STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Madam Chairwoman and Members of the Subcommittee on Health:

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

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

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

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

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[1] http://www.urbanhealthcast.com/NAADPC/SlidesSeamlessTransition.pdf
[2] U.S. Government Accountability Office. Testimony before the House Committee on Veterans' Affairs, GAO-05-1052T, September 28, 2005.

Section 302 of Public Laws 108-422 and 108-447 required VA to designate centers for research, education, and clinical activities on complex multi-trauma associated with combat injuries. In June 2005, VA designated four Polytrauma Rehabilitation Centers (PRCs) to be co-located with the four existing Traumatic Brain Injury (TBI) Lead Centers. In fact, these TBI Lead Centers are not commonly referred to as Polytrauma Centers.

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

DoD's current transition, care and case management program, the Wounded Warrior Care and Transition Policy program, is based on recommendations made by commissions and other review groups[4] that were convened before and after the deficiencies at WRAMC came to light in February 2007.

Taken from the July 2007 report of President's Commission on Care for America's Returning Wounded Warriors, the FRCP was implemented through two Memoranda of Understanding dated August 31, 2007, and October 15, 2007.[5] However, it should be noted that developing the FRCP occurred simultaneously with legislation subsequently enacted in January 2008 as Public Law 110-181, directing VA and DoD to "jointly develop and implement comprehensive policies on the care, management, and transition of recovering Service members."

The law's requirements specifically include:

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

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

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

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

- developing uniform guidelines to provide support for family members of RSMs.

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

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

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

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

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

[7] Established in 2004, AW2 assigns an AW2 Advocate, and the Warrior Transition Units (WTUs) where a service member is assigned a triad of care and development of a Comprehensive Transition Plan. The triad includes a primary care manager (normally a physician), nurse case manager, and squad leader—who coordinate their care with other clinical and non-clinical professionals. WTUs also have platoon sergeants to assist where needed. The Marine Wounded Warrior Regiment commands the East and West Wounded Warrior Battalions and other detachments uses Recovery Care Coordinators to help define and meet a member's recovery plan as well as District Injured Support Cells to assist recovering mobilized reserve Marines. Established in 2005 the Safe Harbor Program offers two levels of support: Non-medical case managers to support and assist member and family needs, and; Recovery Care Coordinators who oversees and assists with the members Comprehensive Recovery Plan. The Air Force Warrior and Survivor Care Program initially depended on family liaison officers and community readiness consultants to assist in community reintegration. Air Force Recovery Care Coordinators were added whose area of responsibility is regionalized and works closely with family liaison officers, patient liaison officers, and medical case managers.

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

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

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

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

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

If FRCs must, by definition, ensure that systemic barriers to care and services are resolved at both the individual and the system level, and the FRCP is to provide a system that transcends all boundaries to coordinate service members' and veterans' care and benefits through recovery, rehabilitation, and reintegration into their home communities, [9] we believe it is only proper that commensurate authority and resources to effect change and accomplish such a lofty task must be provided.

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

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

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

FRCP/RCP Collaboration Recommendations:

Objective: Re-defined Care Coordination Program

Recommendations:

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

Objective: Improved integration of the Care Coordination Program

Recommendations:

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

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

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

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

Madam Chairwoman, we hope the Subcommittee will work with its counterpart in the Armed Services Committee to instill in both DoD and VA a stronger interest in making the FRCP the program that was intended by showing a stronger interest in implementing the

recommendations of its own consensus conference. Moving forcefully on these recommendations may also bring VA into compliance with recommendations of the Government Accountability Office in its March 2011 report to Congress on the VA FRCP.

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