with sufficient advance notice and information that the upcoming change in location or caregiver is anticipated by the RSM and family or designated caregiver, and will be documented in the CRP.
- b. Separation or Retirement. Once the PEB determines that the RSM will not return to duty:
 - 1. The RT shall:
 - a. Work with the RSM and family or designated caregiver to prepare for the transition to retirement and veteran status.
 - b. Ensure transition plans are written prior to the time of separation for RSMs being retired or separated pursuant to chapter 61 of Reference (l).
 - 2. The RCC or FRC shall:
 - a. Discuss with the RSM his or her short- and long-term personal and professional goals such as employment, education, and vocational training, and the rehabilitation needed to meet those goals; identify the options and transition activities in the CRP.
 - b. Ensure the RSM, as appropriate, has received the mandatory pre-separation counseling and has the opportunity to attend the VA benefits briefing and to participate in the Disabled Transition Assistance Program (TAP) and the Department of Labor TAP Employment Workshop. Encourage the RSM to establish a TAP account through the Internet at <http://www.TurboTAP.org>, as outlined in DoDD 1332.35 (Reference (n)).
 - c. Ensure RCRSMs have the opportunity to participate in the Benefits Delivery at Discharge Program as appropriate.

ENCLOSURE 6

WORKLOAD AND SUPERVISION PROCEDURES

1. WORKLOAD

- a. RCCs and NCMCs
 - 1. The wounded warrior program shall assign RCCs and NCMCs a maximum of 40 RSMs to serve. The actual number assigned will depend on the acuity of the RSMs' medical conditions and complexity of their non-medical needs.
 - 2. A waiver will be required by the Secretary of the cognizant Military Department or such individual as delegated the authority by the Secretary

if the maximum number of RSM cases assigned to an RCC or NCMC is exceeded. Waivers shall not exceed 120 days.

- b. MCCMs. Guidance on MCCM workload shall be established by the ASD(HA), in accordance with section 2 of Enclosure 2.
2. SUPERVISION
- a. The Military Departments will provide supervision for the RCCs and NCMCs employed by their wounded warrior programs.
 1. Supervisors of RCCs and NCMCs shall be military officers in the grade of O-5 or O-6, or civilian employees of equivalent grade.
 2. The occupational specialty of persons appointed to supervise RCCs and NCMCs is at the discretion of the Military Departments.
 - b. Supervisors of MCCMs shall be Military Department medical officers in the grade of O-5 or O-6, or civilian employees of equivalent rank or grade within the MCCM's chain of command.
 1. The Surgeons General will oversee the MCCMs employed in the Military Health care System.
 2. The medical occupational specialty of supervisors of MCCMs is at the discretion of the Military Department Surgeons General.

ENCLOSURE 7

RCP EVALUATION PROCEDURES

1. STAFF ASSISTANCE VISITS
 - a. The WWCTP shall conduct only staff assistance visits from the effective date of this Instruction to 1 year after its effective date to allow the Military Departments to implement the RCP and fully staff the wounded warrior programs.
 - b. The WWCTP shall provide a planned visit schedule, subject to change, to the Military Departments within 30 days from the effective date of this Instruction.
2. EVALUATION PROGRAM
 - a. The WWCTP shall:
 1. Develop and conduct an annual, formal RCP evaluation across the Military Departments using existing DoD assessment tools and information found in DoD Instruction 1100.13 (Reference (o)), to measure compliance with Reference (b) requirements.
 2. Conduct a baseline evaluation beginning 1 year from the effective date of this Instruction, and from 6 months of the date of the baseline evaluation shall initiate a recurring program evaluation schedule.
 3. Encourage the Military Departments to conduct internal evaluations as well.
 - b. The RCP evaluation shall focus on the care, management, and transition process of the RSM. The evaluation will include, at a minimum:
 1. A review of RCC roles and responsibilities.
 2. A review of the maximum number of RSMs that RCCs and NCMCs are allowed to serve.
 3. An assessment of RSM, veteran, and family experiences with the RCP.
 - c. The WCCTP shall use the results of the evaluation to implement improvements to the RCP and ensure quality in the delivery of health care services to the RSM and family. The resulting modifications to RCP care, management, and transition processes or procedures will be reflected in a change to or revision to this Instruction.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ASD(HA)-Assistant Secretary of Defense for Health Affairs

CAT-category
 CRP-comprehensive recovery plan
 DoDD-DoD Directive
 FR-Federal recovery coordinator
 FRCP-Federal Recovery Coordination Program
 JTF-CapMed Joint Task Force Capital Region Medical
 MCCM-medical care case manager
 MTF-military treatment facility
 NMCM-non-medical care manager
 PEB-physical evaluation board
 RC-Reserve Component
 RCC-recovery care coordinator
 RCP-recovery coordination program
 RSM-recovering servicemember
 RT—recovery team
 TAP-Transition Assistance Program
 U.S.C.-United States Code
 USD(P&R)-Under Secretary of Defense for Personnel and Readiness
 VA-Department of Veterans Affairs
 WWCTP-Office of Wounded Warrior Care and Transition Policy

PART II. DEFINITIONS

These terms and their definitions are for the purpose of this Instruction.
acuity. The level of severity or urgency of an RSM's medical condition as related to the need for certain care or treatment.

eligible family member. An RSM's spouse, child (including stepchildren, adopted children, and illegitimate children), parent or person in loco parentis, or sibling on invitational travel orders or serving as a non-medical attendee while caring for the RSM for more than 45 days during a 1-year period.

ERC. An individual assigned by the VA to serve as the ultimate point of contact for an RSM and family or designated caregiver to ensure the RSM medical and non-medical needs are met.

FRCP. The program established by the Department of Defense and the VA to provide management and oversight of the resources needed to coordinate care and support to RSMs through recovery, rehabilitation, and reintegration.

invitational travel orders. Military travel orders that allow an RSM's family to travel and stay with the RSM during treatment and recovery after suffering a wound, illness, or injury.

recovery plan. A patient-centered plan prepared by an RT, RSM, and family or designated caregiver with medical and non-medical goals for recovery, rehabilitation, and transition, as well as personal and professional goals, and the identified services and resources needed to achieve the goals.

RSM. A member of the military services who is undergoing medical treatment, recuperation, or therapy and is in an inpatient or outpatient status, who incurred or aggravated a serious illness or injury in the line of duty, and who may be assigned to a temporary disability retired or permanent disability retired list due to the Military Department's disability evaluation system proceedings.

TAP. A program designed to ease the transition of servicemembers from military service to the civilian workforce and community.

temporary disability retired list. A disposition finding by a PEB for an RSM who has one or more Service unfitting conditions that were incurred in the line of duty and that have a combined rating of 30 percent or higher, and who is considered not stable as a result.

transition. A process that may include:

Leaving military service by way of discharge, separation, or retirement.

Release from active duty (REFRAD) for RC members.

Transfer from the military health care system to the VA health care system.

VA. The Federal agency responsible for providing a wide range of programs and services to servicemembers and veterans as required by chapter 77 of title 38, U.S.C. (Reference (p)). The VA includes, among other components, the Veterans Health Administration and the Veterans Benefits Administration.

wounded warrior program. A system of support and advocacy to guide and assist the RSM and family or designated caregiver through treatment, rehabilitation, return to duty, or military retirement and transition into the civilian community. Each Military Department has a unique wounded warrior program that addresses its servicemembers' needs.

