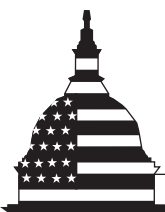


March 2011

DOD AND VA HEALTH CARE

Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges



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Why GAO Did This Study

In 2007, following reports of poor case management for outpatients at Walter Reed Army Medical Center, the Departments of Defense (DOD) and Veterans Affairs (VA) jointly developed the Federal Recovery Coordination Program (FRCP) to coordinate the clinical and nonclinical services needed by severely wounded, ill, and injured servicemembers and veterans. The FRCP, which continues to expand, is administered by VA, and the care coordinators, called Federal Recovery Coordinators (FRC), are VA employees. This report examines (1) whether servicemembers and veterans who need FRCP services are being identified and enrolled in the program, (2) staffing challenges confronting the FRCP, and (3) challenges facing the FRCP in its efforts to coordinate care for enrollees. GAO reviewed FRCP policies and procedures and conducted over 170 interviews of FRCP officials, FRCs, headquarters officials and staff of DOD and VA case management programs, and staff at medical facilities where FRCs are located.

What GAO Recommends

GAO recommends that VA direct the FRCP Executive Director to establish systematic oversight of enrollment decisions, complete development of a workload assessment tool, document staffing decisions, and develop and document a rationale for FRC placement. GAO received comments from DOD and VA; VA concurred with GAO's recommendations.

View [GAO-11-250](#) or key components. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

DOD AND VA HEALTH CARE

Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges

What GAO Found

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

The FRCP faces challenges in determining staffing needs, including managing FRCs' caseloads and deciding when VA should hire additional FRCs and where to place them. According to the FRCP Executive Director, appropriately balanced caseloads (size and mix) are difficult to determine because there are no comparable criteria against which to base caseloads for this program because of its unique care coordination activities. The program has taken other steps to manage FRCs' caseloads, including the use of an informal FRC-to-enrollee ratio. Because these methods have some limitations, the FRCP is developing a customized workload assessment tool to help balance the size and mix of FRCs' caseloads but has not determined when this tool will be completed. In addition, the FRCP has not clearly defined or documented the processes for making staffing decisions in FRCP policies or procedures. As a result, it is difficult to determine how staffing decisions are made, or how this process could be sustained during a change in leadership. Finally, the FRCP's basis for placing FRCs at DOD and VA facilities has changed over time, and the program lacks a clear and consistent rationale for making these decisions, which would help ensure that FRCs are located where they could provide maximum benefit to current and potential enrollees.

A key challenge facing the FRCP concerns limitations on sharing information needed to coordinate services for enrollees, who may be enrolled in multiple DOD and VA case management programs. These limitations are often blamed for duplication of services and enrollee confusion, prompting two military wounded warrior programs to cease making referrals to the FRCP. One such limitation existed because VA had not completed public disclosure actions necessary to enable the sharing of information from the FRCP's information system. In January 2011, VA completed the process needed to resolve this issue. In addition, incompatibility among information systems used by different case management programs limits data sharing. Although the ultimate solution to information system incompatibility is beyond the capacity of the FRCP to resolve, the program has initiated an effort to improve information exchange.

Contents

| | | |
|---------------------|---|-----------|
| Letter | | 1 |
| | Background | 5 |
| | Problems Identifying Potential Enrollees and Reviewing Enrollment Decisions Make It Unclear Whether Those Needing FRCP Services Are Enrolled | 9 |
| | The FRCP Faces Challenges in Determining Staffing Needs and Has Not Clearly Defined or Documented Its Processes for Managing FRCs' Caseloads, Making Staffing Decisions, and Placing FRCs | 13 |
| | The FRCP Faces Challenges That Limit Its Ability to Coordinate Care but Is Taking Steps to Address Them | 20 |
| | Conclusions | 28 |
| | Recommendations for Executive Action | 29 |
| | Agency Comments and Our Evaluation | 30 |
| Appendix I | The Use of Software to Analyze Testimonial Evidence | 34 |
| Appendix II | Comments from the Department of Defense | 35 |
| Appendix III | Comments from the Department of Veterans Affairs | 36 |
| Appendix IV | GAO Contact and Staff Acknowledgments | 40 |
| Tables | | |
| | Table 1: Demographic Information of Federal Recovery Coordination Program (FRCP) Enrollees as a Percentage of FRCP Enrollment, September 2010 | 6 |
| | Table 2: Description of Selected Federal Recovery Coordinator (FRC) Activities | 7 |
| | Table 3: Diagnoses of Federal Recovery Coordination Program (FRCP) Enrollees, September 2010 | 8 |

| | |
|---|----|
| Table 4: Characteristics of Major Department of Defense (DOD) and Department of Veterans Affairs (VA) Programs for Seriously and Severely Wounded Servicemembers and Veterans | 21 |
|---|----|

Figure

| | |
|--|----|
| Figure 1: Location and Number of Federal Recovery Coordinators (FRC), September 2010 | 18 |
|--|----|

Abbreviations

| | |
|------|---------------------------------------|
| DOD | Department of Defense |
| FRC | Federal Recovery Coordinator |
| FRCP | Federal Recovery Coordination Program |
| OEF | Operation Enduring Freedom |
| OIF | Operation Iraqi Freedom |
| VA | Department of Veterans Affairs |

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United States Government Accountability Office
Washington, DC 20548

March 23, 2011

Congressional Requesters

In 2007, in response to critical media reports of deficiencies in the provision of outpatient services at Walter Reed Army Medical Center, various review groups investigated the challenges that the Departments of Defense (DOD) and Veterans Affairs (VA) faced in providing care to recovering servicemembers. The review groups cited common areas of concern, including case management, which helps ensure continuity of care by coordinating services from multiple providers and guiding transitions between providers or agencies or back to the civilian community. One of these review groups, the President's Commission on Care for America's Returning Wounded Warriors—commonly referred to as the Dole-Shalala Commission—issued a report¹ that noted that while the military services did provide case management, some servicemembers were being assigned multiple case managers, having no single person to monitor and coordinate their activities, which often resulted in confusion, redundancy, and delay. To address these shortcomings, the commission recommended strengthening the continuity of care for recovering servicemembers through the use of individualized recovery plans that would be developed and monitored by skilled recovery coordinators who would have the ability to operate across departments. In response, the joint DOD and VA Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) developed the Federal Recovery Coordination Program (FRCP) to assist severely wounded Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) servicemembers, veterans, and their families with access to care, services, and benefits.² The FRCP was envisioned to serve severely wounded, ill, or injured servicemembers and veterans,³ including those who had suffered

¹President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007).

²OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations. Since September 1, 2010, OIF is referred to as Operation New Dawn.

³The FRCP defines severely wounded, ill, and injured individuals as those who, because of their physiological or psychological disease or condition, or a mental disorder, require ongoing medical care, exhibit impaired ability to function independently in their community, are vulnerable and whose personal safety is highly at risk, and require informal and formal support for maintenance of health and safety.

traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairment, and post-traumatic stress disorder. (In this report, we use “severely wounded” to denote severely wounded, ill, and injured servicemembers and veterans, as appropriate.) According to VA officials, the number of severely wounded servicemembers in the OEF/OIF conflicts is not known with certainty because “severely wounded” is not a categorical designation used by DOD or VA medical or benefits programs. Estimates of the size of the severely wounded population vary, depending on definitions and methodology.

Although the FRCP is the first care coordination program jointly developed by DOD and VA, it is but one of several recently introduced or revised programs intended to improve the continuity of care for wounded servicemembers and veterans. Other programs include the wounded warrior programs operated by the military services;⁴ VA’s OEF/OIF Care Management Program; and DOD’s Recovery Coordination Program, which is separately implemented and managed by each military service. However, the FRCP was intended to complement rather than duplicate the efforts of clinical and nonclinical case management programs in both DOD and VA through the use of senior-level coordinators called Federal Recovery Coordinators (FRC). Unlike case managers, FRCs are intended to be *care coordinators* whose planning, coordination, monitoring, and problem-resolution activities encompass both health services and benefits provided through DOD, VA, other federal agencies, states, and the private sector. Care coordination programs⁵ are typically more comprehensive in scope than clinical or nonclinical case management programs, and care coordinators, such as FRCs, may serve as a link between multiple case managers. The FRCs strive to work with each enrollee to create a comprehensive Federal Individual Recovery Plan to identify his or her goals and subsequently to coordinate and monitor the clinical and nonclinical services needed to achieve the enrollee’s goals—interacting with the enrollee for a lifetime if necessary. The FRCP is administered by VA, and the FRCs are VA employees.

⁴The military wounded warrior programs are the Army Wounded Warrior Program, Marine Wounded Warrior Regiment, Navy Safe Harbor, Air Force Warrior and Survivor Care Program, and Special Operations Command’s Care Coalition.

⁵According to the National Coalition on Care Coordination, care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator.

An evaluation of the FRCP during the program's initial implementation phase identified a number of challenges facing the program, including the determination of appropriate staffing levels for FRCs.⁶ This evaluation noted that staffing levels were difficult to determine, given the absence of a widely accepted estimate of the size of the severely wounded population. In addition, the FRCs' unprecedented care coordination role and work activities meant that it was not known how many FRCs would be required to address the needs of enrollees. This evaluation also noted that the program should consider future FRC placement in response to the expected increase in the number of enrollees, who could be located in different parts of the country.

Since beginning operation in January 2008, the FRCP has grown considerably, but the program experienced turmoil in its early stages. At the time of the program's introduction, eight FRCs were placed at three military treatment facilities—Walter Reed Army Medical Center, National Naval Medical Center, and Brooke Army Medical Center. However, within the first 7 months of its implementation, six of the original eight FRCs left the program, VA moved oversight of the program directly under the VA Secretary, and the FRCP Executive Director was replaced in July 2008. Under the new Executive Director, the FRCP enlarged its staff, increased the number of enrollees, and expanded the number of locations where FRCs are assigned. As of September 2010, the program employed 20 FRCs, who were serving about 600 servicemembers and veterans. These FRCs were located at six military treatment facilities, three VA medical centers, and the headquarters of one military service's wounded warrior program. While the FRCs are physically located at certain facilities, their enrollees are scattered throughout the country and may not be receiving care at the facility where their assigned FRC is located.

Our review of the FRCP is one in a series of engagements focused on the continuity of care for recovering servicemembers and veterans, which resulted from requests from multiple congressional requesters. In light of continued concerns about DOD's and VA's efforts to support servicemembers and veterans, this report examines (1) whether servicemembers and veterans who need FRCP services are being identified and enrolled in the program, (2) staffing challenges confronting

⁶Booz Allen Hamilton, *Federal Recovery Coordination Program, Draft Program Evaluation Report for Phase I: November 2007 - April 2008* (McLean, Va.: 2008).

the FRCP, and (3) the challenges facing the FRCP in its efforts to coordinate care for severely wounded servicemembers and veterans.

To address these objectives, we conducted more than 170 interviews of the following groups: FRCs; FRCP leadership, which includes the Executive Director, the Deputy Director for Health, and the Deputy Director for Benefits; leadership officials with DOD and VA case management programs (collectively referred to as program officials), including leadership officials from each military service's wounded warrior program; and medical facility directors and staff at DOD and VA medical facilities (referred to as medical facility staff). We interviewed the FRCs individually to learn about challenges they have encountered, using comprehensive interviews of the 15 FRCs who were working in the FRCP in or before December 2009 and limited interviews of the 5 FRCs who were hired in January 2010. To develop an understanding about how clinical and nonclinical officials and staff interact with the FRCs, we conducted site visits and telephone interviews with program officials at DOD and VA headquarters and medical facility staff at the DOD and VA medical facilities where FRCs are located. These facilities included Walter Reed Army Medical Center; National Naval Medical Center; Brooke Army Medical Center; Naval Medical Center-San Diego; Naval Hospital Camp Pendleton; Eisenhower Army Medical Center; and the VA medical centers in Houston, Texas; Providence, Rhode Island; and Tampa, Florida. In addition, we visited three VA medical centers with which FRCs have significant interaction—the facilities in Richmond, Virginia; Augusta, Georgia; and San Diego, California. We performed content analysis of the qualitative information obtained from the FRCs, DOD and VA program officials, and medical facility staff by grouping their responses by topic and then identifying response patterns. Content analysis of qualitative information obtained from DOD and VA program officials and medical facility staff was conducted using a software package,⁷ which enabled us to analyze responses to specific interview topics for a large number of interviews. (See app. I for a discussion of how we used the software package.) However, the results from our site visits and interviews cannot be generalized because while all DOD and VA facilities could potentially interact with FRCs, our review focused on facilities where FRCs are located as well as some facilities where FRCs have significant interaction. In addition, we obtained and reviewed documentation related to the

⁷We used a data analysis computer software package designed to organize and analyze complex nonnumerical or unstructured data.

FRCP, including VA's October 2009 handbook on care management of OEF and OIF Veterans; the *FRCP Standard Operating Procedures*; the FRCP fiscal year 2010 operating plan; and draft FRCP procedures, such as the VA handbook on the FRCP.

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

Background

Servicemembers wounded in recent conflicts are surviving injuries that would have been fatal in past conflicts, in part because of advanced protective equipment and medical treatment. However, the severity of their injuries can result in a lengthy transition from patient status back to active duty or to veteran status. Most severely wounded servicemembers from the conflicts in Iraq and Afghanistan initially are evacuated to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to military treatment facilities in the United States, with most of the severely wounded admitted to Walter Reed Army Medical Center, the National Naval Medical Center, or Brooke Army Medical Center.

Acute medical treatment and stabilization is the first of three phases in the "continuum of care" experienced by severely wounded servicemembers. The second phase of the continuum is rehabilitation at a DOD, VA, or civilian facility. (The recovery needs of some servicemembers receiving rehabilitation may require their return to a medical center for acute medical care, such as surgical procedures.) The third phase of the continuum is reintegration—either return to active duty or to the civilian community as a veteran, where they may receive health care from DOD, VA, or civilian providers.

FRCP Enrollees

From January 2008—when FRCP enrollment began—through September 2010, the FRCP provided services to a total of 1,268 servicemembers and veterans.⁸ As of September 2010, the program had 607 active enrollees, ranging in age from 19 to 61 years, with a median age of 27 years. About half of the enrollees were or had been married. Fifty-eight percent had designated another person as his or her primary caregiver, and 38 percent had delegated legal authority to another person. (See table 1 for additional demographic information about current FRCP enrollees.)

Table 1: Demographic Information of Federal Recovery Coordination Program (FRCP) Enrollees as a Percentage of FRCP Enrollment, September 2010

| Enrollee's branch of service | | Duty status | | Gender | | Treatment status | |
|------------------------------|---------------------|-------------|------------|--------|------------|------------------|------------|
| Army | 56 percent | Active duty | 57 percent | Male | 94 percent | Outpatient | 77 percent |
| Marines | 29 percent | Veteran | 43 percent | Female | 6 percent | Inpatient | 23 percent |
| Navy | 9 percent | | | | | | |
| Air Force | 6 percent | | | | | | |
| Coast Guard | Less than 1 percent | | | | | | |

Source: GAO analysis of FRCP data.

Note: Totals may not equal 100 percent because of rounding.

FRC Activities

FRCs are senior-level registered nurses and licensed social workers whose principal role is to coordinate services with case managers rather than provide services directly to enrollees. FRCs are expected to serve as the single point of contact for the enrollees and their families and to assist the enrollees in a number of ways. FRCP care coordination guidelines identify FRC activities, which are outlined in table 2.

⁸In addition to active enrollees in the FRCP, this number includes individuals who were evaluated for the program but were not enrolled (in which case the FRCs provided temporary assistance to the individual, redirected the individual to another program, or both) and enrollees who were deactivated from the program because they could not be contacted, no longer required FRCP services, or had died.

Table 2: Description of Selected Federal Recovery Coordinator (FRC) Activities

| Activity | Description |
|--|---|
| Referral | Receiving notification of or identifying potential Federal Recovery Coordination Program (FRCP) enrollees and contacting them |
| Evaluation | Conducting an evaluation of need and whether the servicemember or veteran meets FRCP eligibility criteria; individuals who are referred to but not enrolled into the FRCP may be counseled about alternative sources of support (“redirected”) or provided with short-term services to address a specific issue (an “assist”) |
| Enrollment | Determining that a servicemember or veteran meets eligibility criteria and would benefit from care coordination, and enrolling that individual in the FRCP |
| Creation of Federal Individual Recovery Plan | Developing an individualized plan for each FRCP enrollee |
| Documentation | Entering enrollee information and Federal Individual Recovery Plan into the FRCP data management system, known as the Veterans Tracking Application; FRCs use the Veterans Tracking Application to record subsequent actions taken on an enrollee’s behalf |
| Communication | Contacting enrollee or family at least every 30 days, unless otherwise negotiated |
| Coordination | Identifying, communicating with, and coordinating with providers and case managers from federal, state, local, and private organizations, based on the needs of enrollees |
| Monitoring | Monitoring the enrollee and goal achievement as contained in the Federal Individual Recovery Plan; modifying the Federal Individual Recovery Plan over time in response to enrollee’s changing needs |
| Deactivation | Changing enrollment status to “inactive” in the event that an enrollee dies, no longer needs or desires assistance, or is nonresponsive to FRC communications; otherwise, care coordination may continue over an enrollee’s lifetime |

Source: FRCP handbook (in draft).

According to FRCP policy, the FRC’s primary responsibility is to develop and monitor progress of each enrollee as detailed in that person’s Federal Individual Recovery Plan, which is created and implemented by the FRC with input from the enrollee and his or her family and clinical team. This plan is to be a comprehensive, client-centered plan that sets individualized goals for recovery and is intended to guide and support the enrollee through the continuum of care. FRCs update Federal Individual Recovery Plans to reflect changing conditions or enrollee goals.

Based on their diagnoses and other factors, enrollees are likely to require a complex array of clinical and nonclinical services from multiple providers and facilities. (See table 3.) In providing care coordination services, the FRC may engage with an enrollee’s health care providers, other care coordinators, and case managers, such as those with the military services’

wounded warrior programs. As care coordinators, FRCs are generally not expected to directly provide the services needed by enrollees. However, FRCs may provide services directly to enrollees in certain situations, such as when they cannot determine whether a case manager has taken care of an issue for an FRCP enrollee, when asked to resolve complex problems, or when making complicated arrangements, for example, identifying and arranging admission to a substance abuse treatment program for a veteran who was beginning to develop violent behaviors and had refused to complete a VA drug rehabilitation treatment program.

Table 3: Diagnoses of Federal Recovery Coordination Program (FRCP) Enrollees, September 2010

| Diagnoses | Percentage of enrollees |
|--------------------------------|--------------------------------|
| Traumatic brain injury | 54 |
| Psychological diagnosis | 43 |
| Orthopedic injury | 25 |
| Amputation | 20 |
| Spinal cord injury | 19 |
| Vision loss | 15 |
| Medical diagnosis ^a | 13 |
| Burn | 9 |
| Chest injury | 9 |
| Hearing loss | 9 |
| Intra-abdominal injury | 9 |
| Other ^b | 25 |

Source: GAO analysis of FRCP data.

Note: These diagnoses may not represent each enrollee's primary medical diagnosis. Additionally, approximately 70 percent of FRCP enrollees have more than one diagnosis.

^a“Medical diagnosis” includes diagnoses such as stroke, heart attack, and cancer.

^b“Other” includes diagnoses not otherwise covered in the table, such as anoxic brain injury and inhalation injury.

Problems Identifying Potential Enrollees and Reviewing Enrollment Decisions Make It Unclear Whether Those Needing FRCP Services Are Enrolled

It is unclear whether all of the eligible “severely wounded, ill, and injured” servicemembers and veterans who could benefit from the FRCP are being enrolled in the program. The FRCP cannot readily identify these individuals because the “severely wounded, ill, and injured” classification is not captured in existing data sources. Additionally, the program’s broad eligibility criteria cannot be used systematically to identify potentially eligible servicemembers and veterans. Instead, the FRCP must rely on referrals from others to identify these individuals, although the program has also taken steps to identify potential enrollees through the FRCs’ efforts at medical facilities and through a “look back” initiative to identify eligible veterans who were wounded prior to program implementation. In addition, the FRCs must exercise judgment in applying the program’s criteria for enrollment determinations, and FRCP leadership does not systematically review these decisions to ensure that these criteria are applied appropriately so that referred individuals who could benefit from the program are enrolled, and that individuals who could be served by less intensive services are referred to other programs.

The FRCP’s Potential Enrollee Population Cannot Be Readily Identified from Existing Data Sources, but the FRCP Has Taken a Number of Steps to Identify Potentially Eligible Individuals

FRCP officials have experienced difficulties in identifying the potentially eligible population of “severely wounded, ill, or injured” servicemembers and veterans, and as a result, it is unclear whether all of these individuals who could benefit from care coordination services are enrolled in the program. The Senior Oversight Committee, which created the FRCP, developed a three-level care categorization system to differentiate the population of wounded servicemembers and veterans for different programs based on the severity of their conditions. In this system,

- Category 1 servicemembers are those with *mild* wounds, illnesses, or injuries who are expected to return to duty in less than 180 days;
- Category 2 servicemembers are those with *serious* wounds, illnesses, or injuries who are unlikely to return to duty in less than 180 days and possibly may be medically separated from the military; and
- Category 3 servicemembers are *severely* wounded, ill, or injured individuals whose medical conditions are highly likely to prevent their return to duty and also likely to result in medical separation from the military.

Individuals who fall under category 3 may be considered for enrollment into the FRCP, while individuals falling under categories 1 or 2 may qualify for other types of programs. However, according to the FRCP Executive

Director, these are administrative categories that are not captured in existing VA or DOD medical or benefits data systems or included in medical or benefits records. As a result, the FRCP cannot use this classification to systematically identify the population of potentially eligible severely wounded servicemembers and veterans using available data sources. In addition, the FRCP Executive Director and FRCs told us that the broad eligibility criteria developed for the FRCP must be used on a case-by-case basis to identify potentially eligible individuals for the program because these criteria require some judgment. Therefore, the criteria cannot be used systematically to identify the program's potentially eligible population. These criteria include both specific medical diagnoses and requirements that are somewhat subjective, such as whether an individual may benefit from a recovery plan. To decide whether potential enrollees may benefit from a recovery plan, FRCs reported that they evaluate the complexity of a situation by examining issues such as future medical needs, family dynamics, and any financial or legal problems—information that is not readily available in any one data source.

As a result, to identify potentially eligible individuals, the FRCP relies on referrals from others, including program officials and medical facility staff. Sources of referrals include, for example, wounded warrior program staff, Recovery Care Coordinators, and clinical treatment teams. Of the program officials and medical facility staff we spoke with who discussed referrals, more than half (25 of 47) had made a referral to the program. However, more than half (15 of 27) of the program officials and medical facility staff we interviewed who responded to questions on eligibility also felt that the FRCP eligibility criteria were unclear.⁹ In addition to relying on referrals, the FRCs also take steps to identify potential enrollees. Some FRCs stated that they review their facility's list of incoming severely wounded servicemembers and attend weekly multidisciplinary team meetings where hospital officials and medical staff discuss severely wounded patients' cases.

In an attempt to ensure that eligible veterans who were wounded prior to the program's inception are enrolled in the program, the FRCP conducted a "look back" initiative in May 2010. Because no single data source contains sufficient information, the FRCP Executive Director told us that she combined five DOD and VA data sets and used multiple "proxy"

⁹The denominators for these numbers are different because not all of the program officials and medical facility staff we interviewed responded to every question.

factors to narrow the data from 40,000 veterans' records to the final list of potentially eligible veterans. For example, the Veterans Benefits Administration's 100 percent disability compensation list and medical diagnostic codes were used to help identify this population. Based on this analysis, the FRCP Executive Director reported that the program contacted approximately 300 potential enrollees to determine whether they could benefit from an FRC's assistance. As a result, 35 of those severely wounded veterans will be further evaluated for potential enrollment.

According to the FRCP Executive Director, this analysis was prioritized to focus on severely wounded veterans who were most likely to need FRC assistance. The Executive Director told us that, as a result, the list was not comprehensive—for example, the program did not contact veterans who were already enrolled in VA's OEF/OIF Care Management Program under the assumption that they were already receiving adequate case management. Additionally, the FRCP Executive Director told us that identifying 35 veterans indicated that the FRCP is not reaching all potentially eligible veterans through its normal referral process or that information about the program is not reaching severely wounded veterans. The FRCP Executive Director added that once it is complete, this effort will be assessed to determine whether another "look back" is needed, but as of February 2011, leadership officials had not yet determined whether they would conduct a subsequent "look back."

Enrollment Decisions Require FRC Judgment, and FRCP Leadership Does Not Systematically Review These Decisions to Ensure That Referred Individuals Who Could Benefit Are Enrolled

Following the identification of potentially eligible servicemembers and veterans, FRCs use a more thorough application of the program's eligibility criteria to evaluate these individuals for enrollment. The eligibility criteria are broad and require FRCs to exercise judgment with their enrollment decisions. However, FRCP leadership does not systematically review these decisions to ensure that referred individuals who could benefit from the program are enrolled while those requiring less intensive services are referred to other programs.

Eligibility criteria for the program—developed by the Senior Oversight Committee—specify that enrollees

- be receiving acute care in a military treatment facility;
- be diagnosed or referred for one or more of the following: spinal cord injury, burns, amputation, visual impairment, traumatic brain injury, or post-traumatic stress disorder;

-
- be considered at risk for psychosocial complication; or
 - may benefit from a recovery plan.

Because some of these criteria are subjective, particularly whether an individual is at risk for psychosocial complications or would benefit from a recovery plan, the FRCs must use their judgment when deciding whether an individual should be enrolled in the program. According to the FRCP Executive Director, the program's criteria are intended to provide guidance for the FRCs, giving them the flexibility to enroll severely wounded servicemembers and veterans, rather than being restrictive. The Executive Director added that FRCs strive to enroll severely wounded servicemembers and veterans in cases where having an FRC can add value to existing case management efforts.

To evaluate servicemembers and veterans for program eligibility, FRCs must make subjective assessments of the impact their care coordination efforts could have on potential enrollees. This involves FRCs making assessments of the severity of potential enrollees' medical conditions to determine future medical needs—such as rehabilitation—and nonmedical issues—such as caregiver status. FRCs obtain information from a number of sources, including DOD and VA medical records, as well as records from private sector providers. They may also discuss potential enrollees' situations with members of multidisciplinary teams providing medical treatment, family members, and the potential enrollees. At the end of the evaluation period, the FRC will consider a potential enrollee's need for care coordination based on the collected information and determine whether the individual should be enrolled in the program, provided temporary assistance, or referred to another program.

While it is necessary for FRCs to use their judgment in making enrollment decisions, the FRCP does not systematically review the factors and reasons for enrolling, providing temporary assistance, or referring potentially eligible servicemembers and veterans to other programs. Systematic review could involve the use of a defined protocol for the review of eligibility decisions made by FRCs. According to federal internal control standards,¹⁰ agencies should establish ongoing internal control activities to provide reasonable assurance that decisions are consistent

¹⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

with applicable criteria—in this case, criteria designed to ensure that those in need of care coordination services are enrolled in the program. While the FRCs indicate in their data management system—the Veterans Tracking Application—whether they decided to enroll an individual, FRCP leadership told us they do not require that the FRCs record the factors they considered to support this decision. Additionally, FRCP leadership told us that while they closely review all enrollment decisions made by new FRCs, they do not perform similar reviews of decisions made by more experienced FRCs. Instead, FRCP leadership and experienced FRCs discuss the FRCs’ recommended actions on newly referred individuals as part of weekly telephone conversations. However, FRCP officials acknowledged that these discussions with the FRCs may not be comprehensive and that there is no section in the Veterans Tracking Application dedicated to recording these discussions. Without specific documentation of the factors the FRCs considered when making their enrollment decisions and absent internal controls and systematic oversight of much of the enrollment process, it is difficult to determine whether severely wounded servicemembers and veterans who are referred and could benefit from the program are actually enrolled and severely wounded servicemembers and veterans who could be served by less intensive services are referred to other programs. Additionally, this issue could become even more problematic as the program’s enrollment continues to increase and FRCP leadership has to review more enrollment decisions.

The FRCP Faces Challenges in Determining Staffing Needs and Has Not Clearly Defined or Documented Its Processes for Managing FRCs’ Caseloads, Making Staffing Decisions, and Placing FRCs

Several challenges confront the FRCP in determining staffing needs for the program, including how to manage FRCs’ caseloads, deciding when VA should hire FRCs, and determining where to place them in the field to best serve current and potential enrollees. The FRCP has not established a formal caseload size for FRCs because there are no comparable criteria upon which to determine caseload size because of the program’s unique care coordination activities. Also, while establishing an appropriate caseload size for FRCs may help FRCP leadership determine how many FRCs VA should hire, it remains difficult for FRCP leadership to determine when VA should hire FRCs. Finally, the FRCP lacks a clear and consistent rationale for making decisions about where to place FRCs in the field.

FRCs Have Expressed Concerns about Heavy Caseloads, and the FRCP Is Developing a Workload Assessment Tool That Should Help Address This Concern

The FRCs we spoke with expressed concerns about the high number of enrollees assigned to them and cited the need for improved caseload management. Specifically, 11 of the 15 FRCs we interviewed¹¹ identified inadequate caseload management as a concern. Eight of these FRCs expressed concerns about the large number of cases assigned to them. As of September 30, 2010, FRCs' caseloads ranged from 25 to 48, with two-thirds of the FRCs (10 of 15) having caseloads that exceeded the informal target ratio of 1 FRC for every 30 enrollees established by the FRCP Executive Director to manage FRC caseloads. Some FRCs told us that the large number of cases required them to work long hours and sometimes forced them to limit the amount of time that they could devote to an enrollee. In addition, more than half of the FRCs (8 of 15) expressed concerns that FRCP leadership does not adequately account for the services required by existing enrollees in their caseloads when assigning new cases. For example, one FRC told us that the types of cases assigned to her were stressful. She indicated that she had been assigned two enrollees with terminal conditions because she was skilled at managing the issues related to these types of cases, but she is now reluctant to take another terminally ill enrollee because it is emotionally draining to deal with end-of-life issues. However, an FRCP leadership official told us that FRCs have the flexibility to forward a referral to the FRCP central office for assignment to another FRC as a means of managing their existing caseloads.

According to the FRCP Executive Director, an appropriate caseload is difficult to determine because care coordination is a new type of function, and there are no comparable criteria against which to measure and base caseload size for this program because of its unique activities. Additionally, the FRCs' caseloads are dynamic in that the needs of each enrollee differ and may change over time. For example, out of a caseload of 30 clients, 5 may need intensive crisis management, while the remaining 25 enrollees may only need periodic contact or limited services. However, as noted by FRCP leadership and some FRCs, the needs of these enrollees, and consequently, the time required of an FRC, may change as enrollees move through different stages of the continuum of care.

¹¹This information was obtained from comprehensive interviews with the 15 FRCs who were working in the FRCP in or before December 2009.

As a means of managing FRCs' caseloads, the FRCP Executive Director cited two actions in particular that FRCP leadership uses to assess and manage FRC caseloads.

- FRCP leadership uses an informal FRC-to-enrollee target ratio of 1 to 30 (with a targeted range of 25 to 35 enrollees per FRC), which is based on the FRCP Executive Director's experience in managing the program over time.
- Weekly telephone calls with each FRC are used by FRCP leadership to discuss issues related to their assigned cases and to gauge workload burden.

The FRCP Executive Director told us that the program is developing a customized workload assessment tool to help balance FRCs' caseloads—in other words, to ensure that an FRC's caseload mix is manageable. The objective of the workload assessment tool is to identify specific enrollee characteristics, such as medical diagnosis, and to correlate each characteristic with the amount of time an FRC would be required to spend on addressing issues related to it. One method being considered is the assignment of a point value to each identified enrollee characteristic. Adding up the number of points for the characteristics of all enrollees in an FRC's caseload would provide an estimate of that FRC's workload burden. However, according to the FRCP Executive Director, the development of such a tool has been difficult, primarily because the enrollee characteristics that existing workload assessment tools use to determine how much time it takes to address an issue are not relevant to the care coordination activities that FRCs perform. As a result, program leadership continues to consider different methods of assessing FRCs' workloads, including measurement tools that have already been validated for other purposes, to identify a method that could potentially be relevant for the program. The FRCP Executive Director is uncertain how long it will take to develop a workload assessment tool and has not established timelines to complete this effort. Without a workload assessment tool, the program does not have the data it needs to develop a more comprehensive caseload management strategy and to better determine appropriate caseload size for FRCs.

FRCP Staffing Decisions Are Based on Ongoing Program Monitoring Efforts, but This Process Has Not Been Clearly Defined or Documented

While establishing appropriate FRC caseloads should help FRCP leadership better determine how many FRCs VA should hire, determining when VA should hire FRCs has been another staffing challenge. Currently, the FRCP Executive Director's decisions about when VA should hire FRCs are based on various ongoing monitoring efforts. The FRCP Executive Director told us that staffing decisions regarding FRCs are difficult to make because the FRCP cannot predict the number of potentially eligible servicemembers and veterans, which is affected by the OEF/OIF conflicts. In the absence of being able to project the number of potentially eligible servicemembers and veterans, the FRCP Executive Director said she uses other methods to predict future trends and guide the staffing process. One method involves monitoring FRCs' workloads as an indicator that workload levels are increasing and new FRCs are needed. In this regard, the FRCP Executive Director told us that FRCP leadership conducts weekly telephone calls with each FRC to discuss issues related to their caseloads. The FRCP Executive Director told us that another method she uses to predict staffing needs is through the analysis of the number of new referrals and enrollment rates in the program, which she uses to create a quarterly report that highlights the projected number of FRCs that the program may need. For example, the average number of new referrals grew from 25 a month in 2008 to 35 a month in 2009. VA hired five FRCs in January 2010 in part because of this increase in the number of referrals and the expected resulting increase in the number of enrolled servicemembers and veterans. The FRCP Executive Director told us that the referral data collected in 2010 show that the number of new referrals continued to increase and averaged 50 a month, which indicates a continuing need for more FRCs. According to the FRCP Executive Director, she routinely shares this information with the Secretary of Veterans Affairs as advance notice that a request for additional FRCs may be forthcoming because it takes about 6 months for VA to hire a new FRC. The FRCP Executive Director told us that the program's ongoing monitoring efforts are the most logical approach for determining when and how many FRCs VA should hire in the absence of knowing the number of potentially eligible servicemembers and veterans.

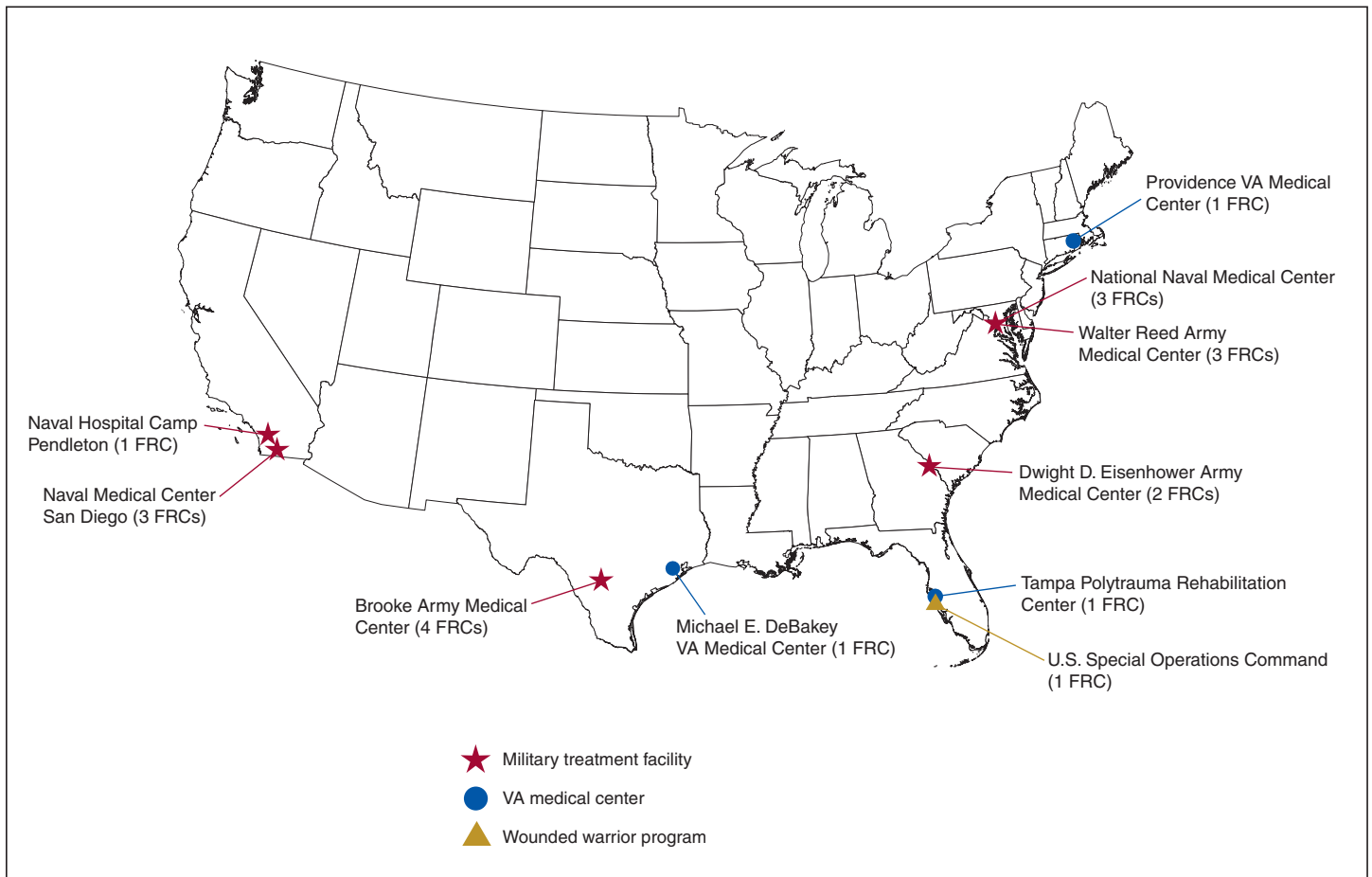
While these methods appear to be reasonable given the lack of overall data on the numbers of severely wounded servicemembers and veterans, the staffing process is not well documented. Internal control standards applicable to all federal agencies state that an agency should effectively communicate its policies and procedures by providing clear documentation that is readily available for examination. Consistent with this internal control standard, we would expect the FRCP to have

documented procedures outlining its process for making staffing decisions. FRCP leadership documented staffing projections for fiscal year 2010 in the program's annual operating plan, citing that ongoing analysis of referrals and enrollment rates was important in making those projections. However, the process used by program leadership—specifically how the referral and enrollment data are used in making staffing decisions—has not been clearly defined or documented in the operating plan or any of the other program policies or procedures. By documenting this information, the FRCP would have greater assurance that the process developed by the current leadership will be maintained during management changes.

The FRCP Lacks a Clear and Consistent Rationale for Making FRC Placement Decisions

Deciding where to place FRCs to best serve current and potential enrollees' needs is another key staffing issue, despite the fact that FRCs often coordinate services for enrollees who are located throughout the country and may not be receiving care at the facility where their assigned FRC is located. The FRCP's basis for making decisions about where to place FRCs has varied over time, and the program currently lacks a clear and consistent rationale for making FRC placement decisions. As of September 2010, 20 FRCs were located at 10 facilities. (See fig. 1.)

Figure 1: Location and Number of Federal Recovery Coordinators (FRC), September 2010



Source: GAO, based on Federal Recovery Coordination Program data.

When the FRCP began operating in 2008, eight FRCs were placed at the three military treatment facilities where the majority of severely wounded servicemembers were receiving treatment. According to the FRCP Executive Director, the placement of FRCs at military treatment facilities helped with the identification of servicemembers who could benefit from FRCP services. In addition, some FRCs told us that being located at the military treatment facilities allowed them to develop relationships with the enrollees, their families, and the case managers who would be providing direct services to the enrollees. However, as the program expanded, placement of some FRCs was not based on a rationale or an analysis of where FRCs could provide the maximum benefit to severely wounded servicemembers and veterans. For example, some DOD and VA officials

we spoke with expressed concerns about the FRCP's placement decisions, particularly the placement of FRCs at facilities that do not treat a large population of severely wounded servicemembers or veterans. DOD officials told us that it was not clear why there were FRCs assigned to a military treatment facility that typically does not treat severely wounded servicemembers. Similarly, a VA medical center official stated that it was unclear why FRCs were initially placed at two VA medical centers that had few FRCP enrollees being treated there, rather than at VA medical centers where a significant number of severely wounded veterans may be receiving treatment. There was no official FRCP documentation that explained the basis for these decisions, which were made by FRCP officials who are no longer with the program.

After the FRCP leadership changed in July 2008, decisions to place FRCs have been based on several factors. According to the FRCP Executive Director, some placement decisions focused on ensuring that enough FRCs were in place to meet the demands of the FRCP workload by replacing FRCs who had left the program and by adding FRCs at facilities where only one FRC was located. She explained that where possible, it is helpful to have at least two FRCs at each facility so that there can be backup support, particularly for administrative purposes such as coverage, when an FRC is on leave. However, the FRCP Executive Director told us that more recently—from March 2010 through September 2010—FRC placement decisions have primarily been based on requests or recommendations from DOD and VA officials. For example, in June 2010, the FRCP relocated an FRC to a military wounded warrior program headquarters facility in response to a request from the program's director. FRCP officials have also decided to place some new FRCs at two VA medical centers where servicemembers and veterans with polytrauma injuries receive care, based on recommendations from DOD and VA officials.

The FRCP Executive Director explained that the FRCP had not established a systematic rationale for FRC placement because the program initially lacked the data upon which to base these determinations. Additionally, she told us that every placement of an FRC at a VA or DOD facility is a negotiation and depends on the facility's ability to accommodate an FRC, including the provision of work space and equipment. However, she told us that she and other FRCP leadership officials have begun to think about how to improve the FRCP's process for deciding where to place FRCs. In August 2010, the FRCP Executive Director explained that a planned update of the Veterans Tracking Application would collect additional information that would allow FRCP

officials to identify the location of individuals who refer potential enrollees.¹² She anticipates being able to use these data to identify the locations and facilities where the most referrals are being made. According to the FRCP Executive Director, this information along with other factors, such as placement recommendations from DOD and VA officials, could be used in making future placement decisions. However, as of December 2010, she had not established a specific time frame for this effort. Developing a clear and consistent rationale for placing FRCs, which includes a systematic analysis of program data, should help ensure that FRCs are located where they could provide the maximum benefit to current and potential enrollees.

The FRCP Faces Challenges That Limit Its Ability to Coordinate Care but Is Taking Steps to Address Them

FRCs and others identified challenges that can limit the FRCP's efforts to coordinate the services needed by severely wounded servicemembers and veterans. One challenge involves limitations on the FRCP's ability to share information with the large number of programs that provide care coordination and case management services to wounded servicemembers and veterans. These limitations—which are the result of restrictions on the disclosure of enrollee information and data systems' incompatibility—have sometimes resulted in confusion and the duplication of services for enrollees. Efforts by the FRCP to improve information sharing are ongoing. Another challenge is that FRCs often have difficulty obtaining resources from the facilities at which they are located—such as telephones, computers, and private office space—that they need to perform their care coordination activities, including communicating with enrollees across the country. This can affect the quality of services to enrollees, and the FRCP is working to resolve these logistical issues.

¹²In January 2011, the Veterans Tracking Application was successfully upgraded to be able to collect location information, according to an FRCP official.

Coordination among the FRCP and DOD and VA Case Management Programs Is Impeded by Limitations on Their Ability to Share Information, and Efforts to Address These Limitations Are Ongoing

Coordination among DOD and VA programs that provide care coordination and case management is difficult because of the large number of such programs that exist to address the needs of wounded servicemembers and veterans and the limitations in the ability of these programs to share information. Although these programs vary in terms of the severity of the injuries among the servicemembers or veterans they serve and the specific types of services they coordinate, many programs have similar functions. (See table 4.)

Table 4: Characteristics of Major Department of Defense (DOD) and Department of Veterans Affairs (VA) Programs for Seriously and Severely Wounded Servicemembers and Veterans

| Program | Severity of enrollees' injuries ^a | Title of care coordinator or case manager | Involvement in the continuum of care | | | | Type of services provided | | |
|---|--|--|--------------------------------------|-------|---------------|--------------------|---------------------------|-------------|---------------|
| | | | Acute care | Rehab | Reintegration | Lifetime follow-up | Clinical | Nonclinical | Recovery plan |
| VA/DOD Federal Recovery Coordination Program (FRCP) | Severe | Federal Recovery Coordinator (FRC) | √ | √ | √ | √ | √ | √ | √ |
| DOD Recovery Coordination Program | Serious | Recovery Care Coordinator | √ | √ | √ | √ | | √ | √ |
| Army Warrior Transition Units | Serious to severe | Triad of nurse case manager, squad leader, and physician | √ | √ | √ | | √ | √ | √ |
| Military wounded warrior programs ^{b,c} | Serious to severe | Case manager or Advocate (title varies by service) | √ | √ | √ | √ | | √ | √ |
| VA OEF/OIF Care Management Program ^d | Mild to severe | Case manager, Transition Patient Advocate ^e | f | √ | √ | √ | √ | √ | √ |

| Program | Severity of enrollees' injuries ^a | Title of care coordinator or case manager | Involvement in the continuum of care | | | | Type of services provided | | |
|---|--|---|--------------------------------------|-------|---------------|--------------------|---------------------------|-------------|---------------|
| | | | Acute care | Rehab | Reintegration | Lifetime follow-up | Clinical | Nonclinical | Recovery plan |
| VA Spinal Cord Injury and Disorders Program | Mild to severe | Nurse, social worker | √ | √ | √ | √ | √ | √ | √ |
| VA Polytrauma System of Care | Serious to severe | Social work and nurse case managers | ^f | √ | √ | √ | √ | √ | √ |

Source: GAO analysis of DOD and VA program information.

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

^aFor the purposes of this table, we have categorized the severity of enrollees' injuries according to the injury categories established by the DOD and VA Wounded, Ill, and Injured Senior Oversight Committee. Servicemembers with *mild* wounds, illness, or injury are expected to return to duty in less than 180 days; those with *serious* wounds, illness, or injury are unlikely to return to duty in less than 180 days and possibly may be medically separated from the military; and those who are *severely* wounded, ill, or injured are highly unlikely to return to duty and also likely to medically separate from the military. These categories are not necessarily used by the programs themselves.

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

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

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

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

^fAccording to VA, in some instances, patients are transferred to VA medical facilities while still in the acute phase of the care continuum and may receive services from VA care management or polytrauma program staff.

Many recovering servicemembers and veterans are enrolled in more than one program. For example, in September 2010, approximately 84 percent of FRCP enrollees were also enrolled in a military service wounded warrior program. According to one FRC, his enrollees have, on average, eight case managers who are affiliated with different programs. Individuals enrolled in multiple programs may have recovery plans or goals that have been developed by different programs. Moreover, some case managers of other programs consider themselves to be the single point of contact for their enrollees, even those enrolled in the FRCP. Because the majority of FRCP enrollees are enrolled in more than one program, there is a high likelihood that without adequate information exchange and coordination, FRCs and case managers could duplicate one another's efforts, confuse enrollees and families, waste resources, or mistakenly believe that

Information Disclosure
Requirements Limited the
FRCP's Information Sharing
with DOD's Wounded Warrior
Programs

someone else has taken care of a task for an enrollee. The extent of overlap and the lack of information sharing by the FRCP have prompted some programs to limit FRCs' involvement with servicemembers when they are receiving initial medical treatment at a military treatment facility. At two of the military treatment facilities we visited, for example, a military program serving wounded servicemembers delays referrals to the FRCP until a servicemember approaches the point when he or she is preparing to transition to another facility or VA.

Prior to January 2011, VA had not completed public disclosure actions necessary to enable the sharing of information from the Veterans Tracking Application, the information system used by the FRCP that contains each enrollee's personal information and Federal Individual Recovery Plan. As a result, VA management had advised the FRCP that the program could not provide staff of non-VA programs (such as those affiliated with DOD) with its enrollees' personally identifiable information, such as names, addresses, Social Security numbers, and details of Federal Individual Recovery Plans.¹³ Specifically, VA had not completed the System of Records Notification process for the Veterans Tracking Application, a process required by the Privacy Act of 1974¹⁴ that requires federal agencies to publish in the Federal Register a notice of the existence, purpose, and routine uses of every "system of records" that contains information that may be linked to individuals.¹⁵

Although this limitation did not prevent FRCs from performing their care coordination responsibilities, it has been a source of frustration for others. Specifically, officials of several of DOD's wounded warrior programs contend that the inability to receive enrollment information from the FRCP has caused difficulties. The director of one program, for example, told us that not having the names of servicemembers enrolled in the FRCP resulted in a situation in which an FRC and a wounded warrior program

¹³FRCs would be able to provide this information to staff of non-VA programs if they obtain the enrollees' written permission. However, FRCP officials stated that because it is not feasible to obtain such permission from each enrollee for logistical reasons, this procedure has not been introduced.

¹⁴See 5 U.S.C. § 552a(e)(4).

¹⁵The Privacy Act defines a "system of records" as a group of any records under the control of any federal agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or personal identifier assigned to the individual. 5 U.S.C. § 552a(a)(5). A "routine use" is a disclosure of a record for a purpose that is compatible with the purpose for which it was collected. 5 U.S.C. § 552a(a)(7).

DOD and VA Data System
Incompatibility Impedes
Information Sharing among the
FRCP and DOD's Wounded
Warrior Programs

Recovery Care Coordinator were not aware that the other was involved in coordinating care for the same servicemember and had unknowingly established conflicting recovery goals for this individual. In this case, a servicemember with multiple amputations was advised by his FRC to separate from the military in order to receive needed services from VA, whereas his Recovery Care Coordinator set a goal of remaining on active duty.¹⁶ These conflicting goals caused considerable confusion for this servicemember and his family. Furthermore, leadership officials of two of the military services' wounded warrior programs told us that they have instructed their staff not to make referrals to the FRCP to avoid confusion and potential duplication of activities, citing issues associated with information sharing.

In August 2010, prompted by the FRCP, VA initiated the public-disclosure process to facilitate information sharing. In December 2010, VA published a notice in the Federal Register that describes the compilation of information in the Veterans Tracking Application and routine uses of that information.¹⁷ VA received no comments on the notice during the public comment period, which ended on January 10, 2011. The new system of records became effective on that date and the FRCP was able to share certain enrollee information, such as the names of enrollees, with DOD programs.

Another factor that limits information sharing is the inability of the information systems used by the FRCP, the DOD Recovery Coordination Program, and the five military services' wounded warrior programs to exchange information directly with one another. As a result, FRCs cannot readily access information from data systems used by case management programs about their enrollees and information about an individual cannot be easily transferred among systems. To help address this issue, the FRCP has spearheaded an effort, known as the Information Sharing Initiative, to identify an approach for the direct exchange of information between DOD and VA care coordination and case management information systems in the future. The FRCP Executive Director explained that this initiative primarily includes identifying the data that need to be exchanged as well as identifying the data systems where these data originate and subsequently developing a technical solution to electronically exchange

¹⁶With the assistance of prosthetic devices, some amputees are able to return to active duty status.

¹⁷75 Fed. Reg. 76,784 (Dec. 9, 2010).

this information. Further, she noted that the Information Sharing Initiative is a grassroots effort and that work on the initiative has been performed by DOD and VA employees in addition to their normal duties, making a completion date difficult to estimate. An official from the Interagency Program Office, which oversees major information technology initiatives jointly undertaken by DOD and VA, said that the Information Sharing Initiative was a well-considered initial step but notes that the ultimate goal of direct information exchange among programs' information systems faces daunting challenges, such as resolving conflicting DOD and VA policies pertaining to information exchange. We have previously reported on DOD's and VA's efforts to electronically exchange health care information, including the departments' progress toward increasing their capabilities to share medical and nonmedical history and physical exam data.¹⁸ We have found that despite the departments' progress, their efforts to meet clinicians' evolving needs to exchange health information and to create a single lifetime electronic record for each servicemember, which is intended to streamline the transition of electronic records between the two departments, are ongoing.

Recognizing that these limitations on information sharing exist, the FRCP is also taking steps to emphasize FRCs' principal role of coordinating with case managers rather than providing services to enrollees themselves, which should help prevent unintentional duplication of effort. Because FRCs may provide a direct service in some instances, proper information sharing is necessary so that staff from multiple programs may not unknowingly perform the same task for an enrollee. For example, an FRC told us that in one instance there were five case managers working on the same life insurance issue for an individual. According to the FRCP Executive Director, the Federal Individual Recovery Plan process has been improved to encourage coordination by FRCs and also to reinforce their primary role as care coordinators. To accomplish these objectives, in January 2011 the FRCP upgraded the Veterans Tracking Application, in which Federal Individual Recovery Plans are maintained, by adding a record of the names of the case managers who are responsible for completing activities linked to enrollees' planning goals. In addition, the Veterans Tracking Application began displaying indicators to inform each

¹⁸For additional information, see GAO, *Electronic Health Records: DOD and VA Interoperability Efforts Are Ongoing; Program Office Needs to Implement Recommended Improvements*, [GAO-10-332](#) (Washington, D.C.: Jan. 28, 2010), and *Electronic Health Records: DOD and VA Efforts to Achieve Full Interoperability Are Ongoing; Program Office Management Needs Improvement*, [GAO-09-775](#) (Washington, D.C.: July 28, 2009).

FRC about the completion status of every goal-related activity planned for each enrollee, based on the completion dates that the FRCs put into the system. The FRCP Executive Director believes that such an indicator system, when linked to the names of the case managers who are responsible for completing the activities, will reinforce the FRCs' care coordination role by encouraging them to actively follow up with others on the status of individual tasks rather than taking on these tasks themselves.

FRCs Face Difficulties in Obtaining Access to Equipment, Technology Support, and Work Space at Their Medical Facilities, but FRCP Leadership Is Taking Steps to Remedy These Issues

FRCs and others identified several types of logistical problems that have affected the FRCs' ability to carry out their responsibilities in dealing with FRCP enrollees and coordinating with wounded warrior programs. These issues center around three specific areas: provision of equipment (such as computers, printers, landline telephones, and BlackBerrys), technology support (such as equipment maintenance, software upgrades, and systems security), and private work space at the medical facilities.

- **Provision of equipment.** Most of the FRCs' work is done using computers, accessing data management systems, and communicating with enrollees and DOD and VA facility staff by e-mail and phone. However, about half of the FRCs told us that they have been hindered in their ability to perform their care coordination responsibilities by the lack of appropriate technology resources at the facilities at which they work. Some FRCs expressed frustration with delays in obtaining appropriate computer or communications equipment when they first reported to their facilities, and this experience was echoed by nearly all of the FRCs hired in January 2010. For example, one FRC said she waited more than 6 weeks at the facility to receive a DOD computer and landline telephone. Another FRC reported that he has found that e-mail is an effective mode of communication with enrollees with traumatic brain injuries because he can provide detailed instructions to them, but when he was hired he did not receive a DOD computer and a landline telephone with long-distance calling capability for 8 months. Consequently, he had to resort to mailing letters and brochures to current and potential enrollees.
- **Technology support.** In addition to the lack of equipment, some FRCs cited the lack of technology support as a factor that hindered their care coordination activities. Technological support includes functions such as connectivity to information systems, installing security systems, and equipment upgrading and repair. An FRCP deputy director told us that the lack of such support is often experienced by new FRCs, but it is also an ongoing issue for many, especially after a facility computer system is upgraded and the FRCs' equipment becomes incompatible. Additionally,

several FRCs have had difficulty with their BlackBerrys, either because the facility was unable to install a security patch needed to access e-mails or because poor reception made the device unusable. Some FRCs also reported their inability to access DOD medical records (although this issue is beyond the scope of a single program to address)—for example, FRCs located at VA medical centers must ask FRCs at military treatment facilities to access enrollees' DOD records and then fax them to the FRCs at the VA medical centers. Finally, FRCP officials noted that equipment repair has been a problem for some FRCs—one FRC told us that she had to use a malfunctioning laptop computer issued to her by the local VA medical center for 8 months.

- **Work space.** Some FRCs noted that they had been assigned work space at the facility that was unsuitable for conducting sensitive conversations with enrollees, family members, and coworkers. At a major medical center, we observed that FRCs were located in tightly spaced cubicles that allowed nearby staff to easily overhear their conversations. A recently transferred FRC told us that when she arrived at her new medical center, she found that she had no office and had been located in an open room that serves as the call center for triage nurses. Lacking the privacy needed to make confidential calls to her enrollees, this FRC resorted to making sensitive phone calls from her car in the parking lot. At another treatment facility, an FRC who shared an office with staff from another program had to take phone calls with enrollees in the stairwell in order to have privacy. Finally, two recently hired FRCs were not only placed in the same office but also had to share the same desk.

The provision of equipment, technology support, and work space is covered by memoranda of agreement between the FRCP and the DOD and VA facilities where FRCs are located. However, an FRCP deputy director told us that obtaining compliance with the memoranda of agreement at some facilities is an ongoing challenge and that equipment maintenance and systems upgrades are persistent issues for all FRCs. In some instances, after FRCs had made repeated requests for needed resources without result, the FRCP Executive Director intervened with medical center officials or through the Senior Oversight Committee to obtain a resolution. A leadership official for a wounded warrior program told us that some military medical centers have difficulty satisfying requests for equipment and space from programs such as the FRCP because these facilities house and support various DOD and VA support programs and all make requests for resources. This official pointed out that at one military treatment facility, a military case manager was relocated in order to make an office available to an FRC. An FRCP deputy director added that given the frequent turnover of military staff, medical center officials are

sometimes unaware that their facility is responsible for providing resources and services to FRCs.

FRCP officials reviewed existing memoranda of agreement between the FRCP and DOD and VA medical facilities to determine where improvements could be made to ensure that the FRCs have the tools and privacy required to do their work. The program has developed three new templates for memoranda of agreement that will be used when FRCs are located in new settings: one each for military treatment facilities, VA medical centers where servicemembers and veterans with polytrauma injuries receive care, and military wounded warrior programs. These new memoranda are more detailed than the previous versions, and they identify who is responsible for providing specific resources and services. The FRCP is using the revised agreements in its negotiations for logistical support for newly placed FRCs at two VA medical centers and with the Special Operations Command wounded warrior program. Following implementation of the new memoranda of agreement, the FRCP plans to revise existing agreements to make them consistent with the newer versions, but no specific timetable has been established to complete these revisions.

Conclusions

Since its inception, the FRCP has increased the number of enrollees, enlarged its staff considerably, and expanded the number of locations where FRCs are assigned. However, the program faces significant challenges as it matures. As the first joint care coordination program for DOD and VA, the FRCP represents a new paradigm in patient support for the departments. Because of its unprecedented nature, the program cannot refer to preexisting data or policies and procedures to manage the program, and as a result, FRCP leadership had to develop management processes as the program was being implemented and has largely relied on informal processes to oversee and manage key aspects of the program. However, now that the program has been operating for several years and continues to grow, it has become apparent that the program would benefit from more definitive management processes to strengthen program oversight and decision making.

While the program has overcome some early setbacks and has established processes related to enrollment and staffing, these processes are not clearly documented or systematic. Because enrollment decisions are not well documented or systematically reviewed by FRCP leadership, it is unclear whether referred servicemembers and veterans who need FRC services are being enrolled in the program. Additionally, as the number of

individuals enrolled in the program steadily increases, it will be important for the FRCP to appropriately balance FRCs' workload to ensure that enrollees receive the services they need and to prevent FRC burnout. While program leadership recognizes this issue and is developing a customized workload tool, there is no firm timeline for the completion of this effort. The FRCP also needs clearly documented processes and criteria for guiding staffing and placement decisions. Without this, it will be difficult to provide continuity to subsequent program leadership and to place FRCs where they would best serve the needs of current and future enrollees.

Some of the daunting challenges facing FRCs and the program are beyond the capability of the program's leadership to resolve. The exchange of information among DOD and VA data systems, in particular, has been a long-standing issue and will require interdepartmental action. Similarly, the duplication of effort resulting from the proliferation and overlap of DOD and VA programs that support recovering servicemembers and veterans can best be resolved through interdepartmental coordination and action.

Recommendations for Executive Action

We recommend that the Secretary of Veterans Affairs direct the Executive Director of the FRCP to take four actions:

1. Ensure that referred servicemembers and veterans who need FRC services are enrolled in the program by establishing adequate internal controls regarding the FRCs' enrollment decisions. To accomplish this, the FRCP leadership should
 - require FRCs to record in the Veterans Tracking Application the factors they consider in making an enrollment decision,
 - develop and implement a methodology and protocol for assessing the appropriateness of enrollment decisions, and
 - refine the methodology as needed.
2. Complete development of the FRCP's workload assessment tool that will enable the program to assess the complexity of services needed by enrollees and the amount of time required to provide services to improve the management of FRCs' caseloads.

-
3. Clearly define and document the FRCP's decision-making process for determining when and how many FRCs VA should hire to ensure that subsequent FRCP leadership can understand the methods currently used to make staffing decisions.
 4. Develop and document a clear rationale for the placement of FRCs, which should include a systematic analysis of data, such as referral locations, to ensure that future FRC placement decisions are strategic in providing maximum benefit for the program's population.

Agency Comments and Our Evaluation

DOD and VA each provided comments on a draft of this report. In its comments, DOD stated that it continues to work with VA to fully integrate their efforts and to increase collaboration between the two departments. (DOD's comments are reprinted in app. II.) In its comments, VA stated that it generally agrees with GAO's conclusions and concurs with our recommendations to the Secretary. (VA's comments are reprinted in app. III.) VA's responses to each of our recommendations are as follows:

- To ensure that referred servicemembers and veterans who need FRC services are enrolled in the program, VA indicated that the FRCP will document decisions and factors used to assess a potential enrollee's eligibility for the program. In addition, the program will establish clear documentation requirements according to a defined protocol within the program's data management system.
- To complete the development of the FRCP's workload assessment tool, VA indicated that the FRCP will continue field-testing a new assessment tool, which will require at least a year to complete.
- To document the decision-making process for determining when and how many FRCs VA should hire, VA stated that the FRCP will clearly document the current process used for making staffing decisions. In addition, the staffing processes and plans will be updated annually in the FRCP business operation planning document.
- To develop and document a clear rationale for the placement of FRCs, VA indicated that the FRCP will develop an FRC placement strategy based upon a systematic analysis of data over the next 6 months. This process will be documented and updated annually in the FRCP business operation planning document.

VA provided an additional comment regarding the progress made toward the exchange of data between VA and DOD's wounded warrior information systems. VA stated that it anticipates that an initial set of data will be available for exchange between VA and DOD by the end of fiscal year 2011. The departments plan to expand the exchange of data to support improved collaboration on care plans in fiscal year 2012.

We are sending copies of this report to the Secretary of Defense and the Secretary of Veterans Affairs and other interested parties. The report also is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix IV.



Randall B. Williamson
Director, Health Care

List of Requesters

The Honorable John F. Tierney
Ranking Member
Subcommittee on National Security, Homeland Defense
and Foreign Operations
Committee on Oversight and Government Reform
House of Representatives

The Honorable Kirsten Gillibrand
United States Senate

The Honorable Jason Altmire
House of Representatives

The Honorable Bruce Braley
House of Representatives

The Honorable Kathy Castor
House of Representatives

The Honorable Yvette Clarke
House of Representatives

The Honorable Steve Cohen
House of Representatives

The Honorable Joe Courtney
House of Representatives

The Honorable Joe Donnelly
House of Representatives

The Honorable Keith Ellison
House of Representatives

The Honorable Gabrielle Giffords
House of Representatives

The Honorable Mazie Hirono
House of Representatives

The Honorable Hank Johnson
House of Representatives

The Honorable David Loebsack
House of Representatives

The Honorable Jerry McNerney
House of Representatives

The Honorable Chris Murphy
House of Representatives

The Honorable Ed Perlmutter
House of Representatives

The Honorable John Sarbanes
House of Representatives

The Honorable Heath Shuler
House of Representatives

The Honorable Albio Sires
House of Representatives

The Honorable Betty Sutton
House of Representatives

The Honorable Tim Walz
House of Representatives

The Honorable Peter Welch
House of Representatives

The Honorable John Yarmuth
House of Representatives

Appendix I: The Use of Software to Analyze Testimonial Evidence

To conduct a content analysis of our interviews with program officials and medical facility staff, we used a qualitative data analysis software package. The software facilitated our analysis of over 150 of the 170 interviews we conducted and helped us to identify and quantify interviewees' responses on various topics. The program's coding capabilities allowed us to group our interviewees' responses into categories. It also provided a centralized location where all of our documents could be reviewed and analyzed.

We took a number of steps to ensure that our analysis was methodologically sound. First, we defined categories to organize the views of the Department of Defense and the Department of Veterans Affairs program officials and medical facility staff by specific topics, including the Federal Recovery Coordination Program's (FRCP) eligibility criteria, the interviewees' interactions with the Federal Recovery Coordinators (FRC), overlap and duplication of activities among the FRCP and the case management programs with which the FRCs interacted, knowledge of the FRC role, and challenges faced by the FRCs. These categories were chosen based on themes we heard during our interviews with the program officials and medical facility staff. We conducted an intercoder reliability check to ensure the accuracy of the category definitions. To do this, two analysts coded a sample of 15 interviews into the categories. A methodologist compared the analyses to determine where inconsistencies occurred and, as a result, what categories needed more specific definitions.

Once the category definitions were finalized, the same two analysts divided the categories among them and coded their categories for all of the interview documents. When the coding was completed, both analysts reviewed every code made by the other analyst and indicated whether they agreed or disagreed with the code. Changes were then made accordingly. We subsequently analyzed the interviewees' responses based on the defined categories. This analysis allowed us to quantify interviewees' responses within each category.

Appendix II: Comments from the Department of Defense



PERSONNEL AND
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

MAR 04 2011

Mr. Randall Williamson
Director, Health Care,
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO 11-250, "DOD AND VA CARE HEALTHCARE: Federal Recovery Coordination Program Continues to Expand, but Faces Significant Challenges," dated February 2, 2011 (GAO Code 290804).

While there were no specific recommendations with regards to DoD, GAO requested that comments be provided. The following comments are provided by the Department: DoD and VA continue to work together to fully integrate their efforts and to increase collaboration between the two departments. To that end, a Joint DoD/VA Committee has been formed to study how to combine or integrate recovery care coordination efforts for wounded, ill, and injured Service members, Veterans and their families.

The Department appreciates the opportunity to review and comment on the draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "John R. Campbell", with a long horizontal flourish extending to the right.

John R. Campbell
Deputy Assistant Secretary of Defense for
Wounded Warrior Care and Transition Policy

Appendix III: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420
March 7, 2011

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "***DOD AND VA HEALTH CARE: Federal Recovery Coordination Program Continues to Expand, but Faces Significant Challenges***" (GAO-11-250) and generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's recommendations and provides additional and technical comments to the report. VA appreciates the opportunity to comment on your draft report.

Sincerely,


John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*DOD AND VA HEALTH CARE: Federal Recovery Coordination Program (FRCP)
Continues to Expand, but Faces Significant Challenges*
(GAO-11-250)

GAO Recommendation: We recommend that the Secretary of VA direct the Executive Director of the FRC to take four actions:

Recommendation 1: ensure that referred servicemembers and veterans who need FRC services are enrolled in the program by establishing adequate internal controls regarding the FRCs' enrollment decisions. To accomplish this, the FRCP leadership should:

- Require FRCs to record in the Veteran's Tracking Application the factors they consider in making an enrollment decision; and
- Develop and implement a methodology and protocol for assessing the appropriateness of enrollment decisions; and
- Refine the methodology as needed.

VA Response: Concur. As pointed out by GAO, evaluation of potential FRCP clients is based on an assessment of the individual's medical and non-medical needs and requirements in order to recover, rehabilitate, and reintegrate to the maximum extent possible. A key feature of this process is the clinical experience of the FRCs and their clinical judgment of whether or not an individual would benefit from care coordination. While many of these decisions are discussed routinely with management, improved documentation of the decision factors is required. FRCP will establish clear documentation requirements, according to a defined protocol, within the program's data management system as a permanent solution. The defined protocol will be developed in concert with the service intensity measurement tool (GAO Recommendation 2 below). In the short-term, the program will implement an immediate requirement that all FRCs discuss each enrollment decision with management.

It is the highest priority of FRCP to ensure that all severely wounded, ill and injured Servicemembers and Veterans who would benefit from care coordination are enrolled. While the program will ensure that adequate internal controls exist for enrolling individuals into FRCP, the program cannot ensure that all potentially eligible individuals are referred to FRCP. FRCP, as currently structured, is a voluntary referral program and, as such, relies on the identification and referral of those who might benefit from FRCP services by others (case managers, Command, Wounded Warrior Programs, etc.). The terms "catastrophic" and "severely", often used to describe the wounded, ill or injured population who should be referred to FRCP, are administrative in nature and whose meaning is left to interpretation. To date, the program has relied on outreach activities and demonstrated outcomes to inform the referral process.

1

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*DOD AND VA HEALTH CARE: Federal Recovery Coordination Program (FRCP)
Continues to Expand, but Faces Significant Challenges*
(GAO-11-250)

Recommendation 2: complete development of its workload assessment tool that will enable the program to assess the complexity of services needed by enrollees and the amount of time required to provide services to improve the management of FRCs' caseloads.

VA Response: Concur. Determining the right caseload for each FRC is a strategic goal for FRCP. Because care coordination is a relatively new concept, particularly as implemented across and within Federal agencies, no clear guidelines or intensity measurement tools exist to accurately determine caseloads. This is a labor intensive task that requires tool development and testing, along with validity and reliability assessments. FRCP is in the process of field testing a new service intensity measurement tool that will likely need refinement and additional testing. We believe that this iterative process will require at least a year to complete.

Recommendation 3: clearly define and document the FRCP's decision-making process for determining when and how many FRCs VA should hire to ensure that subsequent FRCP leadership can understand the methods currently used to make hiring decision.

VA Response: Concur. FRCP will more clearly document the current process used for staffing decisions. The process will be revised when the service intensity measurement tool is in place. Staffing processes and plans will be updated annually in the FRCP business operation planning document.

Recommendation 4: develop and document a clear rationale for the placement of FRCs, which should include a systematic analysis of data, such as referral locations, to ensure that future FRC placement decisions are strategic in providing maximum benefit for the program's population.

VA Response: Concur. FRCP will develop a FRC placement strategy based upon a systematic analysis of data over the next six months. This process will be documented and updated annually in the FRCP business operation planning document.

Additional Comment:

Since the time of this report, significant progress has been made toward a live exchange of data between VA and DoD wounded warrior information systems as part of the Information Sharing Initiative. Leveraging existing VA-DoD data exchange mechanisms, it is anticipated that an initial set of data around the case/care managers assigned to an individual Servicemember or Veteran will be available for exchange by

2

Enclosure

**Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
*DOD AND VA HEALTH CARE: Federal Recovery Coordination Program (FRCP)
Continues to Expand, but Faces Significant Challenges*
(GAO-11-250)**

the end of Fiscal 2011. It is anticipated that this mechanism will provide the ability to accommodate IT systems that are not directly compatible. Additional data to support improved collaboration on care plans is planned for exchange in Fiscal 2012.

3

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Susannah Bloch; Frederick Caison; Elizabeth Conklin; Cynthia Gilbert; Deitra Lee; Lisa Motley; Kristina Martin; Steven Putansu; and Suzanne Worth made key contributions to this report.

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