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# DOD AND VA HEALTH CARE

# Action Needed to Strengthen Integration across Care Coordination and Case Management Programs

Statement of Debra A. Draper
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October 6, 2011

# DOD AND VA HEALTH CARE

## Action Needed to Strengthen Integration across Care Coordination and Case Management Programs

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Highlights

Highlights of GAO-12-129T, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

### Why GAO Did This Study

In a May 2011 testimony before this subcommittee (GAO-11-572T), based on a March 2011 report (GAO-11-250), GAO highlighted challenges for the Federal Recovery Coordination Program (FRCP), developed by the Departments of Defense (DOD) and Veterans Affairs (VA) to assist some of the most severely wounded, ill, and injured servicemembers, veterans, and their families. Specifically, GAO reported on challenges in FRCP enrollment, staffing needs, caseloads, and placement locations. GAO also cited challenges faced by the FRCP when coordinating with other VA and DOD programs, including DOD's Recovery Coordination Program (RCP), which can result in duplication of effort and enrollee confusion.

In this statement, GAO examines the status of DOD and VA's efforts to (1) implement GAO's March 2011 recommendations and (2) identify and analyze potential options to functionally integrate the FRCP and RCP. This statement is based on GAO's March 2011 report and updated information obtained in September 2011.

### What GAO Recommends

We recommend that the Secretaries of DOD and VA direct the Senior Oversight Committee to expeditiously develop and implement a plan to strengthen functional integration across all DOD and VA care coordination and case management programs, including the FRCP and RCP, to reduce redundancy and overlap. We obtained oral comments on the content of this statement from both DOD and VA officials, and we incorporated their comments as appropriate.

View GAO-12-129T. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

### What GAO Found

VA has made progress addressing each of the recommendations from GAO's March 2011 report on program management issues related to enrollment decisions, caseloads, and program staffing needs and placement decisions for the Federal Recovery Coordinators (FRC) the FRCP uses to coordinate care. These recommendations were directed to the Secretary of VA because VA maintains administrative control of the program, and DOD and VA were asked to provide a response to this subcommittee about how the departments could jointly implement these recommendations. DOD has provided limited assistance to VA with the implementation of GAO's recommendation about enrollment through an e-mail communication about referrals to the FRCP to the commanders of the military services' wounded warrior programs. Despite this effort, however, VA officials stated that they have not noticed any change in referral numbers or patterns from DOD since the e-mail was sent.

DOD and VA have made little progress reaching agreement on options to better integrate the FRCP and RCP, although they have made a number of attempts to address this issue. Most recently, DOD and VA experienced difficulty jointly providing potential options for integrating these programs in response to this subcommittee's May 26, 2011, request to the deputy secretaries, who co-chair the DOD and VA Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee). On September 12, 2011—almost 3 months after the subcommittee requested a response—the co-chairs of the Senior Oversight Committee issued a joint letter that stated that the departments are considering several options to maximize care coordination resources. However, these options have not been finalized and were not specifically identified or outlined in the letter. The two departments have made prior attempts to jointly develop options for improved collaboration and potential integration of the FRCP and RCP, but despite the identification of various options, no final decisions to revamp, merge, or eliminate programs have been agreed upon. This lack of progress illustrates DOD's and VA's continued difficulty in collaborating to resolve duplication and overlap between care coordination programs. Furthermore, as we have previously reported, there are numerous programs in addition to the FRCP and RCP that provide similar services to recovering servicemembers and veterans—many of whom are enrolled in more than one program and therefore have multiple care coordinators and case managers. We found that inadequate information exchange and poor coordination between these programs has resulted in not only redundancy, but confusion and frustration for enrollees, particularly when care coordinators and case managers duplicate or contradict one another's efforts. Consequently, the intended purpose of these programs—to better manage and facilitate care and services—may actually have the opposite effect.

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

I am pleased to be here today as you discuss the actions taken by the Departments of Defense (DOD) and Veterans Affairs (VA) to address issues of concern that were raised during your May 13, 2011, hearing on the Federal Recovery Coordination Program (FRCP). Our statement for that hearing,[1] based on our March 2011 report,[2] outlined several implementation issues for the FRCP, which was jointly implemented by DOD and VA to assist some of the most severely wounded, ill, and injured servicemembers, veterans, and their families with access to care, services, and benefits. Specifically, we reported on challenges faced by FRCP leadership when identifying potentially eligible individuals for program enrollment and determining staffing needs and placement locations. We also cited challenges faced by the FRCP when coordinating with other VA and DOD care coordination[3] and case management[4] programs that support wounded servicemembers, veterans, and their families, including DOD's Recovery Coordination Program (RCP). Specifically, we reported that poor coordination among these programs can result in duplication of effort and enrollee confusion because these programs often provide similar services and individuals may be enrolled in more than one program.

Based on the concerns raised during the May 2011 hearing, your subcommittee requested that DOD and VA provide a detailed response on how they plan to jointly implement the recommendations to improve

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

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

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

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

FRCP management that were outlined in our report. You also requested that the two departments analyze potential options for integrating the FRCP and RCP under a single administrative umbrella to reduce redundancy and to better fulfill the goal of establishing a seamless transition for wounded servicemembers and their families. Although a response was requested by June 20, 2011, the departments had not responded by September 2, 2011, when this subcommittee announced that it intended to hold an oversight hearing on continuing concerns about the care coordination issues of the FRCP and RCP.

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

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

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

reasonable basis for our findings and conclusions based on our audit objectives.

## Background

The FRCP was jointly developed by DOD and VA following critical media reports of deficiencies in the provision and coordination of outpatient services at Walter Reed Army Medical Center. It was established to assist severely wounded, ill, and injured Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) servicemembers,[5] veterans, and their families with access to care, services, and benefits provided through DOD, VA, other federal agencies, states, and the private sector. The FRCP is intended to serve individuals who are highly unlikely to return to active duty and most likely will be separated from the military, including those who have suffered traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairment, and post-traumatic stress disorder. From January 2008—when FRCP enrollment began—to September 12, 2011, the FRCP has provided services to a total of 1,827 servicemembers and veterans;[6] of these, 777 are currently active enrollees.[7]

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

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

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

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

program was jointly created by DOD and VA, it is administered by VA, and FRCs are VA employees.

Separately, the RCP was established in response to the National Defense Authorization Act for Fiscal Year 2008 to improve the care, management, and transition of recovering servicemembers. It is a DOD-specific program that uses Recovery Care Coordinators (RCC) to provide nonclinical care coordination to both seriously and severely wounded, ill, and injured servicemembers. Servicemembers who are severely wounded, ill, and injured and who will most likely be medically separated from the military, also are to be assigned an FRC. While the program is centrally coordinated by DOD's Office of Wounded Warrior Care and Transition Policy, it has been implemented separately by each of the military services, which have integrated RCCs[8] within their existing wounded warrior programs.[9] According to DOD's Office of Wounded Warrior Care and Transition Policy, in September 2011, there were 162 RCCs and over 170 Army Advocates[10] who worked in more than 100 locations, including military treatment facilities and VA medical centers. As of September 2011, these RCCs have assisted approximately 14,000 recovering servicemembers and their families and sometimes continue this assistance for those servicemembers who separate from active duty.[11]

The FRCP and RCP are two of at least a dozen DOD and VA programs that provide care coordination and case management services to recovering servicemembers, veterans, and their families, as we have previously reported.[12] Although these programs may vary in terms of the

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

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

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

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

[12]GAO-11-250.

severity of injuries or illnesses among the population they serve, or in the types of services they provide, many, including the FRCP and RCP, provide similar services. (See table 1.)

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

| Program | Severity of enrollees' injuries[a] | Title of care coordinator or case manager | Type of services provided | | |
|---|---|---|---|---|---|
| | | | Clinical | Nonclinical | Recovery plan |
| VA/DOD Federal Recovery Coordination Program (FRCP) | Severe | Federal Recovery Coordinator (FRC) | √ | √ | √ |
| DOD Recovery Coordination Program (RCP) | Serious | Recovery Care Coordinator | | √ | √ |
| Army Warrior Transition Units | Serious to severe | Nurse case manager, squad leader, physician (one of each is assigned) | √ | √ | √ |
| 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] | √ | √ | √ |
| 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 | √ | √ | √ |

Source: GAO analysis of DOD and VA program information.

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

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

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

[c]An FRC placed at the Special Operations Command's Care Coalition headquarters coordinates clinical and nonclinical care for Care Coalition and other FRCP enrollees.

[d]OEF/OIF refers to Operation Enduring Freedom and Operation Iraqi Freedom, respectively. Since September 1, 2010, OIF is referred to as Operation New Dawn.

[e]An OEF/OIF care manager supervises the case managers and transition patient advocates and may also maintain a caseload of wounded veterans.

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

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

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

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

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

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

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

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

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

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

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

On September 12, 2011, the co-chairs of the Senior Oversight Committee issued a joint letter that stated that the departments are considering several options to maximize care coordination resources. However, these options have not been finalized and were not specifically identified or outlined in the letter. According to DOD and VA officials, the development of this response involved a back-and-forth between the departments because of disagreement over its contents. Although officials of both departments collaborated on the development of the letter, changes were made during the review process that resulted in the delay of its release to the subcommittee. According to DOD and VA officials, after VA had signed the letter and sent it to DOD for review and signature, DOD officials unilaterally modified the wording, to which VA officials objected. Officials from both departments told us that the resulting impasse caused considerable delay in finalizing the letter and was resolved only after DOD agreed to withdraw its changes. Issuance of the letter followed notification by the subcommittee that it would hold a hearing on the FRCP and RCP care coordination issue in September 2011.

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

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

- Beginning in December 2010, the Senior Oversight Committee directed its care management work group[14] to conduct an inventory of DOD and VA case managers and perform a feasibility study of recommendations on the governance, roles, and mission of DOD and VA care coordination. According to DOD and VA officials, this information was requested for the purpose of formulating options for improving DOD and VA care coordination. DOD officials stated that following compilation of this information, no action was taken by the committee, and care coordination was subsequently removed from the Senior Oversight Committee's agenda as other issues, such as budget reductions, were given higher priority. Recently, care coordination has again been placed on the committee's agenda for a meeting scheduled in October 2011.

- In March 2011, the DOD Office of Wounded Warrior Care and Transition Policy sponsored a summit that included a review of DOD and VA care coordination issues. This effort resulted in the development of five recommendations to improve collaboration between the FRCP and RCP, including a more standardized methodology for making referrals to the FRCP, and two recommendations to redefine the FRCP and the RCP. However, there was no joint response to these recommendations and no agreement appears to have been reached to jointly implement them. Although DOD officials contend that they have taken action on many of these recommendations within DOD's care coordination program, VA maintains that no substantive action has been taken to jointly implement them. The degree of disagreement that exists between DOD and VA on implementing these recommendations may be illustrated by the continued disagreement between the departments about when the FRC should engage with a seriously wounded, ill, and injured servicemember. In discussing one of the outcomes of this coordination summit, DOD officials asserted that the FRCP should become engaged with the servicemember during rehabilitation after medical treatment has been finished. In contrast, VA maintains that the point of engagement should be in the early stage of medical treatment to build rapport and trust with their clients and their clients' families throughout their course of care.

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

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

The lack of progress to date in reaching agreement on options to better integrate the FRCP and the RCP illustrates DOD's and VA's continued difficulty in collaborating to resolve care coordination program duplication and overlap. We currently have work underway to further study this issue and identify the key impediments that continue to affect recovering servicemembers and veterans during the course of their care. Additionally, as we have previously reported, there are numerous programs in addition to the FRCP and RCP that provide similar services to recovering servicemembers and veterans—many of whom are enrolled in more than one program and therefore have multiple care coordinators and case managers. For example, as of September 12, 2011, 75 percent of active FRCP enrollees also were enrolled in DOD's wounded warrior programs. According to one FRC, his enrollees have, on average, eight case managers who are affiliated with different programs. We found that inadequate information exchange and poor coordination between these programs has resulted in not only redundancy, but confusion and frustration for enrollees, particularly when care coordinators and case managers duplicate or contradict one another's efforts. For example, an FRC told us that in one instance there were five case managers working on the same life insurance issue for an individual. In another example, an FRC and RCC were not aware the other was involved in coordinating care for the same servicemember and had unknowingly established conflicting recovery goals for this individual. In this case, a servicemember with multiple amputations was advised by his FRC to separate from the military in order to receive needed services from VA, whereas his RCC set a goal of remaining on active duty. These conflicting goals caused considerable confusion for this servicemember and his family.

## Conclusions

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

## Recommendation for Executive Action

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

## Agency Comments

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

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

## GAO Contact and Staff Acknowledgments

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

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