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**FEDERAL RECOVERY
COORDINATION
PROGRAM**

**Enrollment, Staffing, and
Care Coordination Pose
Significant Challenges**

Statement of Randall B. Williamson
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G A O

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

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

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

The FRCs’ primary responsibility is to work with each enrollee along with his or her family and clinical team to develop a Federal Individual Recovery Plan, which sets individualized goals for recovery and is

¹OEF, 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.

²According 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.

intended to guide the enrollee through the continuum of care.³ As care coordinators, FRCs are generally not expected to directly provide the services needed by enrollees. However, FRCs may provide services directly to enrollees in certain situations, such as when they cannot determine whether a case manager has taken care of an issue for an FRCP enrollee, when asked to resolve complex problems, or when making complicated arrangements.

The FRCP is administered by VA, and FRCs are VA employees. Since beginning operation in January 2008, the FRCP has grown considerably but experienced turmoil in its early stages, including turnover of staff and management. At present, there are 22 FRCs who have been located at various military treatment facilities, VA medical centers, and the headquarters of two military wounded warrior programs. While the FRCs are physically located at certain facilities, their enrollees are scattered throughout the country and may not be receiving care at the facility where their assigned FRC is located.

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

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

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

⁴GAO, *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).

clinical and nonclinical officials and staff interact with the FRCs, we conducted site visits and telephone interviews with program officials at DOD and VA headquarters and medical facility staff at the DOD and VA medical facilities where FRCs are located.⁵

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

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

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

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

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

- *Challenges in identifying potentially eligible individuals.* It is unclear whether all individuals who could benefit from the FRCP's care coordination services are being identified and enrolled in the program. Because neither DOD nor VA medical and benefits information systems classify servicemembers and veterans as "severely wounded, ill, and injured," FRCs cannot readily identify potential enrollees using existing data sources. Instead, the program must rely on referrals to identify eligible individuals. Once these individuals are identified, FRCs must evaluate them and make their enrollment determinations—a process that involves considerable judgment by FRCs because of broad criteria. However, FRCP leadership does not systematically review FRCs' enrollment decisions, and as a result, program officials cannot ensure that referred individuals who could benefit from the program are enrolled and, conversely, that the individuals who are not enrolled are referred to other programs.
- *Challenges in determining staffing needs and placement decisions.* The FRCP faces challenges in determining staffing needs, including managing FRCs' caseloads and deciding when VA should hire additional FRCs and where to place them. According to the FRCP Executive Director, appropriately balanced caseloads (size and mix) are difficult to determine because there are no comparable criteria against which to base caseloads for this program because of its unique care coordination activities. The program has taken other steps to manage FRCs' caseloads, including the use of an informal FRC-to-enrollee ratio. Because these methods have some limitations, the FRCP is developing a customized workload assessment tool to help balance the size and mix of FRCs' caseloads, but it has not determined when this tool will be completed. In addition, the FRCP has not clearly defined or documented the processes for making staffing decisions in FRCP policies or procedures. As a result, it is difficult to determine how staffing decisions are made, or how these processes could be sustained during a change in leadership. Finally, the FRCP's basis for placing FRCs at DOD and VA facilities has changed over time, and the program lacks a clear and consistent rationale for making these decisions, which would help ensure that FRCs are located where they could provide maximum benefit to current and potential enrollees.

- *Challenges in coordinating with other VA and DOD programs and supporting FRCs.* A key challenge facing the FRCP concerns the coordination of services by the large number of DOD and VA programs that support wounded servicemembers and veterans. Although these programs vary in terms of the severity of the injuries among the servicemembers and veterans they serve and the specific types of services they coordinate, many programs have similar functions and are involved in similar types of activities. Table 1 illustrates the key characteristics of major DOD and VA programs and the activities in which they are involved.

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

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

Program name	Program characteristics			Type of services provided			
	Program description	Severity of enrollees' injuries ^a	Title of care coordinator or case manager	Lifetime follow-up	Clinical	Non-clinical	Recovery plan
VA Spinal Cord Injury and Disorders Program	VA system of care that provides a coordinated continuum of services for servicemembers and veterans with spinal cord injuries.	Mild to severe	Nurse, social worker	√	√	√	√
VA Polytrauma System of Care	VA system of specialized facilities that provides comprehensive, individually tailored rehabilitation to servicemembers and veterans with multiple injuries.	Serious to severe	Social work and nurse case managers	√	√	√	√

Source: GAO analysis of DOD and VA program information.

Note: The characteristics listed in this table are general characteristics of each program; individual circumstances may affect the enrollees served and services provided by specific programs.

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

^bFRCs placed at the headquarters of Special Operations Command's Care Coalition and Navy Safe Harbor coordinate clinical and nonclinical care for enrollees in these two programs and for other FRCP enrollees.

^cOEF/OIF refers to Operation Enduring Freedom and Operation Iraqi Freedom.

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

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

the FRCP to resolve, the program has initiated an effort to improve information exchange.

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

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

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

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

Contacts and Acknowledgments

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

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