LEAVING NO ONE BEHIND: IS THE FEDERAL RECOVERY COORDINATION PROGRAM WORKING?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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LEAVING NO ONE BEHIND: IS THE FEDERAL RECOVERY COORDINATION PROGRAM WORKING?

TUESDAY, APRIL 28, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:07 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Space, Walz, Hall, and Roe.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning, and welcome to the Subcommittee on Oversight and Investigations. This is a hearing on Leaving No One Behind: Is the Federal Recovery Coordination Program (FRCP) Working? This hearing will come to order.

Thank you all for coming today. As I mentioned, the title of this hearing is Leaving No One Behind: Is the Federal Recovery Coordination Program Working?

I ask unanimous consent that the statement from Lorrie Knight-Major be submitted for the record. Hearing no objection, so ordered.

[The prepared statement of Ms. Knight-Major appears on pg. 49.]

Mr. MITCHELL. Before we begin, I would like to introduce everyone to the Subcommittee's new Staff Director, Marty Herbert. Marty is a retired Army Lieutenant Colonel and a veteran of the Gulf War, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). He brings experience and a dynamic perspective to the challenges facing our Nation's veterans.

With his addition to this Subcommittee and his leadership, we are going to continue providing the much needed oversight our veterans deserve and have come to expect from this Subcommittee.

So on behalf of the entire Oversight and Investigations Subcommittee, welcome aboard, Marty.

[Applause.]

Mr. MITCHELL. Time and again, we have heard stories of troops returning home from serving their country with no guidance and no support. Too often we hear of families carrying the burden of the servicemember's recovery and reintegration back into civilian life.

On March 17th, this Subcommittee held a hearing on the Vision Center of Excellence (VCE). In that hearing, we heard testimony from three veterans, Travis Fugate, Gil Magallanes, David Kinney, all three seriously injured, all three seemingly lost in the bureaucratic maze without coordinated care.

The stories of these heroes are part of the systematic problem affecting servicemembers and veterans across the country.

Fortunately, a memorandum of understanding between U.S. Department of Defense (DoD) and U.S. Department of Veterans Affairs (VA) was signed on October 30th, 2007, establishing a Federal Recovery Coordination Program, FRCP. Federal recovery coordinators began working with patients in January of 2008.

We are here today to examine the effectiveness of the FRCP and to assess if outreach has succeeded in bringing coordinated care to veterans who were injured prior to the FRCP.

When a servicemember returns from combat with multiple injuries, we must ensure he or she has a single point of contact to help navigate the bureaucracy of DoD and VA. This is the reason the Federal recovery coordinators (FRCs) must have considerable authority as they navigate the system in ensuring the veteran and families receive component of care in their overall plan and all the benefits due to them.

Oversight of this program is critical to ensure it is fully staffed and fully functioning. I look forward to hearing about what needs the VA has identified within the FRCP.

To put these issues into perspective, we will hear from two veterans, Captain Mark Brogan, an Army veteran who suffered a severe penetrating traumatic brain injury, hearing loss, shrapnel wounds, and spinal cord injury while serving in Iraq in 2006. Captain Brogan receives care through the VA clinic back home in Tennessee, but he was never made aware of the FRCP when he came online in 2008.

We will also hear from First Lieutenant Andrew Kinard, a retired Marine Corps veteran who was injured in Iraq 2½ years ago. First Lieutenant Kinard was referred to the FRCP in January of this year.

Additionally, we will hear testimony from Sarah Wade and Cheryl Lynch, family members of injured veterans, who will give us an additional perspective on the FRCP, as well as the Blinded Veterans Association, who will discuss the impact the FRCP has had on those veterans with eye injuries.

Although there is a solid foundation for the FRCP, there is still work to be done. I am anxious to hear from the Department of Veterans Affairs on how they plan to make the FRCP a program that veterans and their families can look for the care they need and how they plan to conduct the appropriate outreach to ensure all wounded veterans and their families receive the best care and no veteran with multiple traumatic injuries is left behind to navigate the huge health and benefit system alone.

The Dole-Shalala Commission which set out recommendations for the care of wounded warriors said it is not enough "merely patching the system as has been done in the past." Instead the experiences of these young men and women have highlighted the

need for fundamental changes in care management and the disability system.

The Commission emphasized that significant improvements require a sense of urgency and strong leadership. Now with Secretary Shinseki leading the VA, both the sense of urgency and strong leadership is present. And I am confident that we can work together to provide our wounded warriors with the coordinated care they deserve.

I would like to thank all of our witnesses for appearing here today and thank you, both panels, for what you do for our Nation and for our veterans.

Before I recognize the Ranking Member for his remarks, I would like to swear in our witnesses. I would ask that all witnesses raise their right hand from both panels, if they would.

[The prepared statement of Chairman Mitchell appears on pg. 32.]

[Witnesses sworn.]

Mr. MITCHELL. Thank you.

I now recognize Dr. Roe for opening remarks.

OPENING STATEMENT OF HON. DAVID P. ROE

Mr. ROE. Thank you for yielding, Mr. Chairman.

Last month, this Subcommittee held a hearing on the Vision Centers of Excellence during which three veterans related their experiences at the VA and DoD and the care they received. However, upon hearing the witnesses' testimony, one of the things that concerned several of us was the apparent lack of any contact with the veterans from the Federal recovery coordinator team.

I went down the line of the first panel and specifically asked that question and not one of the three severely injured veterans present had been in contact with or even knew if they had a care coordinator assigned to assist them.

This is particularly troubling since the last Congress, this Subcommittee held a hearing on this very issue and Members were assured that the Federal recovery coordinator team was being staffed and that newly injured servicemembers were being contacted and that a team would be going back and contacting previously discharged, severely injured servicemembers to assist them with their needs and concerns as well. From the testimony we heard last month, this apparently was not happening.

Mr. Chairman, I am grateful that you also felt this was an issue that needed immediate attention and that we are now holding this hearing today. I hope we hear better news about the program than what I heard last month and I want assurances that the witnesses who testified last month have now all been contacted by an FRC team and are now receiving the assistance they so richly deserve.

I also want assurances from the witnesses here today that incidences like we heard last month are not going to occur again and that no other veteran will slip through the cracks of bureaucracy. It is bad enough that these veterans who fought so bravely for our freedom have lost their eyesight due to injuries that they received in battle, but to ignore their needs when they return home and more sorely need our help is inexcusable.

Mr. Chairman, I would like to see in 180 days that the progress from this report or this Committee be sent to us, to the staff, and I think several of us would like to be around and be briefed and not be sitting here as I reviewed this information from 2 years ago in March. We want to get started with this. Last year, we were assured it was going to happen. I think 6 months, 180 days from now, we ought to have a report back. And I would certainly like to attend that.

And thank you, and I yield back.

[The prepared statement of Congressman Roe appears on pg. 33.]

Mr. MITCHELL. Thank you.

At this time, I would like to recognize Congressman Space.

OPENING STATEMENT OF HON. ZACHARY T. SPACE

Mr. SPACE. Thank you, Mr. Chairman, for calling this hearing.

And I would like to welcome Marty as counsel to the staff and to the Committee as well.

We have heard far too many stories from veterans and their caretakers who are stymied by the complex web of bureaucracy that stands in the way of the care and benefits our returning heroes have rightfully earned.

Oversight of the care and coordination process for returning servicemembers is one of the highest priorities of this Subcommittee. Unfortunately, the written testimony of the witnesses here today indicates that many veterans are still unaware of this program.

In talking to veterans in my district, I know many remain unaware of other benefits and services available to them through the VA and other service organizations. That is one of the reasons I recently introduced a bill, H.R. 1872, to streamline the transition process by sending our State VA departments electronic separation paperwork so they can reach out to returning servicemembers regarding available service and benefits.

The program we are examining today plays an important role in navigating the VA system, but we must do a better job of reaching out to returning veterans to let them know about services like this.

Mr. Chairman, I regret that I am going to have to leave in a few moments, but I hope to hear some of the testimony and look forward to learning more about the FRCP's plans for future improvement.

I yield back.

Mr. MITCHELL. Thank you.

I recognize Congressman Walz.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Thank you, Mr. Chairman and Ranking Member Roe, for holding this hearing.

And, of course, a special thank you to our witnesses. We are here today to hear from you, to do the most important job we do in Congress and that is to care for our warriors.

There is not a person in all of southern Minnesota that does not want to provide the highest quality of care. It is a moral responsibility. Lots of people may say thank you, but the followthrough that we do to make sure that care is absolutely the best available

is something we have to continue to strive for with absolutely zero mistakes in this.

And I think I agree with my colleagues here. We have heard too many of these stories. We know that the VA provides excellent care. We know there are many things going right, but we also know there are far too many stories of lack of coordination, lack of care, being done the way it should be.

So I cannot tell you how much I appreciate first of all your service to the Lieutenant and to the Captain and to the family members that are here, but also choosing to make it better for everyone else by taking time to come here today, by continuing to talk to about this. There is truly nothing more important that we do.

And, of course, we are going to hear from Tom in a minute who my staff refers to as a force of nature in making this stuff happen. And it is that will and it is that drive to care for our veterans that is going to make us get it right. As I said, there is no greater job that we do here in Congress. So thank you for being here.

And I yield back.

Mr. MITCHELL. Thank you.

I ask unanimous consent that all Members have 5 legislative days to submit a statement for the record. Hearing no objections, so ordered.

At this time, I would like to welcome panel one to the witness table. Joining us on our first panel is Captain Mark Brogan, an Operation Iraqi Freedom veteran from Knoxville, Tennessee; First Lieutenant Andrew Kinard, an OIF veteran here in Washington, DC; Sarah Wade, a spouse of an injured OIF veteran; as well as Cheryl Lynch, a mother of an injured veteran, as well as a traumatic brain injury (TBI) awareness advocate. Also joining us on the first panel is Dr. Tom Zampieri, Director of Government Relations for the Blinded Veterans Associations.

And I ask that all witnesses stay within 5 minutes of their opening remarks. Your complete statements will be made part of the record.

I would now like to recognize Captain Brogan.

STATEMENTS OF CAPTAIN MARK A. BROGAN, USA (RET.), KNOXVILLE, TN (OIF VETERAN); FIRST LIEUTENANT ANDREW KINARD, USMC (RET.), WASHINGTON, DC (OIF VETERAN); SARAH WADE, CHAPEL HILL, NC (SPOUSE OF OEF/OIF VETERAN); CHERYL LYNCH, PACE, FL (MOTHER OF INJURED VETERAN AND TBI AWARENESS ADVOCATE); AND THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION

STATEMENT OF CAPTAIN MARK A. BROGAN, USA (RET.)

Captain BROGAN. Mr. Chairman and Members of the Subcommittee, I am honored to appear before you today to share my experiences for the benefit of other veterans such as myself.

I served as a Captain in the U.S. Army assigned to the 172nd Stryker Brigade, deployed to the Iraq theater in 2005 and 2006.

On April 11th, 2006, while leading the patrol in a market, a suicide bomber walked around a corner behind myself and two of my soldiers, killing one instantly.

I received severe injuries to include a penetrating traumatic brain injury from shrapnel entering the brain, a nearly severed right arm, profound hearing loss, and an incomplete spinal cord from a piece of shrapnel piercing the spinal cord.

My wife traveled from Alaska, where we were stationed, to Walter Reed and immediately took charge of the administrative process. I continued my recovery at Walter Reed as an inpatient until July of 2006 at which point, I was transferred to the James Haley VA polytrauma unit in Tampa, Florida.

Upon my discharge from Tampa, I returned to my home in Tennessee. I would continue my rehabilitation for another 2 years and it will most certainly be a lifetime process.

During this time, there has been a continual confusing maze of systems. Having had a significant traumatic brain injury, my wife has carried the bulk load of my administrative needs. She has been my personal recovery coordinator with no experience in navigating the massive bureaucracy.

My experience with the VA and DoD is no different than many of the stories other soldiers have reported, lost paperwork, confusing processes, and a lack of information. We cannot point to one person to lay blame on because there was no one person. It was on my wife to make sense of the mess.

This brings me to the most important point I want to convey in this testimony. Despite the efforts of good intentioned people and unfortunately some disgruntled, disenfranchised people also, this mostly has been a journey of blind exploration.

My wife has said from the beginning they will not tell you about the process. You just have to stumble upon it and then demand it. This has proven true time and again.

The creation of the recovery coordinators is a brilliant idea even as I am unfortunately yet to have the privilege of their services.

One of the best examples of gaps in the system between DoD and VA due to the lack of central information coordination involves my transfer from Walter Reed care to VA care and return back to Walter Reed.

In October of 2006, I returned to Walter Reed to receive my cranioplastic surgery, a procedure to replace a missing half of my skull. I returned to find that my name was mysteriously no longer on record to have this procedure. To my amazement or expectation based on my experience thus far, no one in neurosurgery, neurology, or any other department could give me any solid answers to why this had happened. We had no singular contact person to inquire with. It took us a full month to finally have the surgery scheduled and all the necessary preparations made.

I have had a total of 13 social work representatives within the VA and DoD systems working on my case, none of whom communicated regularly or jointly to make sure all the bases were covered.

Once I returned to my home in Knoxville, Tennessee, my case was transferred from the Tampa VA to the hospital responsible in the Knoxville area. The local VA clinic in Knoxville handled my primary care appointments. However, the clinic in the area did not provide the extensive amount of continued therapy I required for

my TBI, spinal cord injury, and post-traumatic stress disorder (PTSD).

There is a civilian rehab in Knoxville, Patricia Neal Rehab Center, that specializes in all of the injuries. The obvious solution was to be allowed to attend this facility. However, it was just not that simple. TRICARE does not cover cognitive rehab, so that was not an option.

My wife contacted several people at the VA and was passed around the endless loop of I do not know. She was successful after much hassle and through the VA fee-basing program, I was able to attend an extra year and a half worth of therapy.

I received physical, occupational, speech, and cognitive therapies. I attended a specialized day treatment program for TBI and I also received care from a neuropsychologist who specializes in TBI and PTSD.

I am shocked it was so difficult to get the care. Coordination for the care has been the burden of my wife from day one. Only recently has the VA created a polytrauma clinic at the closest VA hospital. The only problem is their specialty is medical information, not benefits. And when I ask, it turns into the let me forward you to the next person in the loop and the vicious cycle repeats itself.

As you can see from my exhausting journey, the Federal Recovery Coordination Program would have been the best thing that could have happened to me and my wife. I hope that my experiences I have shared will shed some perspective on how much the program really will impact individuals such as myself.

One recommendation I have for the coordinators and any other social workers within DoD/VA system is a boot camp, so to speak, for coordinators to ensure info is learned universally for all coordinators and social workers.

I come before you today with no experience with the Federal Recovery Coordination Program. I have only recently, within the last 2 weeks, become aware of the program through a non-DoD or VA party.

From my subsequent research of the program's intentions, I believe it is an excellent idea as the disconnects I experienced and the unending circle of I do not know, let me connect you with party X, may have been avoided.

In summary, my personal answer to is the Recovery Coordination Program working is not simply due to the fact not one single person has advised me of such a beneficial program. I believe had I been aware and able to receive the resources, it would have certainly been a huge stress relief for myself and family.

I am eagerly awaiting the care this program intends to provide pending it does not follow the frustrating paradigm we have been accustomed to. I appreciate this opportunity to submit testimony to the Committee on Veterans' Affairs Subcommittee.

On behalf of my fellow wounded warriors, I would like to thank you for all the hard work and service you provide. I hope that my testimony will contribute positively in aiding my fellow brothers. Thank you. Captain Mark Brogan.

[The prepared statement of Captain Brogan appears on pg. 33.]

Mr. MITCHELL. Thank you very much.

I would now like to recognize Representative Bob Inglis of South Carolina to introduce our next witness, First Lieutenant Andrew Kinard.

Mr. Inglis, you are now recognized.

OPENING STATEMENT OF HON. BOB INGLIS

Mr. INGLIS. Thank you, Mr. Chairman.

And it is a great honor to introduce to you Andrew Kinard, who is so reflective of America's best. This is a guy who is the son of a very successful physician in Spartanburg, South Carolina, wonderful mom, family that loves him, could have done anything, wanted to go into military service, went to Naval Academy, wanted to be a Marine, became a Marine, wanted to go to Iraq. And shortly after arriving there, perhaps targeted because he was an officer, an explosion cost him both legs, but has not cost him his spirit. And that is what is amazing to me about Andrew.

He will tell you about the many surgeries. You have got to keep up to make sure to keep up with the number. They are ongoing and there are lots of them. But I hope he tells you some about the incredible way God's grace made it possible for him to be here and alive and how that has played out in a number of people who were the means of God's grace in saving his life and restoring him as he appears before you today.

I have tried everything I could to get him to come work in my office, but I think that what he has done is he has figured out what my children say to me is, Dad, yours is the only interesting job in the office. And so I think that some day, he may have this job. But I am safe for at least 3 years because he is going to Harvard Law School in the fall and so I am safe for at least 3 years.

But it is my great honor to introduce to you Andrew Kinard.

Mr. MITCHELL. Thank you.

STATEMENT OF FIRST LIEUTENANT ANDREW KINARD, USMC (RET.)

Lieutenant KINARD. Thank you, Congressman Inglis, for that warm introduction.

Chairman Mitchell, Congressman Roe, Members of the Subcommittee, I am pleased to appear this morning before you to discuss my views of the efficacy of the Federal Recovery Coordination Program.

I was referred to an FRC on January 28th of this year in order to be assisted with specific issues that I had encountered while transitioning from active to retired status. Had I known earlier about the benefits of the FRC Program, I would have requested an FRC much sooner.

In order to best explain how my FRC has been a benefit, I want to share with you a brief summary of my recovery.

I was injured in Iraq 2½ years ago and retired from active service just last month. While I was recovering in the hospital, I had the advantage of constant attention from doctors, nurses, and other medical staff.

When I was discharged from the hospital to continue physical therapy and eventually transition out of the Marine Corps, I was

responsible for keeping track of all the different medical staff and their individual responsibilities on my own.

I had a medical case manager, a nonmedical case manager, a social worker, a medical board case manager, a physical evaluation board liaison officer, a Navy Marine Corps liaison officer, a wounded warrior regimen case manager, and a Marine Corps patient administration team.

The number of support staff is roughly the same for most of the wounded servicemembers and catastrophically wounded servicemembers will often even have more. I recall Captain Brogan mentioning that he had 13. The numbers of case managers that are out there is overwhelming at times to even some of the most aware recovering servicemembers.

But with so many resources available to assist in the recovery, one might ask the question why do we need yet another program. Seriously injured servicemembers need the Federal Recovery Coordination Program for two reasons, accountability and continuity of care.

The net result of the number of support staff is that there is a broad diffusion of responsibility among caseworkers and the recovering servicemember loses confidence in the Government's ability to maintain accountability of his care.

Each caseworker has a specific role in that servicemember's recovery and the burden of responsibility falls on that servicemember to keep track of which case manager provides each service.

Essentially what happened to me was as my case managers would come and introduce themselves, I would end up with a fistful of business cards with the instructions, hey, call me if you need anything, and then I was left wondering, okay, well, I do not even know what I need to ask what I need or not.

The assignment of an FRC provides the recovering servicemember with a single point of contact for decisions regarding his care.

With respect to continuity of care, the long list of case managers and other support staff that I have previously mentioned all fall within the Department of Defense health system. All those eight or nine or ten case managers that I mentioned to you are all within DoD.

Now that I have transitioned into the VA system, I have a whole new list of case managers to keep track of, the ones from the DoD because I am still eligible for TRICARE benefits and now the VA as well. New doctors will still be assigned. And rather than veterans having to navigate a new health system with no institutional memory of their medical history, an FRC can ensure that continuity of care between the DoD and VA.

In summary, I believe that the Federal Recovery Coordination Program, under the leadership of Dr. Guice, should continue its mission of providing comprehensive coordination of case management to those servicemembers who have been most severely injured.

Particular effort should be made to reach back to those who were injured earlier in the war. A common mistake is assuming that just because the veterans have been injured several years ago means that all their problems are fixed. That is in a lot of cases to the contrary.

Recovering from any traumatic injury is difficult at best, but I think the worst casualty of all is being forgotten.

Chairman Mitchell and Members of the Subcommittee, thank you for the opportunity to testify before you today. I look forward to answering your questions.

[The prepared statement of Lieutenant Kinard appears on pg. 35.]

Mr. MITCHELL. Thank you very much.

Sarah Wade.

STATEMENT OF SARAH WADE

Ms. WADE. Chairman Mitchell, Ranking Member Roe, Members of the Subcommittee, thank you for the opportunity to speak to you today about our experiences with the DoD/VA Federal Recovery Coordination Program.

My name is Sarah Wade, wife of Army Sergeant retired Ted Wade.

My husband joined the Army during the summer of 2000 and following the attacks of September 11th, he was called on to serve first in Afghanistan and later on in Iraq.

On Valentine's Day 2004, his Humvee was hit by an improvised explosive device. Ted sustained a severe brain injury. His arm was completely severed above the elbow, suffered multiple broken bones, shrapnel injuries, as well as other complications, and months later was diagnosed with post-traumatic stress disorder.

He remained in a coma for about 2½ months. Withdrawal of life support was considered, but thankfully he pulled through.

After the battle for his life was won, the war for benefits and care began and that continues on today. Due to the severity of Ted's brain injury, he is sometimes unable to fight for himself, so the struggle has become mine.

I was neither prepared for this mission nor trained to serve in the many roles I have been expected to. I am often consumed 24 hours a day by my responsibilities which have left no time for me to return to school, full-time work, or have a life of my own.

More than 5 years later, my schedule continues to be hectic and we still struggle to maintain a reasonable standard of living. Though the journey has been a nightmare at times, people have also listened and responded.

After the situation at Walter Reed imploded in February of 2007, I was fortunate to have the opportunity to be a part of creating some solutions. I was invited to give testimony to the Dole-Shalala Commission and make a presentation to the DoD/VA Senior Oversight Committee or SOC as it is known.

Among other things, I explained that Ted needed a case manager for his case managers, someone to coordinate his amputee case manager, military severely injured center, OEF/OIF coordinator, polytrauma coordinator, psychiatric social worker, soldier family management specialist, and TBI case manager. I think you all probably hear a theme here.

I wanted someone to take care of the administrative items on my daunting to-do list, not just point me in the right direction or hand me an 800 number or business card.

Ted needed a case manager with a smaller patient load, someone that understood his DoD, Medicare, VA benefits and could coordinate them with the fee-basis care he received at a private practice in our community, but more importantly he needed continuity and lifelong assistance. Nine months later, we had an FRC.

Admittedly I have been the biggest support of the FRC Program and at times, its harshest critic. This is because we have experienced two distinctly different programs. When the FRCs first came online, I could not have been happier. The woman to which Ted had been assigned was everything we had wished for and more. But just like a series of other programs that had been promising in the past, it was short-lived.

Four months later, she was gone. Ted was assigned a new FRC and we had to start from square one again like we had done 20 times before. My husband was devastated because he had truly believed that things were going to be different this time.

In my search for answers, I talked to several other families involved with the program only to discover that many of them were on their second FRC as well. It was clear the program was starting to falter because it simply could not work with such a high turnover rate.

Out of desperation, I e-mailed everyone I could think of to make sure they were aware of this issue. I received a call back from the Deputy Under Secretary of Defense, Dr. Lynda Davis, who asked to meet with Ted and I that night on her way home from work and invited someone from VA to come along as well.

Ted and I were very candid with her about our concerns and she seemed very receptive to our ideas. The following day, I received another phone call from the Deputy Secretary of Veterans Affairs, Mr. Gordon Mansfield. He listened to what Ted and I had to say and he immediately took action.

The DoD/VA FRC Program came under new leadership last summer and the Director, Dr. Karen Guice, now reports directly to the Secretary of Veterans Affairs. From what we have seen, she has been receptive to feedback, committed to problem solving, and has continued to reevaluate the program.

Because the FRC Program Director currently has high visibility and access to the leadership, she has leveraged to both resolve individual problems as they arise, but also identify systemic issues and recommend changes at a level where they may be implemented.

Though there are still some glitches, I believe it is important for DoD and VA leadership to promote what is working and continue to provide the willingness and support needed to guarantee the long-term success of this program.

We have seen a string of other resources crop up only to wilt or die off due to change of focus or sponsorship over the years. For once, we need DoD and VA leadership to see just one through.

The FRC Program is unlike any other assisting severely injured servicemembers and veterans. All the other support systems are specific to a branch of service, facility, or a particular injury. They can assist with specific needs, but are unable to coordinate the big picture or are only involved for a defined period of the veteran's recovery.

An FRC is able to connect at bedside after the injury, has the ability to follow them as they move to other facilities or systems for rehabilitation through their transition to civilian live, veteran status, and beyond.

This type of continuity allows the veteran and FRC to build a strong alliance, but also provides a single point of contact that has a complete understanding of all their benefits and a comprehensive life plan.

My husband will continue to face significant challenges for the rest of his life as a severe TBI is never static but a progression of peaks and valleys. Veterans like Ted need support that will be around as long as the injuries they sustained in service to their country.

Just like he needed a team in the military to accomplish the mission, he needs a team at home for the longer war. I hope today we can all work together to identify not only the needs of the veterans but discuss what the needs are of the FRC Program to accomplish this lifelong mission.

Mr. Chairman, thank you again, and I look forward to answering any questions.

[The prepared statement of Ms. Wade appears on pg. 36.]

Mr. MITCHELL. Thank you very much.

Cheryl.

STATEMENT OF CHERYL LYNCH

Ms. LYNCH. Chairman Mitchell, Ranking Member Roe, and Members of the Subcommittee, thank you for the opportunity of speaking with you today.

My name is Cheryl Lynch, mother of PFC Christopher Lynch, U.S. Army retired, who suffered a traumatic brain injury on July 13th, 2000, while on training exercises in France. I am also the founder of a support organization for American veterans with brain injuries and their families.

As a result of my personal experience and daily contact with many other families, I have a unique perspective on the needs and obstacles family caregivers face as we all attempt to help our loved ones rehabilitate from these life-altering injuries.

It is with over 8 years experience of working with and sometimes against the bureaucracies of the DoD and VA as well as other Federal, State, and local agencies that I address the Committee today.

Due to my limited time, this verbal testimony is a condensed version of what I submitted for the record.

First I would like to recognize the positive advancements that have been made since my son's injury. I am very impressed with the many new initiatives and progressive programs currently available to our wounded.

Unfortunately, however, once outside of a polytrauma setting, rehabilitative options and benefits are still in a maze, one that is riddled with bureaucratic obstacles and dead ends. Family members are still left to piece together services in an attempt to continue their loved ones' recovery.

In order to fully appreciate my recommendations, you must also hear at least some of our story. Following Chris' injury, I brought my son to our home in Florida. Since that time, I have been Chris'

caregiver. I knew my job would be difficult, but I did not know that I was also going to be giving up my business to have a life-long career of being a coordinator and mediator of case managers, medical needs, insurance issues, and VA benefits.

At any given time, we had a multitude of case managers and/or social workers who were assigned to my son. Unfortunately, each had their own area of specialty or fell under different geographical regions of the VA.

In my opinion, the FRC Program is one of the most beneficial programs offered in recent years. However, the program is still evolving and after speaking with many families who have been afforded the services through the FRC Program, it seems not all FRCs are created equal.

Some families have expressed that they rarely communicate with their coordinator and a few families are not even aware they have an FRC as it is hard to distinguish case managers from care managers.

Conversely, some families have seen effectiveness of FRCs to serve as a compass for the maze where an FRC has actually been able to provide the necessary oversight to develop and implement a veteran's recovery plan.

Others have been able to call on their FRCs in times of crisis or when bureaucracy has gotten in the way. Some of these variances are due to individual needs of the families, but it is also due to the nature of the new program trying to catch its stride.

In closing, although I understand many enhancements are underway, I would like to make the following suggestions in regards to the FRC Program.

An FRC must have injury-specific knowledge and/or training prior to case management, especially for those with brain injuries and mental disorders. These injuries have long-lasting, ongoing effects on an individual's life and family members and veterans cannot be responsible for educating yet another case or care manager about the residual impairments of an injury.

The FRC Program must continue to have the capability of not only mediating DoD and VA benefits, it would also be extremely helpful if they could assist in the coordination of State and community resources.

With a limited number of individuals serving in the FRC capacity, it is apparent not everyone who could benefit from their services is assigned one. Current staffing levels may be insufficient to address the needs of both the currently assigned and additional cases that need to be referred into the program.

Steps must be taken for the FRC Program to look back and find those who have been struggling. The common misperception that if your loved one was injured years ago, then all your problems have been resolved is false and very dangerous.

Individual outcomes vary and the need for FRC care management must be assessed not only on the severity of the injury but on the family's circumstances and risk variables of the individual veterans.

It is imperative to promote visibility of the FRC Program and streamline the referral process. Veterans may, in fact, outlive an

FRC, therefore, care cases must be accurately documented to assure the lifelong continuity for the veteran.

There is one last comment I would like for you to consider. I am a 54-year-old mother. If something were to happen to me, who will know enough about my son's individual difficulties, medical needs to continue his care? Who will be able to act in his best interest or defense to assure he receives his entitled benefits? Who would be able to put the proper supports in place for my son to not end up on the streets, institutionalized, or even worse?

I believe the answers to these questions lie in the potential of the FRC Program and I am very pleased that the Committee is looking at ways that may improve the FRC Program.

We cannot change the past, but possibly the Committee has the ability to change what the future holds for my son and other injured veterans and their families.

Thank you.

[The prepared statement of Ms. Lynch appears on pg. 37.]

Mr. MITCHELL. Thank you.

Dr. Zampieri.

STATEMENT OF THOMAS ZAMPIERI, PH.D.

Dr. ZAMPIERI. Yes. Thank you again for inviting me to testify twice in a month. I must be doing something right or wrong depending on which side of the table you are at.

But on behalf of Blinded Veterans Association, it is an honor to be here with this panel of veterans like last month with the three blinded servicemembers who told you their stories.

You know, it is sort of interesting. I do a lot of military medical history and if you think this scares you, you have got to go back and look at the number of injured that came back during the Korean war, which I included in my testimony. You know, we at times seem to be like totally overwhelmed with what we are trying to deal with.

But if you look at the Korean war, in a 3-year period, 55,380 came back wounded in just 3 years. And we have got 7 years into the war and 45,000 roughly injured or wounded or medically required evacuation. And we are having these problems. It is sort of like I shudder to think if we had had this huge number of injured earlier in this.

You know, everybody here has touched on the same thing of when I go out to Walter Reed or Bethesda or I have been down to Brooke Army Medical Center, there is more social workers, case managers, DoD liaisons. It is just unbelievable. And, yet, each person seems to be "doing their own thing."

And the Federal recovery coordinators, you know, the concept of that was to bring together one person who would manage everything and I think at times, they have even been overwhelmed with the fact that they are probably spending as much time just trying to communicate to all these other various people that are involved in these cases.

One of the things that I know that the other veteran service organizations would want me to throw into this that has not been mentioned before, but I think is a critical component to fixing any of this, is the fact that you have got to have a DoD/VA electronic

exchange of the medical records and it needs to include the DD–214 and the military occupational background of the servicemembers.

If people cannot find the records of somebody who comes back for follow-up surgery, you know, it is just amazing. You know, oftentimes I hear about individuals who will write and they have notes put into their VA records and then when they get back into the military system, nobody knows what those notes are.

And it is critical that the inpatient records are fully exchanged in this transmission of information. Currently it is primarily outpatient electronic records that are accessible. There are outpatient medications. There are outpatient problem lists, the history of allergies, their outpatient labs, outpatient radiology reports, but what is critical, and last month, this came up when Travis Fugate testified, is the surgical records, the inpatient surgical records, the inpatient diagnostic tests and all those things to avoid repetition of tests being redone.

The other thing that I find frustrating in this is that every time I seem to pick up a new thing from either the Army or Navy or Air Force and it just hit home just the other day preparing this testimony, I found on the AMEDD, Army Medical Department news line, they announced that we are reconfiguring again. The Wounded Warrior Transition Command Office is now merging with the Warrior Transition Unit which is now merging with the Army W2 Program, the Wounded Warrior Program to facilitate and improve communications and cooperation. And I said, you know, wait a minute. Here we go again.

You know, and one of my things in my Ph.D. program that was one of the most interesting courses I ever took was how do you develop policy in government. And one of the most difficult things is when you do incremental layers, this is what happens. You have somebody with 13 different case managers or 10 different case managers or somebody like Sarah or the mom who says who do I really find that answers this question.

I think also, you know, it is easy to identify that one of the things is there is almost with the Federal recovery coordinators, you have got to have a medical model person that is coordinating the rehab and stuff and a benefits person that takes unique charge of handling the benefits questions and helping with whether it is insurance, TRICARE, or VA.

And so there are a bunch of recommendations that are from *The Independent Budget* that I have included in here because I thought that they had covered this extensively.

And I will be willing to answer questions now. Thank you again for the opportunity to testify.

[The prepared statement of Dr. Zampieri appears on pg. 40.]

Mr. MITCHELL. Thank you very much.

I want to thank all of you for your testimony.

I have some questions and then we will ask each Member to ask some.

My first question is to Lieutenant Kinard. How would you characterize the handoff when you left DoD care and entered the VA care?

Lieutenant KINARD. Sir, when I retired from the Marine Corps about a month ago, I was enrolled in the FRC Program. And she and I discussed specific aspects of my transition to include my move of geographic location from Washington, DC, to Boston this summer, how I will coordinate my case management.

I am at a terminal point in my recovery in the sense that I am not undergoing continuous surgeries all the time. But should the need arise for me to seek additional medical care, where am I going to get that? Am I going to get that through TRICARE, because I am still eligible for TRICARE benefits by virtue of my retiring, or am I going to get that care through the Veterans Administration?

And so she and I had sort of talked those out, those scenarios, and her help has been very, very good because she is at both levels of the DoD and VA and gives me that opportunity to sort of say, hey, you know, you bring to bear all of the health care benefits that the Government offers, so let us really talk about how we can sort of hash those issues out.

And also on another note, yesterday I went over to the Washington VA center and met with my OIF/OEF coordinator there at the VA. And I had a very positive experience with him because, you know, say, for example, I did not have the FRC and I just enrolled in the VA as a returning servicemember. You know, he really walked me through all the steps, walked me through the enrollment. And my experience at the VA yesterday was very positive.

So if I did not have the FRC at all, that was good. But having an FRC, I am telling you, gives me peace of mind.

Mr. MITCHELL. Thank you.

Sarah, you testified on your experience at last year's hearing. Can you please discuss what changes you have seen in the FRC Program to date from the time you first talked to us last year?

Ms. WADE. I think one of the most important things that we have seen is that, it is one of the things I included in my testimony today, that the FRC Director is reporting directly to the Secretary of Veterans Affairs.

And we have actually run into a couple instances where there were delays in contracts with fee-basis care or getting bills paid, that sort of thing.

And we were able to climb the ladder and really exhaust all administrative possibilities first, but Ted's FRC was able to call directly to the Director and say, you know, I am running into this problem, can you do something. And no exaggeration, the following day, a contract was approved and Ted was ready to move into the next phase of his rehabilitation.

So one of the things that I have seen that has been extremely helpful is the ability to speed up some of those lags in care that we have seen in the past.

Mr. MITCHELL. Very good.

One other question. From a spouse's perspective, what areas still need to be focused on to continue to improve this FRC Program?

Ms. WADE. Well, I think for someone like my husband whose needs are very intensive, it is important to keep the, I think, caseloads at a minimum. I think it is very difficult to put a number on what those caseloads should be because I think every individual

case will be weighted differently depending on what the level of needs are.

But I think that one of the most important things that can happen is to completely reevaluate the program and the individual FRCs.

And so, for instance, I think different families have different needs. Some people want to just have someone there when they need to go to them. Other people would like somebody just to take the reins and take care of everything.

And I think it is very important to constantly give the family member the opportunity to give feedback, to comment on that person's management style, but also to stay in tune with what the needs are of that veteran, but the family member as well, and to incorporate the family member into the life plan.

Say I want to go back to school. I might need more assistance for Ted, for someone else to be his care provider while I am in school. And so I think it is very important to keep a pulse on what is happening in the household with the children, the spouse, whoever, because that is going to change what the veteran needs.

Mr. MITCHELL. Thank you. I have exhausted my question time. Welcome back.

Dr. Roe.

Mr. ROE. Well, first of all, there are four remarkable people out here. And I have really appreciated you all coming and sharing your testimony.

And also congratulations, Lieutenant Kinard, on going to law school. And please remember, do not go to the dark side and sue doctors. Okay? Appreciate that.

One of the things, and I will bring this up, and Captain Brogan is actually from a town very close to where I live, I will just read a paragraph. The next testimony, I think, summarizes what the problem is.

"And within the overall framework of care coordination, each client's particular needs and goals, the FRCs work with military liaisons, member of the services, Wounded Warrior Program, services recovery care coordinators, TRICARE beneficiary, counseling assistant coordinators, VA vocational and rehabilitation counselors, military and VA facility case managers, VA liaisons, VA specific care managers, Veterans Health Administrations (VHA), and VA OIF/OEF case managers, Veterans Benefits Administration (VBA) benefits counselors, and others."

I have a headache reading all that. And it is no wonder. I know from the practice of medicine over the years somebody had to be in charge and lead the show. And that is exactly what is needed here. You need someone who can step up.

And, Ms. Wade, I know you have put a college career on hold as I understand in taking care of your family. And I think what you said, you had a case coordinator that was just unbelievable. Terrific, had your head in the right direction. That changed.

I think the number of people that, and as I read Dr. Zampieri's entire testimony, and all very compelling, there are not that many that would need that. We can do this. And I do not know and I think your point was very well made about how many—each person, where if you go back to school, Ted's needs may be different.

And if you go back to work, your son's needs may be different. And we need someone to help you coordinate that.

So I do not know. You did not put a number down. Obviously it would vary. But do you have any vague concept about how many people you think a coordinator could handle?

Ms. WADE. Again, I think that is really going to depend on the level of need of the individual. For instance, my husband's brain injury case manager spends in terms of face time, she spends 2 to 3 hours a week with my husband. And that is just his brain injury case manager. That is not the person that coordinates all the other injuries.

So, you know, and she spends a lot of other time on the phone with other people. So with that said, you could have someone that could potentially only handle, I do not know, maybe 20 cases.

But, again, I think it is important to let the FRC probably decide when they are at their maximum because some families, as I said, like to just have someone there when they need a fire put out. Other people like that person to take the reins.

Do not get me wrong. I know we do have a lot of case managers, but I do think it is also important to have someone with expertise in amputee care and someone with expertise in TBI. But I think it is important to let that FRC decide what their load is and what they are able to manage.

Mr. ROE. Dr. Zampieri, how many wounded warriors are now being served by the FRC Program? Do you have a number? Do you know?

Dr. ZAMPIERI. Unfortunately, I do not. I think I better let the next panel answer that. I know it has changed some since last November. As the number of FRCs has increased, I think their caseloads or numbers have increased.

One of the things I found interesting is that, you know, the total number of severely catastrophically injured that have actually gone through the polytrauma centers is less than 850.

Mr. HALL. Would the gentleman yield for a second?

Mr. ROE. Yes.

Mr. HALL. Two hundred and fifty-seven veterans are currently enrolled in the Federal Recovery Coordination Program according to our information.

Yield back.

Mr. ROE. Thank you.

One of the things before we finish is I am from a generation of soldiers who are forgotten, Vietnam era. And I can assure you that this panel will not forget your needs. And we are going to continue to find out if your needs are being met.

And I know, Captain Brogan, you have been through an amazing recovery. And are there any things you can see? I think you just heard about this program what, a couple weeks ago? Could you expound on that?

Captain BROGAN. That is correct. I just recently, probably 2 to 3 weeks ago, heard of the program. It was through a friend in a nonprofit organization.

It is interesting that when I contacted one of my social workers actually through the AW2 Program, I said, hey, have you heard of

this program and she said, yeah, we are training them. And I said that is great. I am really glad you let me know about it.

So it is just frustrating to know. I believe this program has been around for at least a year and, of course, you know, it is an ongoing process all the time. And, you know, here we had no idea.

Mr. ROE. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Congressman Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And to each of you, I cannot tell you how humbling it is to sit here before you. We sit here not as individuals but as representatives of 700,000 people in our respective districts. And to hear your stories is truly humbling.

And, Captain Brogan, is your wife here by any chance?

Captain BROGAN. I am sorry?

Mr. WALZ. Is your wife here today with you?

Captain BROGAN. She is not.

Mr. WALZ. Well, pass along our thanks and I have to tell you our apologies. I cannot tell you every time we hear one of these stories how deeply embarrassed I am. And I approach this from being a Representative but also having spent 24 years in the military and spending that time as a First Sergeant and Sergeant Major with no other responsibility than to care for our veterans.

So when we hear each of your stories, I think, Ms. Wade, you summed it up right and that is the approach that we take here. We will be their strongest supporters and their harshest critics because of that. And the issue you were hitting on is one that I think runs through as a theme and, Lieutenant, you brought it up, too, this issue of continuity of care. It keeps coming back and coming back and coming back.

And there are members sitting behind you who represent veterans service organizations, as Ranking Member Roe said, from other conflicts and we have never gotten this issue right of seamless transition. And I talk about it so much now I know when the VA and DoD see me coming, they are like, oh, God, it is Congressman Seamless Transition again.

At noon, I am going to have the opportunity to sit down face to face, one on one for an hour with Admiral Mullen, the Chairman of the Joint Chiefs, who takes this issue very seriously and understands here systemically we are getting this wrong in the continuity of care.

And it is causing all kinds of issues and when I hear it especially from the family members, and I am glad to see that Ms. Obama is focusing on military families and I have spoken to her about this, this responsibility of care that you provide out of love and dedication to your families is incredible. But we share in that. Your loved ones were injured in defense of this Nation in carrying out what we asked them to do.

So I keep coming back to this issue that asking you to put that career on hold, especially for financial reasons, is absolutely unacceptable, as is that there is a lack of care there.

So my question to each of you is, and I will take this directly there, if you could sit down with the Chairman of the Joint Chiefs, what do they need to do to make sure this happens? What does Ad-

miral Mullen need to do to make sure that this is getting there in that transition from DoD to VA? If anybody wants to tackle that, I will pass along your words.

Ms. LYNCH. One of the problems that I have seen is while active duty, the active-duty servicemember at that point goes into a VA polytrauma setting and once the coordination of care leaves that polytrauma center back to the active duty, there is not a communication of what is going to happen beyond that.

Once they are in that VA polytrauma system, the coordination for them going home should actually be introduced at that point, not wait until it is passed off to another and then passed off to another, and then eventually home.

We have regional issues and that has been a lot of our problem is polytrauma is in VISN 16. We live in VISN 8. And the communication of the care never transpires. This is what happens for a lot of the brain injuries who are going to one of the four polytraumas. Most of them do not live anywhere near those polytraumas, but their care may actually go back to a military treatment facility before they are released from service. Then when they get home, the VISN is not even aware of them.

Mr. WALZ. Anyone else?

Ms. WADE. I would probably echo Cheryl. The importance of someone getting involved at the very beginning and actually kind of paving the path, letting people know when that next transition is coming would be very useful.

But I think in our particular situation, it would have been nice to have a Federal recovery coordinator or someone like that at the very start mapping out what all my husband's needs were because when—because Ted needed very specialized care for his brain injury but also very specialized care for his amputee and orthopedic injuries as well, it was hard to get all the expertise in one location.

And it would have been nice had somebody mapped out all of his needs, decided where the best place was to go for that, and explained to me a long time ago that to get the best care, we may have to move. It would have been nice to have not figured that out over time by accident. It would have been nice to have known before we burned the road up between Washington, DC, and North Carolina coming back and forth to Walter Reed.

But, yeah, having that life plan early on would have been nice, but also one of the things that has already come up is what TRICARE can cover in terms of cognitive therapy and those sorts of things.

My husband would have been best served by staying near Walter Reed Army Medical Center where he could do amputee rehabilitation because upper extremity amputee rehabilitation is something uncommon even in the private sector. And it would have been nice for him to have been able to get services somewhere in the Washington, D.C. area like the National Rehabilitation Hospital or somewhere like that.

But because he was retired, TRICARE could not cover that type of rehabilitation for him. And, again, we are talking about a very small number of individuals and it would be nice if in their cases, they could make exceptions and get the best care in the best location.

Can I jump in real quick since you are going to talk to the Admiral? One of the things is also the Federal recovery coordinators and the VA case managers that are inside the military hospitals that are seeing these individuals, they need to be credentialed and allowed to write consults or, you know, case management notes in the records.

You will not believe this, but, you know, maybe you will, I have stumbled into the fact that individuals out at Walter Reed, the National Naval Medical Center especially, they resist allowing VA case managers and stuff writing actual notes in the charts.

So Congressman Roe and I were talking before the hearing and in our previous lives as health care providers, you know, it is important to be able to look in the chart and know exactly who has recommended what, you know, for the physician who is the supervisor or when I was the physician assistant. And that is not being done.

And, boy, that is an easy fix. You just say, okay, you know, chain of command, if there are ten VA case managers, I do not know what the number is, at Walter Reed and two Federal recovery coordinators, they can write their own consults so there is that record.

Thank you.

Lieutenant KINARD. Sir, if I might jump in. You know, I do not think there is any silver bullet solution to this issue, but one suggestion that I might offer is approaching this through the mindset of the average patient population, you know, the 18- to 24-year-old, you know, grunt who is out there, you know, on the battlefield and ends up in the hospital, much like myself.

The way we learn in our infantry training, you know, big cards with pictures that you can point to and keeping it simple but effective to provide information to the recovering servicemember and their family, something even as simple as a card that has a wire diagram that shows, you know, hey, this is how you get an appointment or this is a list of any potential case manager and a description of what they do because a lot of times when we are at Walter Reed or Bethesda, we see the faces and then they come by and say, hey, how you doing, and I am thinking, okay, well, I do not really know what you do, so I am not going to bring up my stuff to you, you know, I do not know what it is you do, something as simple as that.

Mr. WALZ. That is a great suggestion. Are you saying, Lieutenant, that the VA Web site is not user friendly? They are the target of my scorn quite often. I cannot read the dang thing.

Lieutenant KINARD. The National Resource Directory?

Mr. WALZ. Yes.

Lieutenant KINARD. It is overwhelming because there is just so much there. I mean——

Mr. WALZ. I think that is a great suggestion. Thank you.

And, Captain Brogan, I know I have used up more than my time. I will not come back around. But I do think it is important, each of these questions, again, I will put right to him and make sure that they are listening. So, please, sir.

Captain BROGAN. I apologize. My brain injury, sometimes it takes me a second to get kicked in gear.

One thing with the VA, if you are enrolled in the polytrauma center, it does seem to be a better transition from the VA into your hometown since they have all the information. It was forwarded to my clinic in Knoxville. However, once they received it, and I went in my first appointment and they said, we've never had a case like yours, we are learning. Well, isn't that great to hear?

If somebody had been there to explain it to them without me having to do it, that would have been nice. Fortunately, I had the good fortune of having a wife that from day one was collecting medical records and making sure everything was taken care of. We wondered, wow, what if there was a soldier out there that did not have that good fortune, where would he be? You know, he would just be lost walking around Walter Reed and would never even make it out of there to the VA.

So echoing a few of the other suggestions that were made, specializing in the actual injury and having, like I said, a so-called boot camp and making sure that there is a universal knowledge base and having all the social workers connected so they have contact with each other. So they can actually forward you to somebody they know is going to have the answer. I do not know how many times I have been on the phone and heard, well, let me forward you to this person. It could take a week to figure out, you know, and then you may get an answer and you may not. It is just frustrating.

Mr. WALZ. All right. Well, thank you all very much and I do appreciate it.

I yield back, Mr. Chairman, and thank you for the additional time.

Mr. MITCHELL. Congressman Hall.

Mr. HALL. Thank you, Mr. Chairman and Ranking Member Roe. And thank you to our panel for your sacrifice for our country.

And as I said before when Dr. Roe was kind enough to yield, our information as of today is there are 257 veterans enrolled in the FRCP and only 14 coordinators which averages out to 18 veterans assigned to each coordinator.

Dr. Zampieri, do you think that is a good number or high or low or would you leave it as Ms. Lynch suggested to the coordinators to decide?

Dr. ZAMPIERI. That is tough. And I spent a year on neurosurgery and someone who is in an acute phase the first 6 months when they first come back may require a lot more time. And so I hazard that if you get into one per ten, you run into problems because as they transition into more of their rehabilitative care, they may not need as much intensive casework management.

And so it really is, and no one likes to hear this response, but I think it is hard because as even Sarah said, you know, it has got to be pretty individualized. I think the Federal recovery coordinators need to be able to request help if they find that they are trying to manage 20 people and it is too much, you know, versus, you know, the idea that, well, you are only supposed to have 10.

Mr. HALL. Well, maybe the next panel can answer that question better.

Dr. ZAMPIERI. Yeah.

Mr. HALL. But I just returned from Afghanistan and Iraq over our so-called break and our servicemen and women are using the same creativity and energy and loyalty to our country and to each other and enthusiasm and, you know, handling some very difficult situations in a very expert fashion. And we are all very proud of them as we are of you and of your spouses.

I did meet with Admiral Mullen yesterday and asked some of these same questions to him, especially in terms of the electronic handoff of medical records from active duty to veteran status. And I am assured as I was a year and a half ago when I spoke to the Commander at Landstuhl Medical Center in Germany that it is about to happen. So the question is when and how.

I am told that in Balad when a helicopter lands and a wounded soldier is brought in through those doors into the trauma center that they begin right away entering information into Alta Lite Program, Alta Lite which can be then entered into the full-fledged Alta Program and that they can share MRI results, chest results, CAT scans, what have you at the speed of light with any doctor here or over there in theater or in Germany using MedWeb.

These are things that are, you know, I think maybe there are some hackers in college that we could get to come work for the VA for a couple months and figure how to make it all compatible. If you can take a 44.1 thousand samples per second CD and have a little box that somebody made that converts it into an MP3 in a matter of seconds, then surely we can figure out a way to make DoD's information compatible with VA's system.

But good luck, Congressman Walz. If enough of us ask for this, it will happen.

I also just wanted to comment and then my time will be up that I am glad that our President is including the cost of the conflicts in Iraq and Afghanistan in the budget. It is one of the things that has caused the budget to swell and a lot of people are looking at the total number going, oh, my gosh, that is a huge number, but it is the first time in the 7 years that we have been at war that we have had this is not a surprise anymore, it is in the budget, not in a supplemental, and that is part of the reason.

We also need to realize that taking care of the wounded, those who have served us in those conflicts is part of the cost of war and the country needs to be prepared for that and needs to know that that is coming and be prepared to fulfill our part of the deal with those who have laid their lives on the line and in some cases given their lives.

So thank you, Mr. Chairman. I yield back.

Mr. MITCHELL. Thank you.

I just have one question I would like to add to Cheryl. You know, the organization that you founded, the American Veterans with Brain Injuries, do you have a Web site?

Ms. LYNCH. Yes, sir.

Mr. MITCHELL. And could you tell us some of the common questions that are being asked and do you believe that there is enough outreach to the VA to accommodate and educate all the families about severe brain injuries?

Ms. LYNCH. Initially I started the Web site as a peer support, some place for families to just reach out to other families because we are spread all over the country.

I think the outreach from the VA is very lacking. Family members go home and we just do not know where to start. And that is most of the questions that I get from other family members, where do I get cognitive therapy, how do I get cognitive therapy, there are other things that I am reading about on the Web.

You know, they are getting pieces of information, but it is not necessarily valid information. Family members that are dealing with somebody who has a brain injury are desperate. We want answers. We want opportunities. We want to provide any therapy that may help our loved ones recover.

Well, when there is nobody giving you any clear direction, then you have a tendency to go off in any direction.

An experience that happened for me most recently was my son, we have a new TBI clinic and I thought that was going to be a great opportunity at our VA. My son is nearly 9 years post injury and the first thing they did was screen him for brain injury. And I am thinking if other family members are going into their VA and having those same things happen, you want to knock someone's head and say this is a brain injury, I would like you to understand it.

So I think families are desperate. I think they are looking and the resources are not being handed to them.

Mr. MITCHELL. Just one comment. It is kind of interesting that here is a Web site, which is all done by word of mouth.

Ms. LYNCH. Yes.

Mr. MITCHELL. You are getting inquiries about what to do, where to go.

Ms. LYNCH. Yes, sir.

Mr. MITCHELL. And, yet, the VA has all the resources that it has and people are still out there looking for Web sites and support groups. It might be good if maybe the VA would look at some of these Web sites and get some of the information off of that. It might expand their outreach.

Ms. LYNCH. I would like to add something. Family members get to a point where we do not trust anything that anybody tells us from the DoD and VA. Sometimes we only trust what comes from another family member. So, yeah, I think it would be a great resource for the VA to actually look at some of the family organizations that have been started and some of those who truly can offer peer support.

Mr. MITCHELL. Well, it is pretty obvious that these organizations like yours that are formed are because there is a lack of support some place else. Otherwise, they would not need you.

Ms. LYNCH. Yes, sir.

Mr. MITCHELL. I want to thank all of you for coming today. And this is very meaningful for all of us. It is very appreciative not only for what you are doing now for the future needs of veterans but also what you have all done for your country. We appreciate that very much. And thank you very much.

[Applause.]

Mr. MITCHELL. I would like to welcome panel two to the witness table. And for our second panel, we will hear from Dr. Karen Guice, the Executive Director of the Federal Recovery Coordination Program at the Department of Veterans Affairs. Also joining us will be Dr. Madhu Agarwal, Chief Officer of Patient Care Services for the Veterans Health Administration; accompanied by Dr. Lucille Beck, Chief Consultant for Rehabilitation Services in the Office of Patient Care Service at the Veterans Health Administration and Jennifer Perez, Acting Chief Consultant for Care Management and Social Work for the Office of Patient Care Services at the Veterans Health Administration.

I would like to remind all of you if you could keep it within 5 minutes, we would appreciate that. We do have your written testimony.

And I would like to first of all recognize Dr. Guice for up to 5 minutes.

STATEMENT OF KAREN GUICE, M.D., MPP, EXECUTIVE DIRECTOR, FEDERAL RECOVERY COORDINATION PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MADHULIKA AGARWAL, M.D., MPH, CHIEF OFFICER, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; LUCILLE BECK, PH.D., CHIEF CONSULTANT, REHABILITATION SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JENNIFER PEREZ, LICSW, ACTING CHIEF CONSULTANT, CARE MANAGEMENT AND SOCIAL WORK, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. GUICE. Good morning, Chairman Mitchell, Ranking Member Roe, and Members of the Committee.

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

Joining me today from the Veterans Health Administration are Dr. Madhulika Agarwal, Chief Patient Care Services Officer; Ms. Jennifer Perez, Acting Chief Consultant for Care Management and Social Work; and Dr. Lucille Beck, Chief Consultant for Rehabilitative Services.

Today Captain Brogan, Lieutenant Kinard, Mrs. Wade, Mrs. Lynch, and Dr. Zampieri added their concerns to those that you have heard over the past several years. We simply must do better.

Sixteen months ago, the Federal Recovery Coordination Program was created to address service and benefit coordination problems across two large complex systems of care and benefits. Specifically the program is designed to provide oversight and coordination for very seriously or catastrophically wounded, ill, or injured servicemembers, veterans, and their families.

To do so, the Federal recovery coordinator or FRC develops a customized Federal individual recovery plan that is used to monitor and track the services, benefits, and resources needed to accomplish identified goals.

The goals are those of the servicemember or veteran with input from the family or caregiver and the multidisciplinary team. The

number and types of goals are related to the medical problems, the stage of recovery, and the holistic needs of the client and family.

Developing goals is a methodical process that begins with evaluation. FRCs review the relevant records and discuss specific problems and challenges with the various health care providers and case managers. This preparation allows for a structured dialogue with the client in developing the plan.

The FRC and relevant case managers determine responsibility and a timeline for implementing the steps necessary to reach a goal. The FRC then monitors progress with the case manager and the client, providing support and additional resources to both until the goal is reached.

FRCs frequently organize meetings with providers, case managers, and clients to make sure that objectives and expectations are clear.

The plan and goals change as a client progresses through the stages of recovery, rehabilitation, and reintegration. The FRC provides a single consistent point of coordination through this progression. Accountability for the plan rests with the FRC.

Today, 14 FRCs are located at six military treatment facilities and two VA medical centers. All have a clinical background with most being nurses or social workers. One is a vision rehabilitation specialist. All have prior experience in either the military health care system or the VA health care system.

Collectively, they have over 200 years of professional experience. All are Master's level and many have advanced practice degrees. All have specialized knowledge in one or more clinical areas. They frequently consult each other bringing their collective knowledge and experience to bear for their clients.

Currently 257 clients are enrolled in the program. Generally these clients are very seriously or catastrophically injured or ill and require complex arrays of specialists, multiple inter-facility transfers, and lengthy rehabilitation.

Individuals are either referred to the program or identified by the FRCs from daily census lists and during attendance at specialty team care meetings or down range videoconferences.

Over the past 6 months, key constituencies have received information about the program. A series of focus groups were held with 25 veteran service and nongovernmental organizations. Program updates have been provided to both DoD and facility leadership during site visits. Additional briefings and information sessions have been provided to a variety of other groups.

FRCs also participate in local and National events to promote the program. Because of these efforts, referrals to the program increased twofold. Forty percent of all clients were injured prior to 2008.

On the back of the newly designed brochures, which are on the table outside, is a new toll-free number to make sure that it is easy to refer potential clients or get information about the program. A description of the program is on the National Resource Directory's Web site and the OEF/OIF VA Web site.

The program has a strategy to reach out to those who went through the system before the inception of the program and who might still benefit from a recovery plan and care coordination.

Care coordination is a relatively new concept and what it does is it improves service integration along different delivery systems and eases transition from one system of care to another. It is not a band-aid or an indication of failing systems. Instead it is another step in the evolution toward a fully integrated system where care and benefits are organized around the multiple needs of individuals across the care continuum.

FRCs in keeping with this concept coordinate the delivery of services and resources for servicemembers, veterans, and their families in accordance with the goals identified in the plan. They work with the military services, TRICARE, VHA, VBA, other governmental resources including State and local agencies, as well as the private sector.

For those servicemembers and veterans not enrolled in the program, there are a variety of programs, services, and resources designed to meet their needs through the Departments of Defense and VA.

The Federal Recovery Coordination Program is accountable to the Office of the Secretary in acknowledgment of its corporate responsibility to coordinate benefits among all Federal agencies that provide services to this population of wounded, ill, and injured servicemembers and veterans.

I assure you that I am accountable for the performance of this program. I depend on your input and collaboration as the program continues to mature. It is my obligation and my promise to ensure that this program as part of a client-centered 21st century organization is efficient and effective.

Your support is greatly appreciated and I look forward to your questions.

[The prepared statement of Dr. Guice appears on pg. 44.]

Mr. MITCHELL. Thank you.

You know, I have a couple of questions. First, I think you know that everybody up here wants this program to work and we saw the need for it from the panel before us. And it seemed to me that after all the different programs that Dr. Roe read off and in listening to all the people that these veterans are getting a handful of cards, business cards and so on, at first, I was thinking, well, maybe there are not enough resources, but it seems like there are a lot of resources.

More than anything else, it seems like there is an organizational issue, that maybe it needs to be reorganized because this is a new office, this is a new program. But in order to meet the needs of these veterans coming back, it seems to me like we have got resources that just need to be reorganized.

And I hope you have the authority and obviously you have the ear of the Secretary to get what you need.

One of the other things that was brought up in the last panel was the fact that there seems to be some turnover in the FRCs. And I was wondering if that is caused by lack of resources. Are they overwhelmed with the number of caseworkers? Are they underpaid, they do not have enough support?

It is important as we heard that once a person has some faith in an FRC that they continue on with this person and not all of

a sudden start over. They have already started over many, many times in their career.

I had another question, I should have written it down, that I wanted to ask you about that. But in any case, I will let it go at that and maybe I will come back.

If you have any answers to any of that in terms of resources or the change of—oh, I know what it was. It was about the Web site that was talked about earlier and that maybe some people are afraid or do not trust the VA because they have had so many hand-offs and so many cards and they do not know who to go to.

Is there any effort at all maybe to try a new approach and look at some of these Web sites that people do trust and do go to and find out, wow, here are some concerns? We do not need a hearing. We can just go to these Web sites and find out what people are asking and we could answer those if they would come to us. But maybe they do not come to us because they have been handed off so many times and had new caseworkers and so on.

Dr. GUICE. I will answer your last question first which addresses taking advantage of modern technology and understanding that there are a lot of different ways for information to be exchanged among families and among individuals throughout the country.

Certainly I can speak for my FRCs. They actually watch many of these Web sites and learn a lot about their clients through the information that the clients or the family members share. That is another way for them to get information about what is actually happening and how it is being perceived by the family or the servicemember or veteran with regards to their care, as well as what is happening in their immediate life.

The information through the VA's Web site, for OEF/OIF, has been redesigned. If you have not had an opportunity to look at it, I would encourage you and your staff to do so, give us some feedback on it, make sure that it is working, gives the right information, and is useable and friendly to the viewer.

The other web portal that the FRC Program uses a lot is the National Resource Directory. It is a Web site of about 11,000 resources and helps the FRCs as well as any individual who goes to the Web site identify resources.

I think that the concept of capturing these new innovative ways of exchanging information is very important and we need to continue to work toward making sure that we are adaptable and flexible.

Mr. MITCHELL. One last thing. With all of these, and, again, it sounds like there are a lot of people working, the resources are within the VA, particularly the health services, hopefully there is a way that these people just do not say, well, this is my job and, you know, I understand the frustration they have working with any bureaucracy, saying, well, what you need to do is phone this 800 number, what you need to do is talk to someone else.

And that is why I think you were created, this agency, and I think you have probably got a good sense from the first panel of what needs to be done.

Dr. GUICE. The concept of the Federal Recovery Coordination Program is really one of care coordination. The FRCs are not case managers. Case managers are really facility-based individuals who

serve in a capacity at each one of those facilities to manage certain aspects of an individual's care.

Mind you that these individuals that you heard from the first panel are often transitioning between a DoD facility, a VA facility back to maybe a different DoD facility, maybe to another VA facility. They really make a lot of transfers and transitions; and just managing the complexity of their injuries and their rehabilitative needs is difficult.

The concept of the FRC is to coordinate care to make sure that the transitions are as smooth as they can be for these individuals, that there are plans in place, that the case managers who are sending the individual and involved in those transitions discuss the case with the receiving case managers and that there are plans in place for not only sending the individual but receiving the individual.

FRCs because of where they sit both within the organization and between the DoD and VA are very instrumental to actually improve those transitions.

The FRCs also assist with transitions in and out of the private sector. As you know, many of these individuals get rehabilitative services in the private sector. The FRC is the person who continues to have visibility of the individual and their family as they make those transitions in and out of the private system as well.

Mr. MITCHELL. One last question before I turn it over to Dr. Roe. You know, Cheryl Lynch pointed out, and I think this is where probably distrust comes and not believing what they hear, is that her son after 9 years, they are coming in and starting all over and saying they want to reevaluate. If the system does not already know, how could they be treating him for 9 years?

So I just think that there is an awful lot that needs to be done in terms of just plain communicating with people. And, you know, it is easy for a new person to come in and say, okay, we need to run some tests for something. That ought to be available to them.

And that is really the expertise of Dr. Roe, and I will turn it over to him.

Mr. ROE. Thanks. Thanks very much, Mr. Chairman.

And I think it is not that people are not trying when you read all these. I mean, obviously people are trying. And it seems to be coordination of assets.

And back to what Captain Brogan said was that what he would like to do is just talk to somebody who knows what they are talking about. And that is a fairly reasonable thing, I think.

And it has gotten incredibly complicated, it sounds to me like, and we need to back up and uncomplicate it a little bit. And I think basically what these wounded warriors are looking for is someone to say you need to go this direction and this person they are going to address a very specific type of care.

And I know as a surgeon as you are, you knew who was responsible when you went to the operating room. There was not any question about it, was there? When I went to the operating room, no doubt about who was going to be responsible for the care. That is what we need here, someone who is accountable.

And the Lieutenant said that very, very clearly and he is absolutely dead on right about it is that we need to know that the buck

stops on your desk if this wounded warrior is not getting what they need.

And I think it is now 2 weeks ago, I was fortunate enough to go to Afghanistan and it reminded me very much of my service at the DMZ in Korea years ago. And I can tell you I could not have been prouder of the soldiers, of the care they got there in the battlefield. And an extraordinary number of them live now and much better than in Vietnam at that time.

So what we have got to do is we have got to make, and it was also said, a lifetime commitment to these soldiers because their needs are going to, the Lieutenant said this very clearly, their needs are going to change and they are going to change when you are 40 and when you are 50 and when you are 70.

And for me, I am committed for a lifetime for these warriors. And we have a system in place. I think we have over-complicated the issue. And I think very simply the coordinator is absolutely the way to go, is to say this is the person that is responsible. And you have got to find somebody basically who cares. Books do not care and pamphlets do not care. People do.

Dr. GUICE. Sir, I think you have made a very important observation and I think that it is actually time now. We have a lot of resources. I think, Mr. Chairman, you said that in your comments as well. We have put a tremendous number of resources toward the problem.

And I think it is time for us to step back, examine what we have learned, figure out what is working, figure out what is not working, and try to reorient things so that we have a cohesive, integrated care delivery system between the DoD and the VA and some of the private sector.

Mr. ROE. I think the experts are sitting right there behind you.

Dr. GUICE. Yes, sir.

Mr. ROE. They have been through it and I have never heard anybody that knows more about it than they do. And I was amazed at what they have done for their families.

And I agree with all of them that if they had not had that family commitment, I do not know what would have happened to many of these wounded warriors. And we should not do that. I mean, we can do better. We are better than that. And I think we are going to do better.

And in 6 months, I want to hear how many wounded warriors we have in this program, if there are not enough coordinators. I think the Chairman and I and all the Members of the Veterans' Affairs Committee are willing to go to the mat to make sure that the resources are there to take care of these folks.

Dr. GUICE. Thank you, sir.

Mr. ROE. I yield back.

Mr. MITCHELL. Thank you.

One last comment. And really it kind of hit me with what Dr. Zampieri said about how policy is made in one of the classes he took. And I think this is what has happened with this is that we have just layered it little by little. When a need comes up, we add a policy.

And maybe to have good policy, we need to just restructure the whole thing and start over because I think what we have done is

we have created a program or a policy with each different issue that comes up and not really looking at the total. And I think that to me is what the FRCP is all about and what you are about.

So maybe you will have the authority. I know you have the ear now of the Secretary, that you can go in and say, you know, we need to look at this holistically and things are different than when we first had this program, this program, and this program. It is time to reevaluate it all. And I think now is a great time to do that.

Dr. GUICE. I agree, sir.

Mr. MITCHELL. Well, thank you all very much. And I appreciate what you are trying to do and I appreciate all the services given to our veterans. They deserve nothing less.

One thing, you know, Dr. Roe mentioned a lifetime of service. There was a veteran, I just want to share this with you and you all know this, there was a veteran in my district and he lost both of his legs, a little bit different than the Lieutenant. And I asked him at a program one time, I said, well, Garrett, how much did this leg cost. And he said, well, this leg cost $100,000 because it has a computer chip and you plug it in every night. The other one was only 3,500 because it was below the knee.

And this young man was less than 25 years old. And we know there are going to be some technological advances that are going to make improvements on these. He is going to need more care and this is the rest of his life. And this is a cost and we should not even worry about the cost. We should make sure that they get the very latest and the best care forever. They paid the ultimate price. We have got to continue that.

And I appreciate all of you and the work that you are doing for veterans.

Dr. Roe, did you have another question?

Mr. ROE. No.

Mr. MITCHELL. Okay. Well, thank you very much. And this concludes the hearing.

[Whereupon, at 11:43 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations

Thank you to everyone for coming today to this hearing entitled, *Leaving No One Behind: Is the Federal Recovery Coordination Program Working?*

Before we begin, I would like to introduce everyone to the Subcommittee's new Staff Director, Marty Herbert. Marty is a retired Army Lieutenant Colonel and a veteran of the Gulf War, OEF, and OIF. He brings a dynamic and experienced perspective to the challenges facing our Nation's veterans. With his addition to this Subcommittee, and his leadership, we are going to continue providing the much needed oversight our veterans deserve and have come to expect from this Subcommittee. So, on behalf of the entire Oversight and Investigations Subcommittee—welcome onboard Marty!

Time and again we have heard stories of troops returning home from serving their country, with no guidance and no support. Too often we hear of families carrying the burden of a servicemember's recovery and reintegration back into civilian life.

On March 17th, this Subcommittee held a hearing on the Vision Center of Excellence. In that hearing, we heard testimony from three veterans, Travis Fugate, Gil Magallanes and David Kinney—all three seriously injured—all three seemingly lost in the bureaucratic maze without *coordinated care*. The stories of these heroes are part of a systemic problem affecting servicemembers and veterans across the country. Fortunately, a memorandum of understanding between the DoD and VA was signed on October 30, 2007, establishing a Federal Recovery Coordination Program—FRCP. Federal recovery coordinators began working with patients in January of 2008.

We are here today to examine the effectiveness of the FRCP and to assess if outreach has succeeded in bringing coordinated care to veterans who were injured prior to the FRCP. When a servicemember returns from combat with multiple injuries, we must ensure he or she has a single point of contact to help navigate the bureaucracy of DoD and VA. This is the reason the Federal Recovery Coordinators must have considerable authority as they navigate the system ensuring the veteran and family receives each component of care in their overall plan and all the benefits due to them. Oversight of this program is critical to ensure it is fully staffed and fully functioning, and I look forward to hearing about what needs the VA has identified within the FRCP.

To put these issues into perspective we will hear from two veterans: Captain Mark Brogan, an Army veteran who suffered a severe penetrating traumatic brain injury, hearing loss, shrapnel wounds, and a spinal cord injury while serving in Iraq in 2006. Captain Brogan receives care through the VA clinic back home in Tennessee, but he was never made aware of the FRCP when it came online in 2008.

We will also hear from First Lieutenant Andrew Kinard a retired Marine Corps veteran who was injured in Iraq two and half years ago. First Lieutenant Kinard was referred to the FRCP in January of this year.

Additionally, we will hear testimony from Sarah Wade and Cheryl Lynch—family members of injured veterans who will give us an additional perspective on the FRCP—as well as the Blinded Veterans Association, who will discuss the impact the FRCP has on those veterans with eye injuries.

Although there is a solid foundation for the FRCP, there is still work to be done. I am anxious to hear from the Department of Veterans Affairs on how they plan to make the FRCP a program that veterans and their families can look to for the care they need and how they plan to conduct the appropriate outreach to ensure all wounded veterans and their families receive the best care, and no veteran with multiple traumatic injuries is left behind to navigate the huge health and benefits system alone.

The Dole-Shalala Commission, which set out recommendations for the care of wounded warriors, said it is not enough "merely patching the system, as has been

done in the past. Instead, the experiences of these young men and women have highlighted the need for *fundamental changes* in care management and the disability system." The Commission emphasized that significant improvements require a "sense of urgency and strong leadership." Now with Secretary Shinseki leading the VA, both the sense of urgency and strong leadership is present, and I am confident we can work together to provide our wounded warriors with the coordinated care they deserve.

I would like to thank all of our witnesses for appearing here today and thank you to both panels for what you do for our Nation and for our veterans.

Prepared Statement of Hon. David P. Roe, Ranking Republican Member, Subcommittee on Oversight and Investigations

Thank you for yielding, Mr. Chairman.

Last month, this Subcommittee held a hearing on the Vision Centers of Excellence during which three veterans related their experiences at the VA and DoD in the care they received. However, upon hearing the witness testimony, one of the things that concerned several of us, was the apparent lack of any contact with the veterans from the Federal Recovery Coordinator team. I went down the line of the first panel and specifically asked that question, and not one of the three severely injured veterans present had been in contact with or even knew if they had a Care Coordinator assigned to assist them.

This is particularly troubling since last Congress this Subcommittee held a hearing on this very issue, and Members were assured that the Federal Recovery Coordination team was being staffed and that newly injured servicemembers were being contacted and the team would be going back and contacting previously discharged severely injured servicemembers to assist them with their needs and concerns as well. From the testimony we heard last month, this is apparently not happening.

Mr. Chairman, I am grateful that you also felt this was an issue that needed immediate attention, and that we are now holding this hearing today. I hope to hear better news about the program than what I heard last month, and want assurances that the witnesses who testified last month have now all been contacted by the FRCP team, and are now receiving the assistance that they deserve. I also want assurances from the witnesses here today that incidents like we heard last month are not going to occur again, and no other veterans will "slip through the cracks" of bureaucracy.

It is bad enough that these veterans who have fought so bravely for our freedom lost their eyesight due to injuries they received in battle. But to ignore their needs when they return home and most sorely need our help is inexcusable.

Again, thank you Mr. Chairman, and I yield back.

Prepared Statement of Captain Mark A. Brogan, USA (Ret.), Knoxville, TN (OIF Veteran)

Mr. Chairman and Members of the Subcommittee:

I am honored to appear before you today to share my experiences for the benefit of other wounded veterans. My name is Captain Mark Brogan, and, like many of my brothers-in-arms, I was grievously wounded in Iraq.

Since my injury in 2006, my wife and I have been through quite a lot. Despite the efforts of well-intentioned people—and some disgruntled disenfranchised people along the way—this has mostly been a journey of blind exploration for us. My wife said from the very beginning of this journey: "They will not tell you everything they can do to help. You just have to stumble on it, and then demand it."

This has proven true time and again. For us, recovery has been an unending chorus of "I don't knows," a cycle we must endure until we find the answers ourselves.

I was proud to serve as a U.S. Army Captain assigned to the 172d Stryker Brigade deployed to the Iraq Theater in 2005 and 2006. On April 11, 2006, while leading a patrol in a marketplace, a suicide bomber walked around a corner, directly behind me and two of my soldiers, and blew himself up. One of my soldiers, SGT Kenneth Hess, was killed instantly. I received severe injures, including a penetrating traumatic brain injury from shrapnel entering the brain, a nearly severed right arm, severe hearing loss, and an incomplete spinal cord injury.

I was evacuated through Germany and on to Bethesda national Naval Center, where I lay in a coma for approximately 17 days. During that time, I was transferred to Walter Reed Army Medical Center. My wife flew in from Alaska, where

we were stationed, and immediately took charge of the administrative process. I continued my recovery at Walter Reed as an inpatient until July 2006, at which point I was transferred to the Tampa, Florida, Polytrauma Rehabilitation Center.

Upon my discharge from Tampa, I returned to my home in Tennessee and received follow-up care through TRICARE Standard. I returned to Walter Reed in October of 2006 to have my skull rebuilt. In February 2007, I returned to Walter Reed yet again to out process the Army for my retirement. Upon completion, I went back home to Tennessee to set up my medical care through the local VA and TRICARE.

I have suffered a significant traumatic brain injury, so my wife has carried the bulk load of my administrative needs. She has been my personal recovery coordinator with no experience navigating the massive recovery bureaucracy. My separation from service at Walter Reed was no different from many of the stories other soldiers have reported: lost paperwork, confusing processes, lack of information, and more.

My wife and I couldn't affix blame on one person—there was no "one person." And it was on her to make sense of the mess.

My transfer from Walter Reed to VA care and my October 2006 return back to Walter Reed was a great example of the gaps in the system between DoD and VA. I returned to Walter Reed to receive my cranioplastic surgery, a procedure to replace a missing half of my skull. When I arrived, I was shocked to find my name had fallen off of the list to have the procedure. I should have anticipated no less, but I was amazed to find no one in the Neurosurgery, Neurology, or any other department could give me any solid answers as to why this had happened. We had no single contact person with whom to inquire. It took us a full month to finally have the surgery scheduled and all the necessary preparations made.

This astounded me. How could something as important as replacing part of my skull be lost in the system?

I have had a total of 13 social work representatives within the VA and DoD systems working my case, none of whom communicated regularly to make sure all the bases were covered. Once I completed my retirement paperwork, I returned to my hometown of Knoxville to start a new chapter in bureaucratic dealings. My VA case was transferred from Tampa to the VA hospital responsible for the Knoxville area. At first it was Nashville, and later in Mountain Home.

My wife and I would go to the VA clinic in Knoxville for my primary care appointments, as the clinic in the area did not provide the extensive continued therapy I required for my TBI, Spinal Cord injury, and PTSD. There is a local civilian rehab center in Knoxville—Patricia Neal Rehab Center—that specializes in all of these types of injuries. The obvious answer is to be allowed to attend this facility, but we found out it is just not that simple.

My wife contacted several people at the VA and was again passed around the "I don't know" loop we've become accustomed to since my injury. In the end we were successful and, through the VA Fee Basing Program, I was able to attend an extra year of therapy. I received physical, occupational, speech, and cognitive therapies. I attended a specialized TBI day treatment program and I also received care from their neuropsychologist who is specialized in traumatic brain injury and has experience with PTSD as well. The Neal Center program is nationally recognized and I had the good fortune to be able to utilize this resource as the first and only OIF/OEF veteran to date.

Coordination for my care has been a heavy burden of my wife from day one. Only recently has the VA created a polytrauma clinic at my closest VA hospital which checks on me regularly. The only problem is that their only expertise is medical information. When it comes to benefits, we enter the "I don't know" loop yet again, and the vicious cycle repeats itself.

As you can see through our exhausting journey, the Federal Recovery Coordinator program could have been great for us. It is a brilliant idea. I have yet to have the privilege of their services, but had there been such a program in 2006, our experience may have been averted.

Instead, I come before you today with no experience with the Federal Recovery Coordinator program. I only heard of the program in the last 2 weeks, and not from the DoD or VA. From my subsequent research of the program's intentions, I believe it is an excellent idea—maybe even an answer to the disconnects and the unending circle of "I don't know" we experienced.

In summary, my personal answer to "Is the Recovery Coordinator Program Working?" is yet another "I don't know" in the chorus. I was simply never advised of the program. However, I believe had I been aware of and able to receive the program's benefits, it certainly would have been a huge stress relief for me and my family.

I hope the experiences I have shared will shed some light on how much the Federal Recovery Coordinator program will really impact injured veterans.

I appreciate this opportunity to submit testimony to the Committee on Veterans Affairs Subcommittee on "Is the Federal Recovery Coordinator Program Working?" On behalf of my fellow wounded warriors, I would like to thank you for all the hard work and service you provide. I look forward to answering any questions that you may have on April 28th, 2009.

Very Respectfully.

Prepared Statement of First Lieutenant Andrew Kinard, USMC (Ret.) Washington, DC (OIF Veteran)

Good morning, Chairman Mitchell, Congressman Roe, and Members of the Subcommittee. I am pleased to appear this morning to present my views of the efficacy of the Federal Recovery Coordination Program.

I was referred to a Federal Recovery Coordinator (FRC) on January 28th of this year in order to be assisted with specific issues that I had encountered while transitioning from active to retired status. Had I known earlier about the benefits of having a FRC, I would have requested one much sooner.

In order to best explain how my FRC has been a benefit, I must share with you a brief summary of my recovery. I was injured in Iraq two and a half years ago and retired from active service just last month. While I was recovering in the hospital, I had the advantage of constant attention from doctors, nurses, and other medical staff. When I was discharged from the hospital to continue physical therapy and eventually transition out of the Marine Corps, I was responsible for keeping up with all of the different medical staff and their individual responsibilities on my own. I had a medical case manager, a non-medical case manager, a social worker, a medical board case manager, a Physical Evaluation Board Liaison Officer, a Navy-Marine Corps Liaison Officer, a Wounded Warrior Regiment case manager, and a Marine Corps patient administration team. The number of support staff is roughly the same for most wounded servicemembers; catastrophically wounded servicemembers will often have even more.

With so many resources available to assist in the recovery, one might ask the question, "Why do we need yet another program?"

Seriously injured servicemembers need the Federal Recovery Coordination Program for two reasons: accountability and continuity of care.

ACCOUNTABILITY

The net result of the number of support staff is that there is a broad diffusion of responsibility among caseworkers, and the recovering servicemember loses confidence in the Government's ability to maintain accountability of his care. Each caseworker has a specific role in that servicemember's recovery, and the burden of responsibility falls on the servicemember to keep track of which case manager provides each service. The assignment of a FRC provides the recovering servicemember with a single point of contact for decisions regarding his care.

CONTINUITY OF CARE

The long list of case managers and other support staff that I previously mentioned all fall within the Department of Defense health care system. As servicemembers transition from active to veteran status, most, if not all, of those case managers will be exchanged for new ones in the VA system. New doctors will be assigned. Rather than veterans navigate a new health system with no institutional memory of their medical history, a FRC can ensure a continuity of medical care.

In summary, I believe that the Federal Recovery Coordination Program, under the leadership of Dr. Guice—from whom you will receive testimony in the next panel of witnesses—should continue its mission of providing comprehensive coordination of case management to those servicemembers who have been most severely injured. Particular effort should be made to reach back to those who were injured early in the conflict. Recovering from any traumatic injury is difficult at best, but the greatest casualty of all is being forgotten.

Chairman Mitchell and Members of the Subcommittee, thank you for the opportunity to testify before you today. I look forward to answering your questions.

Prepared Statement of Sarah Wade,
Chapel Hill, NC (Spouse of OEF/OIF Veteran)

Chairman Mitchell, Ranking Member Roe, Members of the Subcommittee, thank you for the opportunity to speak to you today regarding my experiences with the DoD/VA Federal Recovery Coordinator Program. My name is Sarah Wade, wife of Army Sergeant (Retired) Ted Wade.

My husband joined the Army during the summer of 2000, and following the attacks of September 11, he was called on to serve first in Afghanistan and later Iraq. On Valentine's Day 2004, his Humvee was hit by an Improvised Explosive Device (IED) on a mission in Mahmudiyah. He sustained a severe traumatic brain injury (TBI), his arm was completely severed above the elbow, suffered a fractured leg, broken foot, shrapnel injuries, visual impairment, as well as other complications, and months later would be diagnosed with Post-Traumatic Stress Disorder (PTSD). He remained in a coma for over 2 months, and withdrawal of life support was considered, but thankfully he pulled through.

After the battle for his life was won, the war for benefits and care began, and continues today. Due to the severity of his brain injury, Ted is sometimes unable to fight for himself, so his struggle has become my own. I was neither prepared for this mission, nor trained to serve in the many roles I have been expected to. I am often consumed 24 hours a day by these responsibilities, which have left no time for me to return to school, full-time employment, or have a life of my own. More than 5 years later, my schedule continues to be hectic and we still struggle to maintain a reasonable standard of living. Though the journey has been a nightmare at times, people have also listened and been responsive.

After the situation at Walter Reed Army Medical Center imploded in February 2007, I was fortunate to have the opportunity to be a part of creating solutions. I was invited to give testimony to the Dole-Shalala Commission and make a presentation to the DoD–VA Senior Oversight Committee (SOC). Among other things, I explained that Ted needed a case manager for his case managers, someone to coordinate his amputee nurse case manager, the Military Severely Injured Center, OEF/OIF Coordinator, Polytrauma Coordinator, psychiatric social worker, Soldier Family Management Specialist, and TBI case manager. I wanted someone to take care of the administrative items on my daunting "to do list," not just point me in the right direction or give me an 800 number. Ted needed a case manager with a smaller patient load, someone that understood his DoD, MEDICARE, VA benefits, and could coordinate them with the fee-basis care he received at a private practice in the community, but more importantly, he needed continuity and lifelong assistance. Nine months later, Ted had a Federal Recovery Coordinator (FRC).

Admittedly, I have been the biggest supporter of the FRC Program, and at times, the harshest critic. This is because we have experienced two distinctly different programs. When the FRCs first came online, I could not have been happier. We had finally hit the ground running. The woman to which Ted had been assigned was everything we had wished for, and more, but, just like a series of other programs that had been promising, it was short lived. Four months later she was gone, Ted was assigned a new FRC, and we had to start from square one again, as we had done twenty times before. My husband was devastated because he had truly believed things were going to be different this time.

In my search for answers, I talked to several other families involved with the program, only to discover many were on their second FRC too. It was clear the program was starting to falter, because it simply could not work with such a high turnover rate. Out of desperation, I e-mailed everyone I could think of, to make sure they were aware of the issue. I received a call back from the Deputy Under Secretary of Defense, Dr. Lynda Davis, who asked to meet with Ted and I that night on her way home from work. She asked someone from VA to join as well. Ted and I were very candid about our concerns and she was receptive to our ideas. The following day, I received another phone call from the Deputy Secretary of Veterans Affairs, Mr. Gordon Mansfield. He listened to what Ted and I had to say and took action.

The DoD/VA FRC Program came under new leadership last summer, and the Director, Dr. Karen Guice, now reports directly to the Secretary of Veterans Affairs. From what we have seen, she has been receptive to feedback, committed to problem solving, and has continued to reevaluate the program. Because the FRC Program Director currently has high visibility and access to leadership, she has the leverage to both resolve individual problems as they arise, but also identify systemic issues and recommend changes at a level where they may be implemented. Though there are still some glitches, I believe it is important for DoD and VA leadership to promote what is working, and continue to provide the willingness and support needed to guarantee the long-term success of this program. We have seen a string of other

resources crop up over the years, only to wilt, or die off, due to a change of focus or sponsorship. For once, we need the DoD and VA leadership to see this one through.

The FRC Program is unlike any other assisting severely injured servicemembers and veterans, for multiple reasons. All the other support systems are specific to a branch of service, a facility, or a type of injury. They can assist with specific needs, but are unable to coordinate the big picture, or are only involved for a defined period of the veteran's recovery. An FRC is able to connect at bedside after a servicemember is injured, has the ability to follow them as they move to other facilities or systems for rehabilitation, through their transition to civilian life, veteran status, and beyond. This type of continuity allows the veteran and their FRC to build a strong alliance, but also provides a single point of contact that has a complete understanding of all their benefits and a comprehensive life plan.

My husband will continue to face significant challenges for the rest of his life, as a severe TBI is never static, but a progression of peaks and valleys. Veterans like Ted need support that will be around as long as the injuries they sustained in service to their country. Just like he needed a team in the military to accomplish the mission, he needs a team at home for the longer war. I hope today we can all work together, to identify the needs of the veteran, and discuss what support the FRC Program requires of DoD and VA to accomplish this life-long mission. Mr. Chairman, thank you again for the opportunity to share my story with you today. I look forward to answering any questions you may have.

Prepared Statement of Cheryl Lynch,
Pace, FL (Mother of Injured Veteran and TBI Awareness Advocate)

Chairman Mitchell, Ranking Member Roe and Members of the Subcommittee, thank you for the opportunity to speak to you today.

My name is Cheryl Lynch, I am the mother of PFC Christopher Lynch, U.S. Army (Retired), who suffered a severe traumatic brain injury on July 13, 2000, while on training exercises in France. I am also the founder of a support organization for American Veterans with Brain Injuries and their families.

As a result of my personal experience and daily contact with many other families, I have a unique perspective on the needs and obstacles family caregivers face as we attempt to help our loved ones rehabilitate from these life altering injuries. It is with over 8 year's experience of working with, and sometimes against the bureaucracies of the Departments of Defense and Veterans Affairs as well as other Federal, state, and local agencies, that I address the Committee today.

First, I would like to recognize the positive advancements that have been made in the years since my son's injury. I am impressed with the many new initiatives and progressive programs currently available to our wounded. Unfortunately, however, once outside of a polytrauma setting where services are under one roof, rehabilitative options and benefits are still in a maze, one that is riddled with bureaucratic obstacles and dead ends. Family members are still left to piece together services in an attempt to continue their loved one's recovery. It is my opinion that the Federal Recovery Coordinator Program (FRCP) may be the best tool offered for navigating this maze. I am hopeful that through the FRC Program, Veterans and their families will not have to endure, what we have endured.

In order to fully appreciate my recommendations, you must hear at least some of our story and understand that at any given time we had a multitude of case managers and/or social workers who were assigned to my son's case. Unfortunately each one had their own area of specialty or fell under different geographical regions of the VA. For example; the Tampa VA Hospital is in VISN 8 and we live in VISN 16; our local clinic falls under the Biloxi VA of the Gulf Coast Health care system, CWT was initiated through the Tampa VA and transferred the case to our local VR&E office which falls under the direction of Montgomery AL, Compensation and Pension claims and physical exams are done locally, but the rating determinations are done in Saint Petersburg, Florida.

On July 13th 2000, my son fell 26 feet, which resulted in a severe traumatic brain injury. My son was airlifted within minutes of his accident to a French Airborne field hospital in Montauban. He was stabilized and transferred to a civilian hospital in Toulouse, France, where he remained for 28 days in a coma and on life support. Once Chris was removed from the ventilator, yet still comatose, he was transferred to Landstuhl Army Hospital in Germany and the next day we were flown to Walter Reed Army Hospital. Over the course of the following months my son was treated at both Walter Reed and the Tampa VA hospital.

On April 20th, 2001, Chris was released from the Army, and I brought my son to our home in Florida. Since that time, I have been Chris' caregiver. I knew my job would be difficult, but I did not know I was also going to be giving up my business to have a lifelong career of being a co-coordinator and mediator of case managers, medical needs, insurance issues and VA benefits.

Chris' continuum of care was never coordinated with any VA agency or civilian TBI clinic; instead, we were left to figure it out ourselves. We used our local Military Treatment Facility for general health issues, and I researched TBI facilities through out the Country that might help him gain use of his body and mind. Any options I found were met with constant battles of who was responsible for payment.

Due to a lack of appropriate continued therapy Chris' physical impairments worsened and caused increasing difficulties with his ability to feed himself and ambulate. Chris was evaluated at two different out-of-state civilian clinics, where physicians who specialized in Tone and Spasticity determined that Botox injections might relieve some his difficulty. We returned home and appealed to both VA and TRICARE to pay for the Botox treatments, but both refused; stating Botox was not a proven therapy. This has since changed and is commonly used by the VA, yet at that time I appealed to the VA for 2 years, requesting someone pay for the treatments.

After finding out that there were no appropriate cognitive therapies available locally; I submitted a letter to the VA's Vocational Rehabilitation Office. I asked for their assistance to aid my son in attending college classes part time to aid in his socialization, as I thought it would be therapeutic for him. Chris and I were informed that VR&E was not to be used to replace therapy. Eventually he was approved to attend college under an extended evaluation of an Independent Living Plan.

Chris was granted permanent retirement from the Army in 2003 and the VA initiated another C&P evaluation of Chris' condition. A 50-minute appointment with a VA neuropsychologist, created a new battle with the VA to prove Chris' competency. The next 5 months I felt like a lawyer with no assistance or guidance compiling a legal brief. Six months after submitting our defense we received a letter stating the VA had found Chris competent.

Chris was assigned a primary care physician at the Pensacola VA health Clinic in June 2004. The doctor was thorough and compassionate and she referred Chris to a specialist at the Biloxi VA for the increased tone and spasticity. That doctor determined Botox treatments were absolutely necessary as it was causing knee, hip and back problems. He agreed to Fee Base the injections and physical therapy for Chris at a Rehab facility close to our home. Four months later and after a lot of personal phone calls we finally got the authorization and approval. However, 18 months into treatments we got a phone call from the treating physician's office the week before an appointment. The VA had not paid for the last three treatments. The doctor rescheduled the appointment and subsequently canceled it completely, because of non-payment. Thirty-seven phone calls and 5 months later, the bills were finally paid and treatment resumed.

In October 2006, during a TBI summit in Washington DC, I had a chance meeting with Chris' original doctor from the Tampa VA. This Dr was surprised to hear Chris had not been contacted for follow up with the TBI program. He offered for Chris to return to the Tampa VA for additional therapy and to devise a new treatment plan. I found it a wonderful opportunity, but a shame that I had to travel to DC and depend on a chance meeting to find out about the possibility.

Chris was readmitted to the Tampa VA's Brain Injury rehab for 2 weeks in January 2007. Again the staff was very thorough and before Chris' release from the hospital, the TBI team had a phone conference with our local VA office. Chris was released from the Tampa VA with what seemed to be a new treatment plan in place for both his health care and vocation training. Yet when we returned home, we wound up in a perpetual downward spiral and the following months were disastrous.

Just prior to discharge from the Tampa VA, Chris had been prescribed a new medication, which he was receiving through the VA's automatic refill system, but he was not being monitored for its possible side effects, nor was he getting the individual counseling as requested in the discharge plan. Within months my son's mental health and physical well-being was at stake, and I feared for his life. After numerous desperate phone calls we finally got appropriate help from civilian mental health professionals.

More recently we have been confronted with the fact that, although many changes have been made, the system of care and benefits within the VA still does not work as it is intended and there is still a reluctance to send veterans outside of the VA for needed care.

Late last Summer Chris was referred, by his VA Primary Care Physician, to the new TBI Clinic at our local VA. She had hopes that they may be able to provide additional services or therapies, and I had hopes that they may provide additional oversight of his care. During his first appointment with the TBI Clinic last month, it became apparent that they were not prepared at all to provide anything for my son. Apparently no one had even looked at his records. In the first 15 minutes of the appointment they "screened" Chris for a TBI and then asked me if he had ever had cognitive neurological testing. Our saga with the VBA has also continued. Just weeks ago we received the rating results of my son's most recent C&P evaluations. These were ordered as a result of the enactment of the new Schedule of Ratings for the Residuals of Brain Injury. While we were very excited about the new ratings schedule, we were very quickly disappointed when his rating was far below our expectations. Fortunately, I was able to contact the FRC program and they intervened to get the rating reviewed and corrected.

My purpose in being here today is not only to tell you our personal story, but also to let you know that we are not alone. Many of the Veterans and families I am in contact with need the assistance of others not only to help them with daily activities, but also to help navigate the maze and remove obstacles that actually impair the veteran's progress. Care management of our veterans should not matter if the injury was suffered in combat or not. Specifically, the nature of a brain injury is multi-faceted and life altering and the responsibility of providing that lifelong care falls on the family members. The responsibility is daunting, the stress is never ending, and we need a lifeline.

In my opinion, the FRC program is one of the most beneficial programs offered in recent years. It has provided me and others I know that needed lifeline in times of crisis. However; the program is still evolving, and after speaking with families who have been afforded the services provided through the Federal Recovery Coordinator Program; it seems not all FRC's are created equal and the program itself is still not perfected. Some families have expressed that they rarely communicate with their coordinator and a few families are not even aware that they have an FRC, as it's hard to distinguish care managers from the multitude of case managers. Conversely, some families have seen the effectiveness of FRC's to serve as a compass for the maze, where an FRC has actually been able to provide the necessary oversight to develop and implement the Veteran's recovery plan. Others have been able to call on their FRC when bureaucracy has gotten in the way of progress. Some of these variances are due to the individual needs of the families, but it is also due to the nature of a new program struggling to hit its stride.

Although my son is not assigned an FRC; I have had the opportunity to personally see the effectiveness of the program. After we received the results of the most recent Compensation and Pension evaluation, we contacted FRC Program and they made a few calls in my son's behalf. The rating has since been reviewed. Without their assistance, I would have been relegated to months of paperwork and appeals.

In closing, although I understand a number of enhancements are underway, I would like to make the following suggestions regarding the FRC Program:

- An FRC must have injury specific knowledge and/or training, prior to case assignment, especially for those with brain injuries and mental disorders. These injuries have long-lasting, ongoing effects on an individual's life, and family members and veterans cannot be responsible for educating yet another case or care manager about the residual impairments of an injury.
- The FRC program must continue to have the capability of not only mediating DoD and VA benefits; it would also be extremely helpful if they could assist in the coordination of State and Community resources. The VA utilized everything they had at their disposal to rehabilitate my son after his injury, yet there were additional options, progressive medical treatments and therapies available OUTSIDE of the VA that could have been helpful.
- With a limited number of individuals serving in an FRC capacity, it's apparent not everyone who could benefit from their services is assigned one. Current staffing levels may be insufficient to address the needs of both the currently assigned and the additional cases that need to be referred into this program.
- Steps must be taken by the FRC Program to look back and find those who have been struggling. The common misperception that if your loved one was injured years ago, then all of your problems have been resolved is false and very dangerous.
- Individual outcomes vary and the need for FRC care management must be assessed not only on severity of the injury, but on the family circumstances and risk variables of individual veterans.

- I am aware that steps are being taken in this direction, yet it is imperative to promote visibility of the FRC program and streamline the referral process.

There is one last comment that I would like you to consider; I am a 54 year old mother. . . . if something were to happen to me, who will know enough about my son's individual difficulties and medical needs to continue to manage his care? Who will be able to act in his best interest or defense to assure he receives his entitled benefits? Who would be able to put the proper supports in place for my son to not end up on the streets, institutionalized, or even worse? I believe the answers to these questions lie in the potential of the FRC program. However;

- Veterans may in fact outlive an individual FRC; therefore, care cases must be accurately documented to assure lifelong continuity for the Veteran.

I am very pleased the Committee is looking into ways that may improve the FRC program. My hopes are that you will not only continue the program, but find ways to expand its availability to those in need. We can't change the past, but possibly the Committee has the ability to change what the future holds for my son and other injured Veterans and their families.

Thank you for the opportunity to share our experiences, I look forward to answering any questions you may have.

Statement of Thomas Zampieri, Ph.D.,
Director of Government Relations, Blinded Veterans Association

Introduction

Chairman Mitchell, Ranking Member Roe, and Members of the House Veterans Affairs Subcommittee on Oversight and Investigations, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our testimony today. BVA is the only Congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. The Association has now served blinded veterans for more than 64 years.

Large numbers of seriously wounded Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, Afghanistan) returning servicemembers continue to encounter bureaucratic obstacles as they seek health care. These obstacles exist despite attempts within the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to address these issues with new initiatives. The problems have also been addressed by the introduction of various Congressionally authorized programs and the implementation of suggestions from a wide variety of commissions, Presidential task forces, Military Service and Veterans Service Organizations, nongovernmental organizations, and state and local entities. We still find ourselves somewhat frustrated and lost by the barriers we are encountering in assisting our eye-injured servicemembers.

Both the Joint Executive Council (JEC) and the Senior Oversight Commission (SOC) have proposed changes since the era in which problems first surfaced at Walter Reed Army Medical Center in February 2007. However, we still hear stories of frustration that have, sadly, gripped many of our servicemembers and their families as they seek help but are unable to obtain it without serious hardship.

Bureaucratic Obstacles in the Transition Process

A little more than 1 month ago, on March 17, three blinded OIF–OEF veterans (Travis Fugate, David Kinney, and Gilbert Magallanes) appeared before this Subcommittee to explain the problems they had encountered in the area of case management in transitioning from DoD to VA Care.

Approximately 1 year ago, on April 2, 2008, we also heard in this room from two other blinded veterans, Sergeant Brian Pearce and Navy veteran Glen Minney. These two men returned home with severe visual impairments that left them legally blind. They and their families expected an appropriate level of consultation for the specialized VA blind or low-vision services they needed. They waited needlessly for the Case Managers, Wounded Transition Unit (WTU) Liaisons, DoD–VA Social Workers, VA Nurse Case Managers, and recently appointed Federal Recovery Coordinators (FRCs) to make the key VA Visual Impairment Service Team (VIST) contacts. These failures raise serious questions about the reintegration process. While all of the aforementioned were severely injured relatively early in both wars, they nevertheless should have been identified, tracked, and assured that all proper consultations would occur.

OIF and OEF servicemembers who have experienced both eye trauma and Traumatic Brain Injury (TBI) visual impairments have had to wade through a bureaucratic DoD/VA case management system that seems to develop a new organizational plan for improvement every year. For example, this past month the Army Medical Department (AMEDD) Newsline announced that the Warrior Transition Command Office (WTCO) is merging with both the Warrior Transition Unit (WTU) Office and the Army Wounded Warrior Program (AWWP) to facilitate improved cooperation and synergy. The number and variety of offices responsible for Seamless Transition are therefore overwhelming. If it is difficult for policy makers to come up with effective and efficient solutions to these issues, the situation is all the more complex for a young spouse or other family member in trying to find the best care for the loved one who has been injured in combat operations. BVA is concerned that an unresponsive bureaucracy can result in serious medical complications as well as social and economic problems for the veterans and their families.

Various plans for transitioning seriously wounded servicemembers began surfacing at the outset of the conflicts in Iraq and Afghanistan. It was not until March 25, 2007, however, that a new VA comprehensive 62-page handbook, "Transition Assistance and Care Management of OEF and OIF Veterans" 1010.01 was released. Expectations were that "the fix" was here in this handbook. Then, in April 2008, VA announced a plan to contact all seriously wounded going back to 2001 to ensure that no servicemember had been lost to VA follow-up clinical care or benefits. The plan proposed to send letters to more than 527,000 OIF and OEF veterans, alerting them as to how to contact VA for any assistance they needed. The most severely injured would be contacted first. One year later, we ask the following: Was Congress provided any final report regarding attempts to meet the goals of this plan? What were the results? From our observation, the very individuals we have set out to help have become more lost with each new costly Federal plan to increase the number of special warrior call centers, to add WTUs, to appoint the 12 full-time FRCs and then TBI Reintegration Managers, to add information to Government Web sites, and to involve nongovernmental organizations and services in the effort. One anecdotal result of such confusion is that an OIF blinded servicemember recently told us that he has had five case managers during the past 3 years.

Eye Injured and TBI Visual Complications

Mr. Chairman, for more than 4 years BVA has attempted to bring attention to the large number of servicemembers and now veterans who have experienced serious combat eye trauma and TBI visual dysfunction. We have looked specifically to the Armed Services Committees, the Defense Appropriations Committees, the Committees on Veterans Affairs, DoD Health Affairs, and the Veterans Health Administration (VHA). Our emphasis has been the growing numbers of those who have returned with penetrating direct eye trauma (13 percent of all wounded evacuated) and with TBI visual complications (64 percent of those with TBI have screened positive for visual dysfunction).

The top three contributors to combat eye injuries in Iraq have been Improvised Explosive Devices (IEDs), Rocket-Propelled Grenades (RPGs), and mortars. The IEDs have been the leading cause, having been responsible for 56.5 percent of all eye injuries in Iraq. TBI injuries typically involve neuron-sensory visual complications that consist of neurological visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, color vision loss, and an inability to interpret print.

Some TBIs result in visual field defects with enough field loss to meet legal blindness standards. BVA is discovering ever increasing numbers of TBI-related "functionally blinded OIF and OEF veterans" who, while not legally blind, are unable to perform normal daily activities because of loss of vision. More TBI visual screening, diagnosis, treatment, rehabilitation, and new visual research studies should be initiated. Servicemembers identified with TBI need a concrete plan for continued, long-term VA eye care and follow-up. Those who have experienced dual sensory injury and loss should be enrolled in VA specialized services for hearing and vision loss.

Compatible Records Technology

The most recent VSO *Independent Budget* stresses the importance and urgency of full development of an interoperable and bidirectional, fully compatible medical electronic health records technology system for DoD and VA. It is essential to making improvements in care plan coordination and delivery of benefits. The timelines for these improvements have been missed for years. We urge now that full implementation be reached by September 2009. We were encouraged by the recent meeting at the White House in which President Obama, Secretary Gates, and Secretary Shinseki committed their full attention to jointly correcting this lack of progress.

They promised to bring a full exchange of the military, occupational, and DD–214 forms into this bidirectional system in order to improve VA Seamless Transition issues for improved health care and benefits.

Case Management and Staffing Issues

The VSO *Independent Budget* also recommends that seriously injured servicemembers and veterans receiving care from DoD and VA have a clear path of recovery. Rehabilitation services must be clearly at their service. Case management reintegration programs in which servicemembers and veterans might participate must be strictly and closely overseen.

Careful staffing analysis must be conducted so that redundancy is eliminated. Resources must be coordinated and developed for the seriously wounded and their family caregivers. Instead of merely throwing personnel resources at the problems and adding more layers of both personnel and offices, currently existing resources should first be reassessed, then adjusted, and then distributed in order to leverage solutions for veterans and their families. The addition of staffing positions, or in many cases new titles for social work staff, only serve to confuse the wounded and their families rather than fix already existing problems with information and services. Multiple case managers for one individual and his/her family result in reduced efficiency and restrict the ability of veterans to know who is actually charged with helping them with their specialized rehabilitation and benefits assistance.

BVA also seriously questions, for example, why only Registered Nurses are assigned to VA Clinical Case Manager positions when a critical shortage of bedside nurses exists. Why not fully utilize the skills of some of the 1,820 VA Physician Assistants in the vital area of clinical coordination of Case Management? The Military depends extensively upon Physician Assistants for both OIF and OEF medical care. The Army, in fact, has 698 Physician Assistants with an average of more than 28 months of combat field medical duty (Physician Assistants assume primary and emergency medical care for all soldiers in many battalions). VA Physician Assistants could contribute their clinical skills and improve the clinical coordination and consultation between the DoD and VA rehabilitation systems. A very tangible benefit, and important point, would be that many of the seriously wounded would trust and relate to these Physician Assistant providers because they have been with them in the field as their key health care providers in the past.

Seamless Transition and Traumatic Brain Injury

As of September 2008, VHA reported that 8,747 servicemembers had been diagnosed with TBI. Another approximately 7,500 had been in diagnostic testing for possible TBI. IED blasts contributed to more than 64 percent of these injuries. As of March 30, 2009, a total of 45,583 servicemembers had either been wounded or injured from accidents in Iraq and Afghanistan, or had other medical conditions requiring evacuation. Nevertheless, the VA Poly Trauma Centers nationwide have treated fewer than a thousand individuals who have, according to the VA definition, been severely injured or catastrophically disabled. This is not an overwhelming number of severely wounded for whom a Seamless Transition of services must be ensured. One wonders on what scale the current crisis would have escalated if the number of hostile wounded requiring air medical evacuation were as high as that which existed during previous wars. Between 1950 and 1953 in Korea, for example, approximately 55,380 with combat trauma were evacuated compared with the aforementioned 45,583 over a 7-year period in Iraq and Afghanistan. A review found that some 3,470 Korean War-wounded servicemembers required neurosurgery care, demonstrating that head trauma was a prominent injury even back then.

VA's Full Continuum of Care

A positive note is that VA continues to build on a now 60-year history of successful blind rehabilitation programs, which include ten residential centers throughout the United States. At present, the implementation of a sweeping three-year Full Continuum of Care plan is in full swing. Although the plan was originally initiated to serve the projected aging population of veterans with degenerative eye diseases requiring specialized services, 54 new intermediate low vision and advanced blind rehabilitation outpatient programs also have specialized staffing in place to provide the full range of basic, intermediate, and advanced vision services essential to the new generation of eye injured veterans from OIF and OEF. In addition, VA continues to emphasize medical vision research and the latest advances in prosthetic adaptive equipment, new treatments, and access to technology through a coordinated team approach that is designed to benefit blinded veterans of all eras. The new, specialized VA programs for blinded and low-vision veterans must be utilized by DoD, VA Case Managers, and the FRCs, with eventual coordination from the soon-to-be-implemented Vision Center of Excellence. Veterans and their families

must know where these resources are located so that they continue to receive the quality health care that includes constantly emerging vision research.

The mission of the full-time VIST Coordinators is to provide blinded veterans with the highest quality of adjustment to vision loss through services that include rehabilitation training. To accomplish this mission, VISTs have tools at their disposal to locate and identify blinded veterans and review all benefits and services for which they are eligible. They also coordinate admissions to blind or low-vision centers. Unfortunately, DoD Case Managers and sometimes even VA Case Managers are not consulting directly with the VISTs. The VIST concept was created 40 years ago to coordinate the delivery of comprehensive rehabilitation services for blinded veterans. The VIST Coordinators are in a unique position to provide comprehensive case management and Seamless Transition services to returning OIF–OEF service personnel for the remainder of their lives if they (the VIST Coordinators) are indeed contacted by DoD Case Managers. The Coordinators can assist not only the newly blinded veterans but also their families by providing timely and vital information that facilitates psychosocial adjustment to vision loss. VIST Coordinators are now following the progress of 135 blinded OIF and OEF veterans who are receiving VA services. The VIST system now employs 158 VIST Coordinators, 43 of which are part time. Some 40 Blind Rehabilitation Outpatient Specialists (BROS) provide, outside of a clinical environment and most often in the veteran's home, both orientation and mobility instruction and living skills training.

The aforementioned new Advanced and Intermediate Blind outpatient programs are very cost effective for high-need, low-vision OIF/OEF veterans with residual vision from TBI and who require long-term follow-up services. Combined with the VISTs and BROS, the programs can provide a wide network of specialized services for veterans and family members in conjunction with existing VA eye care clinics. The catch is that the eye-injured veteran must be aware of these specialized services. With assistance from FRCs, VA Case Managers should coordinate specialized medical, psychiatry, neurology, blind rehabilitation, physical therapy, occupational therapy, and prosthetics services so that veterans' needs can be served as effectively and efficiently as possible within VA Medical Centers. Effectively providing the full Continuum of Care for OIF and OEF veterans is vital to rehabilitation.

BVA is very concerned that a few private agencies for the blind who wish to serve veterans do not have, as does VA, the full medical, surgical subspecialty, psychiatry services, and co-located staffing within their facilities. Some such agencies are attempting to enter this mix. If veterans and their families were to use such private services, they would be required to travel away from their other care providers to obtain outpatient blind training. This would add wait times for seeing consultants, delays in obtaining prescribed medications, and confusion in developing new integrated treatment plans. BVA would discourage the use of such private blind agencies unless they provide outcome studies and are validated by the Commission on Accreditation of Rehabilitation Facilities (CARF). They should also be required to utilize VA electronic health care records for clinical care and to meet specific quality assurance measures for contracts.

Conclusions

Servicemembers with complex, serious, and often catastrophic injuries should be the first priority of the care management system for wounded warrior transition and caregiver assistance. The families of these returnees should be part of the assistance. Those with significant visual dysfunction associated with TBI or eye trauma must have immediate consultation with the currently existing VA VIST and BROS teams. DoD and VA management must ensure that such consultation occurs.

The problems inherent in a geographically diverse population of wounded, which include hometowns in more remote rural regions, must be avoided. Delays in follow-up care, common in the past, can be overcome by careful VA tracking. They can also be overcome when a single primary Case Manager takes full responsibility for the wounded servicemember or veteran. Although servicemembers, veterans, and their families must possess contact information for the FRCs for case reviews, the latter should not be individually managing such cases. That responsibility should fall to the social workers, who will ensure that necessary individual care is provided.

BVA again expresses its gratitude to the Committee for this opportunity to present testimony on a subject of great importance to our organization, its members and constituents, and our Nation as a whole. We will be pleased to answer any questions you may now have.

Recommendations

- Severely injured servicemembers and veterans receiving treatment from either DoD or VA Case Managers must have one primary VA Case Manager. They

must also have a clear individualized plan in conjunction with the FRC, who should ensure that they or their families have all necessary contact information in the event there are questions. The FRC must have a process in place to review the individual case plan for appropriate specialized services, the tracking of workload, and identifying the geographic location of a veteran's home so that future plans can be monitored and resources identified.

- The case management system must be centered on the patient, the patient's family, and other caregivers. It must provide comprehensive coordination and compassionate Seamless Transition plans that ensure outpatient care and/or specialized long-term care in the veteran's home or community. Support is essential in the acute phase and long-term plans for all seriously wounded. Each National Guard Member, Reservist, or seriously injured veteran from a rural area must have a key state contact for assistance with state or county resources.
- Congress should authorize and fund VA family counseling services for the seriously wounded. Congress should also provide support for respite care and long-term care. Caregiver plans should be documented and financial assessments conducted to ensure that veterans and their families receive assistance with their bills and have all of the necessary governmental/nongovernmental benefits and resources.
- All DoD/VA Case Managers need educational updates on the various VA rehabilitation programs for low-vision or blinded veterans. They also need to know the locations of services that best serve veterans who need hearing loss or vision services. VISTs and BROS must also be promptly notified when servicemembers or veterans are transferred.
- All VA TBI Case Managers must report data on all serious penetrating eye trauma or TBI visual dysfunction cases to the Director of VA Blind Rehabilitation Service within the Veterans Health Administration.
- Because they are the case consultants for all of the seriously wounded, VA Case Managers, social workers, VIST Coordinators, and BROS must be privileged to document the VA care plans and other information in electronic military medical records. They must arrange for the necessary VA follow-up appointments with the DoD and VA health care team responsible for managing the case of the seriously wounded servicemember.
- The establishment of the Defense Intrepid Center of Excellence for Mental Health and the TBI Center of Excellence at the future Walter Reed National Medical Center must include Congressional funding of $3.2 million in the War Supplemental to renovate space for the Vision Center of Excellence. Implementation of full, coordinated services provided by the Vision Center of Excellence will substantially improve the multidisciplinary research, treatment, and rehabilitation programs affecting servicemembers with vision loss due to eye trauma or TBI across the DoD and VA systems.

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

Good morning Chairman Mitchell, Ranking Member Roe, and Members of the Committee. My name is Karen Guice and I am the Executive Director of the Federal Recovery Coordination Program. I am delighted to have this opportunity to update you regarding the Federal Recovery Coordination Program (FRCP) and Care Coordination across VA's health care system.

The FRCP is designed to assist recovering servicemembers, Veterans, and their families with access to care, services, and benefits provided through the various programs in DoD, VA, other Federal agencies, states, and the private sector. The program is operated as a joint program of the Departments of Defense (DoD) and Veterans Affairs (VA), with VA serving as the administrative home. Specific program eligibility criteria were approved by the VA/DoD Senior Oversight Committee in October 2007 and include those servicemembers or Veterans who are receiving acute care at military treatment facilities; those diagnosed with specific injuries or conditions; those considered at risk for psychosocial complication; and those self-referred or Command-referred based on perceived ability to benefit from a recovery plan.

Referral

Recovering servicemembers and Veterans are referred to the FRCP from a variety of sources, including from the servicemember's command, members of the multidisciplinary treatment team, case managers, families already in the program, Veterans Service Organizations and non-governmental organizations. Generally, those individuals whose recovery is likely to require a complex array of specialists, transfers to multiple facilities, and long periods of rehabilitation are referred. When a referral is made, a Federal Recovery Coordinator (FRC) conducts an evaluation that serves as the basis for problem identification and determination of the appropriate level of service.

Federal Individual Recovery Plan

The Federal Individual Recovery Plan is designed to efficiently and effectively move a servicemember or Veteran through transitions by accessing the services and benefits appropriate to the identified needs and goals. The Plan is created with input from the servicemember or Veteran, their family or caregiver, and from members of multidisciplinary health care team. The FRC implements the plan by working with existing governmental and non-governmental personnel and resources.

Staffing

Fourteen FRCs are working at six military treatment facilities and two VA medical centers. They are supported by a VA Central Office staff that includes an Executive Director, two Deputies (one for Benefits and one for Health), an Executive Assistant, and a Staff Assistant. In addition, the program receives personnel support at VA Central Office from the U.S. Public Health Service and DoD, with each sending two individuals on detail.

Predicting the total number of FRCs required for the program at any point in time depends on the number of eligible servicemembers and Veterans enrolling and workload criteria based on intensity of needs. The program has developed a hiring plan based on estimates of eligible populations and a variety of estimated workloads. If referral and enrollment rates are higher or lower than projected, the number of new FRCs hired can be adjusted accordingly.

Coordination

Within VA, a robust system to coordinate care for severely ill and injured servicemembers as they transition from DoD to VA's health care system is in place. VA has strategically placed 27 VA Liaisons for Health Care at 13 military treatment facilities with concentrations of recovering servicemembers returning from Afghanistan and Iraq. Each VA medical center also has an OEF/OIF Care Management team to coordinate patient care activities and ensure that servicemembers and Veterans are receiving patient-centered, integrated care and benefits. Members of the OEF/OIF Care Management Program team include: a Program Manager, Clinical Case Managers, a Veterans Benefits Administration (VBA) Veterans Service Representative, and a Transition Patient Advocate. For those with more severe conditions, such as severe polytrauma and traumatic brain injury, spinal cord injury, or severe visual impairment and blindness there are specialty care managers available. The Federal Recovery Coordinators and VA case managers work collaboratively for those servicemembers and veterans that are cared for within VA.

Roles and Responsibilities

While the concept of care coordination is not new, what is new is its application to managing and assisting injured and ill servicemembers and Veterans as they navigate the various transitions associated with recovery without duplicating services. FRCs do not directly deliver services; they coordinate the delivery of services and serve as a resource for servicemembers, Veterans and their families.

Within the overall framework of care coordination and each client's particular needs and goals, the FRCs work with military liaisons, members of the Services Wounded Warrior Programs, service recovery care coordinators, TRICARE beneficiary counseling and assistance coordinators, VA vocational and rehabilitation counselors, military and VA facility case managers, VA Liaisons, VA specialty care managers, Veterans Health Administration (VHA) and VBA OEF/OIF case managers, VBA benefits counselors, and others.

Within VA, care management begins with VA Liaisons for Health Care, who facilitate the patient's transition from a military treatment facility to a VA health care facility that provides the most appropriate medical services required for their condition nearest to home. VA Liaisons also coordinate closely with DoD Case Managers to identify servicemembers who are transitioning from the military as outpatients. VA Liaisons educate servicemembers and their families about VA's system of care, help coordinate their initial registration with VA, and secure appointments

within VA health care for these servicemembers prior to their leaving the military treatment facility. The FRCs and VA Liaisons work closely to coordinate care and referrals.

All severely injured OEF/OIF Veterans are provided with a case manager, and any other OEF/OIF Veteran screened may be assigned a case manager upon request. The Program Manager ensures that all OEF/OIF Veterans are screened for care management. Clinical Case Managers coordinate patient care activities and ensure that all clinicians providing care to the patient are doing so in a cohesive and integrated manner. VBA team members assist Veterans with the benefit application process and education about VA benefits. The Transition Patient Advocate serves as a problem solver by facilitating activities between the VA medical center, VBA, and the patient or family, serving as a facilitator and problem solver.

The OEF/OIF Care Management team collaborates with the FRC assigned to a Veteran or servicemember as an adjunct team member in coordinating services across the continuum of care. VA has a care management tracking database that is patient specific. This data base provides an immediate identification of the servicemember or Veteran's current VA case manager. FRC's, VA case managers, and VA Liaisons all have access to this database.

Resources

The FRCP is supported by a variety of sources. VA supports the FRCP through office space at Central Office, technical and information technology (IT) support, access to human resources and budget specialists, and an "open door policy" for access to both VBA and VHA for programmatic support. The program also has access to the expertise and guidance from VA's Office of Public and Intergovernmental Affairs, Office of Congressional and Legislative Affairs, and Office of General Counsel.

DoD provides assistance to the program through the Transition Policy and Care Coordination Office and the Senior Oversight Committee and staff. This support includes assistance with reporting requirements, development of appropriate tools, and coordination of activities. Military liaisons to VA from Army Wounded Warrior and the Marines serve as consultants to the program.

FRCs are individually supported by their host facilities. This support includes information technology assistance, office space and supplies, and other support as necessary.

Challenges

The FRCP has undergone two formative program evaluations to assist in its development. From the first to the second evaluation, progress was noted in the following areas:

- The recovery plan is serving its intended purpose for clients by introducing them to goal setting from recovery through reintegration and beyond; and
- Interaction and communication has improved among FRCs, military treatment facilities and VA medical center staff with the recognition that FRCs play a vital role in care coordination.
- Increased interaction among FRCs via conference calls has created a forum for discussing lessons learned, problem resolution and promising or best practices.

Ongoing challenges for the program include the following:

- Continue to build relationships within military treatment facilities' and VA medical centers' leadership;
- Continue to support the FRCs through training and increased IT assistance;
- Investigate reasons for losing contact with Veterans and families and seek ways to better communicate with Veterans and families after reintegration to their communities;
- Continue collaboration with Recovery Coordination Program leadership, liaisons and workgroups to share best practices and jointly problem solve across both programs;
- Modify FRCs' training based on their evaluations and ongoing feedback as they gain more experience with their role and responsibilities;
- Continue to develop an intensity measurement system for the FRCP;
- Identify areas for improvement based on results of customer satisfaction surveys from clients and their caregivers; and
- Establish a formal quality management program with outcome metrics and process measures to identify areas for improvement.

Conclusion

The Federal Recovery Coordination Program is still new and we continue to learn ways to improve the program every day. In closing, I would like to share with you the service pledge recently developed by the Federal Recovery Coordinators. It reads:

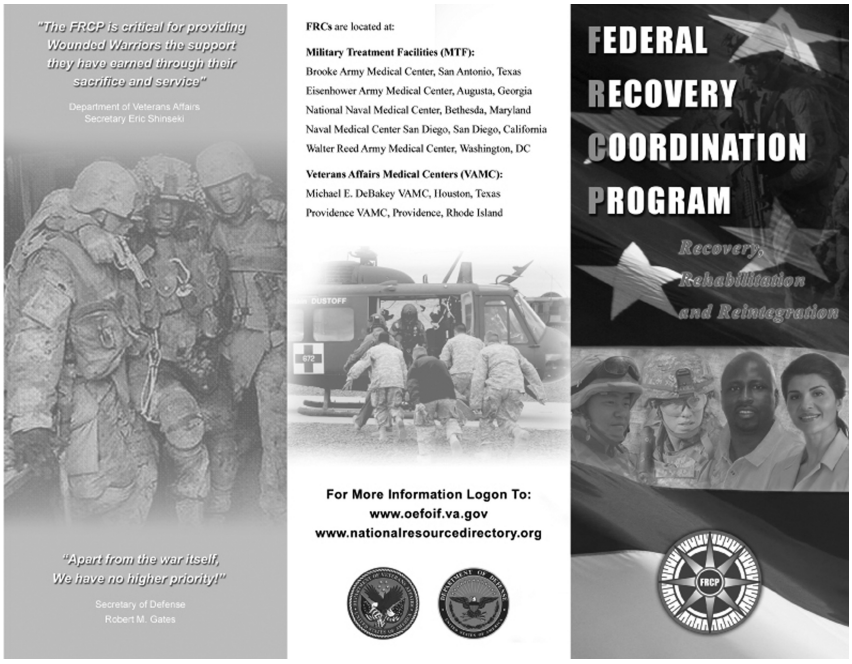
Connect with the servicemember or Veteran, and those who care for them;

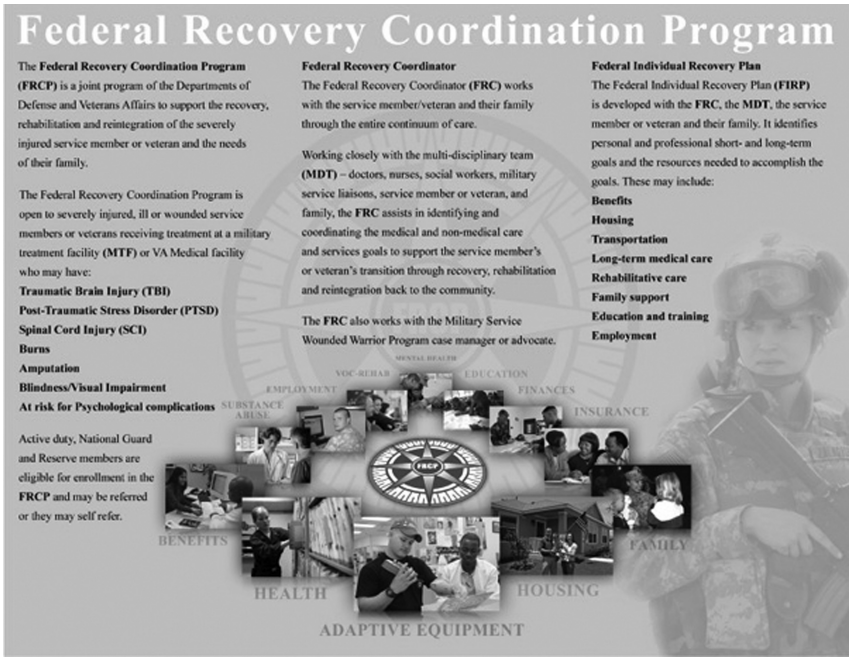
Appreciate the servicemember or Veteran's challenges;

Respond to the needs of the servicemember or Veteran; and

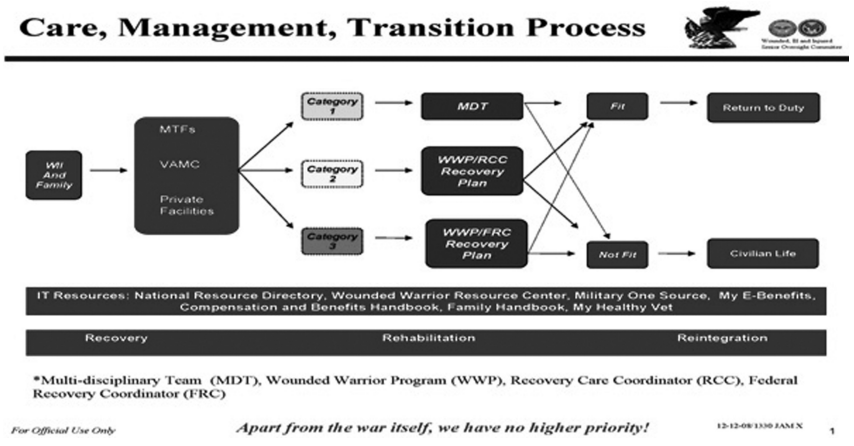
Empower the servicemember, Veteran, family or designee to solve problems.

The FRCP, together with the care management system and processes within VA and DoD, are committed to ensuring that our injured Veterans and servicemembers receive the care, services and benefits that they so richly deserve. Your support is greatly appreciated and I look forward to your questions.




Federal Recovery Coordination Program
The Federal Recovery Coordination Program (FRCP) is a joint program of the Departments of Defense and Veterans Affairs to support the recovery, rehabilitation and reintegration of the severely injured service member or veteran and the needs of their family.
The Federal Recovery Coordination Program is open to severely injured, ill or wounded service members or veterans receiving treatment at a military treatment facility (MTF) or VA Medical facility who may have:
Traumatic Brain Injury (TBI)
Post-Traumatic Stress Disorder (PTSD)
Spinal Cord Injury (SCI)
Burns
Amputation
Blindness/Visual Impairment
At risk for Psychological complications
Active duty, National Guard and Reserve members are eligible for enrollment in the FRCP and may be referred or they may self refer.
Federal Recovery Coordinator
The Federal Recovery Coordinator (FRC) works with the service member/veteran and their family through the entire continuum of care.
Working closely with the multi-disciplinary team (MDT) – doctors, nurses, social workers, military service liaisons, service member or veteran, and family, the FRC assists in identifying and coordinating the medical and non-medical care and services goals to support the service member's or veteran's transition through recovery, rehabilitation and reintegration back to the community.
The FRC also works with the Military Service Wounded Warrior Program case manager or advocate.
Federal Individual Recovery Plan
The Federal Individual Recovery Plan (FIRP) is developed with the FRC, the MDT, the service member or veteran and their family. It identifies personal and professional short- and long-term goals and the resources needed to accomplish the goals. These may include:
Benefits
Housing
Transportation
Long-term medical care
Rehabilitative care
Family support
Education and training
Employment
MENTAL HEALTH
VOC-REHAB
EDUCATION
EMPLOYMENT
FINANCES
SUBSTANCE ABUSE
INSURANCE
FRCP
BENEFITS
FAMILY
HEALTH
HOUSING
ADAPTIVE EQUIPMENT


Federal Recovery Coordination Program
Recovery, Rehabilitation and Reintegration
MENTAL HEALTH
VOC-REHAB
EDUCATION
EMPLOYMENT
FINANCES
SUBSTANCE ABUSE
INSURANCE
FRCP
BENEFITS
FAMILY
HEALTH
HOUSING
ADAPTIVE EQUIPMENT
For More Information Logon To: www.oefoif.va.gov or www.nationalresourcedirectory.org



Statement of Lorrie Knight-Major,
Silver Spring, MD (Parent of OIF Veteran)

Chairman Mitchell, Ranking Member Roe, Members of the Subcommittee, thank you for the opportunity to share my personal experience regarding my experiences with the Department of Defense and the Department of Veterans Affairs Federal Recovery Coordinator Program.

My name is Lorrie Knight-Major. I am the mother of Sergeant Ryan Christian Major. On November 5, 2003, Ryan enlisted in the U.S. Army for a 3 year term, which was later extended for an additional 5 months. On November 10, 2006 at 0300, 5 days after his original discharge date and 2 months prior to his redeployment from Iraq to the U.S., Ryan was critically wounded as a result of an improvised explosive device (IED) blast while on a mission with his unit in Ramadi. This device was hidden under ground. As a result of the blast, Ryan sustained multiple massive injuries including:

- Both legs were amputated above the knee;
- Both arms were broken with multiple fractures;
- Two fingers amputated off each hand;
- Extensive peritoneum injuries;
- Severe right pelvic fracture; and
- Traumatic Brain Injury

Ryan was plagued with numerous deadly infections after arriving stateside. It was touch and go for the first 2 months on whether he would survive. He pulled through. Surviving the massive injuries Ryan sustained was a miracle, but having access to the best medical care to meet Ryan's individual needs was a challenge and continues to require significant coordination.

My primary goal has always been that my son receives the best comprehensive medical care that is available either at a military hospital and/or civilian hospitals. Secondly, that he receives continuity of care and that it is maintained throughout his hospitalizations, rehabilitation, outpatient care and his return back into the community.

Our journey has been fraught with various obstacles that serve as barriers to access to quality care. Navigating the complex maze of treatment options and benefits is a job in and of itself. But we remain determined that Ryan receives the quality care that he was promised when he enlisted to serve in the United States Army should he become injured. Advocating for this quality medical care and the coordination of services has been my mission. But this level of care and advocacy comes at a price. The cost has been my family's financial security. As a result of caring for my Ryan, and the emotional toll it has taken on our family, I have had to leave my job to provide the necessary level of medical care and advocacy that my son required. This has led to a significant financial hardship for our family because of my living on credit cards and a home equity line of credit which have all been exhausted. Families should not have to sacrifice and bear the burden of advocacy, and

compromise their own financial stability to insure that their soldiers' receive the appropriate and necessary medical care.

I recognize that progress has been made in the caring of our injured soldiers. We still have a ways to go. There are many systems working to meet our returning injured veterans' needs. For example, the Warrior Transition Brigade (WTB) case manager is one resource. Yet it is difficult to have continuity of care because of the rapid deployment of the military nurse case managers. We are now on our eighth WTB nurse case manager within the past 2 years. I feel that having a civilian nurse case manager that would not be deployed could help provide the continuity of care that we desire. The one system that is working for our family is the Federal Recovery Coordinator (FRC) program. Ryan's FRC has provided enormous support and assistance for our family.

I was referred to and met Ryan's Federal recovery coordinator on October 7, 2008. After meeting Ryan and I, she hit the ground running with providing coordination of Ryan's surgical schedule, medical care and military benefits and promotion opportunities. Although Rosa has been assigned to Ryan only six months, she has accomplished many tasks for our family. For example, she has facilitated the securing of Ryan's military orders that shows he was actually deployed to Iraq, paperwork that was lost and is necessary for his promotion to E6. She continually assists with Ryan's Coordination of Medical Care with multiple surgeons and facilities. She secured a financial grant from a nonprofit organization for our family during the Christmas holidays. These are just some of the services that Rosa has provided for us.

In addition, she began the groundwork of arranging a meeting with the Baltimore VA so that Ryan has a smooth transition out of the military and into the VA system. She successfully assembled a meeting at the Baltimore VA last week to discuss Ryan's upcoming surgeries and to ask the VA to approve the complicated urological surgical care that is being provided by a surgeon in the private sector in Virginia so that continuity of care is maintained. The people in attendance included Ryan's physicians and a host of disciplines that will be involved in Ryan continued medical care once he separates from the Army.

Ryan is preparing to move into the barracks at Walter Reed this week for one month to assess his independence. I phoned his FRC this morning to discuss my concerns regarding this trial stay such as someone to provide the medical care that our family currently provide him at home. Immediately, she proposed that a home health nurse sees Ryan to care for those ongoing medical needs in the barracks.

As a mother of a severely injured soldier, I have seen firsthand the consequences of inadequate medical treatment for our injured soldiers and veterans and the huge price that they pay. I have seen the negative effects that the burden of advocacy has on the family. I know of the struggles to identify available resources to aid families in transitioning their injured soldiers' home. I have seen the bureaucracy that acts as barriers.

Our family has faced numerous challenges in advocating for the best medical care and services for Ryan both in the military and civilian hospitals. Ryan sustained devastating injuries and as a result, his medical care is complicated and requires significant coordination. This journey has been overwhelming and has caused me considerable anxiety. I am relieved that we have a FRC assigned to us to manage some of the administrative paperwork and coordination of services that are necessary in securing the best care. The services that are provided by the FRC allow me the time to get back to managing my personal affairs and exploring job opportunities.

I applaud the Department of Defense and the Department of Veterans Affairs for establishing the Federal Recovery Coordinator program to assign individuals to the severely injured soldiers and their families to ensure that these soldiers receive quality medical care and all of the benefits that they are entitled to for their tremendous sacrifice for our country. These soldiers must have, and deserve a system in place designed to advocate for them. The families should not have this enormous burden and most families are not equipped to handle this.

There have been insurmountable challenges faced by both Ryan and our family. We continue to face the challenges of advocating for quality care and navigating the bureaucracy that act as a barrier to quality medical care and hinders a soldier's successful recovery and transition out of the military and into the VA system. I appreciate having Ryan's FRC advocating on our behalf and helping us to steer. My only regret is that this program was not established in 2006 when my son was injured.

We owe a tremendous debt to our veterans for their services and sacrifices. It is our social, moral, and ethical responsibility to provide them with the appropriate resources, and the tools and support that are necessary for them to live longer, fuller, and healthier lives. Today, I ask the Department of Defense and the Depart-

ment of Veterans Affairs to expand the FRC Program. The expansion would be instrumental in improving the provision and continuity of services for an increased number of our wounded veterans and aid many more of them.

Again, thank you Mr. Chairman for the opportunity to share my personal experience with the Department of Defense and the Department of Veterans Affairs FRC program.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
May 8, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

Thank you for the testimony of Karen Guice, M.D., MPP, Executive Director, Federal Recovery Coordination Program, U.S. Department of Veterans Affairs who was accompanied by Madhulika Agarwal, M.D., Ph.D., Chief Officer, Patient Care Services, Veterans Health Administration; Lucille Beck, Ph.D., Chief Consultant, Rehabilitation Services Office of Patient Care Services, Veterans Health Administration; and Jennifer Perez, LICSW, Acting Chief Consultant, Care Management and Social Work Office of Patient Care Services, Veterans Health Administration, U.S. Department of Veterans Affairs at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on April 28, 2009 on "Leaving No One Behind: Is the Federal Recovery Coordination Program Working?"

Please provide answers to the following questions by Monday, June 15, 2009, to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigations.

1. Last April the VA announced a plan to contact all seriously wounded veterans retroactively from the beginning of OEF and OIF, approximately 17,000, to ensure no one had fallen through the cracks.
   a. How many of these 17,000 were contacted?
   b. How many of the 17,000 currently are enrolled into the FRCP and have a Federal Individual Recovery Plan (FIRP)?
2. Dr. Guice testified that FRCs monitor Web sites and learn a great deal about clients enrolled in the FRCP through the information that clients share on Web sites. Please give three most popular Web sites that the FRCs habitually monitor and what lessons are learned through the observing each?
3. Out of the 257 veterans currently enrolled in the FRCP, please state how many have visual impairments. In addition, please explain the frequency by which the FRCs are engaging the VISTs, BROs, and VA Blind Rehabilitation resources?
4. Though there is a level of cooperation between the MTFs and VA case managers, please explain the challenges and barriers facing VA case managers?
   a. In addition, please explain how the challenges discussed above impact the FRCs, and
   b. How the FRCP is mitigating the challenges to improve coordination of medical care to injured veterans?
5. Please explain the role of the FRC in reintegrating seriously wounded veterans in their communities who are from rural regions of the country. How does the FRCs interact with state and local agencies, and non-governmental associations?
6. How will an FRC's maximum caseload be determined? In addition, will the program continue to accept enrollees until funding for new FRCs is exhausted, or will additional criteria be placed on enrollees to ensure those in greatest need are receiving the service?
7. How does the FRCP plan to improve outreach to eligible veterans?
8. While the Federal Recovery Coordination Program (FRCP) appears to be doing a good job in providing assistance to the servicemembers and veterans they are currently working with, there seems to be a problem in communicating the availability of the FRCP to servicemembers, veterans and their families. What does the VA plan to do to address this disconnect?

9. What is the methodology used to assign a specific Federal Recovery Coordinator (FRC) to a severely wounded, injured or ill servicemember of veteran?
10. The Booz Allen Hamilton report indicated that none of the seriously wounded, ill, or injured (SWII) individuals currently on role of the FRCP have visual impairments. Please verify is this still the case, and if so, what plans does the FRCP have to reach out to these veterans.
11. On the http://www.oefoif.va.gov/HowDoIGetHelp.asp webpage set up for veterans of OEF/OIF, there is a small discussion of the Federal Recovery Coordinator Program, and it discusses how servicemembers and veterans are referred to the program. Among the medium for referral is included "self-referral" however, the Web site does not address how the individual can do a self-referral. Please explain how a "self-referral" is accomplished.
12. The Web site also provides a list of toll-free numbers to assist veterans, but the toll-free number for more information on the FRCP program is not included in that list. What plans does the VA have to add this number to the list of hotline numbers.
13. When there is a change in assignment of an FRC, how is the seriously wounded, ill, or injured (SWII) and their family notified of the new FRC assigned to them?
14. Will the National Resource Directory (NRD) be incorporating State and Local programs in the master list in order to help the FRCs better assist servicemembers and veterans?
15. How much funding has been allocated for implementation of the IT systems necessary to support the functions of the FRCP?
16. How comprehensive is the Veterans Tracking Application (VTA) system for use by the FRCP in accessing information about OIF/OEF veterans who may need their services?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Majority Staff Director, Martin Herbert, at (202) 225–3569 or the Subcommittee Minority Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

Harry E. Mitchell
Chairman

David P. Roe
Ranking Republican Member

MH/dt

Questions for the Record
The Honorable Harry E. Mitchell, Chairman
The Honorable David P. Roe, Ranking Member
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
April 28, 2009
Leaving No One Behind: Is the Federal Recovery Coordination Program Working?

Question 1: Last April the VA announced a plan to contact all seriously wounded veterans retroactively from the beginning of OEF and OIF, approximately 17,000, to ensure no one had fallen through the cracks. How many of these 17,000 were contacted? How many of the 17,000 currently are enrolled into the FRCP and have a Federal Individual Recovery Plan (FIRP)?

Response: In April 2008, the Secretary of Veterans Affairs directed the establishment of a call center to contact Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans not currently receiving health care through the Department of Veterans Affairs (VA). The primary objectives of this initiative, the *Combat Veteran Call Center*, were to inform the Veterans about VA benefits and services and offer assistance where needed with VA-related issues. Contact was made by EDS, a private contractor employed by VA, beginning on May 1, 2008. The total population identified for contact by the call center was 676,093. The total of seri-

ously wounded Veterans in this population was 15,666 (not 17,000). The remaining 660,427 Veterans were those who had served in combat in Iraq and had not enrolled with VA for health care services.

Of the 15,666 seriously wounded Veterans called by the contractor; direct contact was made with 5,381 or 34 percent. The outgoing calls for this population of seriously ill/injured Veterans were completed in June 2008.

Of the total *Combat Veteran Call Center* targeted population (676,093), EDS officials spoke directly with 24 percent and left messages for approximately 74 percent. Because there was direct contact with only 24 percent of the call center targeted population, VA subsequently conducted an analysis of whether Veterans not reached directly through the call center may have been reached through other VA health care-related and outreach programs. As of the end of April 2009, many of the Veterans not contacted in the initial effort have now been contacted:

- 116,500 are enrolled in VA health care
- 105,600 are currently using VA health care
- 84,600 have used a Vet center
- 95,000 have been briefed through the Reserve/National Guard demobilization initiative

VA has not actively tracked who among the initial cohort reached by the *Combat Veteran Call Center* Initiative has received a Federal recovery coordinator (FRC).

Question 2: Dr. Guice testified that FRCs monitor Web sites and learn a great deal about clients enrolled in the FRCP through the information that clients share on Web sites. Please give the three most popular Web sites that the FRCs habitually monitor and what lessons are learned through observing each?

Response: The goal of the Federal Recovery Coordination Program (FRCP) is to address each client's unique needs. For this reason, FRCs use numerous Web sites. The Web sites and blogs are used to obtain information to better serve their clients. Below are the most commonly used Web sites that help FRCs assist their clients. VA does not specifically track and rank the popularity of Web sites. In addition, FRCs monitor blogs should their clients use that form of communication.

FRC frequently used Web sites

1. National Resource Directory: http://www.nationalresourcedirectory.gov/nrd/public/DisplayPage.do?parentFolderId=6006
2. Home for Our Troops: http://www.homesforourtroops.org/site/PageServer
3. Operation Support Our Troops: http://www.west-point.org/family/support-ourtroops/
4. Deployment Health Clinical Center: http://www.pdhealth.mil/
5. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury: http://www.dcoe.health.mil/default.aspx
6. Department of Veterans Affairs: http://www.va.gov/
7. VA OEF/OIF: http://oefoif.vssc.med.va.gov
8. VA Veterans Online Application: http://vabenefits.vba.va.gov
9. Wounded Warrior Project: http://www.woundedwarriorproject.org/
10. Operation Life Transformed: http://www.operationlifetransformed.org/ra.html
11. Military One Source: www.militaryonesource.com
12. Blinded Veterans Association: http://www.bva.org/
13. Traumatic Brain Injury National Resource Center: http://www.neuro.pmr.vcu.edu/
14. TRICARE: http://www.tricare.mil/
15. Hope for the Warriors: http://www.hopeforthewarriors.org/index.html
16. Brain Injury Association of Florida: http://www.biaf.org/
17. Rebuilding Together Veterans Housing: http://www.rebuildingtogether.org/section/initiatives/veteran_housing

Question 3: Out of the 257 veterans currently enrolled in the FRCP, please state how many have visual impairments. In addition, please explain the frequency by which the FRCs are engaging the VISTs, BROs, and VA Blind Rehabilitation resources?

Response: Currently, there are 338 active clients in FRCP. A total of 28 visually impaired patients are in the program; 21 of them have been referred to visual impairment services teams (VIST)/blind rehabilitation outpatient specialist (BROS), and the remaining 7 will be referred when their medical conditions have stabilized.

Question 4(a): Though there is a level of cooperation between the MTFs and the VA case managers, please explain the challenges and barriers facing VA case managers?

Response: VA liaisons for health care have had positive experiences in integrating with the clinical staff at military treatment facilities (MTF) where they are stationed. When an MTF is identified for the assignment of a VA liaison, there is a significant amount of education that must take place to effectively communicate the role of the VA liaison. Each MTF is unique and the acuity of ill and injured servicemembers varies. Identifying the appropriate clinical teams with which to engage is a critical first step in assuring a smooth transition process. The development of close collaborative working relationships is essential. At times, VA liaisons have experienced challenges when integrating their VA computer equipment/connections within the MTF's firewall. In these instances, we have found that the MTF has designated points of contact to partner with the local VA staff in resolving these issues.

Question 4(b): Please explain how the challenges discussed above impact the FRCs, and; how the FRCP is mitigating the challenges to improve coordination of medical care to injured veterans?

Response: FRCs work with a variety of case managers in both the Department of Defense (DoD) and VA. The experiences have been very positive and a majority of referrals to the program are from these case managers. FRCs are called upon by both VA and DoD teams for assistance in locating resources as well.

The greatest challenge for FRCs is the integration of information technology (IT) access within VA and the MTF. These challenges are met with the assistance of both VA and DoD IT support personnel. Many of these challenges will be overcome with the implementation of more IT integration between VA and DoD.

Question 5: Please explain the role of the FRC in reintegrating seriously wounded veterans in their communities who are from rural regions of the country. How do the FRCs interact with state and local agencies, and non-governmental associations?

Response: FRCs are responsible for assisting each Veteran and servicemember in reaching the goals identified in their Federal individual recovery plans (FIRP). As such, wherever the Veteran or servicemember is located, their FRC will ensure that the activities are coordinated to meet the FIRP's goals. FRCs have many resources and tools at their disposal for ensuring successful reintegration in any setting, including rural. Key to FRCs assisting clients is direct communication. In addition, FRCs routinely identify resources which are then shared with other FRCs. FRCs also use the national resource directory that currently has over 11,000 contacts which can assist OEF/OIF Veterans and servicemembers. This directory has both private and public information, including State and local governments. All of these resources, tools, and continued education ensures that FRCP remains a dynamic program which seeks out what is best for the Veteran or servicemember wherever they may be located.

Question 6: How will an FRC's maximum caseload be determined? In addition, will the program continue to accept enrollees until funding for new FRCs is exhausted, or will additional criteria be placed on enrollees to ensure those in greatest need are receiving the service?

Response: Having an appropriate tool that measures the impact of an injured or ill servicemember or Veteran enrolled in the FRCP is critical for staffing needs and measuring outcomes. A maximum workload or case ration for FRCs is not specifically established, as there are no comparable data or rations. FRCP staff is developing an intensity based measurement tool that will score each patient along several possible parameters. The composite score will determine the intensity level of each case and can be measured over time to document improvement. The documented levels will also serve as a base for caseload determination and manpower needs. At no time will a qualified Veteran or servicemember be turned away from the program based on lack of resources. This program has the full support of both DoD/VA and as such, will continue to be funded as necessary.

Question 7: How does the FRCP plan to improve outreach to eligible veterans?

Response: FRCP has taken tremendous steps during the past several months to strengthen outreach to Veterans, servicemembers and other stakeholders. FRCP has a brochure that has been disseminated throughout VA and DoD facilities as well as to private and public entities which serve OEF/OIF Veterans and servicemembers. This brochure contains information on the program. Included in the brochure is the FRCP active hotline number (1–877–732–4456) for those interested in finding out more about the program or referring an individual (or self). FRCP is also featured on the OEF/OIF Web site, www.oefoif.va.gov, as well as in the national resource directory, www.nationalresourcedirectory.org. FRCP posters are distributed

throughout VA and DoD facilities to ensure that the program maintains a high-profile within the pertinent population. FRCP has weekly "virtual staff meetings" by conference call or through video link (if available) during which we often have a private or pubic program speaker to discuss what they can provide to FRCP and vice versa. FRCs are frequently invited to discuss the program in local and community settings. In the past 12 months, FRCP staff participated in over 60 conferences, panels and other training forums. These requests confirm the growing knowledge of this program as well as the overall concept of care coordination. FRCP is always looking for more opportunities to increase awareness of the program.

Question 8: While the Federal Recovery Coordination Program (FRCP) appears to be doing a good job in providing to the servicemembers and veterans they are currently working with, there seems to be a problem in communicating the availability of FRCP to servicemembers, veterans and their families. What does the VA plan to do to address this problem.

Response: Both VA and DoD believe strongly in the mission of FRCP and are constantly seeking opportunities to increase awareness of the program to those who may benefit. We have taken steps to increase the program's outreach to those Veterans and servicemembers who may benefit from the program. We have been engaged in active outreach over the past year. This has resulted in a four-fold growth in the number of clients over the past year.

Question 9: What is the methodology used to assign a specific Federal Recovery Coordinator (FRC) to a severely wounded, injured or ill servicemember or veteran?

Response: The FRC conducts an assessment of the referred individual's needs and makes a determination to enroll or redirect no later than 30 days from the date of referral. The decision to enroll in FRCP requires active consent from the individual or guardian. An evaluation to determine appropriateness for enrollment in the program includes direct discussion(s) with the servicemember, Veteran and/or family/caregiver. The assignment to a specific FRC is dependent upon FRCs' caseloads as well as what is best for each client.

Question 10: The Booz Allen Hamilton report indicated that none of the seriously wounded, ill, or injured (SWII) currently on roles of the FRCP have visual impairments. Please verify that is this still the case, and if so, what plans does FRCP have to reach out to these veterans.

Response: Booz Allen Hamilton's second program evaluation showed 10 FRCP clients with visual impairments. Currently, there are 28 clients with visual impairments. FRCP will continue to enroll those Veterans and servicemembers who meet the criteria of the program and choose to become a client.

Question 11: On the http://www.oefoif.va.gov/HowDoIGetHelp.asp webpage set up for veterans of OEF/OIF, there is a small discussion of the Federal Recovery Coordinator Program, and it discusses how servicemembers and veterans are referred to the program. Among the medium for referral is "self-referral", however, the Web site does not address how the individual can do a self-referral. Please explain how a self-referral is accomplished?

Response: Veterans can call the FRCP hotline number, which is now available on the Web site for anyone interested in the program-for themselves or someone they know. The hotline is staffed by FRCP personnel who can assist the Veteran or servicemember in determining if they meet the qualifications for FRCP enrollment. If they are in need of assistance from another program, FRCP staff will ensure that they are provided the necessary information.

Question 12: The Web site also provides a list of toll-free numbers to assist veterans, but the toll-free number for more information on the FRCP program is not included in that list. What plans does the VA have to add this number to the list of hotline numbers?

Response: The FRCP hotline number was added to the Web site during the month of May, 2009. It can be found on the front page which features FRCP.

Question 13: When there is a change in assignment of an FRC, how is the seriously wounded, ill, or injured (SWII) and their family notified of the new FRC assigned to them?

Response: The philosophy of the FRCP is to provide continuity through a single FRC who will follow the client through all phases of recovery, rehabilitation and reintegration, regardless of geographic location. As a result, transfer of a client from one FRC to another is done only under extenuating circumstances. If a client and/

or family/caregiver requests transfer to an alternate FRC, the request is forwarded to the FRCP leadership (deputies or executive director) for review.

The transfer of a case cannot occur without the express consent of the client and/or family/caregiver. Their consent must be documented. The accepting FRC will make contact with the client and/or family/caregiver within 2 business days of the transfer.

Question 14: Will the National Resource Directory (NRD) be incorporating State and Local programs in the master list in order to help the FRCs better assist servicemembers and veterans?

Response: The NRD currently has 11,000 resources available and continues to add resources for this population. Additional resources are being considered and partnership opportunities discussed to add community and State resources.

Question 15: How much funding has been allocated for implementation of the IT systems necessary to support the functions of the FRCP?

Response: VA has allocated $5,715,000 in fiscal year (FY) 2009 for the implementation of the IT systems to support the FRCP. Additional funds in FY 2010 will address completion of the implementation scheduled for July 2010.

Question 16: How comprehensive is the Veteran Tracking Application (VTA) system for use by the Federal Recovery Coordinator Program in accessing information about the OIF/OEF veterans who may need their services?

Response: Once an individual participates in the FRCP, Veteran tracking application (VTA) is used to track their activities as they progress within the program.

The FRCP uses VTA to track and manage clients. Basic demographic information is directly fed from DoD information sources into VTA and is routinely used to establish a new record within VTA. While meeting the basic needs of the FRCP, VTA's utility is limited by its lack of interfaces to other key information and resources, such as Veterans Benefits Administration (VBA) compensation information.

Currently, the data available within VTA provides the FRCP with some information to assess referred servicemembers or Veterans. VA is developing a new FRCP data management tool that will interface with other resources, provide a more comprehensive reporting capability, identify potential FRCP clients for outreach, and broaden the data capture for all servicemembers and Veterans who might need FRCP services. This data management tool, when completely developed, will interface with other VA and DoD applications and provide the FRCP with more information to conduct initial assessments and assist clients. The first release of the enhanced functionality is tentatively scheduled to be fielded by July 2010.

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